Six Critical Questions for Brief Therapeutic Interventions

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Brief therapy strategies and techniques are used by professionals from various disciplines (e.g., nursing, psychiatry, psychology, social work) who use a variety of theoretical approaches to treat numerous mental health problems. Such strategies and techniques are characterized by design to be short term, directive, and change focused in the delivery of mental health treatment. Over the past decade brief therapies have continued to develop rapidly and are currently viewed as state of the art in the field. This article outlines six critical questions related to brief therapeutic interventions that must be considered in treatment planning and subsequent future research. These questions are elucidated as follows: when is a brief therapeutic intervention appropriate, who should deliver the intervention to whom, what brief therapy interventions are most effective with which clients, where and at what setting should the intervention take place, when should the intervention occur and how long should it continue, as well as how is behavior change maintained? Such findings when translated into practice guidelines will enhance practice and move the field of brief therapy forward. [Brief Treatment and Crisis Intervention 2:279–285 (2002)]

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Monumental economic and political forces have reshaped the way medical, mental, and social services are delivered in the United States. Such forces have contributed to brief therapy becoming a common treatment modality for many psychological disorders (Bloom, 2002; Lambert & Anderson, 1996; Levenson, Speed, & Budman, 1995). In particular, managed mental health care companies have become focused almost exclusively on the delivery of brief clinical services (Budman & Armstrong, 1994). Such brief therapy strategies and techniques are used by professionals from various disciplines (e.g., nursing, psychiatry, psychology, social work) who use a variety of theoretical approaches to treat numerous mental health problems (Cameron et al., 1999). Such strategies and techniques are char-
characterized by design to be short-term, directive, and change focused in the delivery of mental health treatment (Bloom, 2001; Nicoll, 1999).

Over the past decades brief therapies have continued to develop rapidly and are currently viewed as state of the art in the field (Nicoll, 1999). Consistently, outcome studies have indicated brief therapy approaches to be as effective as traditional time-unlimited therapies (Bloom, 2002; Garfield, 1998; Koss & Shiang, 1994).

The evaluation of brief therapy is complicated by the multiple theoretical models using brief therapy with a variety of client populations and problems. Koss and Butcher’s (1986) literature review identified 53 models. Since that review, additional models have appeared (Epstein & Brown, 2002). A recognition of the proliferation of models is found in the term brief therapies, which represents the multitude of treatment methods packaged in brief therapy formats. Examples include problem-solving methods, task-centered methods, psychodynamic approaches, cognitive behavioral approaches, crisis intervention, as well as family and group approaches (Epstein & Brown, 2002). Thus, practitioners must be astute in selecting which brief therapy approach to use with which client problem, a task that can be quite complex (Roberts, 2001). Researchers can assist in the identification of specific brief therapy approaches to use with which client problems by conducting outcome studies that break down the multiple brief therapies to identify specific effectiveness.

When Is Brief Therapeutic Intervention Appropriate?

Pressure from third party payers has resulted in brief therapy being the primary treatment for many psychological disorders (Lambert & Anderson, 1996), often without regard for its appropriateness for treatment of particular client problems or for specific client groups. Certainly the efficacy of brief therapy has been demonstrated (Anderson & Lambert, 1995; Koss & Shiang, 1994; Lambert & Bergin, 1994), but based on empirical evidence, when is it the therapeutic intervention of choice? What are the parameters of when it is appropriate to implement?

As with all psychotherapies, brief therapies are beneficial for certain clients and client populations (Cameron et al., 1999). However, Lambert and Anderson (1996) contend there is little consensus regarding which specific client characteristics bode well and which bode poorly. Nevertheless, their conclusions found that currently four main client characteristics must be considered in the selection criteria as they ap-
pear to have at least a moderate relationship to success or failure in brief therapy: severity of disturbance, readiness to change, ego strength, and capacity to relate. Our roles as practitioners in the evolving systems of care is to screen out through the assessment process which clients will not benefit from brief therapy strategies and techniques and provide them with alternative therapeutic approaches. Inaccurate assessment that results in a client’s assignment to brief therapy wrongly can be risky as there is less time to correct diagnostic errors and the treatment plans on which they are based (Lambert & Anderson, 1996). Consequently, a thorough assessment that incorporates standardized measures is not only necessary, but essential (Corcoran & Boyer-Quick, 2002). A variety of rapid assessment instruments (RAIs) are now available to aid in the assessment process. Such instruments are short, easily administered and scored, and found to be as accurate as longer instruments (Corcoran & Boyer-Quick, 2002; Rapp, Dulmus, Wodarski, & Feit, 1999; Springer, 2002). Incorporation of RAIs into the assessment phase not only identifies those clients in crisis who need immediate intervention (Lewis & Roberts, 2002), but also maximizes time utilization and assists with accurate client assignment to crisis intervention and brief therapy.

Who Should Deliver the Intervention and to Whom?

Empirical research has found a number of therapist variables, such as social class, race, ethnicity, religion, age, sex, and verbal skills, have been related to therapeutic outcome (Beutler, Machado, & Neufeldt, 1994). One practice generalization taken from the literature is that differences between clients and therapists should be minimal and matching client and therapist demographic variables enhances effectiveness (Harrison, Wodarski, & Thyer, 1992). Beutler et al. (1994) suggest that future research must concentrate on more complex therapist variables such as cultural attitudes, coping patterns, and directiveness. Therapeutic style is also important as clients’ affective experience is highly correlated with patient-rated session quality (Saunders, 1999). In addition, more complex client variables such as client expectations and attitude toward therapy must be delineated (Garfield, 1994). As we consider brief therapy, how do such therapist variables impact client outcomes, or don’t they? What type of therapist intervenes most effectively with which type of client and which type of problems are the more important questions facing researchers and therefore practitioners?

Also of importance is what level of education and training is necessary to deliver brief therapy interventions (e.g., paraprofessional, professional, specialist). Levenson et al. (1995) found in their research that many clinicians are practicing brief therapy without adequate training. In particular to psychologists, Levenson and Davidovitz’s (2000) national survey found that 89% of their sample use some form of brief therapy, though only half of them had never taken a course in brief therapy. Recently, Roberts (2002) documented the dearth of graduate-level required courses in crisis intervention and brief treatment at graduate schools of social work, and departments of psychology. This lack of training and educational preparation is cause for alarm when one considers the complexity of crisis intervention and brief therapy that requires maximum outcomes from limited sessions.

What Brief Therapeutic Intervention Is the Most Effective With Which Clients?

Perhaps not to every client with a particular difficulty, and perhaps not to the point of complete resolution or cure, but for many problems we are now in a position to offer therapeutic approaches, including brief therapy, that are
effective. The American Psychiatric Association, the American Psychological Association, and the National Association of Social Workers have begun developing practice guidelines that are slowly emerging that contain guidance as to what treatments are first indicated for particular problems (Rosen & Proctor, 2002; Thyer, 2002; Vandiver, 2002). Within the American Psychological Association, careful compilations are being made of psychosocial interventions that work for particular disorders (Sanderson & Woody, 1995), and this information will have an increasing influence on the conduct of practice.

Contrary to Witkin’s (1991) nihilistic view that virtually any intervention can be justified on the grounds that it has as much support as alternative methods, numerous outcomes studies comparing various forms of psychosocial treatment regularly find that certain types of interventions work better than others for particular problems. Consult any recent issue of Research on Social Work Practice, the Journal of Consulting and Clinical Psychology, or the Archives of General Psychiatry for evidence of this contention.

Yet, these interventions are not effective with all clients. Clients are heterogeneous, even when they have the same disorders, ethnicity, or religious backgrounds. Consequently, the advanced practice and research question would be to examine treatment effectiveness within groups and between groups.

Where Should the Brief Therapeutic Intervention Take Place and at What Level?

Few empirical studies have delineated the parameters or criteria for determining whether interventions are especially effective in particular settings or at particular levels. Brief therapeutic interventions can be delivered in a variety of settings (i.e., inpatient hospital, outpatient clinic, criminal justice setting, home, etc.). Does the setting have an impact on the intervention? Do some brief interventions become more effective or weaker in certain locations?

Few studies have also concentrated on the level of practice appropriate for intervention delivery. Is individual, family, group, or community-level treatment best for achieving change in a given situation? Or should a combination of levels be utilized? Criteria need to be developed concerning who can benefit from what level of treatment in which locale. Such knowledge will only be forthcoming when adequately designed and funded research projects are executed in which clients are randomly assigned to varying levels of treatment to control for confounding factors, such as type of behavior, age, gender, ethnicity, and academic and social abilities.

When Should the Brief Intervention Occur?

Intervention timing is a particularly relevant question for the complex problems clients present to practitioners. Roberts (2002) aptly points out that triage psychiatric and psychological assessment should take place soon after the acute crisis situation or life-threatening traumatic event. Furthermore, in the aftermath of major depression, suicide attempts, or traumatic events such as the September 11 attacks, brief crisis intervention and trauma treatment should be implemented as soon as it is feasible and the citizens and community at large are safe (Roberts, 2002). Comorbidity, which has been identified as the rule rather than the exception (Bierderman, Faraone, Mick, & Lelon, 1995; Clarkin & Kendall, 1992), compounds the delivery of effective interventions. Our knowledge base is limited when it comes to the effectiveness of interventions for comorbid disorders. First and foremost, with clients suffering from
two or three disorders simultaneously, how does
the therapist decide which mental disorder to
treat first or does he or she treat them simulta-
neously? Should depression be treated prior to
conduct disorder, social phobia before obses-
sive compulsive disorder, alcohol abuse after
anxiety, or should they be addressed simulta-
neously? Is brief therapy an appropriate treat-
ment modality for each disorder?

How Long Should It Continue and
How Do We Address Maintenance
of Change?

Bloom (2001) eloquently suggests that the most
important question in the field of psycho-
therapy is to know when enough psycho-
therapy has been done. In the past, therapy was
considered to be a long and involved process,
but current trends in brief therapy limit the
number of sessions (Austin & Roberts, 2002).
Bloom (2001) found that the outcome studies on
single session treatment indicate that only per-
sons suffering from relationship problems such
as a broken romance can benefit from a single
in-depth treatment session. However, Bloom’s
(2002) recent review of the 59 outcome studies
measuring the efficacy of 4 to 16 sessions of brief
therapy with persons suffering from anxiety
disorders indicate that the majority of clients
benefited. Empirical research needs to begin to
ascertain the most effective timing for brief in-
terventions and how timing may differ for dif-
ferent clients.

The last three decades, however, have pro-
duced a substantial number of evaluative stud-
ies that support brief therapy approaches and
that indicate brief therapeutic interventions
have a consistent outcome advantage in the
treatment of a multitude of disorders (Bloom,
2001, 2002; Giles, Prial, & Neims, 1993). How-
ever, since disorders differ, research studies
need to continue to identify how long interven-
tions need to continue to provide substantial im-
provement in clients. Once treatment has con-
cluded how are gains perpetuated? Will booster
sessions be utilized? If so, how often and when?
Considerable study is needed to delineate those
variables that facilitate the generalization and
maintenance of behavior change. Such proce-
dures will be employed in future sophisticated
and effective social service delivery systems.

Future Directions

The challenge before us in relation to brief ther-
apy has been outlined and reviewed in this ar-
ticle as: who can deliver the most effective treat-
ment to which clients, what is effective treat-
ment for all of our clients, where and at what
level should the intervention take place, when
should we implement that treatment, for how
long, and how is behavior change maintained?
Partial answers to these questions are addressed
in the professional research literature. To assist
practitioners, it is imperative that brief therapy
research findings to date be summarized into
practice guidelines. Together, as scientists con-
duct cutting edge research related to the specific
questions outlined in this article and subse-
quently assist practitioners in translating such
research findings into practice, the field of brief
therapy will be advanced and clients will ulti-
mately benefit.

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