Brief and Intermittent Approaches to Practice: The State of Practice

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This article is written to provide an overview of the past and present use of two common types of time-limited therapy. Brief (also known as 'short term') and intermittent therapies are explored. Using these time-limited frameworks, a structure and procedural review for conducting evidence-based intervention strategy is presented. Several popular methodologies that use a time-limited focus are reviewed. Recommendations, practice guidelines, and strategy for use of these methods are presented. [Brief Treatment and Crisis Intervention 8:147–163 (2008)]

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Over the years, the overall effectiveness and applicability of brief therapy often referred to as short-term or intermittent therapy has been considered a well-established way of providing care (Bloom, 1992; Dziegielewski, 1997, 2004, 2005, 2006; Mancoske, Standifer, & Cauley, 1994; Wells, 1994). This accepted form of practice has made the various types of short-term treatment a useful strategy with clients that suffer from a broad range of different problems (Congress, 1995; Dziegielewski, 2004; Dziegielewski & Leon, 2001; Dziegielewski & Roberts, 2006). In practice, particularly in the health care arena, brief therapy has evolved into what some in the field have come to call “intermittent therapy.” Intermittent therapy is very similar to traditional brief therapy with one major difference. In traditional brief-planned treatment, the central ingredient was often linked to delivering a planned intervention as quickly and efficiently as possible. In intermittent therapy, the premise of speed and effectiveness remain; however, the sessions are often not planned and may occur purely when available (Dziegielewski, 2004). For the most part, intermittent brief therapy has evolved in the areas of social work practice where the pressure is great and traditional forms of planned strategy are almost impossible to perform (Dziegielewski, 2004; Dziegielewski & Leon, 2001).

In the health care arena, for example, social workers are often forced to go beyond the traditional bounds of their practice wisdom and selecting the best practice strategy is based firmly within the reality of the environment. Therefore, the type of brief therapy utilized may be highly influenced by social, political, cultural, and economic factors. In addition, regardless of the type of brief therapy used or the setting of practice, the pressure for evidence-based interventions continues to be intense. Few professionals would disagree that
evidence-based interventions influence current brief intervention strategies—with most claiming it dictates it.

The pressure to engage in evidence-based brief treatment remains strong as social workers similar to other practitioners are being forced to deal with numerous practice-related issues such as limited reimbursement patterns, declining health care admissions, and numerous other restrictions and methods of cost containment (Long, Homesley, & Wodarski, 2007; McNeece & Thyer, 2004). Struggling to resolve these issues has become necessary based on the inception of prospective payment systems, managed care plans, and other changes in the provision and funding of health care (Johnson & Berger, 1990; Simon, Showers, Blumenfield, Holden, & Wu, 1995). This turbulent environment now requires social workers to struggle with not only what method of brief intervention to use but also which one can be most effective in the shortest amount of time.

**Short-Term versus Long-Term Therapy**

Historically, the differences between brief or short-term and long-term therapy are extensive with one primary difference being the way the client is viewed. From a short-term perspective, the client is seen as a basically healthy individual who is interested in increasing personal and/or social changes (Budman & Gurman, 1988; Roberts & Dziegielewski, 1995). Short-term therapy is also considered most helpful during certain periods of a person’s life, whereas long-term therapy is seen as ongoing for an extended period of time. In short-term treatments, the goals of therapy are mutually defined by both the client and the social worker (Wells, 1994). This is different from long-term more traditional forms of psychotherapy where the goal is often defined and known first by the practitioner and later shared with the client (Budman & Gurman, 1988). In short-term treatment, goals are concretely defined and many times addressed beyond the time allotted in the actual therapy session in the form of homework (Epstein, 1992, 1994). This is different than long-term therapy in which memories of what happened outside of the session are actually addressed during the session itself (Budman & Gurman, 1988). In short-term therapy, the practitioner is seen as very active and assumes a consultative role with the client (Wells, 1994). The time-limited approaches do not generally recognize insight, and this type of realization is not considered essential or necessary for treatment progress. Finally, in short-term interventions, preparing for termination is discussed early in the therapeutic environment (Wells, 1994). Actually, many times this can mean setting specific limits and a time for termination in the first session. This, however, is very different from long-term therapy where in many cases termination is not discussed or determined in advance.

**Brief Therapy and Evidence-Based Practice Strategy: A Union for Accountability**

Brief interventions that are evidence based mix research and practice with this combination designed to achieve both quality of service and cost-effectiveness. Although this union of evidence-based interventions with brief practice strategy may differ greatly from the roots of long-term therapy but is essential to ensure delivery of efficient and effective services. Thyer (2007) believe that this union is a natural one as practice and research are embedded in the experience of reality for all clients. Therefore, it makes sense that this “reality” would be identified and the subsequent brief strategy would be broken into concrete goals and objectives designed to measure the identified problem (Dziegielewski & Roberts, 2006;
Dziegielewski, Wodarski, & Feit, 2005). The social worker must be able to show how identified goals and objectives have been met, and often this begins with clear and specific problem identification and contracting (Hepworth, Rooney, & Larsen, 2002). To achieve this, supporting information such as concrete measurement instruments are needed with the social worker assuming responsibility for selecting and implementing these appropriate measures. Scales (Corcoran & Fischer, 2000) and other rating schemes for individual, family, and social rankings can be given to each client at the beginning and end of treatment. Furthermore, in addition to the measurement of the intervention itself, it is further suggested that the social worker measure his or her own perceived effectiveness (Fischer, 1976). When a social worker measures his/her own intervention, it allows for clarification and modification and helps to see what techniques and strategies might work best for future cases that require similar intervention.

As the importance of evidence-based interventions grows, so does the union with brief therapy models. Many clients not only prefer it as a mode of treatment but also request it. They simply do not have the time, desire, or money for long-term treatment (especially the poor). Many social workers prefer it based on demands from both clients and agencies (Araoz & Carrese, 1996). They also like the structure and focus a short-term model of treatment can provide. This union is critical because many times the agencies we service prefer it simply because funding sources require it. The days of insurance that covered long-term therapy encounters no longer exist and simply charting that a client reports feeling better have ended. At times, clients have reported greater satisfaction with long-term therapy (Consumer Reports, 1995); however, more controlled research in this area has not been as convincing (Bloom, 1992; Wells, 1994; Wells & Phelps, 1990). Actually, the duration of most therapeutic sessions, regardless of the intervention used or the orientation of the social worker remains relatively brief. Most of these therapeutic encounters generally range from six to eight sessions (Wells & Phelps, 1990). Lack of planning for this, in the treatment context, can result in a great deal of unplanned terminations.

**The Principles of Evidence-Based Brief Intervention Strategy**

In general, evidence-based brief treatment strategy starts with the assessment, the intervention plan, and the evaluation plan (O’Hare, 2005). In the assessment phase, a social history and problem formulation begins. In the initial assessment, problem formulation starts with mutually agreed upon and specific personal and behavior change methods over an explicitly defined period of time (see Table 1). To date, there are multiple types and variations of brief treatment strategy although this article will focus primarily on outlining traditional brief therapy, intermittent therapy and/or a combination of both. Regardless of the model of brief intervention used, all methods of short-term intervention should follow the same basic rules and procedures. In traditional brief therapy approaches, practice occurs in a close-ended therapeutic environment. In intermittent therapy, sessions are spread out over a period of time and only incorporated on an as-needed basis. In today’s high-pressured environment, it is
not uncommon for planned treatments to become intermittent approaches or for intermittent approaches to be used in planned treatment as a follow-up measure (Dziegielewski, 2004). When sessions are planned, 6–10 planned sessions are considered the average; however, as many as 20 have been noted (Fanger, 1994). Generally speaking, the lowest number of sessions is one and the greatest number in a short-term format is 20. Intermittent short-term therapy generally uses fewer sessions, but these sessions can be spread out over a longer period of time. Regardless of the type of intervention used, the objective of all types of short-term therapy is to bring about positive changes in a client’s current lifestyle.

In evidence-based brief therapy, a strong emphasis is placed on measuring the effectiveness of the intervention and reaching success in the fastest way possible. The foundation for evidence-based practice starts with accurate problem assessment framed into a specific question, and the resultant methodology is supported through clinical trials (Rosenthal, 2006). All methods strive to have as little face-to-face therapeutic encounters as possible (Fanger, 1994), and when utilized, these encounters need to be based in research or operationally tested methods. Therefore, the basic premise is to use the best tested methods that help the client return to a healthier state of being in the shortest period of time possible (Fimerson, 1996). Although many models can fall under the umbrella of brief-term treatment, there can be subtle differences between them. For example, short-term treatment models can be somewhat different from traditional crisis intervention strategies. In crisis intervention, the strategy is generally to help the individual achieve a homeostatic balance or return to equilibrium (Roberts & Dziegielewski, 1995). In short-term therapy, the progress of the individual can and often does go beyond resuming homeostasis. Therefore, many forms of short-term therapy often result in new and better coping styles and patterns of behavior.

In the past, the advocating for use of a model of short-term therapy was generally based on treating specific client problems. For example, individuals who suffered from phobic reactions were generally treated with a behavioral technique called systematic desensitization. Today, however, the selection and preferences for the use of a particular model has been expanded. The basic premise is that for a model to be considered a viable brief-term approach, it must include mutually negotiated concrete and realistic goals, a plan for measuring effectiveness, and a specific time frame for conducting the intervention. In this setting, the role of the social worker is somewhat different from the longer more traditional approaches to therapy in several ways. First, the practitioner is expected to be very active and directive. This means that he/she must help the client at all times to focus on the determined directive. This means that he/she must encourage the client to go beyond the bounds of the therapy session and include homework assignments and different forms of bibliotherapy (reading materials) to accompany the intervention. In addition, it becomes important for the practitioner to convince the client that not only is the client competent and capable of change but also the practitioner is capable of helping it to be achieved.

Each client is expected to establish specific but limited goals (Hepworth et al. 2002). A goal stated simply is defined as the desirable objective that is to be achieved (Moorhead & Griffin, 1992). This means that the worker must establish a climate where goals, and the specific objectives to meet them, are viewed as realistic, obtainable, and measurable. In this environment, the encounter is often sealed with a contract that provides a mutual agreement reflective of specified objectives (Dziegielewski, 2004).
**The Phases of Intervention**

Generally, in the short-term treatment environment, certain phases and the tasks to be completed in each phase are addressed (Wells, 1994). The first phase of brief-planned treatment is generally referred to as the “initial phase.” Here, a hopeful environment is created where the client begins to feel confident that his/her problem can and will be addressed. It is important that the social worker communicate and start to build rapport by creating a sense of nonjudgmental listening and understanding, accurate empathy, and positive regard. In this phase, it is important for the social worker to be active in identifying the concrete problems of living a client is suffering from (Wells, 1994). This includes establishing the groundwork for the development of concrete goals and objectives as well as establishing a treatment contract (Roberts & Dziegielewski, 1995). To assist the evidence-based practitioner, the most notable development has been the emergence of numerous brief pencil-and-paper assessment devices known as “Rapid Assessment Instruments” (RAI). These standardized measures, RAIs, share a number of characteristics in common and work well in a brief-planned context. Administration of these measurements can be done quickly and are relatively easy to administer, score, and interpret. For the most part, self-report measures are completed by the client, usually within 15 min. RAIs also fit well in the brief therapeutic environment because these instruments are independent of any particular theoretical orientation and as such can be used with a variety of clinical settings (Dziegielewski & Powers, 2005). Use of these measurement instruments can provide a systematic overview of the client’s identified problems and can be used to stimulate discussion related to the information elicited by the instrument itself. The score that is generated provides an operational index of the frequency, duration, or intensity of the problem. Furthermore, most RAIs can be used as repeated measures and thus are adaptable to the methodological requirements of both research design and goal-assessment purposes. In addition to providing a standardized means by which change can be monitored over time with a single client, RAIs can also be used to make equivalent comparisons across clients experiencing a common problem (e.g., individual functioning difficulty).

RAIs can also assist to provide information concerning reliability and validity. Reliability refers to the stability of a measure as well as whether different individuals interpret like questions similarly (Dziegielewski & Powers, 2005). If a measurement instrument is found to be reliable, it can be determined how useful this information is for repeatedly measuring outcomes (Thyer & Myers, 2007). The concept of validity answers the general question of whether an instrument does in fact measure what it purports to measure. If an instrument is considered to be reliable but not valid, a wrong interpretation of a concept could be measured repeatedly. Therefore, both are critical to measurement with validity tending to be a little more elusive. There are several different approaches to establish validity (Chen, 1997; Cone, 1998; Dziegielewski & Powers, 2005; Powers et al. 1985; Schutte & Malouff, 1995, each of which is designed to provide information regarding how much confidence we can have in the instrument as an accurate indicator of the problem under consideration. Although levels of reliability and validity vary greatly among available instruments, it is very helpful to the social work professionals to know in advance the extent to which these issues have been addressed. Information concerning reliability and validity, as well as other factors related to the standardization process (e.g., the procedures for administering, scoring, and interpreting the instrument), can help the
professionals make informed judgments concerning the appropriateness of any given instrument. Therefore, the use of these types of standardized measures will help the practitioner to utilize an instrument that yields consistent predictable data.

The key to selecting the best instrument for the intervention is knowing where and how to access the relevant information concerning potentially useful measures. Fortunately, there are a number of excellent sources available to the clinician to help facilitate this process. One such compilation of standardized measures is “Measures for Clinical Practice” by Corcoran and Fischer (2000) and another is by Schutte and Malouff (1995) “Sourcebook of Adult Assessment Strategies.” These reference texts can serve as valuable resources for identifying useful RAI suited for the kinds of problems most commonly encountered in clinical social work practice. Schutte and Malouff (1995) provide a list of mental health-related measures for adults and guidelines for their use with different types of practice-related problems. In addition to an introduction to the basic principles of measurement, these books discuss various types of measurement tools, including the advantages and disadvantages of RAIs. Corcoran (2001) also provides some useful guidelines for locating, selecting, evaluation, and administering prospective measures. The availability of these, as well as numerous other similar references related to special interest areas, greatly enhances the social work professionals’ options with respect to monitoring and evaluation practice (Buros, 1978; Mitchell, 1983a, 1983b). Overall, the RAIs can serve as valuable adjuncts for the social work professionals’ evaluation efforts.

Another type of measurement used to enhance documentation that helps to record a client’s functioning level are the practitioner-directed rating scales provided in the Diagnostic and statistical manual of mental disorders-fourth edition, Text revision (DSM-IV-TR) on Axis V (Global Assessment of Functioning [GAF]), the scale provides individual rating scores for each client served (Dziegielewski & Powers, 2005). In this method, ratings of a client’s functioning are assigned at the outset of therapy and again upon discharge. The scales allow for an assigning of a number that represents a client’s behaviors. The scales are designed to enable the worker to differentially rank identified behaviors from 0 to 100, with higher ratings indicating higher overall functioning and coping levels. By rating the highest level of functioning a client has attained over the past year, and then comparing it to his or her current level of functioning, helpful comparisons can be made. Utilizing this scale can help professionals to both quantify client problems and document observable changes that may be attributable to the counseling relationship. This allows the worker to track performance variations across behaviors relative to client functioning. See the DSM-IV-TR published by the American Psychiatric Association (APA, 2000) for a copy of the scale.

Also, in the DSM-IV-TR “Criteria Sets and Axes Provided for Further Study,” there are two scales that are not required for the formal multiaxial diagnosis yet can provide a format for ranking function that might be particularly helpful to social work professionals. The first of these optional scales is the relational functioning scale termed the Global Assessment of Relational Functioning (GARF). This index is used to address the status of family or other ongoing relationships on a hypothetical continuum from competent to dysfunctional (APA, 2000). The second index is the Social and Occupational Functioning Assessment Scale (SOFAS). With this scale, the individual’s level of social and occupational functioning can be addressed (APA, 2000). The complimentary nature of these scales in identifying and assessing client problems is evident in the fact that all three scales, the GAF, GARF, and SOFAS, use the same rating system. The rankings for each scale
range from 0 to 100, with the lower numbers representing more severe problems. Collectively, these three tools provide a viable framework within which human service workers can apply concrete measures to a wide variety of practice situations. They also provide a multidimensional perspective that permits workers to document variations in levels of functioning across system sizes, including the individual (GAF), family (GARF), and social (SOFAS) perspective.

In summary, within the first phase of brief therapy, selecting the tools that will help document client change is essential in problem identification and case planning. A number of excellent sources are available that discuss in detail the kinds of information one would need in order to make informed decisions regarding their selection and application to specific cases (Bloom, Fischer, & Orme, 2003). Once the problem behavior is identified, case plan development can use this wide array of measures to operationally define the various dimensions of the intervention process. These measures can be utilized to establish a baseline thereby providing an initial ranking to compare client functioning at the beginning and end of treatment. Lastly, in this initial phase, and often in the first session, the agreed upon time frame for how long the therapeutic intervention will last needs to be established. Having an agreed upon time frame makes it clear for all involved the time frame available to accomplish the goals that have been outlined.

The “main or middle phase of treatment” is generally based on the model and format chosen in the initial phase. This is the most active of the stages because this is when concrete problem solving actually takes place (Dziegielewski, 1997). Guidelines that can assist in this stage regardless of the model chosen include planning each session in advance, summarization of each session, and maintaining flexibility if renegotiation needs to take place in regard to the problem-solving process. Planning each session in advance requires that the social worker recognize the need for commitment of time outside of the therapy session. Most times, this planning is not reimbursable. Therefore, both the client and the social worker must be willing to commit time to the treatment outside of the traditional session.

The technique of summarization should also be incorporated (Dziegielewski, 2004). When incorporating this technique, initiation of each session involves the client clearly stating the agreed upon goals to be addressed as well as the ones that have been accomplished. This will allow both client and social worker to quickly focus on the task at hand. Summarization also should take place at the end of the session. This is where the client again states whether they believed progress toward the agreed upon goals was made. This is done with the client expressing progress in his/her own words rather than allowing the practitioner to summarize. In doing this, the client is helped to take responsibility for their own actions and helps to incorporate the task as their own.

In closing of this phase, it is important to maintain flexibility for renegotiation of contracted goals and objectives. It is here that the effectiveness of the therapeutic measurement will be conducted. The type of measurement used will depend on the model chosen by the social worker. Lastly, this phase will close with consideration for arrangement of follow-up (Wells, 1994).

In the “final phase” of treatment, a follow-up contact is generally planned. Here, the practitioner is to either meet the client in person or to arrange for telephone communication in order to review and evaluate current client progress and status (Wells, 1994). A recommended time lapse of 1–4 months is recommended. The social worker should prepare in advance for this meeting in order to continue and reaffirm previous measurement strategies (Dziegielewski, 1997).
Specific Application of Brief-Planned Practice Strategy

In this article, several areas usually linked to the provision of brief-term therapy will be addressed: interpersonal psychotherapeutic or psychodynamic approaches, cognitive–behavioral or dialectical approaches, and solution-oriented therapies. In the psychodynamic approaches, as opposed to the evidence-based approaches, a focus on history and past issues can lend credence to current problem-solving efforts. In many of these models, the unconscious is considered immediately accessible and changeable (Ecker & Hulley, 1996). Interpersonal psychotherapy (IPT) is one approach in this category where learning about identified personal problems and the concrete means to address them is considered essential. In the cognitive–behavioral approaches, focus on understanding the complex relationship between socialization and reinforcement as it affects thoughts and behaviors in the current environment is stressed. This results in a clear emphasis on specific goals and objectives that can measure practice effectiveness. Lastly, in the solution-focused therapies, a solution (or course of action) is identified and specific attempts are made to attain it.

Psychotherapeutic Approaches

IPT, a form of brief psychotherapeutic therapy, is used to help clients reduce symptoms and deal with interpersonal problems. Originally, IPT was used as a time-limited outpatient treatment for depressed clients (Weissman & Markowitz, 2000), in which studies of effectiveness have been reviewed throughout the years (Friedlander, 1993; Klerman, Weissman, Markowitz, Glick, Wilner, Mason, & Shear, 2000). IPT has also been used to successfully treat substance problems such as cocaine abuse (Rounsaville, Gawin, & Kebler, 1985). IPT is recommended for professionals such as MD, PhD, MSW, or RN’s (Weissman & Markowitz, 1994) and has been used with individuals, couples, and families (Friedlander, 1993). Efficacy has also been stressed for the treatment of depression with special populations such as the elderly (Sholomskas, Chevron, Prusoff, & Berry, 1983; Miller et al. 1994). Currently, it is highlighted as a viable short-term acute treatment to directly address symptom removal and prevention of relapse. In addition, it is also viewed as helpful for clients having difficulty relating to significant others, careers, social roles, and/or life transitions (Karasu, Docherty, Gelenberg, Kuper, Merriam, & Shadoan, 1993).

IPT treatment that generally addresses the present situation and focuses on the “here and now” is generally assumed (Weissman & Markowitz, 1994). Generally, a focus on recent interpersonal events is stressed with a linking of the stressful event to the client’s current mood. Practitioners are seen as active and supportive and a contributing factor in therapeutic gain (Rounsaville et al. 1987). Stages in the therapeutic process are usually broken down into three phases.

In the first phase (usually one to three sessions), an assessment and intervention plan are devised. Assessment includes a diagnostic evaluation and psychiatric history. Particular attention is paid to changes in relationships proximal to the onset of symptoms. The client’s interpersonal situation is highlighted, and focus is directed toward interpersonal problem areas such as grief, role disputes, role transitions, or deficits. Focusing on one of these interpersonal areas will allow the social worker to identify problems in the interpersonal and social context that need to be addressed (Weissman & Markowitz, 1994).

The middle phase of treatment is the goal-oriented phase in which treatment strategy is applied. Treatment strategy is directly related to the identified interpersonal problem. For
example, if it is a role dispute or conflict with a significant other, treatment would begin with clarifying the nature of the dispute. Options to resolve the dispute are considered. If resolution does not appear possible, strategies or alternatives to replace it are considered.

In some cases, application manuals can be acquired and followed that give specific treatment approaches in regard to certain interpersonal problem areas (Weissman & Markowitz, 1994). The use of manuals in this area has increased particularly in regard to establishing efficacy through research. The use of manuals continues to gain popularity based on the current pressure to use specific goals and objectives. The use of manuals allows for greater detail in operationalization of the particular treatment approach utilized (Rounsaville, O’Malley, Foley, & Weissman, 1988).

In the final phase of treatment, summary and incorporation of therapeutic strategy are highlighted. This type of pre- and postreview will help the client focus on the accomplishments made. This time can also be used to address and propose preventive measures as well as ways the client can generalize the treatment strategy learned in these clinical appointments to situations and/or symptoms that may arise in the future. This emphasis helps the client to focus on what accomplishments have been made and what will need to be maintained in order for continued success.

Cognitive–Behavioral Intervention Approaches

In the early 1970s, the importance of applied behavioral analysis and the power of reinforcement on the influence of human behavior were explored (Skinner, 1953). However, many theorists believed that behavior alone was not enough and that human beings acted or reacted based on an analysis of the situation and the thought patterns that motivated them. This helped to incorporate the ideas of social learning theory (Bandura, 1977) into the practice base. In this model of brief intervention, social learning theory underscores the cognitive–behavioral framework implemented. Here, the thought process and how individual emotions are influenced by cognitive processes and structures are highlighted (Roberts & Dziegielewski, 1995). When specifically addressing the roots of cognitive therapy, the work of Aaron Beck is often described (Beck, 1996). Beck and his colleagues postulated the use of this form of therapy in addressing numerous mental health problems that can be used across many different population groups (Beck, Emery, & Greenberg, 1985; Beck & Freeman, 1990; Beck, Rush, Shaw, & Emery, 1979; Beck, Wright, Newman, & Leise, 1993).

When working from a cognitive–behavioral perspective, it is important for social workers to be aware of the following terms. The first involves the development of “schemas” (Beck & Freeman, 1990). Entering the social world presents events that create the basis for the development of early childhood experiences. These experiences are transformed into what an individual believes to be true within certain limits or conditions. The schema that develops is referred to as the cognitive structure that organizes experience and behavior (Beck & Freeman, 1990). Schemas involve the way individuals view certain aspects of their lives including relationship aspects such as adequacy and the ability for others to love them. Once these schemas have been formulated as part of normal development, the individual will be exposed to critical incidents as part of the normal life process. These critical incidents will be interpreted and thusly reacted to by the individual (Roberts & Dziegielewski &., 1995). The resulting reaction will be based on the basic and conditional beliefs that an individual has developed and incorporated into their schemas.
The literature supports that individuals develop different styles or patterns of information processing based on their life experiences, and these schemas may influence an individual’s reaction resulting in cognitive distortion when interpreting a current situation or event (Beck et al. 1979; Burns, 1980). Beck et al. listed the types of systematic errors that can lead to emotional distress as “arbitrary inferences,” where individuals may reach conclusions that are not based on accurate supporting evidence; “selective abstractions,” where an individual focuses on one or more details in a situation that are taken out of context, while seeming to ignore the more pronounced features of the incident or situation; “overgeneralization,” where an individual draws a global generalization from a single and possibly isolated incident; “magnification and minimization,” where the individual distorts what has happened, inappropriately representing the magnitude of what has actually transpired; “personalization,” where an individual relates external events to him/herself without any basis for doing so; and “absolute, dichotomous thinking,” where experiences are perceived in an intense and possibly polarized manner.

Cognitive–behavioral therapies focus on the present and seek to replace distorted thoughts and/or unwanted behaviors with clearly established goals (Fanger, 1994). Simply stated, a goal constitutes what you and the client want to accomplish, and the behavioral objectives state exactly what you plan to do to address the identified goals (Roberts & Dziegielewski, 1995). It is important to note, however, that many professionals do not make the fine distinction between goals and objectives and often use the terms interchangeably.

Cormier and Cormier (1991) stress the importance of clearly defined goals in direct practice. They see goals as providing direction and structure for the professional practice intervention. This is particularly important when dealing with individuals in short-term settings; as many times these individuals feel distress and the desire for change, however, they lack the ability to establish direction for their efforts.

Goals also permit the practitioner to establish whether he/she has the skills and/or desire to work with the client (Cormier and Cormier, 1991). It is important in time-limited treatment to be sure that the individual will be able to secure the services that are needed and, in turn, to ensure that the practitioner is able to help the client focus on the change efforts.

Brower and Nurius (1993) suggest two key characteristics that need to be present when designing effective intervention goals. First, goals need to be specific, clear verifiable, and measurable. This remains consistent with a short-term therapy approach as the established goals need to be as concrete and behavior specific as possible. The objectives, therefore, should be designed to further quantify the goals. A second point made by Brower and Nurius (1993) is that goals must be mutually agreed upon by both the helping professional and the client. This may seem difficult at times in time-limited treatment where the helping professional may be required to take on an active role in order to help the client. However, this role should always be one of facilitation where the client is helped to achieve what he/she has deemed essential in order to regain an enhanced homeostatic balance. The client must also contribute in order to determine whether the goals and objectives sought are consistent with their own culture and values. It is up to the practitioner to help the client structure and establish the intervention strategy; however, the emphasis on mutuality is central to the development of goals and objectives.

In summary, in a cognitive–behavioral approach to short-term treatment, goal setting is a crucial element in measuring the effectiveness of treatment (Brower & Nurius, 1993).
Goals should always be stated positively and realistically so that motivation for completion will be increased (Brower & Nurius, 1993). Also to facilitate the measurement of effectiveness of what is being done, goals and objectives (particularly the objectives) must be stated in as concrete and functional terms as possible. In setting the appropriate goals, the focus is not necessarily on process but rather on the outcome that is desired (Roberts & Dziegielewski, 1995). The adaption of cognitive and behavioral principles in the short-term framework creates a viable climate for change in the short-term setting.

One type of brief therapy that clearly has its roots with cognitive–behavioral therapy is dialectical behavior therapy. For many practitioners working with clients who suffer from a personality disorder can be challenging and frustrating (Dziegielewski, 2002). According to the DSM-IV-TR, individuals who suffer from this disorder often exhibit a pervasive pattern of instability of interpersonal relationships, self-image and affects, and marked impulsivity that begins by early adulthood and is present in a variety of contexts (APA, 2000, p. 706). One type of brief intervention sometimes used with clients who suffer from borderline personality disorder is dialectical behavior therapy (Corwin, 1996; Swenson, Sanderson, Dulit, & Linehan, 2001). This type of therapy is a broad-based cognitive–behavioral treatment that can be applied specifically for individuals with borderline personality disorder with its use supported through controlled clinical trials. For adoption into the brief intervention format what appears most effective with individuals with borderline personality disorder is a combination of individual psychotherapy and skills training. The goal of skills training is the acquisition of adaptive skills, and the goal of individual therapy is getting the client to use the skills in place of maladaptive behaviors (Koerner, 2000).

The dialectical perspective contains three main characteristics, each of which is important in understanding borderline personality disorder. First, with individuals who suffer from conditions such as borderline personality disorder focus on the dialectic and what is said can direct the client’s attention to the immediate and larger contexts of the resulting behavior as well as to the interrelatedness of individual behavior patterns. Second, reality is comprised of internal opposing forces that can be manipulated thereby evolving into a new set of opposing thoughts or behaviors. Individuals often engage in extreme thinking that results in emotions and behaviors that can block more functional forces making progress difficult. When these types of though patterns are identified, they can be addressed. The third characteristic is an assumption that the individual and environment are undergoing continuous transition. This aims to assist the client to become more comfortable with change. Because the core disorder in borderline personality disorder is emotion dysregulation, this type of therapy creates a type of emotional regulation teaching the client to label and modulate arousal, to tolerate distress, and to trust his or her own emotional responses as valid interpretations (Linehan, 1993). In the first phase, the problem behaviors are identified. This often includes suicidal threats, treatment compliance, feelings of abandonment, and co-occurring problems such as substance abuse or homelessness. Once these problem behaviors are identified in the initial phase, the middle phase will concentrate heavily on trying to help the client reframe dysfunctional behaviors as part of the client’s learned problem-solving skills. This engages both the practitioner and client in active problem solving. At the same time, constant emphasis is placed on understanding the client’s current emotional, cognitive, and behavioral responses. In this brief-planned method, the practitioner is expected in the initial phase to
identify and develop a plan to address all of the client’s problem behaviors in a systematic manner and in the middle phase to implement and problem-solve newly identified problem behaviors. This includes conducting and updating a collaborative behavioral analysis, formulation of hypotheses about possible variables influencing the problem, generation of possible changes, and trying out/evaluating solutions. This intervention emphasizes the necessity of teaching clients to fully accept themselves and their world as they are in the moment. In the last phase of the process, a review of the particular behavioral coping skills needs to be outlined. These skills can be applied to current and future behaviors. For example, in emotional regulation, the client learns to identify this feeling and to gain control over this emotion. The thought or communicative pattern is linked directly to the mastery activities designed to control the emotions expressed.

In summary, in the short-term encounter, Linehan (1993) outlined four specific skills training modules aimed at treating these difficulties. In the first module, core mindfulness is taught in which the client learns emotional regulation skills. In the second module, the client learns interpersonal effectiveness skills to deal with chaotic and difficult relationships. The third module teaches the client emotion regulation skills. The fourth skills training module teaches the client distress tolerance skills helping the client to learn to consciously experience and observe surrounding events.

Because the individual with borderline personality disorder often reflects a pattern of behavioral, emotional, and cognitive instability and dysregulation, follow-up of some type is highly recommended. Dialectical behavior therapy can form the foundation of a sound brief practice model to follow when establishing a treatment plan for individuals with borderline personality disorder. Once dysfunctional dialect is identified, the practitioner may become able to help by improving the client’s overall level of functioning. For individuals with borderline personality disorder, the treatment drop-out rates are high, medication non-compliance is common, and the rate of substance abuse is great (Linehan, 1999). Practitioners must stress the need for clients to comply with all aspects of treatment and to monitor for the potential of substance abuse. In terms of follow-up and homework strategy, linking the client to Alcoholics Anonymous groups or substance abuse treatment centers or both will help them develop a support system that revolves around abstinence.

**Solution-Focused Therapy**

In solution-focused therapy, it is assumed that clients possess the skills they need to address their problems and remain capable of change (deShazer, 1985, 1988). In the initial phase of the intervention, a hopeful atmosphere is created where the emphasis is placed on finding possible solutions to a problem as opposed to specifically solving it. Little emphasis is placed on recognizing and/or establishing the cause or actual function of the problem because change can occur without this link (O’Hanlon & Weiner-Davis, 1989). Pathology is not stressed, and as Fanger (1993) stated succinctly “learning to be the person you want to be is quite different—and often less time consuming—than learning why you are the way you are” (p. 88).

In the initial and middle phases, when applied to a brief therapy format, the practitioner is active in helping the client and/or family to find and identify strengths and existing functional patterns of behavior (Corcoran, 2000). For the most part, mental health labels and/or diagnoses are avoided, and if they cannot be avoided for insurance purposes, invite the clients in selecting a label they feel fit (Selekman, 2005). Once solutions are identified, analyzed,
and developed, the middle phase of the intervention is rich with a dialog of “change talk.” This type of communication is stressed as opposed to “problem talk” (Walter & Peller, 1992). In change talk, the problem is viewed positively with patterns of change highlighted that appear successful for the client. In this framework, it is expected that all clients have strengths and resources and are capable of change (Selekman, 2005). Positive aspects and exceptions related to the problem are explored allowing for alternate views of the problem to develop. Once the small changes have been highlighted, the client is invited to take part in the changes and becomes empowered to elicit larger ones (O’Hanlon & Weiner-Davis, 1989; Walter & Peller, 1992). In the final phase, the plan outlined is followed and plans for follow-up are arranged.

In summary, in order to adopt a solution-based approach to short-term practice, the social worker is urged to consider the following steps: (a) create a hopeful atmosphere while eliciting the client’s definition of the problem, (b) establish from the client what is the desired outcome, (c) begin to analyze and develop solutions, (d) develop and implement a plan of action, and (e) assist with termination and follow-up issues if needed.

Conclusion

Practitioner interest in brief therapeutic approaches has greatly increased and will most probably continue to increase over the years (Bolter, Levenson, & Alverez, 1990). A planned short-term therapy format for intervention appears to be both a viable and essential practice modality because health maintenance organizations and employee assistance programs generally favor highly structured brief forms of therapy (Wells, 1994).

Workshops and other forms of continuing education that highlight teaching social workers this type of intervention strategy continue to gain in popularity. Updated information is essential because with so many changes in the social environment, there is little consistency in the delivery of social work services. A central theme, however, that does appear to surface is cost containment (Dziegielewski, 2005). Administrators are now being forced to justify each dollar billed for services. This can result in little consideration given to the provision of what some term as “expendable services” such as mental health and well-being. Unfortunately, this is the type of service social workers often provide. Stated simply, social workers must remain viable “dollar generators” or they will feel the brunt of initial dollar line savings attempts.

Practitioners in the field are aware of this pressure and realize that they may be replaced with concretely trained nonprofessionals simply to cut costs. Therefore, no matter what short-term therapy is applied, it is important for counseling professionals to be viewed as an essential part of the service delivery team. In fulfilling this position, they will be required to provide both needed direct clinical services as well as fiscal support for the agency setting. Brief-planned practice modalities with an emphasis on evidence-based methods for establishing effectiveness are recommended to assist social work professionals to compete in this ever-changing market.

Social workers like other health care providers are being forced to follow and adapt to managed care strategies; however, in the role, advocacy and empowerment for the client should never be forsaken (Keigher, 1995). This means that social workers need to be the first professionals committed to ensure that medical practices that violate the health and/or well-being of our clients are reported and stopped. Further, the goal for insight-oriented intervention and cure focused therapy seems to have subsided to goals that are considered more
realistic and practical because social work practitioners, similar to physicians, do not generally cure problems for our clients—nor are we expected too. What we are expected to do, however, is to help our clients to utilize their own potential to help diminish or alleviate symptoms and/or states of being that cause discomfort. Emphasis on the individuality of our clients and time-limited concrete changes are not only expected but also now required as “state of art” practice.

The need for use of evidence-based brief time-limited therapies has been clearly established. Methods such as those discussed in this article can help demonstrate effectiveness and appear to be both the present and future of social work in behaviorally based practice. In general, social workers are suggested to accept a more eclectic approach to practice in which allegiance to one particular model is discouraged. Therefore, the days for the use of long-term psychotherapies in our current practice environment truly have ended. Today, it is essential that the choice of any brief intervention strategy needs to include a time-limited treatment strategy, mutually negotiated goals and objectives, reality-based intervention strategies, and concrete problem-solving methods based primarily on the needs of the client—not the preference of the practitioner. This is not only what service agencies expect but also what our clients so rightfully deserve.

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References


