

## Chapter One: A Brief Review of Brief Therapy

*Remember kids, it is not second hand smoke that kills; it is second hand thoughts.*

George Herms, Artist

This may be the first book you've read on the topic of brief therapy, or it may be the fiftieth. In either case, it can be useful to go through a general orientation (or re-orientation) to the theory and practice of brief therapy. This is what we will aim to accomplish in this chapter: First, we will provide a general framework for determining what a brief therapy is, and isn't. Second, we will examine some common myths and misconceptions about how people change, how therapy produces change, and what clients hope to gain by seeking therapy. Third, we will give you a brief history lesson so that you can understand the origins of the brief therapy movement and how it has evolved up to the present day. Finally, we will briefly review significant issues in brief therapy that may be limiting its acceptance by the wider mental health community. If, by the end of this chapter, you are interested in learning more about the theory and practice of brief therapy, there are many useful texts to choose from (i.e., Hoyt, 2001, 2008; O'Hanlon & Weiner-Davis, XXXX).

### **Defining Brief Therapy: Not As Simple As It Sounds**

A long-standing conceptual problem is how to define "brief therapy". In part, this is because "brief" is in the eyes of the beholder. For a psychoanalyst used to seeing clients 2 times a week for years, seeing a client for only one year might be considered brief. Indeed, many published studies of "brief psychodynamic therapy" involve 20 session protocols, exceeding the length of many full bore cognitive behavioral treatments. A clinician used to treating depressed

patients with a 16 session cognitive therapy protocol might consider 8 sessions as brief. To complicate matters, there are several seemingly synonymous terms that are often used as if they are interchangeable: brief strategic therapy, time-limited therapy, short-term therapy, time effective therapy, and brief intervention to name a few. We thus have an alphabet soup of terms that can potentially create a lot of confusion on top of the difficulty inherent in pin-pointing the right definition of brief therapy.

Let's start the clarification process by taking on the issue of time. "Time effective" treatment is an approach emphasizing getting the most "bang for the buck" out of each therapy session. If a client is seen 12 times and the maximum clinical impact has been obtained by virtue of the 12 sessions, then that is "time effective" treatment. "Time-limited" and "short-term" therapy means that a pre-set and limited number of therapy sessions are delivered as part of a treatment program; for example, an 8-session group designed to develop personal problem solving skills. A "brief intervention" usually refers to a 1 or 2 session protocol for addressing high risk behaviors like smoking, drinking, or substance use. It is often delivered in primary care, hospital, jail, or crisis settings where the ability to meet with patients over time is very limited.

A different approach to this issue is to think of therapy in general as a "horse race" between what the treatment model requires versus what the client is willing to accept. Whereas the client's motivation for therapy decreases steadily over time, many therapeutic approaches sequentially introduce certain concepts and skills over the course of treatment. Unfortunately, many clients will have already dropped out of treatment and won't benefit from those strategies slated for the latter stages of treatment. For example, the average number of sessions completed by a typical client during a single episode of therapy in the United States is between 4 and 6, depending upon the source studied (Brown & Jones, 2004; Talmon, 1990; Olfson et. al., 2009).

Our view is that a brief therapy is designed for completion before this natural breaking point is reached. In this definition, brief therapy is really the philosophical acceptance by the clinician that the amount of time available to help a client is going to be limited, that the therapy process needs to be “client driven” and the clinician’s mission (should he or she decide to accept it) is to help the client achieve meaningful behavior changes during the time available.

## **Harmful Myths and Misconceptions**

In this section, we want to examine some myths and misconceptions that have lead many behavioral health clinicians to dismiss brief therapy as a legitimate form of treatment. Although research on the traditional brief therapies is sparse, the field of psychotherapy research in general, and cognitive behavior therapy in particular, has a wealth of scientific data that will prove pertinent to this discussion.

### **Myth: Clients Want Lots of Therapy**

Clients enter therapy because of heightened levels of psychological distress and, as their distress dissipates, they are less and less inclined to return for additional therapy sessions (Brown & Jones, 2004). This suggests that clients’ primary motives in seeking help are emotional reassurance and practical problem solving. These two outcomes are easily achieved for most clients within the first few sessions of therapy. It is important to remember that, although a therapy session consumes only one hour of the therapist’s time, it consumes far more time for the client. The client may have to hire a babysitter, take time off work without pay, commute to and from the therapist’s office, and pay for gas on top of it all. In reality, therapy is, unfortunately, an inconvenience for most clients.

Research shows that most clients will finish therapy quickly, with or without the agreement of their therapist. While results vary somewhat, a safe estimate is that 30 to 40 percent

of clients drop out of treatment without consulting their therapist (Talmon, 1990, Olfson et. al., 2009). In a naturalistic study of over 9000 clients in therapy, a large majority had completed treatment by the fifth session, and *the modal number of psychotherapy visits was one* (Brown & Jones, 2004). Imagine the implications that this single finding has for traditional mental health practice. The first session is usually devoted to taking an extensive history of the client and preparing a treatment plan. Interventions are often put on the back burner for later sessions due to the time-consuming intake process that takes place during the first. Meanwhile, the most likely scenario is that the patient will not return for that second visit! One brief therapy model, called Single Session Therapy, takes this client tendency very seriously; it is based on the assumption that the therapist and the client will see each other only once and, therefore, the goal is to have as much of an impact on the client's life as possible in the first session (Talmon, 1990). There is a relatively small group of clients who prefer long-term therapy and consume a disproportionate amount of the total therapy services provided in the United States (Howard et. al., 1989). Interestingly, what predicts clients staying in therapy is continued high levels of psychological distress (Brown & Jones, 2004). **In other words, they're staying in therapy because it *isn't* working, not because it *is*!**

Interestingly, a client satisfaction survey conducted by the first author showed no differences in therapy outcomes among clients who stopped therapy on their own versus clients who stopped therapy by agreement with their therapist. In this same survey of several hundred clients, we saw no outcome differences between clients seen once versus clients who had multiple therapy sessions. The only difference was that clients who dropped out of therapy reported lower levels of satisfaction with their care. The take home message is that what drives client preferences for therapy and how much of it they are willing to tolerate has been virtually

ignored by the mental health community. If we are to be guided by the data, it appears that most client PREFER brief therapy!

## **Myth: The Amount of Change Is Dependent Upon Time Spent In Therapy**

A common myth prevalent in the mental health community is that the benefits of therapy accrue over time; hence, the longer the client is in therapy, the more benefits the client will experience. Research has been conducted on the “dose-effect” relationship between number of therapy sessions and the amount of change a client experiences. The seminal study in this area was published about 25 years ago, but seems to have been largely ignored (Howard, Kopta, Krause & Orlinsky, 1986). There are a number of important findings that warrant discussion. First, approximately 15 percent of clients are clinically improved before they arrive for the first session! It appears that the act of deciding to get help is actually a form of help in its own right! Further, 50 percent of all clients are clinically improved by the 8<sup>th</sup> session. After the 8<sup>th</sup> session, progress in therapy slows significantly. To get 75 percent of clients clinically improved requires at least 26 sessions. A more recent study of the dose-effect relationship showed that clients undergoing brief treatments show relatively fast rates of change compared with clients who underwent longer-term treatment. Interestingly, number of therapy sessions was not a significant predictor of clinical change, leading the authors to conclude that change is a non-linear process (Baldwin et. al., 2009).

## **Myth: The Longer the Therapy, The More Powerful The Effects**

A related, but slightly different myth is that longer-term treatment produces superior outcomes compared to shorter-term treatment. For example, 16 sessions of cognitive therapy for

depression should produce greater reductions in depression among more clients than 8 sessions. In a test of this idea (Molenaar et. al., 2010), results indicated that the degree of symptom reduction and improvement in social functioning was just as great in an 8 session treatment as in a 16 session treatment. This finding has also been observed in studies comparing long- and short-term family therapy for anorexia (Lock, Agras, Bryson & Kramer, 2005), short- and long-term family based treatments for childhood behavior problems (Smymios & Kirkby, 1993), brief and longer-term cognitive behavioral therapy for PTSD (Sijbrandij et. al., 2007) and a brief intensive 2 day treatment for panic disorder (Deacon & Abramowitz, 2006). The recent research suggests that brief treatments are just as effective as prolonged treatments for the same disorder. This finding has been observed with depression and a wide range of anxiety disorders (Cape et. al., 2010).

## **Myth: Brief Therapy Is a Superficial Intervention With Few Long Term Benefits**

A key issue in the delivery of any kind of psychotherapy is the long-term impact it has on the client's life functioning. Treatments that only reduce transient symptoms of distress, but don't affect longer-term patterns of maladaptive behavior will create a "revolving door" problem. Specifically, clients repeatedly have to seek therapy to address new problems created by long standing behavioral issues. One theory of change in psychotherapy, called the "phase model", holds that clinical response occurs in three discrete phases that are assumed to be time dependent (Howard, Lueger, Maling & Martinovich, 1993). The first phase is termed "re-moralization", which involves a sense of subjective improvement as the client starts to do something about the problem; the second phase is termed "remediation" as clinical symptoms are reduced to low levels; the final phase is "rehabilitation" in which stable improvements in

functioning begin to appear. Since rehabilitation is thought to be a longer-term process, one could argue that brief therapies will do little to promote functional improvement.

In a recent study examining this potential issue, 338 consecutive clients participating in a brief consultation program in primary care were administered a measure based on the phase model at each visit. The average number of brief intervention sessions per client was 1.5, with the mode being 1. Among clients receiving two or more sessions, results suggested clinically and statistically significant changes in all three phases of change (Bryan, Morrow & Kanzler-Appolinio, 2009). Another recent study examined the effectiveness of a 2-4 session cognitive behavioral intervention for regular amphetamine users and found a significant increase in the probability of abstinence among clients receiving at least two sessions (Baker et. al., 2005). These results suggest that the process of therapeutic change is not yet well understood and may in part be influenced by the subtle or not so subtle communications and expectations of the therapist! If the client hears that some specific personal issue is going to take a long time to deal with in therapy, the client may dutifully comply with that suggestion.

### **Myth: Rapid, Large Clinical Gains Are Rare In Therapy**

For over a decade, two of us (Strosahl and Robinson) worked in a brief therapy center where we co-led many groups for depressed patients. Many of our clients had depression scores in the severe range and had been depressed for a long time. While co-leading these groups, we noticed a curious thing: After one or two group sessions, a certain percentage of these clients would exhibit large sudden reductions in depression and stay that way for the rest of the group. Even severely depressed patients exhibited this pattern.

As it turns out, we were not alone in seeing this effect. It is estimated that 40 to 45 percent of depressed clients exhibit sudden large gains within the first 2 to 4 treatment sessions

(Doane, Feeny & Zoellner, 2010). Similar observations of clients making rapid progress in the initial sessions of cognitive behavior therapy have been noted for PTSD (52 percent of clients; Doane, Feeny & Zoeller, 2010), adolescent depression (Renaud et. al., 1998), binge eating (62 percent of clients; Grilo, Masheb & Wilson, 2006) and irritable bowel syndrome (30 percent of clients; Lackner et. al., 2010). What is equally intriguing is that rapid response is associated with long-term improvements in functioning, as well as a reduction in relapse rates (Crits-Cristoph et. al., 2001; Lutz, Stulz & Kock, 2009). This tendency of rapid responders to show better longer-term functioning was also found in a sample of depressed adolescents (Renaud et. al., 1998). So, rapid gains in therapy are not evidence of a “flight into health”, but rather are clear signs of enduring radical change.

## **History 101: Evolution of Brief Therapy**

Now it’s time to look back and look at the roots of the brief therapy movement in the United States. There were two principle progenitors of brief therapy, both of whom continue to have large numbers of dedicated followers.

### **Milton Erickson & Clinical Hypnosis**

Milton Erickson was a psychiatrist who is regarded as the founder of modern day hypnotherapy (Rosen, 1991). Afflicted with a nearly fatal case of polio as a child, and crippled and in pain for much of his life, Erickson developed a unique approach to accessing non-verbal learning processes via therapeutic interventions. He believed that verbal self-knowledge was as harmful as it was helpful and spent most of his career developing non-verbal methods for inducing change.

Erickson mastered the use of paradoxical interventions, confusion, metaphor, indirect suggestion and encouraging resistance. A paradoxical intervention is one in which the client is



instructed to “practice the problem” more intently, or to do more of it. The concept underlying such interventions is that most clients feel they have no control over whether a particular problematic behavior or emotion occurs. Therefore, instructing them to generate the problem paradoxically demonstrates they have control over whether it occurs

Another core element of the Erickson approach is the use of confusing language practices. The motive behind creating confusion in therapy is that it draws the client out of a familiar “frame of reference”. This is the well worn, familiar, and ineffective mental model the client brings into therapy about “the problem”. By drawing a client out of the frame of reference, a mental operation begins that attempts to integrate confusing information into the existing frame of reference. Since this is not possible, it is the frame of reference that must expand to include the inconsistent or confusing information.

Indirect suggestion was a defining feature of Erickson’s clinical approach. Indirect suggestion can involve embedding a non-specific, positive “suggestion” in the dialogue (i.e., I’m looking forward to hearing about the other ways you notice yourself reacting when you get into this situation again). Indeed, clinical hypnosis arguably is the art of making indirect suggestions that subtly influence the client’s subsequent behaviors. Erickson also developed non-verbal strategies to make clients more susceptible to suggestion. One of the better known is a tactic called pacing. In pacing, the therapist mimics a particular feature of a client’s verbal or non-verbal behavior (i.e., head nodding, foot tapping, frequent use of a verbal behavior such as the phrase “you know”). Whether verbal or non-verbal, indirect suggestion strategies are thought to increase the client’s receptivity to change by accessing mental processes that are not under the direct control of language.

Erickson was also the first to explore the notion of “encouraging resistance”, a technique designed to offset the natural tendency of clients to get into a “push-pull” relationship with the therapist. Erickson’s approach involved “riding with resistance”, allowing the client to withhold any information deemed irrelevant or too emotionally threatening. This tactic is really a paradoxical intervention in reverse; the more it is suggested that the client certainly won’t want to discuss some painful issue, the more the client might be tempted to bring that issue into the therapy conversation.

Erickson’s work remained largely unknown outside of the clinical hypnosis community until the publication of *Uncommon Therapy*, by Jay Haley (1993). Haley’s book brought Erickson’s unique perspective and clinical methods into the mainstream of the brief therapy community. Even today, the Milton Erickson Foundation ([www.erickson-foundation.org](http://www.erickson-foundation.org)) continues to be a leading force in the development of novel strategic therapy approaches and sponsors an annual conference devoted to advances in brief therapy and hypnotherapy.

### **Problem Focused Brief Therapy**

The second major force in the evolution of brief therapy was the Mental Research Institute in Palo Alto, California. Founded by anthropologists Gregory Bateson and Donald Jackson in 1958, the MRI began a long-term study of cross cultural communication practices using cybernetics-systems theory. One of the most famous findings of this project was the “double bind” theory of schizophrenia (Bateson et. al., 1956), which stimulated research into the communication practices of families of patients with schizophrenia that continues to this day. The notion that communication practices within a family could promote the onset of schizophrenia triggered a major resurgence of clinical and research interest in interventions for family systems. Arguably, the MRI is responsible for the family therapy movement in the United

States and, indeed, offered the first formal family therapy training program. Informed by the work of John Weakland (Weakland & Ray, 1995), and Paul Watzlawick (Watzlawick, Weakland & Fisch, 1974), the MRI Brief Therapy Center opened in 1966 and developed a unique form of brief therapy called Problem Focused Brief Therapy. One of the seminal concepts of the problem focused model is that it is the client's solution, not the client's problem, that is the problem (Watzlawick, Weakland & Fisch, 1974). This simple, but counter-intuitive idea has become a cornerstone of almost every brief therapy. It implies that the client's strategies for solving what is perceived as "the problem" are either creating or amplifying the problem. Another major contribution attributed to Watzlawick is the concept of Type 1 versus Type 2 change. In Type 1 change, small changes in perspective might occur but the client is still locked into a system that is dysfunctional on a larger scale. . In Type 2 change, the client's perception suddenly shifts, such that the existing world-view is replaced by an entirely perspective. FACT seeks to promote Type 2 change by changing the relationship the client has with emotions, thoughts, memories and other distressing material.

## **Contemporary Approaches to Brief Therapy**

In recent decades, two important schools of brief therapy have capitalized on the emerging health care philosophy of providing briefer, lower cost therapy: Solution Focused Brief Therapy (deShazer, 1985, 1988, 1991) and Narrative Therapy (White and Epston, 1990, White, 2007).

### **Solution Focused Brief Therapy**

Early in his career, Steve deShazer was a member of the MRI brief therapy team. He noticed that the more clients talked about a "problem" in therapy, the more self-deprecating and rigid they became. He theorized that systematically directing the therapeutic conversation to

focus on client strengths and solutions would enable clients to change more quickly. This led deShazer to develop an alternative approach called Solution Focused Brief Therapy (SFBT; deShazer, 1985, 1988, 1991).

A key tenet of SFBT is that “problem talk” creates a shared assumption between therapist and client that the client is “stuck” and nothing can change. Clients enter therapy with the belief that talking about their “problem” will help them discover ways to fix it. From an SFBT perspective, the more clients engage in this kind of problem talk with the therapist, the more the problem is magnified. The goal of SFBT therefore is to change the therapeutic conversation such that problem talk is replaced by “solution talk”. This is accomplished by focusing on client strengths and successes, rather than on deficits. There are many SFBT interventions strategies that are designed to shift focus to what the client is doing “right” to help the client imagine what a better life might look like and what steps the client can take to move in that direction. SFBT might be thought of as an approach that really focuses on the impact of small positive change.

## **Narrative Therapy**

Narrative Therapy was developed by Michael White in Adelaide, Australia (White & Epston, 1990, White, 2007). We describe this approach as a brief therapy with some trepidation because the only existing clinical study of the approach used an eight session protocol to treat depressed patients (Vromans & Schweitzer, 2010). This would qualify as a “time limited” or “time effective” treatment by our definition, but not as a “brief therapy”. However, many brief therapists note that they integrate concepts and strategies of Narrative Therapy into practice, so we briefly review this approach just to be on the safe side.

White was heavily influenced by philosophy called “post-modernism”. A highly simplified description of this philosophy is that humans create reality through their mental

constructions of it; there is no objective “reality”. Thus, the same situations, events and interactions can be interpreted in endless ways. Human narratives are made up of events, linked by a theme, occurring over time and organized according to a plot. A story emerges as certain events are selected out over other events as more important or true. As the story takes shape, it invites the client select only certain information while ignoring events that do fit the storyline.

When clients seek therapy, they are often being dominated by “problem-saturated” stories. Problem-saturated stories can also become identities (e.g., I’ve always been a social misfit). These stories can exert a powerful negative influence on the way people see their lives and capabilities. Narrative therapy focuses on destabilizing the personal narratives that clients hold as “reality”. A classic narrative intervention is to “externalize” the narrative by writing it on documents, by having an external witness (often a friend or acquaintance of the client) be present to hear the client’s narrative, or by giving the narrative its own properties or motives that are at odds with the client’s goals and desires. The goal is thus to allow more compassionate narratives to compete with harsh, critical, and self-rejecting narratives.

## **Brief Therapies: Barriers to Buy In**

Over the years, the popular appeal of brief therapy within the larger mental health-health community has waxed and waned. It would be fair to say that most practicing clinicians have had at least some level of exposure to one or more brief therapy approaches. However, widespread adoption of brief therapy as the preferred approach to mental health care has been met with several criticisms, some practice based, some theoretical, and some empirical.

## **Managed Care Conspiracy?**

There is little doubt that the rise of managed care has been a major boon to the field of brief psychotherapy, so much so that some practitioners incorrectly equate brief therapy with the

exploitative goals of managed care. As we have seen, brief therapies had been in existence for decades before the beginning of managed care reform movement. Nevertheless, critics argue that managed care networks were conveniently quick to adopt brief therapy as a preferred practice model with the intent to deprive clients of needed longer-term therapy services and to make money for the insurance company by doing so. This link between managed care and brief therapy has engendered unnecessary resistance to the expansion of brief interventions and therapies in settings where these are the only viable treatment approaches, such as in primary care, emergency rooms, crisis programs, and school based programs.

## **Hazy Theories of Clinical Change**

Since their inception, brief therapies such as the MRI and SFBT models have been renowned for their “catchy” sayings and techniques, and have taken a rather iconoclastic stance with respect to the sacred assumptions of more traditional therapeutic approaches. This has no doubt generated a lot of interest among practicing clinicians, who want to add as many techniques as possible to their therapeutic tool bag. It has also helped promote the dissemination of brief therapies because of their relative simplicity. The downside is that brief therapies often are based on vague or poorly articulated models of intervention and change. The result is that it is difficult to conduct “dismantling” studies of brief therapy approaches to isolate their active ingredients. For example, we would have trouble identifying which solution focused techniques are the “core ingredients” of the treatment that produce change because the change process itself is not described, just the techniques that are used to induce change. There is a big difference between simply describing the intervention methods of a particular treatment and articulating how those methods work to produce change.

## **Lack of Evidence**

A common criticism that has been present for decades is that brief therapy approaches lack scientific support for their clinical effectiveness (Jacobson, XXXX). The world of mental health is changing and, whereas it was fashionable a decade ago to blast the notion of evidence-based treatment as unachievable in the mental health field, it is now considered the gold standard. Mental health centers, and the clinicians that practice in them, are now being required to use treatments that have some scientific evidence. It is no longer trendy to argue that mental health outcomes cannot be quantified, measured and used to improve the quality of treatments we are offering clients.

It is indeed ironic to point out, on the one hand, the abundant evidence for rapid change in therapy and, on the other, to state that none of the traditional brief therapy approaches discussed in this chapter would “make the cut” as an evidence-based treatment. Solution Focused Brief Therapy has received the most scrutiny, but the studies are limited in number, often are “post hoc” in nature, and lack essential methodological controls (i.e. random assignment to control groups or the use of wait list controls or comparison treatments). There are two published meta-analyses of SFBT in the American literature (Gingerich & Eisengardt, 2000; Kim, 2008). Both conclude that SFBT cannot be considered an evidence-based treatment at this time. The most recent meta-analysis calculated effect sizes for SFBT, and found them to be in the range of .11 to .23. These would be considered as only mild treatment effects. As a comparison, meta-analyses of Acceptance and Commitment Therapy considered across a very wide range of clinical complaints have shown average effect sizes of .62.

We were able to find only one outcome study for Narrative Therapy involving a cohort of depressed adults (Vromans & Sweitzer, 2010). It does not appear that there was a control group or comparison treatment used in this study, so the results must be viewed with caution. However,

the treatment produced very impressive reductions in depression among clients who completed treatment. The calculated effect sizes were approximately 1.26, which would be comparable to most evidence based treatments for depression. Unfortunately, it must be noted that this is the only scientific study of the Narrative Therapy in the nearly 20 years since its introduction.

## Summary

We believe most people are equipped with the psychological tools necessary to transcend their suffering, and they can do so rapidly given the right circumstances. When it comes to therapy, more is not necessarily better. The “insight” and “understanding” clients often gain from longer-term therapy can be a double-edged sword. As we often tell clients, understanding how you got into this mess has no bearing on how you will get out of it! If insight and understanding is not combined with meaningful, real world behavior change, it has little practical benefit.

In reality, our scientific understanding of why and how people change is so limited that we would gladly exchange all that we currently know for all that we don't know. This is an interesting paradox for a field that is over 60 years old and has generated literally thousands of research articles on the effects of therapy. As we shall see in the next chapters, Focused Acceptance and Commitment Therapy attempts to unravel portions of this unsolved mystery by proposing a new approach in which human suffering and human vitality are linked to the same underlying mental processes.