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Assessing psychotherapy outcomes: criteria, indicators, and implications illustrated through solution-focused brief therapy

Ocena efektów psychoterapii: kryteria, wskaźniki i implikacje na przykładzie terapii krótkoterminowej skoncentrowanej na rozwiązaniu

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Abstract

Introduction and objective: This article aims to examine how psychotherapeutic approaches that diverge from traditional theories of change and emphasise non-pathological indicators of effectiveness, such as solution-focused brief therapy, can gain wide recognition within mental health care. **Materials and methods:** For this purpose, indicators and criteria of effectiveness proposed within mainstream therapeutic approaches are contrasted with a model whose theory of change and clinical practice depart from traditional frameworks. Solution-focused brief therapy was used as an illustrative example, given the dominant position it has achieved in Finland following its inclusion in the public health system. This approach is grounded in clinical observation and informed by a theory rooted in social constructionism. **Results:** Solution-focused brief therapy demonstrated effectiveness both through client-centred measures and classical indicators of efficacy. Nevertheless, the approach encountered various challenges on its path to wider recognition. The promoted indicators of effectiveness vary from those of the medical model by prioritising clients' feedback related to progress towards goals and personal strengths instead of pathology. However, it cannot be assumed that similar alignment will characterise other emerging therapeutic modalities. This raises critical questions about whether legislation and policymakers should continue to privilege established frameworks or instead create more flexible pathways for evaluating and adopting new treatments. **Conclusions:** Arguments for a balanced perspective that values rigorous evidence while also fostering openness to innovation and diversity were put forward in order to encourage continuous development of psychotherapy to better respond to the evolving needs of clients.

Keywords: common mental disorders, empirically supported treatment, efficacy, indicators of effectiveness, solution-focused brief therapy

Streszczenie

Wprowadzenie i cel: Celem artykułu było omówienie, w jaki sposób podejścia psychoterapeutyczne odbiegające od tradycyjnych teorii zmiany i akcentujące niepatologiczne wskaźniki skuteczności, takie jak terapia krótkoterminowa skoncentrowana na rozwiązaniu, mogą zyskać uznanie w opiece zdrowia psychicznego. **Materiał i metody:** Wskaźniki i kryteria skuteczności zaproponowane zgodnie z głównymi podejściami terapeutycznymi zestawiono z modelem opartym na teorii zmiany i praktyce odbiegającej od tradycyjnych rozwiązań. Jako przykład wykorzystano terapię krótkoterminową skoncentrowaną na rozwiązaniu, biorąc pod uwagę dominującą pozycję, jaką osiągnęła ona w Finlandii po uznaniu jej w systemie zdrowia publicznego. Podejście to jest zakorzenione w obserwacji klinicznej, a jego teoria wywodzi się z konstruktywizmu społecznego. **Wyniki:** Skuteczność terapii krótkoterminowej skoncentrowanej na rozwiązaniu można wykazać zarówno poprzez wskaźniki uwzględniające perspektywę klienta, jak i poprzez klasyczne wskaźniki skuteczności. Na drodze do uznania napotkała ona jednak różne wyzwania. Promowane wskaźniki skuteczności różnią się od modelu

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medycznego, kładąc nacisk na opinie klientów dotyczące postępów w realizacji celów i osobistych mocnych stron, a nie na patologię. Nie można jednak zakładać, że podobna zgodność będzie charakterystyczna dla innych nowych modalności terapeutycznych. Rodzi to pytania, czy ustawodawstwo i polityka zdrowotna powinny nadal faworyzować klasyczne ramy oceny czy raczej tworzyć elastyczniejsze ścieżki dopuszczania innowacyjnych metod. **Wnioski:** Autorzy postulują perspektywę równoważącą rygor dowodów naukowych z otwartością na innowacje i różnorodność, aby sprzyjać ciągłemu rozwojowi psychoterapii oraz lepiej odpowiadać na zmieniające się potrzeby osób korzystających z pomocy.

Słowa kluczowe: powszechne zaburzenia psychiczne, leczenie potwierdzone empirycznie, skuteczność, wskaźniki skuteczności, terapia krótkoterminowa skoncentrowana na rozwiązaniu

INTRODUCTION

There is an ongoing debate regarding which criteria and indicators should be the basis for assessing empirical evidence and the soundness of psychotherapeutic approaches recommended in mental health services. Several conceptualisations have been proposed over time, evolving alongside progress in science and knowledge. The most notable are the proposals of the American Psychological Association (APA), whose expert panels have been composed predominantly (Chambless, 1993), or, at times, exclusively (Tolin et al., 2025) of representatives of cognitive behavioural and psychodynamic approaches. Cognitive behavioural therapy (CBT) is more likely to accumulate evidence according to the proposed criteria (Chambless, 1993), and is therefore more often included in evidence-based lists and promoted within publicly funded mental health services. For example, in the United Kingdom, among recommended public treatments for depression and anxiety, CBT accounts for 49.8%, while interpersonal psychotherapy represents only 1.5%, despite the latter showing higher rates of recovery and improvement (National Health Service England, 2025). Public funding in Germany is limited to CBT, psychoanalysis, psychodynamic therapy, and family therapy (Melcop et al., 2019). Nevertheless, in Finland, all mainstream therapies have been surpassed by solution-focused brief therapy (SFBT) following its inclusion in mental health care, and it has maintained a dominant position since 2017 (Selinheimo et al., 2024).

This paper aims to examine how psychotherapeutic approaches that diverge from traditional theories of change and emphasise non-pathological indicators of effectiveness, such as SFBT, can gain wider recognition in mental health care. SFBT is used as an illustrative example to analyse its compatibility with evolving criteria of efficacy and effectiveness, and to identify the key challenges associated with its recognition.

On this basis, recommendations supporting greater openness within the field are highlighted, in contrast to current lists of recommended treatments that tend to become ossified (Chambless, 1993). While recognising that the trajectory of SFBT does not automatically apply to other emerging therapeutic approaches, it may be useful to consider that openness to development should be maintained while ensuring empirical soundness.

In this paper, the term "indicator" refers to psychotherapy outcomes used as measures of efficacy and effectiveness (e.g. symptom reduction, functional improvement, client satisfaction). The terms "criteria" or "methodological standards" refer to research designs or procedural requirements (e.g. randomised controlled trials – RCTs, or treatment manuals). This distinction is important for clarifying how different types of evidence impact the recognition of psychotherapeutic approaches.

CHALLENGES RESULTING FROM DEFINITIONS OF INDICATORS OF EFFICACY AND EFFECTIVENESS IN SFBT VERSUS TRADITIONAL MODELS

SFBT emerged in the early 1980s at the Brief Family Therapy Center in Milwaukee, Wisconsin, through the analysis of thousands of sessions aimed at identifying therapist interventions that facilitate change (Lipchik et al., 2012). This process was inspired by the Mental Research Institute in Palo Alto and was later framed as empirically supported principles of change (ESP) (Rosen and Davison, 2003), which prioritise what is effective in practice rather than what is assumed in theory.

The result was a goal-directed, collaborative therapeutic method that emphasises clients' strengths and resources rather than defining psychopathology or deficits (Korman et al., 2020; Lipchik et al., 2012). Indicators of effectiveness were conceptualised as clients' strengths and their perception of progress towards desired goals, assessed directly by the client. This aligns with the first proposed contemporary definition of psychotherapy (Norcross, 1990), according to which psychotherapy aims to purposefully apply clinical methods based on psychological principles to assist individuals in modifying personal characteristics, including behaviours, cognitions and emotions, in the direction they themselves desire.

A first discrepancy between SFBT and mainstream therapeutic approaches can be observed when considering the latter's reliance on pathology-focused indicators, in line with the APA's stated aim of psychotherapy to diagnose, assess, and treat impairments, disturbances, or deficiencies in emotional reactions, ways of thinking, and behavioural patterns (VandenBos, 2015). These expected outcomes place the professional in the position of determining when the indicators are reached. The promotion of pathology-focused

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indicators aligns with those used in the medical model in the APA's efforts to counteract the pharmacologisation of common mental disorders (Chambless, 1993). Nevertheless, if the definition of the European Association for Psychotherapy (2003) is considered, it becomes evident that the treatment of psychosocial, psychosomatic, or behavioural disturbances or states of suffering serves a broader aim, namely to relieve disturbing attitudes towards change and to promote maturation, development, and health. A similar definition is adopted in Finland, where individuals' ability to solve problems on their own and thus become less reliant on the therapist is considered an expected outcome (Finnish Medical Society Duodecim and the Academy of Finland, 2006). This definition may have facilitated the inclusion of SFBT in Finnish mental health care, in contrast to Germany, where psychotherapy is aimed exclusively at the healing process (Melcop et al., 2019).

Therefore, it becomes clear that adopted definitions lay the groundwork for the inclusion or exclusion of specific psychotherapeutic approaches based on the expected outcomes. When mainstream indicators of effectiveness are pathology-based, an approach should demonstrate its impact on those particular indicators, despite evidence showing that changes in pathology do not necessarily translate into improved functioning (Tolin et al., 2015). Implementing pathology-focused indicators is a challenge for SFBT due to the focus on creating hope within sessions (Franklin et al., 2025).

Recently, the APA proposed a new definition of psychotherapy, with the recommendation that all approaches should first demonstrate their theoretical foundations and alignment with psychological and scientific knowledge, specifically the coherence of their core assumptions about procedures and mechanisms of change and the engagement of cognitive, emotional, behavioural, or interpersonal processes, before considering existing evidence against criteria and indicators of efficacy and effectiveness (Tolin et al., 2025). This raises potential issues when older theoretical concepts are disputed, a process that historically has often resulted in exclusion and marginalisation within psychotherapy since the time of psychoanalysis (Buchanan and Haslam, 2019). Jungian therapy, individual psychology, and relationship therapy all emerged from dissatisfaction with existing psychoanalytic ideas, to name only a few. Only concepts defended through perseverance have a chance to survive, and this remains relevant today, as further examination of SFBT against the APA's new definition of psychotherapy shows.

FITNESS OF SFBT'S MECHANISM OF CHANGE AGAINST THE CURRENT DEFINITION OF PSYCHOTHERAPY

Development grounded in clinical observation and psychological science

In parallel with the practice-based observations described earlier, the Milwaukee team developed a theoretical foundation, grounded in brief therapy assumptions, systemic thinking, social constructionism, Maturana and Varela's theory of cognition, Sullivan's interpersonal theory, and particularly the work of Milton H. Erickson on utilising clients' competencies and small changes (Korman et al., 2020; Lipchik et al., 2012). A further major influence came from Ludwig Wittgenstein's philosophical ideas on language games as a means of creating meaning and realities, which influence individuals' interactions with reality (Korman et al., 2020; Lipchik et al., 2012). SFBT can therefore be situated within postmodern approaches (Franklin et al., 2025). The theory explains what makes therapy effective, rather than creating complex assumptions about the client, as is common in traditional approaches.

The mechanism of change is centred on solution building, which differs from problem solving by focusing on defining realistic goals, envisioning daily life after goal achievement, and analysing progress or existing exceptions. Assessment emphasises skills and resources rather than problems, in line with the assumption that clients have self-actualising potential. Clinical observations show that conversations on these topics foster hope and expectancy of change by identifying realistic, small steps toward solutions, implementable soon after the session in real-life situations (Franklin et al., 2025; Korman et al., 2020).

The core of solution building lies in a co-constructive process in which the therapist actively listens and builds on clients' responses (Franklin et al., 2025). Questions and statements closely follow the client's language, reflecting the social constructionist view that meaning and reality are created through interaction. The therapist helps define the goals and the preferred future, highlights strengths and resources, and uses specific core interventions such as envisioning the preferred future (e.g. through the miracle question), exploring past successes (exception questions), and assessing progress and planning next steps (scaling questions). This promotes realistic actions, hope, and a non-judgmental, collaborative relationship.

Despite its empirical and theoretical grounding, SFBT has encountered several challenges on its path to recognition, most notably difficulties in gaining a voice when challenging old assumptions. For example, SFBT reframed the classical concept of resistance by assuming that clients are always in a collaborative stance and that the therapist's role is to find how best to collaborate with them. This idea took five years and six major revisions before being accepted for publication (de Shazer, 1989).

Engagement of cognitive, emotional, behavioural, or interpersonal processes

The solution-building process engages all components identified in Tolin et al.'s (2025) new definition of psychological treatment. The entire co-construction process, with its focus on clients' language, activates cognitive aspects and has implications for emotional processes by fostering positive

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emotions of hope and expectancy of change (Franklin et al., 2025, 2017). Clients' desired change is co-constructed through interaction with the therapist, with a focus on behavioural and interpersonal aspects relevant to goal formulation, description of the preferred future, and analysis of exceptions and progress (Franklin et al., 2025; Korman et al., 2020; Lipchik et al., 2012). Relationship-focused questions used across core interventions illustrate this engagement: clients are invited to describe what others see – or will see – them doing (Franklin et al., 2025; Lipchik et al., 2012). Sessions usually conclude with observational or behavioural tasks aimed at building self-competence and facilitating change (Franklin et al., 2025; Lipchik et al., 2012), thereby engaging all processes beyond the therapeutic encounter.

EMPIRICAL SUPPORT FOR SFBT'S MECHANISM OF CHANGE AND CORE ELEMENTS

The core interventions of SFBT emerged from clinical observation and have therefore been supported empirically. A meta-analysis of process studies employing microanalysis, significant-event methodology, or qualitative analysis of helpful factors confirmed the effectiveness of the co-construction process and the focus on strengths and resources in producing positive outcomes (Franklin et al., 2017). Better outcomes were observed when core elements were used together (Franklin et al., 2017; Neipp and Beyebach, 2024; Żak and Pękala, 2024), supporting the importance of treatment fidelity. Qualitative interview analyses indicate high client satisfaction with the solution-building, co-constructive process. Clients identified all core interventions as helpful, appreciating therapists' curious and non-judgmental stance, acting as a guide rather than an expert with ready-made solutions (Żak, 2022). The in-session co-construction of between-session changes was associated with perceived progress towards goals (Herrero de Vega and Beyebach, 2004). In line with its assumption of brevity, SFBT has often been associated with fewer sessions needed compared with other known approaches, thereby representing a cost-effective treatment for conditions such as depression and anxiety (Knekt et al., 2020, 2016).

CHALLENGES RESULTING FROM EVER-CHANGING CRITERIA OF EFFICACY AND EFFECTIVENESS

Originating from the need to counter the growing dominance of pharmacotherapy (Chambless, 1993), the first proposed criteria of efficacy were heavily influenced by the medical framework. RCTs became the methodological gold standard (Chambless, 1993), despite clear differences between controlling the characteristics of medication and controlling psychotherapeutic interventions (Tolin et al., 2015). Inspired by CBT practice (Chambless, 1993), a treatment manual was considered a necessary criterion to ensure both standardisation and fidelity, requiring approaches based on moment-by-moment co-construction processes, such as SFBT, to adapt their description of intervention processes. Treatments were categorised as "well-established" or "probably efficacious" based, among other factors, on the number and quality of studies (at least two well-designed RCTs or a large series of single-case studies), while those lacking such evidence were labelled "experimental" (Chambless, 1993). The two former categories were often promoted in publications and recommended lists of interventions, often without sufficient clarification that unlisted approaches should not be regarded as ineffective.

These initial criteria underwent critical scrutiny for their overreliance on RCTs, which are not free from methodological bias and do not reflect the naturalistic conditions in which therapy is typically delivered (Tolin et al., 2015). Additional concerns included the promotion of methodological standards favouring CBT, such as treatment manuals; a strong focus on pathology-related outcomes at the expense of health-related ones (Tolin et al., 2015), and failure to consider relevant contextual factors such as the therapeutic alliance or clients' expectations and engagement (Wampold, 2017). Most importantly, the proposed criteria are inherently arbitrary (Chambless, 1993), which means that recommended lists depend on the standards adopted.

Following these critical voices, the APA proposed revised criteria (APA Presidential Task Force on Evidence-Based Practice, 2006), placing greater emphasis on systematic reviews assessing the methodological quality of studies instead of separate RCTs, and also considering findings from non-randomised studies of interventions performed in naturalistic settings, and accounting for health-related outcomes, although still at a secondary level and with comparatively lower attention in research. The current trend favours umbrella reviews, which synthesise evidence across systematic reviews and their included primary studies. These newer criteria require a sufficient number of well-conducted studies meeting systematic-review standards, followed by several systematic reviews to enable an overarching analysis. This creates a vicious circle: a treatment must first be included in mental health care in order for its efficacy to be researched. This is particularly problematic given that well-designed RCTs are typically conducted in academic/hospital settings.

SFBT initially accumulated RCTs in non-psychiatric settings (Gingerich and Peterson, 2012), showing consistent benefits and no evidence of harm (Gingerich and Peterson, 2012; Neipp and Beyebach, 2024). Its inclusion in Finish mental health care enabled the examination of efficacy in a large RCT including over 300 participants followed over a 10-year period. Results showed that 12 SFBT sessions yielded outcomes comparable to 20 short-term or approximately 240 long-term psychodynamic sessions (Knekt et al., 2020, 2016). Long-term psychodynamic therapy yielded only small, though longer-lasting, additional symptom gains at 10 years, with no differences in personality or

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social functioning compared with SFBT (Knekt et al., 2016). Notably, only SFBT was delivered using a treatment manual (Knekt et al., 2016), in line with APA-promoted criteria. A recent umbrella review of SFBT found high confidence in its effectiveness for adult depression and overall mental health, moderate confidence across different outcomes and age groups, and no consistent evidence of harm (Żak and Pękala, 2024).

The new APA proposal continues to follow the developments from the medical model, which itself has undergone a revision. Psychiatry is changing from expert-driven to patient-driven care, recognising that even pharmacological treatment needs to be individualised and that diagnostic approaches require reconsideration (Stein et al., 2022). Expert-driven indicators of effectiveness are based on a treatment's impact on pre-defined symptoms and diagnoses, without accounting for patients' goals for therapy, with potential unfavourable impact on treatment engagement, adherence, and outcomes (Laska et al., 2014). This has also been confirmed by research on SFBT, where lack of progress towards clients' goals within the first three sessions predicted therapy drop-out (Herrero de Vega and Beyebach, 2004), indicating that early small improvements influence future engagement in the therapeutic process. This may explain the lower drop-out rates in SFBT compared with other therapeutic approaches (Knekt et al., 2016).

In the attempt to de-medicalise psychotherapy, client-centred indicators of therapeutic effectiveness, such as satisfaction with treatment or perceived progress towards individual goals have been proposed, grounded in ecological validity and clinical applicability, accounting for idiographic and contextual factors. Among these most notable contributions are practice-based evidence (PBE) (Barkham and Mellor-Clark, 2003), empirically supported principles of change (ESP) (Rosen and Davison, 2003), and feedback-informed treatment (FIT) (Lambert et al., 2003). PBE suggests that aggregating data from routine clinical practice provides a richer and more context-sensitive picture of effectiveness than classical efficacy trials. ESP advocates returning to the origins of psychotherapy research by focusing on process-outcome studies to identify and select only those intervention components relevant to change. FIT is based on collecting clients' feedback throughout the session and adjusting the intervention accordingly.

These alternative perspectives do not reject the importance of empirical support; rather, they call for a broader and more nuanced definition of what constitutes valid and useful evidence in clinical practice. They focus on empirical proof and soundness of the mechanisms of change while moving beyond changes in pathology-focused indicators. They consider real-world effectiveness and clients' voices, thus creating an environment open to development grounded in empirical evidence, rather than one centred on creating lists of arbitrarily defined criteria based on current knowledge, which later requires effort to incorporate emerging evidence.

IMPLICATIONS FOR MAINTAINING OPENNESS IN DEVELOPMENT WHILE DEFINING INDICATORS OF EFFECTIVENESS AND EFFICACY

The present examination of indicators and criteria of effectiveness shows that all proposed indicators are anchored in specific theoretical models (e.g. medical or non-medical) (Chambless, 1993; Wampold, 2017), and thus impact what is included or excluded when creating recommendation lists (Tolin et al., 2025). This poses a challenge for emerging approaches, especially when their theories of change diverge from the mainstream, as in the case of SFBT (de Shazer, 1989). Nevertheless, the Finnish example shows the potential to enrich available support within mental health care (Selinheimo et al., 2024) through openness to empirically testing promising approaches against established ones (Knekt et al., 2020, 2016).

Both development and defining indicators of effectiveness are important in psychotherapy, and neither should be compromised for the sake of the other. Development may be hindered if established criteria are treated as universally valid without acknowledging their subjective and theory-bound nature (Lambert et al., 2003; Wampold, 2017). The relevance of indicators and criteria of effectiveness should move beyond merely ensuring that treatments achieve their intended outcomes (Chambless, 1993; Tolin et al., 2015). They should also serve as a guide for development by highlighting what needs further examination and refinement, rather than functioning as instruments of exclusion. When ongoing development suggests that other indicators or criteria are more suitable, existing ones should be adapted rather than rigidly enforced using a Procrustean approach.

Assessment criteria in psychotherapy are embedded within an ever-changing context: societies evolve and implicitly the beneficiaries of psychotherapy change. New scientific evidence is published daily, while clinical practices and societal expectations constantly reshape what is considered valid and reliable evidence of effectiveness. This is reflected in constant updates to definitions and sets of criteria (APA Presidential Task Force on Evidence-Based Practice, 2006; Tolin et al., 2024). Such dynamics imply a need for continual openness to revisiting current theories and practices.

To maintain openness towards emerging approaches while ensuring methodological soundness in the context of the current practice involving lists of recommended treatments for specific issues, several steps may be proposed to balance methodological rigour with the need for development:

- Any proposed set of indicators should be flexible and open to revision in light of new advancements and emerging evidence.
- When defining indicators, it is crucial to include representatives of diverse theoretical orientations beyond the main approaches – cognitive behavioural, psychodynamic, systemic, humanistic-experiential, and integrative –

to ensure genuine diversity in thinking and practice. This prevents dominance by a single mainstream group that might exclude others based on divergent theoretical views, while giving voice to the range of modalities included under main approaches.

- Priority should be given to empirical evidence, and theoretical frameworks should undergo continuous updating, instead of applying a Procrustean method to eliminate elements that do not fit existing theory.
- Recommendation lists of valid treatments should transparently present information about the affiliations of the commissions responsible and the methodological standards taken into account, including potential biases.
- Proposed lists should publicly state that they include only empirically examined treatments and recognise that "all others are not yet examined", in line with the state of fact (Chambless, 1993; Tolin et al., 2025), to avoid the misconception that unlisted approaches are invalid.
- Health care systems should allow the controlled admission and testing of promising approaches in comparison with existing ones and make recommendations based on empirical findings.
- Policy frameworks should encourage funding mechanisms that allocate resources not only to mainstream approaches but also to rigorous research on innovative practices.
- Continuous professional education should include training on evaluating and critically interpreting indicators, fostering a culture of openness to new methods and emerging evidence.

By embracing these steps, clinical practice and policy can foster a dynamic and inclusive field that balances the need for evidence with openness to ongoing innovation.

CONCLUSIONS

SFBT illustrates how a clinically grounded, feedback-informed approach can move from marginal to empirically supported practice – both through client-centred indicators and by meeting mainstream criteria that have evolved over time. Future innovations may not align as neatly with existing frameworks, raising questions about privileging conformity over innovation. It may therefore be necessary to emphasise the need for flexible indicators and a culture that values established methods while remaining open to rigorously tested, practice-based innovations.

Conflict of interest

The authors do not report any financial or personal connections with other persons or organisations which might negatively affect the content of this publication and/or claim authorship rights to this publication.

Author contribution

Original concept of study; collection, recording and/or compilation of data; analysis and interpretation of data; writing of manuscript; critical review of manuscript; final approval of manuscript: AMŻ, KAP.

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