UNIT 3 SHORT TERM PSYCHOTHERAPIES

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3.0 INTRODUCTION

There have been major changes in the way different therapeutic paradigms approach treatment length. At one time, conventional wisdom suggested that psychodynamic therapy was invariably long-term and cognitive-behavioural therapies (CBT) were short term. This is no longer the case, with the development of a range of brief psychodynamic therapies and of longer-term behavioural and

cognitive therapies. The first half of this unit deals with the defining features of short term or brief therapy. The second half gives an overview of brief therapies along with research evidence on the length of therapy in relation to its effects and its suitability for a range of clients.

3.1 OBJECTIVES

After completing this unit, you will be able to:

- Describe the defining features of short term or brief therapy;
- Discuss the different types of brief therapies under different approaches; and
- Evaluate these therapies in relation to their effects and suitability for a range of clients.

3.2 SHORT TERM PSYCHOTHERAPY

A major shift has occurred in the last 20 years from delivery of long-term psychotherapy to briefer, time limited approaches. There are many reasons for this, that is

i) There have been immense pressures from healthcare industry for cost-effectiveness and cost containment;

ii) Innovation and refinement of technique has resulted in more efficient therapy

iii) Research trials expediently focus on shorter-term approaches, which then become influential.

iv) The conventional psychoanalytic view that 'longer is better' has been increasingly challenged by the evidence; and

v) Many therapists have espoused brief approaches because they see intrinsic merit and therapeutic potential in this way of working.

'Brief' is a relative term, and the time span of a brief or short term therapy can vary between one and about 25 sessions, from a single meeting to a year's work. There is a distinction between very brief therapy (one to five sessions, less than 2 months), brief therapy (six to 16 sessions, 2 to 6 months), and time limited therapy (17 to 30 sessions, 6 to 9 months), while recognising that such distinctions are inevitably arbitrary.

A common definition of short term or brief therapy is up to 25 sessions in duration. However, the majority of therapy delivered falls into this category, either because the therapy offered is short term by design, or because although the therapeutic modality is long term or open-ended, by the 25th session most patients have decided to leave.

It also used to be common wisdom that only highly selected client groups were capable of benefiting from brief work, and that these methods were unsuitable for people with more severe and complex mental health problems.

Now there are powerful arguments and well developed methods for offering shorter term interventions to people with higher levels of distress and impairment.

We have reached the stage in the history of psychotherapy where brief or time limited therapy is mainstream practice and it will continue to be the norm for psychotherapeutic work to be conducted briefly and to time limits.

3.3 DEFINING FEATURES OF SHORT TERM THERAPIES

Common features of brief therapies include working to a time limit, the therapeutic focus, and therapist activity. Taken together they imply a form of therapy that is perhaps better termed intensive rather than brief, compared with longer term methods that could be described as extensive.

3.3.1 Time Limits

Therapies that set a time limit manage the frustrations and disappointments that this can arouse, in both patients and therapists, in contrasting ways, either to facilitate them or to minimise them. Despite the polar differences between these views, there is little research evidence base for which of these two approaches leads to the best outcomes, for which clients.

The former approach sees the time limit itself as of immense therapeutic significance and potential. James Mann (1978) is the prime example and most eloquent advocate of this view. The time limit of therapy is seen as a profound metaphor for the finiteness of time itself for any individual. It evokes, he argues, the reality of loss and death, but, if faced and endured, is a powerful maturational experience.

Mann gives the time factor most attention, but a number of psychodynamic and relational therapies emphasise setting an exact, nonnegotiable time limit, to facilitate the experience of anxiety, disappointment, and anger. Expressing these warded off emotions, it is argued, within a facilitating therapeutic relationship, leads to their being safely experienced, assimilated, and mastered.

These therapies work on the assumption that what was perceived as catastrophic can be transformed into something both manageable and personally empowering. Other therapies take the opposite line, reducing the significance of the time limit, either by interpreting it very flexibly, by using follow-up appointments, or by making it clear further therapy will be available in the future ‘as needed’.

For example, Budman and Gurman (1998) argue that there is little empirical evidence that emphasising termination in therapy leads to better outcomes, and assert that it is therapists rather than patients who have difficulty ending. They do not see therapy as a ‘one-shot’ operation, instead preferring to conceptualise the therapist as a ‘psychological family doctor’, available over the life span to respond to different needs in a developmental process. They also emphasise a team approach, with no one therapist being all things to all patients.

On the whole it is those therapies rooted in psychodynamic theories that emphasise the time limit and the therapeutic value of the fixed termination, and those rooted in pragmatic eclecticism, and the cognitive-behavioural approaches, which are less concerned with this.

The use of time in brief therapy goes beyond fixing the number of sessions or setting a time limit. It can include varying the length of sessions, the frequency of sessions, and the flexibility with which therapy is delivered. For example, Mann's rigid adherence to the 12-session limit does not preclude considerable flexibility in how they are delivered. Variations to weekly sessions are mentioned, including in one instance weekly 15-minute sessions for 48 weeks. The key issue is that there is no ambiguity or uncertainty about the pattern and duration of the sessions (Mann, 1978).

3.3.2 Therapy Focus

The therapeutic focus is the second broad factor shared by most, if not all, brief therapies. It can relate to manifest symptoms or a presenting problem. For example, cognitive therapy was originally a brief problem-focused therapy for depression. Most brief cognitive and behavioural therapies have a problem focus, such as panic, although longer-term cognitive therapy with a schema focus has also been developed.

The focus for interpersonal therapy (IPT) is developed in the early sessions, relating to one of four problem areas: grief, role disputes, role transitions, and interpersonal deficits. Psychodynamic, relational and some eclectic therapies often take an intrapsychic or interpersonal focus, a central emotional dilemma or an issue in personal development. Such a focus is referred to in diverse ways; the 'dynamic focus', 'core conflictual relationship theme', 'core neurotic conflict', 'nuclear conflict', 'central issue', 'interpersonal-developmental-existential focus'.

Omer (1993) describes how the focus in brief therapy has tended to be either symptom focused or person oriented, and argues for the value to the therapeutic alliance of combining the two into an integrative focus.

3.3.3 Therapist Activity

An active therapist is a feature of working in short term therapy. In the behavioural and cognitive methods, therapists have always been active, irrespective of the length of treatment, in collaboratively setting an agenda for the session, teaching, giving advice, using Socratic questions in guiding discovery, setting homework, suggesting structured activities and coaching. In the psychoanalytic and some humanistic traditions, the therapist is relatively less active, waiting for the client to speak at the start of the session, refraining from intervening to end a silence, following the patient's (or client's) train of thought and rarely initiating a topic or actively structuring the session.

In brief psychodynamic therapies, by contrast, the therapist is more active in interpreting the transference, unconscious conflicts and in confronting resistance. Therapists in eclectic, relational, or integrative modes are also active, for example in clarifying and collaboratively exploring the client's material, negotiating treatment goals, structuring sessions, making links between interactions in the therapist-client relationship and past relationship patterns, and possibly setting or discussing between-session tasks.

3.3.4 Range of Applicability

The brief therapies also differ widely in the range of difficulties to which they are considered applicable. The different forms of symptom-focused CBT have

intrinsic selection criteria, with separate therapy 'packages' developed for panic, depression, health anxieties, obsessive-compulsive disorders, eating disorders, substance abuse, anger management problems, posttraumatic stress disorders (PTSD), and suicide prevention. Some brief psychodynamic therapies are restrictive, with long lists of exclusion criteria. For example, Sifneos (1972) considers his Short Term Anxiety Provoking Psychotherapy suitable only for people of above average intelligence, who have had at least one meaningful relationship, are able to express emotion in the assessment, have a specific chief complaint, are motivated to work hard, and have realistic expectations of treatment.

Messer (2001) described brief dynamic therapists as avoiding clients who are too severely disturbed to use an insight-oriented approach or those who need more time to work through their problems, but other brief therapists take a more liberal view of suitability. For example, Wolberg (1965, p. 140) states that 'The best strategy, in my opinion, is to assume that every patient, irrespective of diagnosis, will respond to short-term treatment unless he proves himself refractory to it'. Garfield (1995), has only the three criteria that the client be in touch with reality, is experiencing some discomfort, and has made the effort to seek help.

From this overview of common features of brief therapies from a range of theoretical backgrounds and practice methods, we can discern some general working assumptions for brief therapies.

This way of working tends to see therapy as catalyst for change in a complex system rather than as a 'one-shot' curative method.

Therapists aim to maximise the therapeutic alliance and avoid regression.

3.4 OVERVIEW OF BRIEF THERAPIES

In describing the various models and modalities in shorter term and time limited therapy, there are several possible ways to classify them. The categories used here are psychodynamic, cognitive/behavioural, relational, eclectic, and very brief.

3.4.1 Psychodynamic Approaches

Early psychoanalytic therapies were much briefer than their successors. Some of Freud's early therapies were very brief indeed, famously no longer than a walk in the woods. Modern brief psychodynamic therapies have their roots in the pioneering work of Ferenczi (1920) and Alexander and French (1946). They felt that, although psychoanalysts knew there is no simple correlation between therapeutic results and the length and intensity of treatment, they clung to a belief that quick therapeutic results could not be genuine.

3.4.2 David Malan and the Triangle of Insight

David Malan developed an influential approach to time-limited therapy he first termed as radical and later as intensive (Malan, 1963, 1976, 1979). The implication was that for some carefully assessed and selected patients, the time limit of a shorter therapy could accelerate the process of resolution of the central problem, or at least an important aspect of psychopathology.

Unlike most, this approach favours a time limit (i.e., an agreed end date) rather than a predetermined number of sessions, to avoid the common difficulty of deciding when or whether sessions missed for any reason will count towards the total. However, an upper limit of sessions was set at 30, although most people were seen in fewer.

Malan placed great store by a careful psychodynamic assessment of the patient's family and medical history, past and current relationships, to understand how events precipitating the current difficulty had emotional significance in the light of early experience. The therapist also attends carefully to the quality of the interaction. The assessment allows the therapist to judge whether to attempt a trial interpretation and the patient's response to this is an important factor in deciding whether this form of brief dynamic therapy is likely to be of benefit. The method itself is psychoanalytic, interpreting the transference, linking experience in the therapy relationship with childhood.

Malan described this in terms of two triangles, 'the triangle of conflict' (impulse, anxiety, defense) and 'the triangle of persons' (current relationship, therapist, parent). The two triangles formulation is an economical and clear way for therapists to think about the focal conflict. Holmes (2000) gives the example of someone suffering from agoraphobia defending against anxiety by avoidance and dependency. Underlying this there may be hidden feelings of dissatisfaction and aggression, immediately towards a spouse, and in the past towards a controlling but unaffectionate mother.

The therapist makes links between the anxiety, the defense, and the hidden impulse and between past relationships (usually with a parent), current relationships with others and the therapeutic relationship. In such a way, the patient is helped to tolerate anxiety and express hidden feelings, so that the triangle of conflict is no longer enacted in current relationships.

3.4.3 The Work of Habib Davanloo

Davanloo's (1978, 1990) method relies at heart on an orthodox psychodynamic drive/conflict model, derived from early Freud. He attracted controversy because his method involves pressurising the patient in a relentless pursuit of any prevarication, vagueness, avoidance, or withdrawal, all seen as signs that important anxieties are being warded off. Repeated confrontation elicits anger, which is interpreted in terms of the triangle of persons (i.e., a transference interpretation). This can lead to the powerful re-experiencing of warded-off anger from the past.

3.4.4 Anxiety Provoking and Anxiety Suppressive Therapies

Peter Sifneos (Sifneos 1972, 1979) distinguishes between anxiety suppressive and anxiety-provoking short-term treatments. His anxiety-provoking technique is based upon careful selection criteria, early and active use of transference interpretations, and confrontation. Relatively little attention is paid to termination. Sifneos places a high emphasis on the first meeting with a new patient, seeing it as a microcosm of therapy. Active himself as a therapist, he expects the same response from his patient.

Anxiety-provoking therapy is applicable to any patient with well-circumscribed neurotic symptoms, and aims at limited dynamic change, emphasising problem-

solving and crisis intervention. Anxiety-suppressive therapy is aimed at the more disturbed patient and is more supportive in nature.

In *anxiety-provoking therapy*, Sifneos includes only patients who can be seen to have problems at an oedipal level of functioning. Clinical assessment requires some evidence that the patient's difficulties have originated from the oedipal stage of development, a legacy of a three-person relationship.

A patient thought to evidence pre-oedipal problems, a result of a faulty or disturbed dyadic relationship, is thought to be inappropriate for anxiety provoking therapy, since they would have difficulties establishing the basic trust fundamental to the forging of a working therapeutic alliance and terminating treatment.

This continues to be an important distinguishing criterion used by some contemporary time-limited therapists. Treatment is seen as 'anxiety-provoking' because it confronts the patient's defences directly, rather than attempting to 'interpret the meaning or function of the defences'. Transference is interpreted rigorously, as is any form of resistance. Resistances are attacked directly, but only on the basis of 'data' received from the patient.

Sifneos does not use the framework of a definite termination date. No time limit is set, but the patient is informed from the outset that the treatment will only last 'several months', and is encouraged to share responsibility for the decision of when to terminate. Termination is in part the patient's responsibility, which decreases their dependence and passivity. Sifneos's anxiety-provoking therapy has a maximum of 20 sessions, and mostly lasts between 12 and 16 sessions.

His selection criteria are carefully drawn and include the following. :

- Ability of the patient to present with a circumscribed complaint.
- Evidence of a meaningful relationship during childhood.
- Capacity to relate to the therapist in the first meeting and to be open in expressing feelings.
- Psychological sophistication and intelligence.
- Motivation for change over and above symptom relief.
- Ability to see symptoms as having a psychological dimension.
- Emotional honesty and capacity for introspection.
- Able to participate actively in treatment and curiosity.
- Realistic view of what can be achieved in therapy and a willingness to make 'the necessary sacrifices'.

Sifneos contrasts anxiety-provoking therapy with *anxiety suppressive therapy*. This is aimed at less-healthy patients who might be discomforted by the confrontational stance of anxiety provoking therapy. It is aimed at more disturbed, by implication pre-oedipal patients and is more supportive in nature and includes environmental manipulation, reassurance and if necessary, medication. Crisis support could last up to two months, brief therapy from two months to one year, while for patients with long-standing psychological difficulties and a history of poor interpersonal relationships longer-term therapy may be indicated. However, the selection criteria are similar to those for the anxiety-provoking therapies.

Patients receiving anxiety provoking therapy are seen weekly over a period of time, but anxiety-suppressive patients are frequently seen more intensively, often a number of times in a week, but sometimes only for a few minutes. This reflects the more crisis-oriented and supportive direction of the therapy.

3.4.5 The Work of James Mann

James Mann (1978) was working within a psychoanalytic tradition, but has profoundly influenced the field of brief psychodynamic and relational therapy with his existential method of time-limited psychotherapy. He argues coherently that time is insolubly linked to reality and there is a ubiquitous human yearning to deny time, reality, and death by regaining a lost childhood paradise of timelessness. This is achieved in adulthood by dreams, daydreams, falling in love, drinking, or using drugs, or in mystic states of ecstasy. He describes how brief therapies evoke the horror of the finiteness of time and posits that as soon as the patient learns that the amount of time for help is limited, he or she is subject to magical, timeless, omnipotent fantasies.

Dismissive of eclecticism, Mann advocates one or two intake interviews to establish a formulation of the central conflict, linking current suffering to past sources, tracing the chronically endured pain. The focus for therapy is on improving the patient's self-image, but the formulation will differ according to the underlying difficulties. This formulation is given to the patient with a goal for therapy and an explicit offer of 12 sessions 'no more, no less'.

The frequency and length of sessions within that limit seems to have been quite flexible, however. The calendar is consulted and the time for each appointment given, plus the exact date of the last (12th) meeting. He argues for as little ambiguity or evasion as possible about the time limit, and describes a typical course of therapy of early relief and improvement, a middle phase where enthusiasm wanes and ambivalence is felt (in a re-enactment of earlier relationship patterns).

As the patient moves towards ending, anxiety is evoked of 'separation without resolution from the meaningful, ambivalently experienced person'. In the end phase, affects of sadness, grief, anger, and guilt are intensely experienced and relived in the disappointing ending of therapy. The therapist too feels the pressure to prevaricate and imply that the end is not the end, in order to evade the anxiety of separation without resolution. Mann emphasises that active management of the termination will allow the patient to internalise the therapist and this time the internalisation will be more positive, less anger-laden, less guilt-laden, and thereby making separation a genuine maturational event. Any anger is acknowledged as normal and explored more rather than less.

3.4.6 Cognitive and Behavioural Approaches

Following the development of brief psychodynamic therapies, brief therapies based on behavioural, CBT, and cognitive theories began to appear. These arose from a research-based tradition and over the last 30 years have burgeoned, applied to an every-wider range of difficulties in mental health care, physical health problems, and health promotion. Many authors aggregate all these approaches into a common term as CBT and in routine practice many therapists are rather eclectic in their choice of method within this broad framework. However, there

are important differences between forms of CBT that integrated cognitive concepts into behaviour therapy and those springing from the work of Beck, a different tradition of cognitive therapy that was not based on behaviour therapy.

3.4.7 Cognitive Behaviour Therapy (CBT) and Cognitive Therapy

Both methods were designedly brief, focusing in the first instance on depression, anxiety disorders, and obsessive-compulsive disorders, all without comorbid personality disorders. Since then the range of mental health problems addressed has grown to include PTSDs, eating disorders, and somatic problems. Some of the newer applications are not brief, for example, CBT for personality disorders and psychosis.

CBT emphasises a functional analysis of the problematic behaviour or unwanted emotion in terms of antecedents, cognitions, behaviours, and consequences. This formulation then guides the choice of active techniques such as Psychoeducation, relaxation, imaginal or in vivo exposure, response prevention, cognitive restructuring, and behavioural activation. Cognitive-behavioural therapists tend to emphasise the therapist's role in facilitating new experience and behaviour as well as cognitive changes, maintaining clients' awareness of their success experiences and the differences between their present and past functioning.

Cognitive therapy based on Beck's cognitive model of emotion (Beck, 1967; Beck et al., 1979) emphasises that there are always alternative ways of perceiving and appraising any situation. People with mental health problems are trapped in a specific and unhelpful way of perceiving events, because of particular assumptions or beliefs they learned earlier in life.

The therapist works collaboratively and empirically, inviting the client to explore whether or not there are alternative ways of appraising their situation, and empowering them to have choices over their response. The fundamental concept is of guided discovery of these alternatives, and support in testing out the consequences of new ways of thinking. Cognitive therapists tend to focus less than cognitive-behaviour therapists on the role of behavioural antecedents and consequences including the impact of the patient's behaviour on other people.

There is sparse discussion of treatment length in cognitive and cognitive-behavioural literature. Therapy length tends to be fixed (either for research purposes or by the constraints of the service setting) or pragmatically negotiated with the client in routine practice. Typically therapies last between 8 and 20 sessions, although the use of follow-up and booster sessions is common, for example in relapse prevention in depression, and in clinical practice many CB therapists not wishing to terminate therapy abruptly will gradually reduce the frequency of sessions and intensity of treatment. For this reason, some CBTs are in practice long term.

3.4.8 Interpersonal Therapy

Interpersonal therapy (IPT) (Klerman et al., 1984) was developed by psychiatrists as an adjunct to medication in the treatment of depression. It was based on the interpersonal psychiatry of Harry Stack Sullivan and others, and on research findings showing the intense impact of the formation, disruption, and renewal of

attachment bonds, and the link between neurosis and deficits in social bonds. Theoretically grounded in social risk factors for depression as an illness, the method avoids an intrapsychic emphasis, whether psychodynamic or object relations, and has been shown to have much in common with CBT in using active techniques to ameliorate present difficulties.

IPT explores four problem areas which are salient for a given patient: grief, role disputes, role transitions, or interpersonal deficits. In the early phase, assessment and negotiation of the treatment contract includes review of symptoms, confirmation of the diagnosis and legitimisation of the sick role, assessment of interpersonal relationships, and choice of problem area, and medication plan. Within a medical model of depression, there is a psychoeducational emphasis in promoting understanding of the effects of depressive illness, hence reducing self-blame.

Therapy continues using specific techniques depending on which of the four foci are agreed. For example, the therapist could aim to facilitate mourning, to identify issues in disputes and alternative actions, could encourage the patient to view role transitions in a positive way, or could work on remediating interpersonal deficits. Therapy is time limited but not constrained to a fixed number of sessions. Typically it lasts between 9 and 12 months.

3.4.9 Problem Solving Therapy (PST)

Problem solving therapy (PST) is a brief psychological treatment for depression based on cognitive behavioural principles (D'Zurilla and Goldfried, 1971; Nezu et al., 1989). It has also been used extensively as a form of crisis intervention following deliberate self-harm or attempted suicide (Hawton and Kirk, 1989).

Like CBT it is structured, collaborative and focuses on generating solutions to current problems. Problem solving is seen as having five stages: adopting a problem-solving orientation; defining the problem and selecting goals; generating alternative solutions; choosing the best solution; and implementing the best solution and evaluating its effects. Methods used include cognitive modelling, prompting, self-instructions, and reinforcement. It is usually delivered in about six treatment sessions.

3.4.10 Computerised CBT and Guided Self-Help

Computerised CBT and guided self-help have also been developed as brief therapy approaches to anxiety and depression, particularly to reduce the time spent in therapist contact, so that CBT can become more accessible to the large numbers of individuals who may benefit from it. The principles of "stepped care" suggest that briefer, simpler, and most accessible therapies should first be offered, and more complex, expensive, and effortful therapies only if the patient has not responded to the simpler approach. A research review of self-help interventions in mental health reported that almost all are based on CBT principles, and that computers may best be seen as another way of providing access to self-help materials (Lewis et al., 2003).

A systematic review of 16 studies of computerised CBT, of which 11 were randomised controlled trials, suggested that for mild to moderate anxiety and depression, CCBT may be as effective as therapist-led CBT and better than standard care, although the evidence was by no means conclusive (Kalenthaler et al., 2003).

3.5 RELATIONAL APPROACHES

A third broad grouping of focal brief therapies can be termed as 'relational' in that they see mental health difficulties as fundamentally interpersonal and they explicitly link the interpersonal to the intrapsychic in a 'two-person' psychology. Although these approaches have been influenced to a greater or lesser extent by psychoanalytic theory, they all emphasise relational rather than drive or structural aspects. Some have been influenced by cognitive psychology. These therapies pay close attention to the unfolding process within the psychotherapeutic relationship as a metaphor for, or an enactment of, the patient's problematic and repetitive interpersonal and intrapsychic patterns. They tend to use collaborative methods to guide discovery of these links and are wary of any notion that the therapist can stand aside from "the transference" in order to interpret it authoritatively.

3.5.1 Time Limited Dynamic Psychotherapy (TLDP)

Time-limited dynamic psychotherapy (TLDP) (Schact et al., 1984; Binder and Strupp, 1991) is a collaborative method that avoids the therapist imposing the focus by overtly pushing, manipulating, seducing, coercing, badgering, controlling, extorting or indoctrinating the patient. The aim is to develop a 'working model' of interpersonal roles into which patients unconsciously cast themselves, the complementary roles into which they cast others, and the maladaptive interaction sequences, self-defeating expectations, and negative self-appraisals that result. The TDLP focus is a structure for interpersonal narratives, describing human actions, embedded in a context of interpersonal transactions, organised in a cyclical maladaptive pattern, that have been both a current and recurrent source of problems in living. The time limit is not rigid, depending on the clarity with which a treatment focus can be established, but a "time-limited attitude" is maintained.

3.5.2 Psychodynamic Interpersonal Therapy (PIT)

Psychodynamic-interpersonal therapy (PIT) (Hobson, 1985) uses the 'here-and-now' relationship as a vehicle for learning about oneself in relation to others. Hobson has a process focus on the therapist and patient collaboratively developing a shared language for feelings. The therapist does not interpret transference, but offers tentative exploratory links, making use of metaphor, and seeking to offer his or her own understanding of the patient's unarticulated emotions in the context of an authentic human relationship. Also known as the 'conversational model' of therapy, because of its emphasis on the therapeutic dialogue, a training manual and other materials have been systematically developed and evaluated in the UK. It has been extensively researched in relation to depression (in both eight-session and 16-session formats), psychosomatic difficulties, with treatment-resistant problems in psychiatric outpatient setting and as a brief intervention following self-poisoning.

3.5.3 Brief Relational Therapy (BRT)

Brief relational therapy (BRT) is a thoroughgoing relational approach developed in the USA by Jeremy Safran and Christopher Muran (2000), based on a dialectical constructivist perspective (Hoffman, 1998). As with Hobson's method, there is an intense focus on the 'here-and-now' of the psychotherapeutic relationship,

where the therapist urges collaborative exploration of both the patient's and the therapist's contributions to the interaction. The therapist is urged to be cautious about making interpretations based on generalised relationship patterns, but to explore the nuances of the patient's experience and the relational meaning of this experience, through unfolding therapeutic enactments. There is extensive use of meta communication about the meaning of what is happening between the therapist and patient, with disclosure of the countertransference.

The therapist refrains from early case formulation or content focus for the sessions. Safran and Muran argue that as the therapist can never stand outside the interaction to create a formulation that is not shaped by unwitting enactment; such a therapist-derived focus is inimical to a fully relational method. As in cognitive analytic therapy (CAT) ruptures and repairs to the therapeutic alliance are seen as a particularly effective way to gain awareness of problematic relationship patterns. Links between the therapy relationship and relationship patterns outside therapy are made tentatively, the therapist making an effort to be aware of his or her own motivations.

3.5.4 Cognitive Analytic Therapy (CAT)

Cognitive analytic therapy (CAT) is an integrative approach developed in the UK by Anthony Ryle (1990) and further extended both theoretically and clinically by others (Ryle and Kerr, 2002). Ryle aimed to integrate the effective elements of various preceding traditions not simply at the level of therapeutic technique, but in the underpinning theory of development, personality, and psychopathology. CAT theory is rooted in Kelly's personal construct theory, cognitive and developmental psychology and in psychoanalytic object relations theory. Theoretically it emphasises repetitive aim-directed sequences of cognition, emotion, behaviour and their consequences (called as procedures), similar to Goldfried's (2003) 'STAIRCASE' (Situation, Thought, Affect, Intention, Response, Consequence, and Self Evaluation) CBT model. However, CAT theory also draws on object relations theory and Vygotsky's activity theory to assert the pervasively dialogic nature of the human world, where internalised self-other relationship patterns become the basis of reciprocal role procedures governing intrapersonal as well as interpersonal relationships.

CAT, while theoretically and methodologically integrative, is therefore a fundamentally interpersonal and relational therapy. In common with BRT it requires the therapist to reflect collaboratively with the patient what reciprocal roles are being enacted in the therapy relationship, particularly at points where the therapeutic alliance is being threatened. In contrast to BRT, however, the initial few sessions of CAT are devoted to an extended assessment leading to a jointly agreed reformulation of a patient's story, its personal meaning and the relation to it of the problem procedures they have brought with them. The narrative account is redrafted on the basis of the patient's feedback and is supplemented by a diagrammatic reformulation. Both forms of reformulation are seen from the Vygotskian perspective as psychological tools, fostering jointly focused attention and the capacity for self-reflection. The reformulation forms the basis of intervention, which often includes cognitive-behavioural methods of procedural revision.

As in psychodynamic brief therapies there is stress on the therapeutic value of the issues provoked by a fixed termination point. Ending is seen from a CAT perspective to minimise regression and avoid protracted, and usually collusive, dependency. It is also an opportunity to work through the unassimilated issues from earlier losses and to enact new reciprocal role procedures. The ending is formally and symbolically celebrated by the therapist writing a further letter of farewell to the patient. This acknowledges the achievements of therapy but also anticipates loss and possible grief and anger. The patient is encouraged to write a farewell letter from his or her own perspective.

3.6 PRAGMATIC, ECLECTIC THERAPIES

A number of brief therapies draw pragmatically on a range of theories and methods to yield approaches that are eclectic.

3.6.1 Interpersonal, Developmental and Existential Therapy (IDE)

'Interpersonal, developmental and existential therapy' (IDE; Budman and Gurman 1988) attempts to integrate interpersonal, developmental and existential conflicts into a therapeutic framework which is time-sensitive and highly focused. Taking issue with long-term therapies, which they see as inevitably leading to therapeutic drift, the major feature of IDE is the belief that most therapeutic benefit occurs early in treatment; the law of diminishing returns applies.

Combining developmental, existential and interpersonal paradigms, IDE is based on the premise that during the patient's early development there has been some 'faulty learning'. This can be either conscious or unconscious, but importantly becomes 'a *template* for future behaviour and relationships'. It is this template which influences feelings, behaviour and relationships. The key question is 'Why has this person come for help now?', and is viewed from a perspective that is both environmental and developmental (an 'obsessive fear of death is rather different at age twenty-five than it is at age seventy five'). The focus is then related directly to the patient's life stage. There is a flexible attitude to time. Therapy appears to be between 20 and 40 sessions in length and includes the variable spacing of sessions. Rather than 'the more therapy the better', therapy is seen as the springboard for change which happens outside or after the completion of therapy.

The use of the time can be a major therapeutic variable and an important intervention which needs to be acknowledged for each individual patient. However, the flexible use of time, which in IDE includes follow-up appointments and further courses of therapy when a developmental obstacle is encountered, is very different from using time as a central organising framework for therapy.

3.6.2 The Work of Garfield

Garfield (1989, 1995) describes an eclectic brief therapy model based on maximising the impact of the common factors identified in therapy research. Therapists are engaged in listening, reflection, suggestion, explanation, interpretation, providing information, confrontation, reassurance, homework assignments, modelling and role play, questioning, and cautious self-disclosure. In common with Budman and Gurman and Cummings, he takes a relaxed

approach to treatment length, and to selection criteria. Garfield also challenges the assumption that if people do not respond to short-term therapy, they will benefit from long-term work. He seems this as having little empirical justification, as there has been almost no research on long-term therapy.

3.6.3 Winston and Winston

Winston and Winston (2002) describe a pragmatic eclectic approach, which they term as integrated; although it does not seem fully integrated at the theoretical level, compared with, for example, CAT. Their case formulation method uses the concept of a continuum between psychological sickness and health, according to level of psychopathology, adaptive capacity, self-concept and ability to relate to others. The individual treatment plan depends on the patient's position on this continuum, with cognitive-behavioural methods being used for the more impaired and more psychodynamic, expressive techniques for the least impaired. By this means, a brief intervention can be offered for more severe and complex difficulties, such as borderline disorders.

3.6.4 Very Brief Therapy

This includes Crisis Intervention and Critical Incident Debriefing . Very brief therapies of up to five sessions have been developed in differing treatment modalities. Sheard et al. (2000) describe a one- to three-session CAT-derived method to improve the response of psychiatrists to repeated deliberate self-harm in the context of emergency hospital care. Outcome studies are not yet available.

Newman et al. used a four-session CBT intervention for panic disorder, assisted by the use of palmtop computers for self-monitoring and assessment, with similar results to a 12-session treatment.

3.6.5 Motivational Interviewing

The clinical method of motivational interviewing (Miller and Rollnick, 1991) has been used as a very brief intervention either alone or in addition to standard treatment, particularly for alcohol and substance misuse problems. It was developed on the basis of a review of active ingredients in effective brief therapy with these client groups, which suggested the importance of giving feedback, promoting personal responsibility for change and self-efficacy, giving straightforward advice, and offering a menu of alternative strategies. The method is nondirective and avoids any confrontation with resistance or lack of motivation, instead taking an acceptant and empathic approach to changing motivational states. The aim is to help those reluctant to change problematic behaviours move from the pre-contemplation stage, or ambivalent contemplation, to preparation where change options can be explored and then action and maintenance of change.

3.6.7 Solution-Focused Brief Therapy (SFBT)

Solution-focused brief therapy (de Shazer, 1985; Walter and Peller, 1992) developed from brief strategic therapy in work with families and individuals, and is often delivered over four to five sessions. It pays no attention whatsoever to the origin or etiology of problems and instead focuses on helping clients to change problem-maintaining behaviour, to define their goals (recognising that their own definition may or may not be congruent with problems as perceived by professionals), and to generate solutions to difficulties they face. Questions about

goals are posed in such a way that the client is able to speak about what the world would be like without their current problems. It is in this sense that the method is solution focused rather than problem solving. The focus is on collaborative identification and amplification of the patient's strengths, with extremely positive feedback and an emphasis on small aspects of meaningful change.

3.6.8 Crisis Interventions and Critical Incident Debriefing

There is a wide range of brief interventions aimed at responding to crises. The theory and practice of crisis intervention developed from the work of pioneers in the 1960s, such as the community psychiatrist Caplan (1961), and the psychoanalytic crisis therapist, Jacobson (1980). A fundamental concept is that during crisis, people are unusually receptive to restructuring their psychological processes, providing a window of opportunity for a brief intervention to have a substantial positive effect. Crisis intervention uses the intense affect associated with the crisis state in order to facilitate constructive change. The personal meaning of the crisis is explored, in terms of both present and past aspects (e.g., a loss event could re-evoke feelings associated with an earlier loss), coping resources, and components of crisis that render these ineffective. The crisis may be formulated in a way that gives individuals or family members a cognitive understanding of what has happened, so that the emotional assimilation of this is facilitated, and new coping resources are mobilised.

Critical incident debriefing was designed as a rapid response to a traumatic event, aiming to reduce vulnerability to developing PTSD or other mental health conditions, and usually delivered in a single session. Although intuitively appealing to many clinicians, it is now clear that single-session debriefing immediately after exposure to a traumatic event is ineffective, and that on the contrary there may be an adverse impact for some individuals.

Overall it is clear that single session interventions cannot be recommended as part of routine practice, and the English Department of Health guideline on treatment choice in psychological therapies (2001) explicitly argues against their use. This does not imply that individuals in distress should not be offered support, nor does this general conclusion contraindicate more extended psychological intervention at some point from the initial trauma, if posttraumatic disorder were to develop.

Self Assessment Questions

1) What is the difference between brief, very brief and time-limited therapies?

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2) What are the general working assumptions of brief therapies?

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3) What are triangles of insight?

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4) What is the selection criteria for Short term anxiety provoking psychotherapy?

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5) What is Problem-solving therapy?

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6) What is the aim of motivational interviewing?

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3.7 LET US SUM UP

We term one to five sessions as very brief, six to 16 sessions as brief, and 17 to 30 sessions as time-limited therapy. Therapies of up to 25 sessions are the modal form of therapy delivery, either by design or by default. In third-party payment healthcare systems, there is pressure towards brief therapies because of the need to contain costs, but they also have intrinsic value. Well-conducted brief therapies are effective in a range of moderate difficulties, such as anxiety disorders and depression. There is a plethora of brief and very brief interventions within a range of therapeutic paradigms. Some of these emphasise the time limit as a vehicle for assimilating warded-off anxieties; others do not impose a rigid time limit, using follow-up sessions, or intermittent episodes of therapy, to attenuate the ending. Methods are continuing to develop to find time-efficient ways to benefit people with more severe and complex mental health problems. Training in longer-term methods does not equip practitioners to deliver brief therapies competently. Training specific to brief modalities is required, particularly in the key area of competence in maintaining the therapeutic alliance.

3.8 UNIT END QUESTIONS

1) Describe in detail the defining features of brief or short term psychotherapies?
2) Discuss the different models of brief therapies using psychodynamic approaches?
3) Write about the short term therapies under cognitive behavioural approaches?
4) Write about cognitive analytic therapy (CAT)?
5) What are very brief therapies and discuss motivational interviewing and solution-focused brief therapy?

3.9 SUGGESTED REASDINGS

Coren, Alex. (2001). *Short-Term Psychotherapy.* London: Palgrave.

Gabbard, Glen O., Beck, Judith S. and Holmes, Jeremy. (2005). *Oxford Textbook of Psychotherapy*, 1st Edition. Oxford: Oxford University Press.

Dewan, Mantosh J., Steenbarger, Brett N., Greenberg, Roger P. (2004). *The Art and Science of Brief Psychotherapies: A Practitioner's Guide*. London: American Psychiatric Publishing, Inc.