

Practical Research for the Solution-Focused Practitioner: A Follow-Up to Wheeler's Article on Quick and Dirty Research

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Abstract

In a recent article in this journal, Wheeler (2014) encouraged practitioners to engage in practical research illustrated by some of his experiences. In addition, he encouraged a movement from evidence-based practice to practice-based evidence. The purpose of this article is to amplify some of the points made in that article with particular attention to (a) guidelines for practical research for the clinician, and (b) a clarification of the distinctions between evidence-based practice and practice-based evidence. In the first part of this article, practitioners are encouraged to engage in research that adheres to fundamental principles of science without becoming obsessed with technical perfection. In this pursuit, the practitioner can partner with experts who could be technical consultants while the process of study is under the leadership of the practitioner. In the second part of this article, solution-focused practice is discussed in regard to distinctions between practice-based evidence and two different ways of conceptualizing evidence-based practice. The evidence on solution-focused practice makes its use consistent with both of the views of evidence-based practice and with the perspective of practice-based evidence.

Keywords: solution-focused, practical research, evidence-based practice, practice-based evidence

The article by Wheeler (2014) in a recent edition of this journal inspired a reply and extension of the thoughts offered. Wheeler's main purpose was to encourage more clinically useful research, especially research done by practitioners. In this endeavor, he discussed his own experience doing what he referred to as "quick and dirty research"—referencing Fain (2013)—which could also be described as *practical research*.¹ Wheeler also encouraged a movement from evidence-based practice to practice-based evidence.

This article seeks to build on Wheeler's article in an effort to (a) discuss how university-based research can be improved in terms of its usefulness to the practitioner, (b) provide basic guidelines for practical research by the clinician, (c) discuss the rudiments of evidence-based practice and practice-based evidence in terms of similarities and differences, (d) provide conclusions regarding the aforementioned themes as they relate to solution-focused

practices, and (e) provide an overview relative to the current evidence supporting solution-focused brief therapy (SFBT) as a method of treatment.

How University-Based Research Can Be Improved

To understand how university-based research can be improved, it is important to look at the nature of the PhD program. From the beginning of the experience, it tends to be the expectation that the PhD student will contribute highly original research that meets rigorous standards of methodology and theory. Whether this is of importance to the everyday practice society is of less concern. How well does the research meet the high standards of the experts in the associated field? That is the question. So, a student might develop a research question that is much too focused on a narrow spectrum of knowledge to be of optimal use for the practitioner. Generally, it is the PhD students who teach in universities. When the PhD graduate becomes a college professor, the first task is to obtain tenure. How is this achieved? Sometimes, it is through the continued pursuit of a narrow path of research and the refinement of scientific methods. Fortunately, there are academicians who pursue a different path, as Wheeler's (2014) described in discussing the guidance he received.

¹ *Practical research* refers to the building of knowledge useful to practice that adheres to the basic principles of scientific inquiry—clearly defined research questions, valid measures of behavior, systematic collection and analysis of data, and appropriate conclusions (i.e., not overstated). Practical research could further be distinguished from *basic* research and *theoretical* research (note by the authors).

Some professors focus so much attention on the pursuit of technical perfection that some useful and scientifically legitimate research is labeled fundamentally flawed. After all, who is ever able to do the perfect study? The answer is, no one. We believe excessive attention to technical perfection has led to some academicians to undertake research that is not highly useful to the practitioner. What then is the difference between a major flaw in research and a limitation? A *flaw* would be exemplified by a study in which the methodology is clearly biased in the direction of only one research answer or in which the data analysis is misleading—the conclusions inconsistent with the data. But *imperfections* or *limitations* are everywhere and do *not* make the study flawed; limitations are a necessity of any study. It is important to choose scientific methods that are well-suited in order to address the particular question under study.

Finally, the refinement of theory is another source of contention. The idea is that the academician should contribute something highly original to the current knowledge base. It can be useful to always have in mind that a single theory seldom is a useful guide to every aspect of practice with a given client. Even the highly researched therapies, such as cognitive-behavioral therapy, are very often delivered with certain elements of the theory included while others are not.

We hope this article will be helpful in closing the gap between the researcher and the practitioner. Thus, a good deal of what Wheeler called “quick and dirty research” should be encouraged and communicated among practitioners. A problem, however, lies in the fact that many scholarly journals are focused on publishing highly controlled research rather than a multitude of attempts to research a given issue.² We suggest that it would be more useful to publish a wide array of research with methods of varying levels of sophistication, and allow the reader to assess the credibility and usefulness. In this environment, one might find useful research that is somewhat weak in methodology (but not flawed), but at the same time, very useful for practice.

The Fundamentals of Practical Research

Wheeler encouraged the practitioner to engage in quick and dirty research. In his examples, he employed a consultant from academia and found that partnership useful. It is not difficult to engage in simple studies that adhere to the fundamentals of scientific research. In higher education, students are introduced to the nature of scientific research and are required to review such literature. Below is an overview of a variety of research fundamentals:

- The spirit of scientific inquiry is a process of discovery, not justification. You do not engage in research for the

purpose of proving a point. Instead, you do it for the purpose of finding out.

- The purpose of the study must be clear and must fit with the research methods. Wheeler made a number of comments regarding how he was encouraged to slow down and make things more clear as he engaged in his experience with quick and dirty research.
- Research methods should be transparent and should reveal to the consumer the results, such that the credibility of the study can be evaluated and explained in manner such that the study could be replicated.

These are just a few research fundamentals, and it is important to note that a consultant who knows research methodology and statistics and accepts the assumptions of practical research can aid research projects. A useful guide is the framework of utilization-focused evaluation by Patton (2008) where the research expert facilitates research for intended users and also serves as technical consultant. In this endeavor, it is the intended users (i.e., practitioners) who determine what will be evaluated and how it will be evaluated, starting with a clear picture of how the research will be put to use.

A Few Guidelines for Practical Research

There are a number of guidelines for practical research (York, 2009). These guidelines are designed to heighten awareness of the types of research that can be done in practice that are consistent with the nature of scientific inquiry.

A. There are several levels of scientific inquiry that can be useful for practice. However, it is important to note that such levels are not restricted to those levels necessary for publication.

1. At the first level, (i) you might construct a survey for clients asking for their evaluations of service and their suggestions, (ii) measure outcomes at intake and discharge, or (iii) interview a group of clients or practitioners about some issue of importance to practice. While this could be conceived as the first level of research, it adheres to the basic tenets of scientific inquiry, using transparent methods that lend equal opportunity for the support of more than one conclusion.

It is important not to fall into the category that Wheeler called a “self-deluding feedback loop” (Wheeler, 2014, p. 3). Two key terms here are *method* and *transparency*, primarily because they distinguish scientific inquiry from other forms of inquiry. In scientific inquiry, tools for measurement should be reported, sampling methods should be clear, and data should be fully reported. When using qualitative methods for interview studies, it is necessary to report protocols for the interviews as well as for the analysis of data. These protocols should be credible if others are to view the research as scientific. It would not be sufficient to simply report, for example, the conclusions of 10 interviews conducted with clients, even if the conclusions are endowed with selected quotes. The latter is sufficient for the newspaper reporter and may be useful for some

² The *International Journal of Solution-Focused Practices* represent a category of scholarly journals that, as the authors suggest, aims to publish a wide array of research with methods of varying levels of sophistication. In this context, a small and simple study can very well be more important than a large and highly controlled study (note by the editor).

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practitioners, but it is not sufficient to call such a study scientific research because the latter requires more in the way of transparent methods, a key principle in science. When research is complete, the researcher should be able to describe the methods sufficiently enough for others to be able to replicate them.

This level of inquiry may or may not employ statistical analysis of data. If a group of clients made a 30% improvement from intake to discharge, the researcher can draw conclusions on the clinical significance of these results for this sample of persons without the benefit of statistical analysis. If the researcher wishes to examine the issue of chance (i.e., how often the data would occur by chance), there are easy ways to do so, such as using a simple Excel spreadsheet (York, 2009). If the researcher wishes to generalize findings to the population, he or she will also need to consider the way in which the sample was drawn. Ultimately, examining the relevance of these findings to this group of clients requires only that you have reason to believe that the data are credible, but generalizing the data or considering the issue of chance requires other steps.

2. At the next level, the researcher might statistically compare outcomes from clients with those on the waiting list. The advantage of using a comparison group design is that there is a basis for considering normal growth and development over time as an alternative explanation for the client's gains. Additionally, the advantage of the statistical analysis of data, as noted beforehand, is the ability to rule out chance as a legitimate explanation of the data.

At this second level, using a different example, the researcher might employ a recognized protocol for the analysis of qualitative data in a study examining methods of practice for clinicians or an examination of agency records for information on practice policies. This type of analysis entails going beyond the methods of the news reporter in developing and reporting the methodology employed.

3. At the third level, the researcher could engage in research normally conducted by academicians and often published in scholarly journals. This level is not the focus of this article, however, so we will not go far down that road. Suffice to say, this level requires more sophisticated methods of sampling, validity testing of measurement tools, research design, and statistical analysis of data.

The point is that there is more than one legitimate level of inquiry and we can employ one or the other depending on the need and availability of resources.

B. The practitioner is the expert on what level of inquiry is sufficient to generate useful research. However, the practitioner cannot exercise that expertise without sufficient knowledge of methods used by others (when reviewing that research) or knowledge on how to construct research itself (when the practitioner is the researcher). This knowledge level is easy to develop, but might sometimes require the use of a consultant. In this regard, consulting Patton's (2008) utilization-focused evaluation, which is described briefly in York (2009, pp. 73–77), might be a useful alternative.

C. Below are some suggestions to the practical researcher in making choices and constructing a viable study:

1. Consider the idea of face validity in the examination of the validity of a measurement device rather than the more sophisticated methods (e.g., test–retest reliability, content validity, construct validity, etc.). This simply means that the measurement tool has been reviewed by key individuals in an agency (or elsewhere) and that the key individuals have offered the opinion that the tool does a reasonable job of measuring what it is intended to measure. Conducting a pilot of the tool would also be useful. This means giving it to a few persons and seeing how they respond.

2. Examine the data naturally collected from clients using certain activities associated with solution-focused practice. Review these data over time with regard to types of clients and goals to see if there are areas of inquiry that emerge from them. Next, test these inquiries more directly, or suggest that others do so. Both outcome data and data on client characteristics could be examined, as well the relationships between them using practical tools for data analysis like those in York (2009).

3. If statistical analysis is one part of the study, consider the use of a more liberal standard for statistical significance (i.e., $p < .10$) rather than the more conservative standard employed in the social sciences (i.e., $p < .05$). The standard employed is arbitrary—there is no scientific basis for either standard. The difference lies in whether it is more important to avoid the error of concluding that a service is effective when it is not (the conservative alternative) or avoid the error of concluding that a service is not effective when it actually is effective (the liberal alternative). The former is the approach of the typical academic researcher who lives in a different world than the practitioner. They want to be sure that their conclusions will be supported by later research. The practitioner, on the other hand, must make decisions with limited data and thus, needs to find some guidance and move on quickly. The idea of improving the odds that service is effective is the key.

Furthermore, there are simple statistical tests that will work fine with the practical approach to research. It makes more sense to use a statistical test that is understood than to employ a more sophisticated statistic that is not understood. Moving from a basic statistic to a more sophisticated one usually does not make a difference in the basic conclusions that are drawn from the data when considering the practical implications of the intended research.

The use of *scaling* is commonplace in solution-focused practice, so practitioners could consider collecting data from various clients and prepare a report that addresses useful themes for practice. Perhaps there is an apparent trend that shows which techniques seem to work better with certain clients. In another example, a practitioner could review clinical notes using a basic protocol for content analysis of qualitative data or conduct a survey with clients to gain more insight into critical issues. Finally, the Session Rating Scale and the Outcome Rating Scale offered by Miller, Duncan, Brown, Sorrell, and Chalk (2006) could be employed to track client progress and report trends. There are a number of research initiatives a practitioner could

employ and this section offers merely a few. However, while developing a research initiative, it could be useful to develop a partnership with a technical consultant and/or seek someone in academia who embraces the idea of practical research.

How To Move From Evidence-Based Practice to Practice-Based Evidence?

Wheeler (2014) noted some problems with evidence-based practice and suggested a shift toward practice-based evidence. His complaint was that evidence-based practice places inordinate focus on the testing of theory, while the solution-focused practitioner, following the lead of de Shazer and Berg (1997), would be better advised to pursue the “naturalistic inquiry” approach. In order to understand how to make this transition, it is important to clarify research terms and define both evidence-based practice and practice-based evidence.

Evidence-Based Practice Versus Practice-Based Evidence

Evidence-based practice emerged from the field of medicine and has been picked up by clinical psychology, social work, and other helping professions. The early definition of evidence-based practice involved the employment of the conscientious, explicit use of current best evidence in making decisions about the care of individuals (Sackett, Rosenberg, Gran, Haynes, & Richardson, 1996). A more contemporary definition is the conscientious, explicit use of the best available evidence, along with considerations of client characteristics and treatment preferences, to inform practice (Dozois et al., 2014).

It is not easy to argue with this definition unless one has no belief in science. The biggest problem has emerged from misunderstandings about what this perspective really is and how it should be implemented. Unfortunately, some believe that it means always using the treatment that has the best score of evidence—regardless of other considerations—and never deviating from strict adherence to that model at all times with the client regardless of how the client is responding. No one who writes about evidence-based practice has ever, to our knowledge, suggested anything that is remotely close to this understanding of the nature of evidence-based practice. An agency policy that says that all clinicians will employ cognitive-behavioral therapy in the treatment of depression is *not* operating according to the principles of evidence-based practice because the best available evidence for a given client and practitioner may suggest another approach to treatment, especially if considering client preferences and practitioner expertise. A practitioner who employs a therapy strictly by the manual and views lack of success as so-called “client resistance,” without consideration of other alternatives, is not operating according to the principles of evidence-based practice. Unfortunately, these things have happened and have given some people an impression that this is the way evidence-based practice is supposed to be. If this is the main

contribution of the evidence-based practice movement, then we must assert that this has not been a good movement.

This leads into the distinction between two ways to characterize evidence-based practice. One is evidence-based practice as *process*, and the other is evidence-based practice as *product* (see, for example, Chapter 2 of Palinkas & Soydan, 2011). The primary writers on evidence-based practice prefer that it be viewed as a *process* where the practitioner reviews the current available evidence regarding the goal being pursued and treats it with respect in determining the course of action for each individual client. Evidence-based practice as *product* is the idea of using a practice that is supported by evidence without regard for the other critical conditions of practitioner expertise or client preferences. Unfortunately, some agencies advertise that they only use evidence-based practices based on the idea that their practices have some supporting evidence without regard to the goal of treatment or the other critical aspects of practitioner expertise and client preferences.

While the proponents of evidence-based practice advocate for the perspective of evidence-based practice as *process*, the current reality is that the clinical dialogue seems to favor the idea of evidence-based practice as *product*. Human services agencies and practitioners often market themselves as using evidence-based practices without clear reference to evidence about the particular method of treatment employed for the specific condition being treated. Using a treatment with some evidence is better than using one with none, unless, of course, practitioners and/or researchers are engaging in a clinical experiment that has a logical rationale and are seeking new knowledge for the field. Furthermore, as long as data on client outcomes are systematically collected, the practitioner is being accountable without regard to the evidence in the literature.

Barkham and Mellor-Clark (2003) suggested that the difference between evidence-based practice and practice-based evidence is that the former focuses on very specific research, optimally addressing the issue of causation regarding whether a particular intervention has a specific, measureable effect on a given condition. Practice-based evidence, according to this view, focuses on research that is more relevant to normal practice. The latter is concerned with the effectiveness of treatments across broad populations and service settings. That early conceptualization, however, seems to have given way to a debate on whether the practice based research actually suggests that one bona fide treatment is superior to another.

To illustrate what practice-based evidence and evidence-based practice is, it is important to examine the basic therapeutic process. First, the practitioner and the client engage in a dialogue that leads to the determination of the goals of treatment. Next, the practitioner and the client collaborate on the decision of what the treatment will entail. Then, the practitioner and the client engage in the service process and collectively monitor client progress. The approach of practice-based evidence follows this process, encouraging the clinician to systematically collect data on both service process and client outcome. This approach is also compatible with evidence-based practice, which calls

upon the practitioner to use the best available evidence, in conjunction with considerations of practitioner expertise and client preferences. The clinician using evidence-based practice will collaborate with the client on treatment goals, search for evidence on what works, share that evidence with the client, and collaborate on the treatment plan. So, what is the difference between practice-based evidence and evidence-based practice?

One key difference between these two perspectives lies in how evidence guides the decision of what kind of treatment to employ. Advocates for practice-based evidence have concluded that the evidence about practice outcomes fails to show that one bona fide treatment is superior to another. However, the evidence is very clear on the importance of the common factors in therapy (Flückiger, Wampold, & Symonds, 2011; Horvath, Del Re, Flückiger, & Symonds, 2011; Marsh, Angell, Andrews, & Curry, 2013; Munder, Flückiger, Gerger, Wampold, & Barth, 2012). The common factors are those things that promote good outcomes regardless of the approach taken to treatment. Prominent among those common factors are the therapeutic alliance between client and practitioner, the skills of the clinician, and variables related to the individual client, such as hope. Practitioners should therefore strengthen the common factors and employ a bona fide method of treatment that is compatible with their skills and the clients' interests. Culling through evidence on whether cognitive-behavioral therapy is better than SFBT for the treatment of anxiety or depression is basically a waste of time. Evidence is available supporting both, and most likely the preponderance of evidence fails to show superiority of one approach to treatment over another. Thus, the focus should be on practitioner skills and other common factors.

Solution-focused practice is both a bona fide treatment and one that has been supported by a great deal of evidence in regard to a number of target behaviors. If this practice fits with a practitioner's expertise and a client's preference, it would make sense to use it, according to the model of evidence-based practice as process. This situation would also fit with the perspective of practice-based evidence. However, if a practitioner employs it for behaviors that have not been tested in research, then he or she is drifting out of the bounds of evidence-based practice as process. Therefore, if a practitioner wants to claim that he or she is following the guidelines of evidence-based practice, it is suggested that he or she systematically monitor client outcomes and employ these data in determining what works for that client.

Exploring and reading evidence of certain bona fide treatments that are superior to others for a given behavior leads to the daunting task of analyzing the evidence from conflicting articles found in the literature. For example, some reviews of evidence on the relative effectiveness of cognitive-behavioral therapy in the treatment of depression suggest it is superior to certain other treatments (Tolin, 2010), but some reviews suggest it is not (Baardseth et al., 2013). The evidence picture is surely not clear about what works best for which behavior. Perhaps it can help us to avoid therapies that might cause harm and can encourage us to try therapies with solid evidence, but it is clear that the

common factors are more important than the specific ingredients of the treatment approach taken.

Solution-Focused Practice, Naturalistic Inquiry, and Practice-Based Evidence

Steve De Shazer and Insoo Berg (1997) understood the roots of SFBT practice to lie in the "naturalistic inquiry" approach to knowledge building. Macdonald (2011) stated that the development of solution-focused therapy emerged from "feedback from the clients as to which elements of therapy were effective in increasing goal attainment" (p. 88). This observation and feedback formed the foundations of solution-focused practice as people and families were engaged in a conversation about what they wanted, as well as what they have already done to move toward their own expressed goals and desired outcomes. Although seeing people for the most part in a particular setting (i.e., an office) differs from merely engaging them in their own settings, the basic principle of being curious about learning from one's clients still applies; what clients want to be different in their lives does not impose any particular perspective or theory on how they should be living, nor does it depend on any preconceived way of getting them to change for the better, as defined by the therapist's worldview. In contrast, Kirmayer (2012) commented on the complexity of research-based practice in the context of social and cultural values and made the point that "the rhetoric of evidence base practice tends to obscure the social, moral and political contexts that necessarily shape both research and clinical practice" (p. 252).

Solution-focused practice, as a form of *naturalistic inquiry*, enables people and families to reveal in their own way and in their own words the nature of their challenges and also recognize the times when they have been able to make things better or cope with critical conditions. This opens the conversation in terms set by the client and reveals the client's strengths, implicit capacities, possible alternative lives, and the potential means for creating a better life for themselves.

What Can the Practitioner Do?

If a practitioner embraces solution-focused practice as well as *practice-based evidence*, he or she should engage the client in a collaboration related to the goals of service and service methods, collect data on service process and service outcome, and then collaborate with the client on what to do next. What could come next is a change in methods, referral to other services, or a termination of service because it is no longer needed.

This process is not very different from *evidence-based practice* as *product*, provided that one's methods are consistent with solution-focused practice, a treatment that has been found to be supported by evidence regarding many different types of outcomes (Franklin, Trepper, Gingerich, & McCollum, 2012). However, if a practitioner embraces

evidence-based practice as *process*, he or she would review the evidence and potentially move in a different direction than solution-focused practice if the evidence favors a different approach with a given client and the practitioner is either skilled in the alternative therapy or prepared to seek training. If not, then evidence-based practices as product, as process, and practice-based evidence are not really different.

One of the major hurdles that a solution-focused practitioner may encounter if interested in using evidence-based practice as process is that using it as process assumes that different behaviors are better treated with different therapeutic methods. The differences in behaviors tend to be viewed in light of the idea of diagnosis, even though there is nothing specific to evidence-based practice as process that requires a diagnosis. The fact is that much of the evidence is grounded in diagnosis. To the solution-focused practitioner, the focus is on strengths and solutions rather than problems and causes. However, it is important to note that this is not limited to solution-focused practitioners and therefore also applies to practitioners that use other treatment models.

Practice-Based Evidence and Solution-Focused Practice

The majority of solution-focused practitioners use scaling in sessions to access the client's subjective evaluation of his or her situation and feelings over time. How they evaluate their subjective experience in terms of better or worse is a guide for both the practitioner and the client to understand the behaviors and contexts that would produce change, and to employ those actions that lead to making things better or bringing the client closer to achieving his or her stated goals.

The practice-based evidence perspective has placed a lot of emphasis on the use of systematically collected data from the client. One tool is the Session Rating Scale (Miller et al., 2006), which asks the client to rate each session at the end according to the presence of certain behaviors that promote a therapeutic alliance. For example, did the session focus on things of special concern to the client? Another tool is the Outcome Rating Scale (Miller et al., 2006), which asks the client at the beginning of each session to rate the extent to which he or she has experienced certain general outcomes since the previous session. For example, how has the client's life been socially?³ Thus, there is a subjective means of sharing outcomes between the practitioner and the client both during the process and at the end. Research has demonstrated the efficacy of scaling by comparing scaling with standard inventories to assess outcomes (Dahl, Bathel, & Carreon, 2000; Gostautas, Cepukiene, Pakrosins, & Fleming, 2005; Nelson & Kelly, 2001; Wiseman, 2003). These studies have demonstrated that scaling is significantly related to instrument-measured outcomes at the end of treatment and after extended periods of time following treatment. Therefore, it might be useful for practitioners to utilize these scores and the changes as general indicators of real and lasting change.

Beyond Scaling to the Current Evidence Base of Solution-Focused Practice

Seeking empirical evidence to support practice can be a daunting task. However, there are a number of resources available to solution-focused practitioners allowing for more efficient and accessible evidence to support SFBT as a method of treatment. For example, Alasdair Macdonald (2014) maintains a running list of SFBT evaluations. This list can be accessed from the Solution-Focused Brief Therapy Association research page. As of November 2013, there were a total of 133 documented studies on SFBT, including two meta-analyses, five systematic reviews of the literature, and 125 follow up research-based papers. The follow-up research-based papers consist of 28 randomized/control group findings, 47 comparison studies, and 50 naturalistic studies summarizing a variety of mental health issues. In 2012, Franklin et al. published an edited book titled the *Solution-Focused Brief Therapy: A Handbook of Evidence-Based Practice*, which provides practitioners with an elaborate overview of SFBT with diverse client populations. Gingerich and Peterson (2013) presented a systematic review of evidence on solution-focused therapy showing its effectiveness for a wide range of behaviors. Finally, the continued growth of SFBT research studies has led to recognition of SFBT as a promising evidence-based practice by the Substance Abuse and Mental Health Service Administration's National Registry of Evidence-based Programs and Practices (<http://www.nrepp.samhsa.gov/>) and the Australian Psychological Association (2010) review of evidence-based psychological intervention.

As the evidence supporting SFBT as a method of treatment continues to grow, so will the recognition of SFBT as an evidence-based practice by national government organizations. Given the political realities of government sponsors for research, the insurance industry, and the pressure for professional organizations to join the mix with other service providers, evidence-based practice is often touted as the *best practice* to be used in a particular setting and with particular clients. Therefore, it is advantageous for SFBT to be recognized by government and appear on national registries. In some cases, practitioners may find that their agency has taken on one of these evidenced practices. In this situation, solution-focused practitioners find themselves searching for and recognizing the extensive research already done with solution-focused practice under the label of evidence-based practice. Utilizing the available resources mentioned above is a useful means of obtaining such information.

Conclusions

The practitioner with an interest in exerting more effort to use research to inform practice or to engage in research that informs practice can use our practical guidelines for research and seek partnerships with academicians to engage in a practical research project. Using the basic principles of

³ For more information see <http://www.centerforclinicalexcellence.com>

utilization-focused evaluation, such a project makes the practitioner and the academician collaborators. These practical research projects can take a form that falls into any of a number of categories, from research conducted on current clients for one's own development, to research conducted for reports that might be shared with others, to research that might be of a wider interest and published in scholarly journals. In each case, there are fundamental research methods to be implemented.

Those who adhere to the principles of practice-based evidence may employ solution-focused practice if they are skilled in this approach and can effectively implement the common factors in therapy. Those who prefer to consider themselves evidence-based practitioners can consider the wide array of research supporting solution-focused practice as a basis for their claim in using evidence-based practice as product. To claim to be employing evidence-based practice as process, however, the practitioner will need to spend some time with the evidence for each client and consider what the best approach is.

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