Effectiveness of brief therapy: an analysis

Brief Therapy – Promising or Abusive?

Brief and time-limited therapy experienced much controversy about its usefulness before it has finally established itself as a valid form of therapy for certain patient populations while being accepted by most professionals in the field. Some therapists have even hailed brief therapy as having already filled the place of longer-term psychotherapy and having emerged as the 21st century's preferred treatment (Carlson & Sperry, 2000). This brief paper intends to investigate whether these assertions are acceptable or whether brief therapy should be rejected in favour of traditional longer-lasting intervention models.

Definition and Characteristics of Brief Therapy

Brief therapy is neither unequivocally defined nor represents a unity as demonstrated by Sperry (1989) who compared eight contemporary brief therapy models. He concluded that none of the investigated models would agree upon the ideal clients to treat, the ideal definition which decides over what is exactly comprised by the term *brief* and most importantly in the targets and aims for brief therapy (Manaster, 1989). The present paper will focus on these points and also emphasise the practical and ethical bases for brief therapy.

Psychotherapy generally embraces a *therapeutic negotiation* which can last from a few months to a few years (brief vs. long-term therapy) although these therapeutic transactions may even take place after shorter periods of time during a therapeutic dialogue. Notwithstanding, there was for a long time the notion persisted among leading therapists that the longer a therapy

endures the better the improvement experienced by the patient (Fiester and Rudestan, 1975). This belief, however, was neither backed up by scientific research nor by clinical experience. In contrast, recent research repeatedly and uniformly demonstrated that therapeutic interventions which are designed for shorter amount of sessions are more effective than longer lasting interventions (Sperry, 1989). As a result of these findings, brief therapy enjoyed greater popularity and it became necessary to finally formulate the brief therapy model more thoroughly. Thus, Koss and Shiang (1994) identified in the fourth edition of the Handbook of Psychotherapy and Behaviour Change the basic principles of brief therapy. They concluded that it involves around six general considerations that enable therapeutic processes to be brief: 1) time-limitation 2) focus on change over the client's life span, 3) working alliance between counsellor and client, 4) therapists pro-activeness, directiveness, optimism, 5) flexibility of technique, 6) focus on termination issues (Nicoll, Bitter, Christensen, and Hawes, 2000; Bitter and Nicoll, 2004).

Number of Treatment Sessions

A fundamental and enduring discordance between idealised hypothesis and realisable practice involves the average number of treatment sessions undertaken by patients.

Hansen, and colleagues (2002) discovered that the median number of treatment sessions in time-unlimited therapies is below seven. However, after having reviewed the literature it can be said that most definitions regard brief therapy as including at maximum 20 to 30 sessions while the numbers appear arbitrary. Most investigated interventions, however ranged

from seven to 25 sessions (Sperry, 1989). Shulman (1989) notes that prior to the emergence of psychoanalysis the necessary time period for psychotherapy was not an issue. Nonetheless, by the time psychoanalysis indicated to be both popular and lengthy length of time required for successful psychoanalysis interventions became an issue. Ferenczi (1951) and Rank (1945) pioneered in finding new ways to reduce the treatment period.

Consequently, Shulman (1989) defined brief therapy by the therapist's endeavour to significantly improve the client's condition in a short period of time while Gentry (1981) described brief therapy as emphasising on " current observable behaviour and social interaction." Brief therapists, as a conclusion, excludes the exploration of childhood traumas and experiences as it is not intended to make the client aware of impact of past experiences upon current functioning. Thus the fundamental aspect of a brief therapy definition seems to be the focus on keeping therapy short and limited rather than specifying the maximum allowed amount of necessary time (Manaster, 1989). Limiting targets and time are the two ways which have been identified by therapists as making it possible to keep therapies as short as possible. Limiting targets involves reducing the attention to a specific resolution of an identifiable trouble or problem. This approach is characterised by understanding individuals in parts in such a form that it is possible to treat their crisis more briefly. Those who prefer a more holistic approach regard patients as more complex and believe that thus it is only feasible to treat solely superficial dilemmas and crises. Consequently, according to Evans (1989) it is very complicated to vindicate the limiting of

targets in a holistically based therapeutic transaction (e. g. Individual Psychology).

The matter of setting joint targets is important as clinicians often have different expectations about treatment results than their clients. Whilst most therapists attempt to succeed in achieving more complex and thorough treatment results most clients are normally requiring relief from psychotherapy (Beutler and Crago, 1987).

As a matter of fact, the therapist should strive towards being professional, and thus, offer as many sessions as necessary. As a consequence of choice given to clients or economic and policy considerations, the norm in both Britain and America is that to undertake brief therapy in no more than about 25 sessions.

The new trend, however, are currently so-called ultra-brief therapies which involve therapies of less than six sessions. Again, these ultra-brief therapies result due to treatment services and resource constraints. A few recent experiments have already tried to establish its usefulness. Copeland and colleagues (2001), for instance, contrasted one- and six-session cognitive-behavioural interventions aiming on clients to cease and maintain abstinent from cannabis usage and revealed that only the six-session group demonstrated observable decreased amounts of cannabis consumption relative to controls while one-session programmes resulted only in marginally significant reductions in cannabis usage.

Brief Therapy Conditions (Referral, Contracts)

As Randolph (1992) maintained " brief therapy is viewed as realistic and geared to the demands (and needs) of clients and not to the restraints of the market place" (p. 159). In other words, brief therapies are more client-focused and centred in contrast to long-term therapies and therefore it is important to consider for which type of clients brief therapy is more meaningful and promises to be more effective.

Hence, both referral out and in should be based upon cautious and thorough assessment of patient' suitability for brief therapy. Most time-limited work takes place in settings and as a consequence involves more than the therapist alone. In essence, what is made available to the patient is usually determined on the applied exclusion and inclusion criteria. Additionally, the practising counsellor should be preferably the only person who decides over what exactly can be done to improve the patient's condition, who is the ideal person to assess the present client and future patient and how the therapy has to be set up, contracted, conducted, and ceased. Due to limited resources it is not always possible to consider the client's choice over what s/he desires to receive. Both prognosis of potential outcome and availability play mostly a more important role than the patient's ideal therapy plan. There are no strict rules of how contracts have to be negotiated as they are very context specific. They can be arranged as Mander (2003) noted by " the therapeutic couple or by service managers who hold the purse strings and stipulate the number of sessions allowed."...Starting clients off will depend on whether they are ready to engage in an active working alliance and have sufficient trust to reveal at assessment the extent of the emotional crisis that

has made them seek help.” (p. 486-487). Although both parties generally agree on the fact that the therapy should remain brief it should be possible to arrange a prior or post-therapy referral-on when a serious problem and crisis has been discovered. This referral-on should be very flexible and could even include relocation and therapist change if necessary. It makes sense to regard brief therapy as a kind of pit-stop which has the power to update, re-energise and adjust the human minds vehicle while allowing the individual to come back to the repair station whenever it is needed again. Thus clients can be accompanied by brief therapies from childhood to maturity. Self-evidently not everyone will be in need of constant check-ups and pit-stops as the majority of individuals will adapt and acquire skills to deal with the working-through processes independently. The therapist him or herself can view this service as similar to intermittent parenting of an individual (Mander, 2003).

Despite the fact that some (e. g. Bitter and Nicoll, 1994) view the integration of time limits into the intervention programme as leading to both meeting and leaving people in the middle of their lives other researchers are of the opinion that it must be possible to extend the contract in a therapeutic alliance and that the counsellor must even feel free to transform a brief therapy into a long-term therapy.

In a nutshell, in deciding who to treat, clinicians of different fields should aim to match their techniques, clinical experience and theory with patients who they evaluate as being ideal to be helped by this intervention model. Whitaker (1996) noted furthermore that some groups like students with disabling emotional problems should not be included in brief therapy

programmes. Likewise, severe eating or personality illnesses or serious sexual perversion and severe alcohol and drug addiction are hardly curable in intensive but limited and brief therapeutic interactions. Cooper and Archer (1999) added that the clinical service mission and criteria for therapy must underlie a well-defined, unambiguous and clear assessment model like the Diagnostic and Statistical Manual of Mental Disorders (DSM IV).

Suggestions for a Counsellor in Training

Starting to practise as a brief therapist is both very challenging and rewarding. However it can also become difficult to constantly motivate oneself to continue if the desired outcomes do not become evident in the short available time.

It is rewarding as one has the opportunity to see how patients' conditions transform and improve in a short period of time whereas achieving set goals is certainly an uplifting and worthwhile experience. The real secret and difficulty for the beginning counsellor is, however, to know themselves perfectly and to not only be aware but also to tightly monitor one's strengths and weaknesses. For example, " being able to bear the repeated hellos and goodbyes of brief therapy may depend on how the therapist has managed the meetings and partings in their own life, and their ability to focus on significant psychodynamic details will be a function of how they analyse their own life experience in terms of linking past and present". (Mander, 2003; p. 498).

Without both it is rarely possibly to allow patients to move on when their contract has terminated. Discussing and being aware of transference helps

additionally not to hanker about past clients while receiving and accepting new patients in need of brief therapy. It is debatable whether a young counsellor has already achieved a certain level of maturity which is necessary in order to accept imperfect rather than ideal treatment outcomes. Consequently, one must permanently be empowered to control for the balance in both the practitioner’s and patient’s expectations while being utterly optimistic that both expectations will be met. One has to constantly bear in mind that the client needs to leave the treatment sessions with a positive impression and feeling as a client will have to force and push him or herself real hard to ask for help the next time s/he needs therapeutic help again.

Conclusion

By setting targets and a time limit clients may feel that they are not imprisoned by the therapy but that an improvement of their condition is both in sight and tangible. This optimism unleashes positive energies which benefit the overall therapy. Additionally, patients may perceive for the first time that the therapy is more tailored to their own needs and that the therapist is not so much interested in the potential commercial benefits but is more concerned that the set goals are achieved in a brief period of time.

The fact that clients may feel better understood enables a beneficial therapeutic relationship to develop which facilitates clients to come back after the brief therapy and attempt to tackle another experienced personal problem or crisis.

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