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RESEARCH ARTICLE

Effectiveness of solution-focused brief therapy: An umbrella review of systematic reviews and meta-analyses

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Abstract

Objective: This umbrella review of systematic reviews and meta-analyses evaluates the effectiveness of Solution-Focused Brief Therapy (SFBT) across various populations and settings.

Method: A total of 25 systematic reviews, including 15 meta-analyses, were analyzed. Reviews were included if they used systematic search methods and quality assessments and focused on the effectiveness of SFBT as a therapeutic approach.

Results: SFBT demonstrated significant positive outcomes across different issues, settings, and cultural contexts, with no evidence of harm. High confidence in evidence of effectiveness was established for depression, overall mental health, and progress towards individual goals for the adult population. In addition, findings indicated mainly moderate confidence in evidence of SFBT effectiveness for a wide variety of outcomes for all age groups. No difference was found in the confidence in the evidence by world region, though Western and Eastern studies researched some different aspects.

Conclusion: SFBT is an effective therapeutic approach for various psychological, social, school, medical, couple, or self-related issues. Further research with rigorous methodologies and comprehensive reporting is needed to strengthen the confidence in these findings and provide evidence for the brevity of the intervention.

Keywords: solution-focused therapy; effectiveness; umbrella review; research synthesis; systematic review

Clinical or Methodological Significance of this Article: This is the first umbrella review of evidence on solution-focused brief therapy (SFBT) effectiveness. It maps the evidence so far on the effectiveness of SFBT across the globe. It also identifies the confidence in findings and shows for which clients and issues SFBT effectiveness is well established and for which more research is needed.

Introduction

Solution-Focused Brief Therapy (SFBT) is a psychotherapeutic approach developed in the 1980s by Steve de Shazer, Insoo Kim Berg, and their colleagues at the Milwaukee Brief Family Therapy Center. Solution-focused therapists use the client's specific language to co-construct solutions based on the description of the preferred future where the current problem stops impacting the client's life

and on analysis of past successes to increase awareness of already existing personal strengths and resources (de Shazer, 1994). SFBT is applied to a wide variety of clients, issues and settings with positive effects after an average of 4–6 sessions (Macdonald, 2011). Since its development, much research has been done and hundreds of articles have been published (Beyebach et al., 2021; J. Kim et al., 2019), followed by an increase in systematic

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reviews (SRs), with or without the use of meta-analysis (MA).

The next logical step in synthesizing current evidence is to conduct an umbrella review to synthesize existing SRs. By comparing and contrasting the evidence from various SRs, an umbrella review has the advantage of showing if consistency in findings is met for the same effectiveness question, indicating also potential sources of discrepancy. The overview accounts for more aspects of effectiveness than is examined in a single SR, thus offering a wider picture. This makes umbrella reviews an additional aid to health-care decision makers (Aromataris et al., 2015; Cant et al., 2022).

We considered the potential of SFBT to be an effective therapy for clients of different age groups in various fields and cultures as indicated by the frequently cited SRs (Gingerich & Eisengart, 2000; J. S. Kim, 2008; Schmit et al., 2016; Stams et al., 2006). The shorter duration compared to alternative treatments makes it a more cost-effective option both for individuals seeking therapy (Gingerich & Peterson, 2012) and the public health system (Medina et al., 2022), SFBT being also associated with lower risk of burnout for practitioners (Medina & Beyebach, 2014). This umbrella review aims to provide a summary of what has already been established, having in mind both practitioners and health care policy makers.

Review Aims

This umbrella review synthesizes the state of evidence on the effectiveness of SFBT across the globe with the aim of finding answers to the following questions: (1) For what types of clients and issues is the effectiveness of SFBT well established? (2) How much reliability do those findings have? and (3) What factors (e.g., therapy format, setting) were found to moderate the effectiveness and could they explain inconsistencies in results? The answers to these questions may help establish the position of SFBT among effective treatments while also directing future research.

Method

Inclusion Criteria

To be included, a review had to (a) use a systematic literature search to ensure a comprehensive view of the studied phenomenon, (b) provide inclusion criteria, (c) employ quality assessment methods even if only set by selected study design, and (d) be performed on outcome studies concerned with the effectiveness of SFBT as a (psycho)therapeutic approach.

No restrictions based on the characteristics of the participants were applied.

We excluded SRs (a) concerned with theoretical models, (b) dealing with non(psycho)therapeutic application (e.g., coaching), (c) evaluating SFBT exclusively as a part of other programs (e.g., DIALOG+), (d) not employing any quality assessment method, or (e) presenting results in an aggregated form with other approaches so that specific effectiveness could not be identified. To provide a global overview, no restrictions were imposed on language, date, or publication status.

Search Strategy

Five electronic databases were searched (i.e., Cochrane Database of Systematic Reviews, ERIC, Europe PubMed Central, PubMed, and World Wide Science) between July and August 2021 by the first author. Because SFBT is defined as an approach, practice, or therapy, the keywords used were simply “solution focused” or “solution-focused,” each paired with “review” or “meta-analysis.” The research lists from the European Brief Therapy Association and Solution-Focused Brief Therapy Association websites were also manually searched alongside the references cited in articles of interest. An alert was set on Google Scholar to identify new publications. The last addition was made in August 2023. No new SR fitting the inclusion criteria has been identified up to April 2024.

Data Collection and Analysis

The answers to the umbrella review questions are based on both the synthesized findings of the SRs and on individual findings of the primary studies (PSs) included in the SRs. The synthesized information from each SR was extracted separately by each author following a mutually agreed-upon framework detailing information on the population (e.g., age, gender, country), intervention (e.g., format, number of sessions), control group (e.g., number of participants, type of control), methodology of PSs (e.g., design, randomization), and main outcomes. All disagreements were discussed and an agreed-upon form was set as a basis for current results.

The individual findings of each PS reported in the SRs was extracted in Excel format by the first author and categorized according to age group (adult vs children and adolescents), outcome category (e.g., effectiveness for internalizing issues) and subcategory (e.g., effectiveness for depression), and type of study, i.e., randomized (RCT) vs non-randomized studies of intervention (NRSI, including non-

randomized control studies, pretest-posttest, and single-case designs). Categories and subcategories were created when a minimum of three PSs examined the same outcome. All data resulted from the SRs; the PSs were not re-examined. If a PS was reported by several SRs, it was included only once to avoid multiple counting. Data from other SRs on the same PSs was added if missing or contrasted if different. Only SRs from which data were extracted were cited by specific category or subcategory. The database thus created was then checked for accuracy against the original data from the SRs by the second author. Following confirmation of accuracy, the first author formulated umbrella review quantitative finding statements based on identified categories, then analyzed and summarized the data for each finding. The results of the analyses were then checked for correctness by the second author.

Quality Assessment

The methodological quality and risk of bias for each SR were assessed using the AMSTAR 2 (Shea et al., 2017) given that all identified SRs included both RCT and NRSI, with three exceptions (Carrick & Randle-Phillips, 2018; Franklin et al., 2023; Zhang et al., 2018). First, each author assessed the SRs independently. Then, assessments were compared and all disagreements were discussed until consensus was reached.

The quality of evidence within SRs was assessed using the Grading of Recommendations, Assessment, Development, and Evaluations at the Level of an Umbrella Review (GRADE-UR) (Antonio et al., 2020). GRADE-UR evaluates confidence in evidence as high (relatively well-studied outcome and further research is unlikely to show different findings), moderate (reasonable representation of the phenomenon), low (understudied or predominance of methodological weaknesses or inconsistent findings), or insufficient (not sufficient credible information). Five criteria were used: limitations (methodological quality of PS), directness (the outcome variable to be measured directly and a direct consequence of the independent variable), consistency (vote counting of different PSs examining the same outcome with the same direction of results; consistency is reached if 65% or more PSs point in the same direction), precision (degree of certainty in the conclusions based on more than 3 PSs and at least 65% of PS reported statistical information), and reporting of bias (if it was assessed by the SR). Two modifications were made. Firstly, the directness was set based only on the measurement used since in (psycho)therapy all outcomes are

under the influence of a multitude of factors (Asay & Lambert, 1999). Secondly, the limitation criterion was renamed the methodological quality of the primary study (MQPS) in line with its assessment in the SRs to avoid confusion, because different criteria for study quality are employed in GRADE. Specifically, the study limitations are set in GRADE by absence of allocation concealment, absence of blinding, especially when outcomes are subjective, no intention to treat analysis, high losses at follow-up, ending early for benefit, and not reporting all outcomes, especially when no effect was found (Guyatt et al., 2008). In turn, all SRs assessed the MQPS based on modified APA criteria for presence of randomization, active control group, well-defined sample selection, large sample size, objective measures, and fidelity of treatment (Gingerich & Eisengart, 2000).

The results were analyzed separately by RCT and NRSI, except when the minimum of three PSs per overview finding was not met. For each finding a total rating for both RCT and NRSI was also computed.

Results

2,080 papers were screened for title and abstract relevancy by the first author. The full-text analysis of the 131 selected papers was separately performed by both authors. The inter-rater agreement coefficient was almost perfect, Cohen's kappa = 0.83 (95%CI, .679 to .974), $SE = .075$. Disagreements were discussed, leading to the selection of 16 SRs fitting the inclusion criteria. Additionally, six SRs were identified through manual search and three new publications were identified after the search period through Google Scholar Alert leading to a total of 25 SRs included in this umbrella review. The screening and selection process is illustrated in Figure 1 in line with the PRISMA guidelines for reporting (Liberati et al., 2009).

Overlap of Review Evidence

The overlap was examined for 22 SRs, because three SRs (Bilgin, 2020; Huoliang & Weisu, 2015; D. Kim et al., 2017) did not provide a list of included PSs. A total of 71 PSs was cited 224 times, representing 51.5% of all citations within the 22 SRs. Among those, 33 PSs were cited in two SRs, 18 PSs in three SRs, eight PSs in four SRs, five PSs in five SRs, three PSs in six SRs, three PSs in seven SRs, and a single PS in eight SRs. The corrected coverage area (CCA) (Pieper et al., 2014) was 24%, indicating a very high overlap. Nevertheless, all SRs were

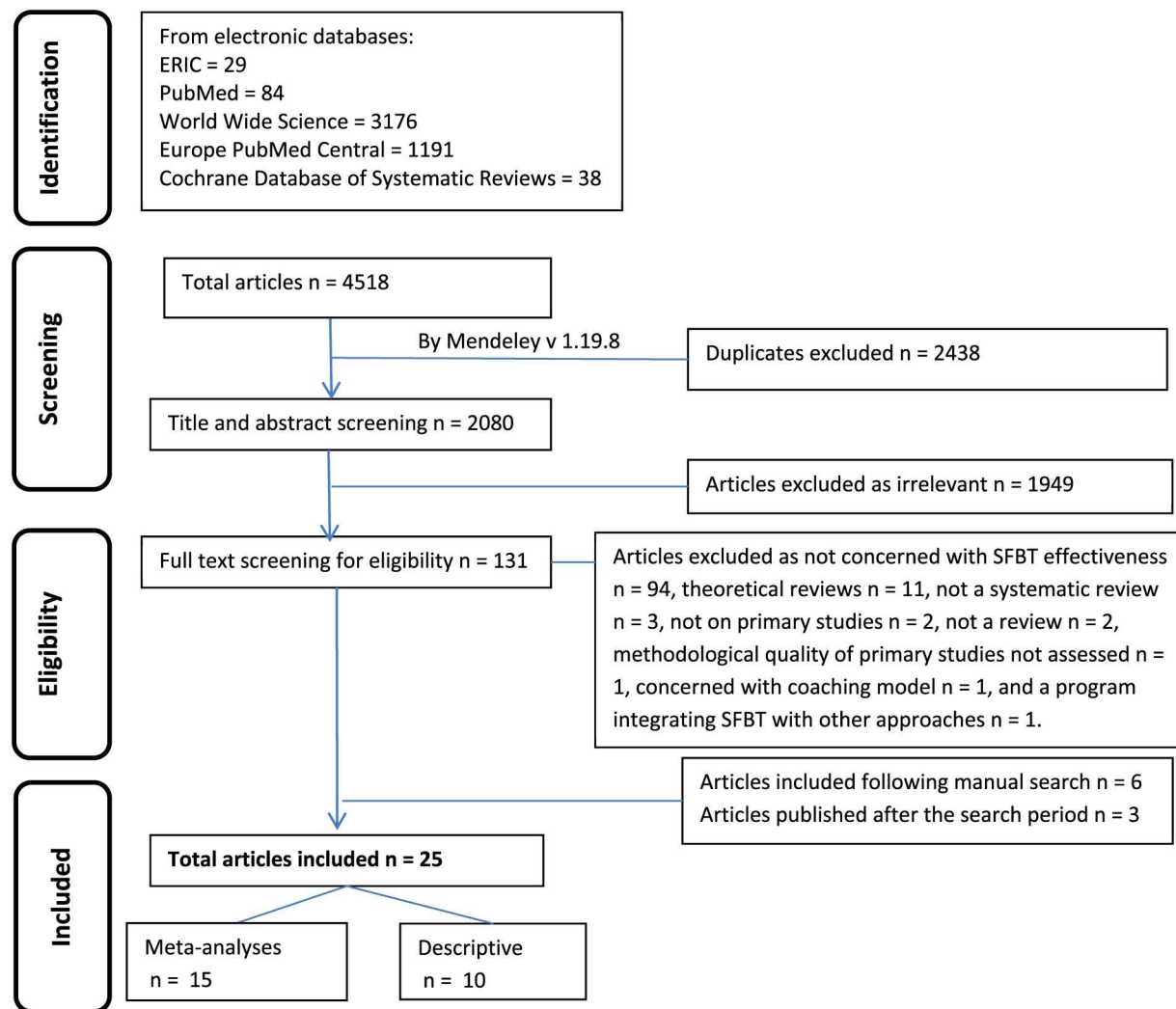


Figure 1. PRISMA flow chart of the literature search and selection process.

considered for analysis as each provided relevant information either for overall results or for specific PSs; deletion of older SRs did not lead to a decrease in overlap. PSs reported in various SRs were counted only once for each umbrella review finding.

Description of Included Reviews

The SRs included in this umbrella review were published between 2000 and 2023 and included PSs from 1987 until 2021. Three SRs included only RCT (Franklin et al., 2023; Zhang et al., 2018) or NRSI (Carrick & Randle-Phillips, 2018). The remaining SRs included all study designs with prevalence for experimental studies. SRs based on Eastern PSs included predominantly or exclusively passive controls, mainly no treatment, while Western-based SRs included mainly active controls, i.e., treatment as usual (TAU) or other therapeutic approach.

Nineteen SRs contained data suitable for quantitative synthesis of specific outcomes while the remaining six had information fit only for overall synthesis.

Quality of included reviews. The AMSTAR 2 scores indicated an overall low (20%) or critically low (80%) confidence in the results of all SRs because each had at least one critical flaw (see Fig. 2). Most SRs used a partial comprehensive-literature search strategy (88%), but failed to list and justify the excluded studies (60%). The risk of bias in PSs was considered when discussing the results (76%), but not a priority at study selection (84%) and was not measured with a satisfactory technique (84%). Among the 15 MAs identified, 11 did not provide separate pooled-effect estimates for randomized and non-randomized studies, yet in seven MAs the Hedge's unbiased estimator was used, and nine MAs examined the publication bias.

Quality Assessment According to AMSTAR-2

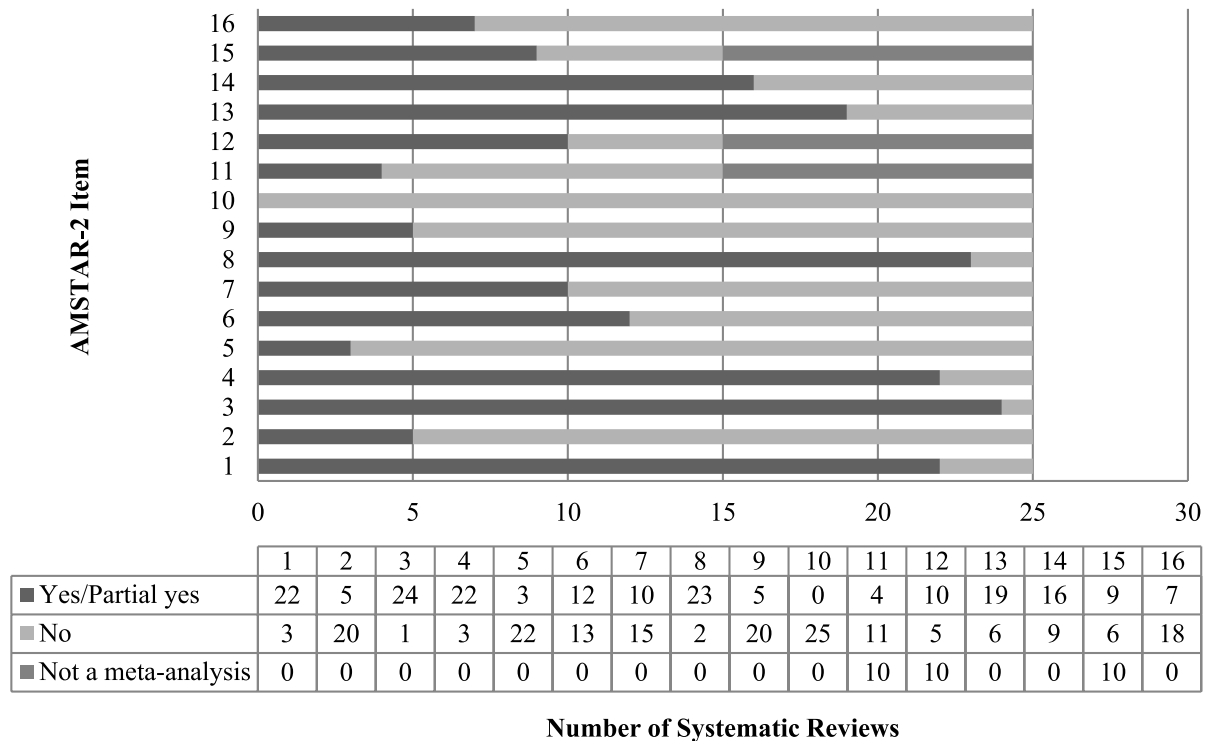


Figure 2. Quality assessment of systematic reviews included in the umbrella review according to AMSTAR-2 tool.

Participants. Most SRs were concerned with children and adolescents (Bond et al., 2013; Hsu et al., 2021; Huoliang & Weisu, 2017; Karababa, 2023; J. S. Kim & Franklin, 2009; Mohammadyari & Hoseinian, 2019; Park, 2014) or overall population (Corcoran & Pillai, 2009; Gingerich & Eisen-gart, 2000; Gingerich & Peterson, 2012; J. S. Kim, 2008; Stams et al., 2006). Single SRs focused on specific population: couples (Mohammadyari & Hoseinian, 2018), trauma survivors (Eads & Lee, 2019), individuals with internalizing disorders (Schmit et al., 2016), substance use (Franklin & Hai, 2021), or intellectual disabilities (Carrick & Randle-Phillips, 2018). Some SRs contained exclusively or predominantly Eastern population from China (Huoliang & Weisu, 2017, 2015; J. S. Kim et al., 2015), Korea (D. Kim et al., 2017; Park, 2014), Iran (Mohammadyari & Hoseinian, 2018, 2019), or Turkey (Bilgin, 2020; Karababa, 2023). Few included both Western and Eastern population (Franklin et al., 2022; Gingerich & Peterson, 2012; Hsu et al., 2021). The remaining 13 SRs were based exclusively on Western population. The school setting was most often examined (Franklin et al., 2022; Huoliang & Weisu, 2017; Karababa, 2023; J. S. Kim & Franklin, 2009; Mohammadyari & Hoseinian, 2019; Park, 2014). The community

(Franklin et al., 2023) and medical (Zhang et al., 2018) setting was examined in single SR. Sample size in PSs ranged from 1 to 760 (Bond et al., 2013).

Intervention. Group therapy format was predominant in all Eastern SRs, in some being the only format examined (Huoliang & Weisu, 2017; Karababa, 2023; D. Kim et al., 2017; Park, 2014) and present also when the SR was concerned with couple therapy (Mohammadyari & Hoseinian, 2018). In Western-based SRs, the group format was present in 42.9% to 64% of PSs (Franklin & Hai, 2021; Gonzalez Suitt et al., 2016; Hsu et al., 2021; J. S. Kim & Franklin, 2009). Otherwise, SFBT was examined also in individual format, couple/family, mixed, or other formats, such as applied in classroom or by telephone.

Outcomes overall. Several MAs were concerned with SFBT effectiveness overall, not accounting for age group or type of outcome. Differences in effect size, methodology, and intervention were observed between Western and Eastern MAs. Namely, a small effect size was found in Western MAs, both overall, $ES = 0.37$ (Stams et al., 2006), and for specific issues such as internalizing, $ES = 0.26$ – 0.31 (Schmit et al.,

Table I. Summary of findings on SFBT effectiveness for adult population.

Category and subcategory of examined issue (SR first author, year)	Strength of evidence, direction (design, no of PSs per study, no of participants total/ receiving SFBT)
SFBT is effective for internalizing issues (Bilgin, 2020; Carrick & Randle-Phillips, 2018; Corcoran & Pillai, 2009; Eads & Lee, 2019; Franklin & Hai, 2021; Gingerich & Eisengart, 2000; Gingerich & Peterson, 2012; Gonzalez Suitt et al., 2016; J. S. Kim, 2008), i.e.,	Moderate, + (all studies) High, + (RCT, 11, 799/ 290 ^a) Moderate, + (NRSI, 11, 672/ 289 ^c)
• depression	Moderate, + (all studies) High, + (RCT, 8, 645/245) Low, + (NRSI, 6, 335/127 ^b)
• anxiety	Moderate, + (RCT, 3, 326/97)
• overall mental health	High, + (all studies) High, + (RCT, 6, 449/147) High, + (NRSI, 5, 226/68 ^a)
SFBT is effective for externalizing issues (Carrick & Randle-Phillips, 2018; Franklin & Hai, 2021; Gingerich & Eisengart, 2000; Gingerich & Peterson, 2012), i.e.,	Moderate, 0 (all studies: RCT, 1, 59/30; NRSI ^x , 9, 497/ 204)
• alcohol related issues	Low, + (NRSI, 4, 157/157)
• challenging behaviors in adults with ID	Low, + (NRSI, 4, 15/15)
SFBT is effective for social issues (Bilgin, 2020; Carrick & Randle-Phillips, 2018; Franklin & Hai, 2021; Gingerich & Peterson, 2012).	Moderate, + (all studies) Moderate, 0 (RCT, 3, 286/ 125 ^a) Moderate, + (NRSI ^x , 3, 125/ 55)
SFBT is effective for self-aspects (Eads & Lee, 2019; Gingerich & Eisengart, 2000; Gingerich & Peterson, 2012), i.e.,	Moderate, + (all studies: RCT, 2, 174/ 87; NRSI, 2, 205/ 123)
• self-esteem	Moderate, + (all studies: RCT, 1, 40/20; NRSI, 2, 205/ 123)
SFBT is effective for medical aspects (Bilgin, 2020; Corcoran & Pillai, 2009; Gingerich & Eisengart, 2000; Gingerich & Peterson, 2012; Gonzalez Suitt et al., 2016), i.e.,	Moderate, + (all studies) Moderate, + (RCT, 6, 578/159 ^a) Moderate, + (NRSI ^x , 3, 148/ 67)
• return to work	Moderate, + (RCT, 3, 161/84)
• adjustment to illness	Moderate, + all studies (RCT, 2, 182/91; NRSI, 1, 12/6)
• coping	Moderate, + all studies (RCT, 2, 78/39; NRSI, 1, 60/30)
SFBT is effective for couple issues (Bilgin, 2020; Corcoran & Pillai, 2009; Gingerich & Eisengart, 2000; Gingerich & Peterson, 2012; Gonzalez Suitt et al., 2016; J. S. Kim, 2008), i.e.,	Moderate, + all studies (RCT, 1, 20/NR ^a ; NRSI, 4, 198/ 114 ^a)
• marital adjustment	Low, + (NRSI 4, 99/57 ^a)
SFBT is effective for parenting or caregiving (Bond et al., 2013; Corcoran & Pillai, 2009; Eads & Lee, 2019; Gingerich & Eisengart, 2000; Gingerich & Peterson, 2012; Huoliang & Weisu, 2017; D. Kim et al., 2017; J. S. Kim, 2008).	Moderate, + (all studies) Moderate, + (RCT, 3, 132/64) Moderate, + (NRSI, 12, 992/453)
SFBT is effective for hope (Bilgin, 2020; Gingerich & Peterson, 2012; D. Kim et al., 2017).	Moderate, + (all studies: RCT, 1, 52/26; NRSI, 3, 119/ 52)
SFBT is effective for individual goals (Corcoran & Pillai, 2009; Gingerich & Eisengart, 2000; Gingerich & Peterson, 2012; Gonzalez Suitt et al., 2016), i.e.,	Low, 0 (NRSI, 7, 624/131 ^c)
• goal attainment	Insufficient, 0 (NRSI, 4, 426/10 ^c)
• progression towards goals	High, + (NRSI, 3 198; 121)

Note. Specific aspects are reported only for outcomes examined in at least 3 PSs. Strength of evidence is reported based on GRADE-UR. Direction is set on confirmation of effectiveness (+) if at least 65% of PS found statistical significance levels or moderate to strong effects, or non-effectiveness (0) if predominant prevalence of findings did not reach statistical significance levels or effect size was small or weak. No PS reporting evidence of harm was found. The distribution of participants in the SFBT group was not reported for ^a = one PS, ^b = two PSs, ^c = three PSs, or NR = overall and not possible to compute. ^xThe methodological quality of the PSs was often not assessed by the SRs and was, thus set by default to moderate.

2016; Zhang et al., 2018), externalizing, ES = 0.13, family and relationship, ES = 0.26 (J. S. Kim, 2008), health-related psychosocial issues, ES = 0.34, health-related behavioral outcomes, ES = 0.28, and functional-health outcomes, ES = 0.21 (Zhang et al., 2018). Effectiveness was examined more often in comparison to active rather than passive controls (Schmit et al., 2016; Stams et al., 2006; Zhang et al., 2018).

Effectiveness was examined using both RCT and NRSI methodology, with one exception (Zhang et al., 2018), where only RCTs were included. When reported, a similar frequency of applying SFBT as individual and group format was observed (Schmit et al., 2016; Stams et al., 2006).

Predominantly Eastern MAs found large effect size overall both at post-test, ES = 0.99–1.26 (Huoliang

& Weisu, 2015; J. S. Kim et al., 2015), and 1–24 weeks follow-up, $ES = 1.07$ (Huoliang & Weisu, 2015). SFBT effectiveness was examined exclusively in group format (Huoliang & Weisu, 2015; D. Kim et al., 2017) compared exclusively (Huoliang & Weisu, 2015) or mainly (J. S. Kim et al., 2015) to passive controls (no treatment) (Huoliang & Weisu, 2015) or not reporting the type of control (D. Kim et al., 2017). MAs were exclusively based on experimental studies not reporting whether randomization was used (Huoliang & Weisu, 2015; D. Kim et al., 2017).

When Western and Eastern PSs using RCTs were taken together, moderate effect size was found overall, $ES = 0.654$, and for specific aspects such as health and wellbeing, $ES = 0.394$, psychosocial, $ES = 0.410$, anxiety, $ES = 0.522$, behavioral and health functioning, $ES = 0.573$, family, $ES = 0.615$, and depression, $ES = 0.652$ (Franklin et al., 2023).

Small (Zhang et al., 2018) to substantial heterogeneity was found in both Western (J. S. Kim, 2008; Schmit et al., 2016; Stams et al., 2006) and Eastern (Huoliang & Weisu, 2015; J. S. Kim et al., 2015) MAs. Publication bias was examined only in Western MAs, indicating no (Franklin et al., 2023; Stams et al., 2006; Zhang et al., 2018) or small (Schmit et al., 2016) risk of bias.

Specific moderators were analyzed. MAs found significantly larger effects when SFBT was compared to passive vs active controls (Stams et al., 2006), applied in group vs individual or other formats (Schmit et al., 2016; Stams et al., 2006), in school vs medical settings (Huoliang & Weisu, 2015), including a majority of core elements vs few selected ones (D. Kim et al., 2017). No significant moderation was found by gender (D. Kim et al., 2017; Stams et al., 2006), socio-economic status, therapist's experience, therapy duration, PS design or publication status (Stams et al., 2006), and number of participants per group (D. Kim et al., 2017). Inconsistencies were found regarding age, ranging from no moderation (Schmit et al., 2016) to better effects for adolescents than adults (D. Kim et al., 2017), respectively for adults than children (Stams et al., 2006). Overall number of sessions was not a significant moderator (Stams et al., 2006), yet group format was more effective when applied in 6–10 vs more sessions (D. Kim et al., 2017). Type of outcome was not a significant moderator in a Eastern MA (D. Kim et al., 2017) while a significantly higher effectiveness was found for externalizing than for relational, psychiatric, or other problems in a predominantly Western MA (Stams et al., 2006).

Effectiveness for adult population. A single MA examined the specific effectiveness of SFBT on an adult population, finding a large effect size for couple therapy in Iran, $ES = 1.1$ (Mohammadyari & Hoseinian, 2018). This finding was reported by the MA authors to be higher than the effectiveness found by other MA for cognitive-behavioral therapy (Mohammadyari & Hoseinian, 2018).

Effectiveness for adult population was examined in 12 SRs (see Table I). Nine categories of findings were identified based on studied outcome: internalizing, externalizing, social, self-aspects, medical, couple, parenting or caregiving, hope, and individual goals. Additionally, twelve subcategories were identified. In general, the population studied was often heterogeneous, originating from all world regions, presenting various characteristics, such as adults with intellectual disabilities, substance use, emotional disorders, child sexual abuse history, with marital problems or long-term unemployed. The intervention was most applied in all formats, individual, group, couple or family, between 1 and 25 sessions, containing between 3 and 8 core elements.

High confidence in the effectiveness of SFBT was found for internalizing issues, specifically for depression and overall mental health based on evidence predominantly from Western countries (Finland, Sweden, USA) (Corcoran & Pillai, 2009; Eads & Lee, 2019; Gingerich & Eisengart, 2000; Gingerich & Peterson, 2012; Gonzalez Suitt et al., 2016). Findings from Eastern PSs indicated moderate confidence in evidence of effectiveness for internalizing issues, and more studies are needed to adequately represent the phenomenon. The reported effect size was larger in Western RCT (Corcoran & Pillai, 2009; Eads & Lee, 2019; Gingerich & Eisengart, 2000; Gingerich & Peterson, 2012) than Eastern NRSI (J. S. Kim, 2008), $ES = 0.76$ – 5.344 vs $ES = 0.23$ – 0.56 . Effectiveness was established mainly in comparison to other therapeutic approaches, such as psychodynamic or cognitive-behavioral therapy in the Western PSs vs no treatment in Eastern PSs. In both world regions, the population examined was heterogeneous, thus increasing the generalizability of the findings, i.e., individuals diagnosed with depression, anxiety, or other clinical disorders, in psychiatric or medical patients (with cancer or musculoskeletal disorders), and also general population such as parents, family members, or adults on long-term unemployment.

High confidence in evidence of effectiveness on progression towards goals was found based on Western NRSI, examined mainly in staff working with individuals with intellectual disabilities compared to TAU (Carrick & Randle-Phillips, 2018).

Table II. Summary of findings on SFBT effectiveness for children and adolescent population.

Category and subcategory of examined issue (SR first author, year)	Strength of evidence, direction (design, no of PSs per study, no of participants total/ receiving SFBT)
SFBT is effective for internalizing issues (Bond et al., 2013; Corcoran & Pillai, 2009; Eads & Lee, 2019; Gingerich & Eisengart, 2000; Gingerich & Peterson, 2012; Huoliang & Weisu, 2017; J. S. Kim, 2008; J. S. Kim & Franklin, 2009; J. S. Kim et al., 2015), i.e.,	Moderate, + (all studies ^x) Moderate, + (RCT ^x , 5, 246/92 ^a) Low, 0 (NRSI, 23; 745/423 ^d)
• depression	Moderate, + (all studies: RCT, 1, 56/28; NRSI, 6, 132/23)
• anxiety	Moderate, + (all studies: RCT, 1, 14/7; NRSI, 2, 72/64)
SFBT is effective for externalizing issues (Bilgin, 2020; Bond et al., 2013; Corcoran & Pillai, 2009; Franklin & Hai, 2021; Gingerich & Eisengart, 2000; Gingerich & Peterson, 2012; Huoliang & Weisu, 2017; J. S. Kim, 2008; Park, 2014), i.e.,	Low, 0 (all studies) Moderate, + (RCT, 4,194/86) Low, 0 (NRSI, 30, 1058/532 ^c)
• aggression	Insufficient, 0 (all studies: RCT, 1, 40/20; NRSI, 4, 188/38 ^a)
• anger management	Low, + (NRSI, 3, 81/37)
SFBT is effective for social issues (Bilgin, 2020; Bond et al., 2013; Franklin & Hai, 2021; Gingerich & Peterson, 2012; Huoliang & Weisu, 2017; J. S. Kim, 2008; J. S. Kim & Franklin, 2009; J. S. Kim et al., 2015), i.e.,	Moderate, + (all studies) Low, + (RCT, 3,180/79) Moderate, + (NRSI ^x , 20,690/405 ^b)
• interpersonal relationships	Low, + (NRSI, 9, 236/118)
SFBT is effective for school issues (Bilgin, 2020; Bond et al., 2013; Franklin & Hai, 2021; Gingerich & Eisengart, 2000; Gingerich & Peterson, 2012; Gonzalez Suitt et al., 2016; Huoliang & Weisu, 2017; Karababa, 2023; D. Kim et al., 2017; J. S. Kim, 2008; J. S. Kim & Franklin, 2009; Park, 2014), i.e.,	Low, 0 (all studies) Moderate, + (RCT; 10,410/98) Low, 0 (NRSI, 25,772/ 450)
• adaptation to school life	Moderate, + (NRSI, 6, 96/41 ^a)
• exam anxiety	Moderate, + (all studies: RCT, 3, 111/55; NRSI, 1, 59/29)
• academic motivation	Moderate, + (NRSI, 3, 66/26)
• academic achievement	Moderate, 0 (all studies) Moderate, 0 (RCT, 3, 154/1 ^b) Moderate, 0 (NRSI, 4, 200/94)
• school attendance	Moderate, 0 (all studies: RCT, 2, 111/19 ^a ; NRSI, 3, 156/72 ^a)
SFBT is effective for self-aspects (Bilgin, 2020; Bond et al., 2013; Corcoran & Pillai, 2009; Franklin & Hai, 2021; Gingerich & Eisengart, 2000; Gingerich & Peterson, 2012; Gonzalez Suitt et al., 2016; Huoliang & Weisu, 2017; J. S. Kim, 2008; J. S. Kim et al., 2015; Park, 2014), i.e.,	Moderate, + (all studies) Low, 0 (RCT, 4, 430/ 60 ^a) Moderate, + (NRSI, 37, 1299/554 ^a)
• self-esteem	Moderate, + (all studies) Low, 0 (RCT, 4, 430/ 60 ^a) Moderate, + (NRSI, 15, 335/160)
• self-efficacy	Moderate, + (NRSI ^x , 8, 388/200)
• career self-efficacy	Moderate, + (NRSI ^x , 5, 278/45 ^a)
• self-concept	Low, 0 (NRSI, 4, 159/49 ^a)
SFBT is effective for medical aspects (Bilgin, 2020; Bond et al., 2013; Gingerich & Peterson, 2012).	Moderate, + (NRSI, 9, 276/172)
SFBT is effective for coping aspects (Bond et al., 2013; Franklin & Hai, 2021; Gingerich & Eisengart, 2000; Gingerich & Peterson, 2012; Gonzalez Suitt et al., 2016; Huoliang & Weisu, 2017; Park, 2014)	Moderate, + (all studies) Moderate, + (RCT, 3, 444/NR) Moderate, + (NRSI ^x , 4, 89/33)
SFBT is effective for cognitive aspects (Bond et al., 2013; Gingerich & Peterson, 2012).	Moderate, + (RCT, 3, 158/111)
SFBT is effective for problem solving (Bilgin, 2020; Bond et al., 2013; Gonzalez Suitt et al., 2016).	Low, + (NRSI, 3, 172; 50)
SFBT is effective for hope (Bond et al., 2013; Gingerich & Eisengart, 2000; Gingerich & Peterson, 2012; J. S. Kim, 2008)	Moderate, + (all studies: RCT, 3,96/ 49; NRSI, 1,67/35 ^a)
SFBT is effective for individual goals (Bond et al., 2013; Corcoran & Pillai, 2009; Franklin & Hai, 2021; Gingerich & Eisengart, 2000; J. S. Kim, 2008), i.e.,	Moderate, + (all studies) Moderate, + (RCT, 3, 401/ NR) Moderate, + (NRSI, 4, 91/ 52)
• goal attainment	Moderate, + (all studies: RCT, 2, 341/10 ^a ; NRSI, 1, 61/22)

Note. Specific aspects are reported only for outcomes examined in at least 3 PSs. Strength of evidence is reported based on GRADE-UR. Direction is set on confirmation of effectiveness (+) if at least 65% of PS found statistical significance levels or moderate to strong effects, or non-effectiveness (0) if predominant prevalence of findings did not reach statistical significance levels or effect size was small or weak. No evidence of harm was found. The distribution of participants in the SFBT group was not reported for ^a = one PS, ^b = two PSs, ^c = four PSs, ^d = five PSs, or NR = overall and not possible to compute. ^x The methodological quality of the PSs was often not assessed by the SRs and was, thus set by default to moderate.

No included PS on Eastern population was concerned with this outcome.

Moderate confidence in evidence of SFBT effectiveness was found for social issues (Bilgin, 2020; Carrick & Randle-Phillips, 2018; Franklin & Hai, 2021; Gingerich & Peterson, 2012) and hope (Bilgin, 2020; Gingerich & Peterson, 2012; D. Kim et al., 2017), mainly studied in Eastern countries, for medical aspects such as returning to work or coping and adjustment to illness (Bilgin, 2020; Corcoran & Pillai, 2009; Gingerich & Eisengart, 2000; Gingerich & Peterson, 2012; Gonzalez Suitt et al., 2016), examined on both Western and Eastern population, and for couple issues (Bilgin, 2020; Corcoran & Pillai, 2009; Gingerich & Eisengart, 2000; Gingerich & Peterson, 2012; Gonzalez Suitt et al., 2016; J. S. Kim, 2008), parenting or caregiving (Bond et al., 2013; Corcoran & Pillai, 2009; Eads & Lee, 2019; Gingerich & Eisengart, 2000; Gingerich & Peterson, 2012; Huoliang & Weisu, 2017; D. Kim et al., 2017), and self-aspects, specifically for self-esteem (Eads & Lee, 2019; Gingerich & Eisengart, 2000; Gingerich & Peterson, 2012), for which the country of the PS was mainly not reported. Moderate confidence was found in the neutral effect of SFBT on externalizing issues from Western PS (Carrick & Randle-Phillips, 2018; Franklin & Hai, 2021; Gingerich & Eisengart, 2000; Gingerich & Peterson, 2012). In turn, low confidence in evidence of effectiveness was found for alcohol-related issues and challenging behaviors in adults with intellectual disabilities. No evidence of harm was found.

Effectiveness for children and adolescent population. MAs performed on predominantly Western PSs showed a small to moderate effect of SFBT in children and adolescents overall and for specific aspects such as internalizing, behavioral, social, school, or medical, $ES = 0.115\text{--}0.43$ (Franklin et al., 2022; Hsu et al., 2021). Effectiveness was researched mainly compared to passive controls, i.e., no treatment or waitlist (Franklin et al., 2022; Hsu et al., 2021). Larger effect was found when SFBT was applied integrally compared to the use of selected elements, $ES = 0.771$ vs 0.382 , though the difference was not statistically significant (Franklin et al., 2023). In turn, significant difference in effect size was found between world regions, with larger effects specific to Eastern (Chinese) as opposed to Western PSs, $ES = 0.230$ vs 0.108 , in classroom (group) vs individual format, and for studies with higher percentage of female participants (Franklin et al., 2022). Study design was not a significant moderator (Franklin et al., 2022; Hsu et al., 2021).

In fact, MAs performed predominantly on Eastern PSs found large effects overall, $ES = 0.80\text{--}1.8$ (Huoliang & Weisu, 2017; Karababa, 2023; Mohammadyari & Hoseinian, 2019; Park, 2014). Large effects were found by MAs performed on Chinese and Korean PSs for specific issues, such as internalizing, $ES = 1.06$, family and relationship, $ES = 0.94$, maintained at follow-up, $ES = 1.09$ (Huoliang & Weisu, 2017), or for self-esteem, self-efficacy, interpersonal abilities, and adaptation to school life, $ES = 1.605$, 1.025 , 1.067 , and 1.349 , respectively (Park, 2014). In turn, small to moderate and large effects were found by an MA of Iranian PSs for individual, relational, and academic problems, $ES = 0.23$, 0.57 , and 1.57 , respectively (Mohammadyari & Hoseinian, 2019). SFBT effectiveness was examined exclusively in group format in experimental studies without information on randomization use or type of control (Huoliang & Weisu, 2017; Mohammadyari & Hoseinian, 2019; Park, 2014). Larger effect was found for elementary and college students than for junior high-school ones, $ES = 1.16$, 1.16 vs 0.61 (Huoliang & Weisu, 2017). Increased number of sessions was associated with larger effects on self-esteem and adaptation to school life while increased session duration led to lower effects on adaptation to school life (Park, 2014). No moderation by age and number of participants per group was found (Park, 2014).

When examined, small (Park, 2014) to moderate (Franklin et al., 2022; Huoliang & Weisu, 2017) and substantial (Hsu et al., 2021; Karababa, 2023) heterogeneity was found, with small (Huoliang & Weisu, 2017) to no risk (Franklin et al., 2022; Hsu et al., 2021; Karababa, 2023; Park, 2014) of publication bias in both Western and Eastern MAs.

Specific information on SFBT's effectiveness on children and adolescent population was extracted from 16 SRs. Eleven categories and fifteen subcategories of studied issues were identified (see Table II). In general, the population studied was often heterogeneous, originating from all world regions, presenting various characteristics, such as disruptive or aggressive behaviors, pregnancy, living in foster care or with divorced parents. The intervention was most often applied in group format, between 5 and 16 sessions, containing between 4 and 8 core elements.

Moderate confidence in evidence of SFBT effectiveness was found for internalizing (i.e., depression, anxiety), externalizing and school issues (only by RCT), self-aspects (i.e., self-esteem, self-efficacy and career self-efficacy), social, medical, coping and cognitive aspects, hope and individual goals (i.e., goal attainment). However moderate confidence was sometimes reached by all study designs, and sometimes separately by RCT or NRSI. No

clear pattern was observed, as both RCT and NRSI separately indicated moderate or low confidence in evidence of effectiveness for different outcomes on both Western and Eastern population. In turn, moderate confidence in evidence of non-effectiveness for specific school aspects such as academic achievement and school attendance was found based on predominantly Western PSs. For the remaining issues examined, confidence in evidence was low or insufficient. High confidence in evidence was not identified for any finding.

Three NRSI indicated evidence of harm (one on externalizing issues and two on school attendance) compared to no treatment, from which only one reached statistical significance on school attendance on Western population. Thus no confidence in evidence of harm was found.

Discussion

This umbrella review is the first one performed to date with the aim of summarizing the knowledge on the effectiveness of SFBT. The 25 SRs that fit the inclusion criteria each indicated consistently that SFBT is a useful intervention that has positive effects for clients of all age groups on a wide variety of issues, cultures, and settings. The current overview took a step further and synthesized the evidence by providing a view on the type of clients and issues for which SFBT effectiveness was established alongside confidence in evidence.

Both the synthesized findings of the included SRs and the evaluation of umbrella review findings based on individual results of the PSs included in the SRs indicated positive effects of SFBT for all age groups on a wide variety of outcomes. No consistent evidence of harm was found. The moderators examined by the MAs included in this umbrella review indicated that SFBT was more effective than no treatment/waitlist and similar or better than TAU or other known treatments (e.g., psychodynamic, or cognitive-behavioral therapy) regardless of the age group, issue, culture or setting. These findings are in line with a recent review of global outcomes which indicated transcultural effectiveness of SFBT for a variety of issues and found similar moderators of effectiveness (Neipp & Beyebach, 2022).

Larger effects were characteristic to SRs based on Eastern studies while small to moderate effect size was specific to predominantly Western SRs, regardless of the issue or setting examined. This apparent cultural difference must be interpreted with caution given that Eastern PSs used mainly non-randomized designs, passive controls, and applied SFBT in group format. All these aspects were associated with larger

effects (Neipp & Beyebach, 2022; Schmit et al., 2016; Stams et al., 2006). In turn, Western SRs included more RCTs, active controls, and various forms of intervention. To better understand cultural difference in effectiveness on specific outcomes, both world regions should first apply the same methodology. This umbrella review found no difference in confidence in the evidence by world region, though Western and Eastern studies place greater emphasis on different aspects in research. For example, effectiveness for adult population was more often studied in Western PSs while effectiveness for children and adolescents was studied in both Western and Eastern PSs.

The positive results identified across SRs seem not to be associated with publication bias as 18 SRs included unpublished theses in a proportion of 6% to 95% of included PSs. Additionally, no risk of publication bias was confirmed in six (Franklin et al., 2022, 2023; Karababa, 2023; Park, 2014; Stams et al., 2006; Zhang et al., 2018) out of nine SRs that examined it while the risk of bias identified in the remaining three (Hsu et al., 2021; Huoliang & Weisu, 2017; Schmit et al., 2016) SRs was small or had no influence on the results. Nevertheless, slight to substantial heterogeneity (Franklin et al., 2022; Hsu et al., 2021; Huoliang & Weisu, 2017, 2015; Karababa, 2023; J. S. Kim, 2008; J. S. Kim et al., 2015; Park, 2014; Schmit et al., 2016; Stams et al., 2006; Zhang et al., 2018) was found by all SRs examining it, potentially resulting from the large diversity of the studied population.

The confidence in evidence of SFBT effectiveness mainly reached a moderate level, suggesting that more studies overall are needed to provide an accurate representation of the phenomenon. Specifically, moderate confidence in evidence of SFBT effectiveness was found for all age groups on internalizing, social, or medical issues, self-aspects, and hope. Also, moderate confidence in evidence of effectiveness was found on couple and parenting or caregiving issues for adults, and on specific school aspects (e.g., exam anxiety, adaptation to school life), coping, cognitive aspects and goals for children and adolescents, respectively.

Interestingly, despite being an approach focused on behavioral change, current evidence indicates an overall neutral effect of SFBT on externalizing issues in both age groups, resulting from less than 65% of PSs showing statistical significance levels for positive change due to predominant use of case-study designs in adult population as well as from weak or mixed effects reported for children and adolescents on a wide variety of behavioral outcomes. Evidence of effectiveness was found for specific behavioral outcomes, such as alcohol related issues or

challenging behaviors in adults with intellectual disabilities or anger management in children and adolescents. Nevertheless, confidence in evidence was also low due to few PSs concerned with one specific aspect. More rigorous studies focused on one specific behavioral outcome are needed for each age group.

In fact, the large number of rigorous studies (RCT) performed on specific internalizing issues led to high confidence in SFBT effectiveness for adults on depression and overall mental health. More studies are unlikely to change this finding. Also, high confidence in evidence of SFBT effectiveness on progress towards goal for adults was found, although based on NRSI. The question still remains whether this approach, given its brevity, can achieve similar therapeutic effects to other bona-fide methods but with fewer sessions. This aspect was seldom examined in the PSs included in the SRs. Considering that the established high confidence in evidence of effectiveness is specific to adult Western populations, more rigorous studies on Eastern population can further increase the generalizability of the findings.

Potential Biases in the Umbrella Review Process

Our comprehensive analysis is constrained by the inherent limitations within the SRs and MAs included in the umbrella review. Each SR had at least one critical flaw based on AMSTAR 2, indicating low or very low confidence in findings. Nevertheless, it is worth noting that low confidence in results of SRs of medical or psychological interventions as assessed by AMSTAR 2 is rather frequent (Karakasis et al., 2024; Matthias et al., 2020) and not specific to SFBT reviews. A large overlap was found across SRs indicating that the same PSs stand at the basis of various SRs or MAs. This suggests that, despite an increase in publications on the SFBT effectiveness (Beyebach et al., 2021; J. Kim et al., 2019), the majority of studies are not well enough designed to be included in systematic reviews. When the methodological quality of the PSs was examined in the SRs beyond the study design, only about a third of the papers fitted high-quality criteria, the remaining being most often of moderate or poor quality. Most often Eastern SRs did not provide information on methodological quality of the PSs beyond the inclusion of experimental designs. In this case the confidence in evidence may be inflated due to the recommendation of assuming a good methodological quality when MQPS was not assessed (Antonio et al., 2020). This was most prevalent for SRs on children and adolescents. Also, information on selection bias was often missing across all SRs while information

on study design (use of randomization) or outcome measurement was not provided consistently by SRs, leading to a decrease in the confidence in evidence. There is a need for more research with robust methodologies and comprehensive information to strengthen confidence in findings.

There are also more typical limitations of our umbrella review. Firstly, we cannot be certain to have captured all possible SRs, as we may not have the access to all sources. Secondly, being an overview of reviews, it does not apply any additional statistical analysis. Nevertheless, the present article may be useful, as it shows confidence levels in evidence of effectiveness of SFBT and suggestions for methodological improvement of future research.

Conclusions

This umbrella review adds evidence to the effectiveness of SFBT by showing high or moderate confidence in evidence of effectiveness for a wide variety of outcomes regardless of age group or culture.

SFBT can be used with high confidence as an effective therapeutic intervention for addressing depression symptoms and overall mental health in adults. Also, SFBT with high confidence impacts adults' progression towards individual treatment goals. In addition, SFBT can be considered as a potentially effective approach for a wide variety of issues (e.g., internalizing, social, medical, self-aspects, and hope) regardless of the clients' age or specific to a particular age group (e.g., adaptation to school or couple issues). Using more than four core elements is recommended given the higher effectiveness found with increased fidelity (Franklin et al., 2023; D. Kim et al., 2017; Neipp & Beyebach, 2022). More studies focused on a single specific aspect are needed to provide an adequate image of effectiveness especially when regarding externalizing issues.

Given that SFBT was constantly proven to be more effective than no treatment, future studies should focus more on comparisons with active controls such as other known effective treatments and examine the possibility of reaching the same outcome in a shorter time. If SFBT is used in combination with other approaches, controlled studies are recommended to compare the difference in effectiveness of the pure vs combined forms. This might be pertinent for practitioners and novices, especially since training frequently encourages a strict application approach. Future primary studies should provide enough information on the methodology, intervention, and demographic variables so that novel systematic reviews can examine the potential

effects of these moderators as well. This is of importance considering the significant heterogeneity found between studies by all reviews that examined it. Future systematic reviews of SFBT are encouraged to provide an assessment of the methodological quality of the PSs and full information in line with the GRADE (Guyatt et al., 2008) evaluation system to aid at the established confidence in findings.

Disclosure Statement

No potential conflict of interest was reported by the author(s).

Ethical Approval

An ethics statement is not applicable because this study is based exclusively on published literature.

Data Availability Statement

Data is available after contacting the authors.

Author Contributions

AŻ and KP both authored the article. AŻ conceived and designed the analysis, as well as collected the data. Both authors were equally involved in the data extraction and analysis.

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