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Brief Therapy: The Process of Change and Episodes of Care

J. Scott Fraser, Ph.D. and Andrew D. Solovey, LISW

Brief therapy seems to be all the rage today. In most countries, third party payers, government health bodies, and service provider agencies are increasingly demanding "cost-benefit" or "cost-effectiveness" support for all outpatient psychotherapy. Employers supporting employee assistance programs, to help workers through life difficulties, are equally interested in the most time-effective interventions to retain valued employees and restore their productivity. In truth, it is the rare client who wouldn't choose a treatment promising the quickest resolution to their distress. Yet, what *is* brief therapy, and is the pressure to practice it causing more problems for practitioners than the approach promises to fix? Are there any central factors to guide us in this pressure-to-produce environment?

Such pressure for "quick-fix" treatments can create dichotomies, conflicts and apparent vacuums. Is it either long-tern treatment or brief therapy? Is it all about the active ingredients of techniques, or are we "throwing out the baby with the bathwater" by overlooking the power of the therapeutic relationship and alliance? If evidence based treatments fit in this demand for time-effectiveness, then what, if anything, connects *these* approaches? Finally, is brief therapy defined as a specific approach; by the number

of sessions allowed; or is it a product of practicing from a different position on the process of change and the role of the therapist in that process?

This brief practice update addresses these questions by first defining brief therapy and then identifying literature-based elements common to all efficient and effective psychotherapies. Finally, a process of change perspective will be offered as a potential "golden thread" that when followed, may assist clinicians with organizing an integrative time-effective practice.

Brief Therapy Defined

Brief by Chance or by Plan?

By now, most practitioners should be aware that most psychotherapy is, in fact brief--if not by design than by fact. Budman and Gurman (2002) note that classic reviews have found the median number of sessions across various approaches and settings to be from 5 to 6 sessions, with most patients stopping before 20 sessions. Various studies of the mean length of treatment in different settings from clinics to private practices report the average length of treatment to range from 8 to 12 sessions, with the upper limit for brief therapy typically set at 25 sessions (Koss & Shiang, 1994). Regarding the "dose-effect" issue, or the question, "are more sessions better," other classic reviews have shown us that improvement is proportionally greater in earlier sessions and increases more slowly as sessions increase (Orlinsky & Howard, 1986); with the greatest amount of change occurring within the first 6 to 8 sessions (Smith, et al., 1980). Studies suggest that 56% to 71% of the variance related to change across treatments occurs during the early sessions of treatment (Fennell & Teasdale, 1987; Howard et al., 1993). Thus, the amount of time clients typically stay in treatment tends to match the time in which they

typically achieve the greatest benefit. Most effective therapy is, in fact, brief. So what do we, as practitioners, need to do to design brief treatment with the majority of our clients?

False Dichotomies

Before proceeding further, it is important to note that the pressure to do deliberate brief treatment has implicitly caused several false dichotomies to arise. The first of these is that we must practice *either* brief or long-term therapy, and that one has more value than the other. Clearly there is a place for both. For some clients, the desire for personal growth and understanding is paramount and, within the limits of their means, desirable. For still others, who are, for example, impacted by multiple factors (economically, socially, intellectually) or who struggle with major and persistent psychotic problems, longer term interventions are of course important. In fact, a "both-and" approach is often useful. Clients with more serious problems might benefit from more than one clinician such as a case manager who sustains clients needs while another clinician designs more time-limited intensive "episodes of care" during stress-inducing incidents and transitions. Of course these services would include a psychiatric component. While there are other examples, the point is that both longer term and short-term treatments have value, and should not be set in competition with each other.

A second dichotomy rises from the press to identify the so-called "active ingredients" in efficient and effective psychotherapy. This has fueled the longstanding debates between those who advocate the effects of therapeutic techniques versus those supporting the effects of therapeutic relationship and alliance. Books like *A Guide to Treatments that Work* (Nathan & Gorman, 2002) offer an array of evidence based treatments for a wide variety of problems. The implicit message is that these are the best

practices or techniques for each problem. On the other hand, books like *Psychotherapy Relationships that Work* (Norcross, 2002) provide equally compelling research to support the dominant effects of relationship factors. Wampord (2001) does an excellent job reviewing the literature on the so-called technique versus common factors debate. He concludes that general effects account conservatively for at least 70% of the variance in effective treatment compared to the relatively minor influence of techniques. In our own work (Fraser & Solovey, 2007), we make the point that relationship and intervention or techniques are inseparable. There is clearly a wide range of approaches that are effective, and they are similar in how they address problems and initiate desired change. We will return to this after further describing the general characteristics shared by most all brief approaches, noting how they coincide with many of the key components of most all effective therapy across approaches.

Common Elements of Planned Brief Therapy

Doing planned brief therapy may be more of a product of shifting our point of view on problems and their resolution than it is anything else. Budman & Gurman (2002) contrast dominant values of long and short term therapists. In short, they suggest that planned brief therapists: value parsimony and least radical interventions; see change as inevitable in a developmental perspective; emphasize client strengths and resources; attempt to initiate change that will continue outside and beyond the end of therapy; maintain focus on the stated problem of the client and agree on resolving it; respect the client's world view as important to their problem and its resolution; engage with and use resources in clients' lives; and plan and evaluate outcomes (Budman & Gurman, 2002, p. 11-21).

These same authors go on to a set of key elements common to most all brief therapy approaches. These converge on what many others have suggested (cf. Koss & Shaing, 1994; Johnson, 1995), and include:

- **Maintaining Clear and Specific Focus**
  All brief therapists share the practice of setting and maintaining clear and agreed upon goals. This is also highly correlated with effective therapy across treatments.

- **High Therapist Activity Level**
  All brief therapists tend to be active in setting session structures, setting session agendas, taking more active and collaborative roles in planning courses of action with clients, and agreeing upon homework or tasks outside sessions.

- **The Explicit Use of Time**
  Brief therapists typically contract for set numbers of sessions in which to address agreed upon goals. The length and timing of sessions is adjusted, including meeting for longer sessions, meeting more often, or spacing sessions to maximize effectiveness of the therapy contract.

- **Using Outside Factors and Systems**
  In addition to consistently using homework outside of therapy sessions, most brief therapists engage with the multiple systems in which clients are engaged. This includes actively engaging clients' families and social networks, other social agents involved, and collaborating with other resources such as religious or other community support networks.

- **Using Episodes of Care**
  Most brief therapists operate on models similar to those of family physicians in terms of meeting with clients for a rather intensive course of brief therapy and then having the client return to their life. Clients are encouraged to return for another course of therapy as needed.

Brief Therapy as Effective Therapy

An interesting point is that most if not all of the above characteristics of brief therapy coincide with factors common to all effective therapies across approaches. If most therapeutic change in effective treatment occurs within the first 8-12 sessions, then it is important to deliberately maximize those elements found to correlate with success. Some of these highlighted in Norcross's edited text (Norcross, 2002) include:

- **Deliberately Maximizing the Working Alliance**
  Horvath and Bedi (2002) drive home that one of the most potent factors in early effectiveness of therapy is the alliance, including a personal bond between therapist and client, and a collaboration and agreement on setting goals and procedures for therapy.

- **Deliberately Maximizing Perceived Empathy**
  The clients' perception that the therapist understands his or her frame of reference, and felt emotions, and that the therapist expresses this actively in treatment (Bohart et al., 2002) is highly correlated with the alliance as well as with success across treatments.

- **Deliberately Maximizing Goal Consensus and Collaboration**
  Tryon & Winograd (2002) complete this set of common factors by concluding that engaging clients at the outset of treatment, gaining collaborative goal consensus, and maintaining collaborative involvement throughout the course of care, are highly correlated with clients staying in and successfully completing treatment.

What All Effective Therapies Do

Jerome Frank (Frank & Frank, 1991) has proposed a classic set of components shared by all therapy across models. Wampold (2001) referred to Frank's view as a contextual rather than a medical model, and he has made a compelling case for how that contextual model best accounts for the effectiveness of most psychotherapy. Frank's contextual model suggests that all effective therapies provide:

- **A healing setting** that enhances clients' expectations of help.
- **An emotionally charged, confiding relationship** with a helping person.
- **A therapeutic rationale, conceptual scheme, or therapeutic "myth"**:
  - Providing a plausible explanation for the patient's symptoms, and
  - Prescribing a set of procedures for resolving them.
- **The instillation of "hope"** in clients, thus countering demoralization and enhancing compliance with procedures facilitating change. In fact, such hope is

> not necessarily an ethereal factor. It has been defined in the literature as the response to a rationale explaining a person's dilemma that implies a pathway for resolution and the ability and will to take action in that direction (Snyder, Michael, & Cheavens, 1999).

This position suggests, therefore, that the particular therapeutic rationale for treatment (or the specific "school" or approach to brief therapy) is less important than the client and therapist's agreement on the credibility of the rationale, and their enthusiasm and investment in the implied goals and contract to work through the related therapeutic procedures toward agreed upon goals. In sum, any therapist desiring to do time-effective therapy should definitely and deliberately try to maximize all of the above characteristics of planned brief therapy, and the elements of purely effective psychotherapy (which is, after all, most often brief). Yet, isn't there some other key general principle or perspective which unites these often very different evidence based practices and schools of therapy? Logic points to considering how they all approach the idea of change.

The Process of Change

In our book, *Second-Order Change in Psychotherapy: The Golden Thread That Unifies Effective Treatments* (Fraser & Solovey, 2007), we point to the process of change as the unifying thread connecting all effective psychotherapies. In this work, we first define the process of change and use it to integrate relationship and intervention. We then trace its path through evidence based approaches to anxiety, depression, couple difficulties, parent-child issues, chemical dependency, and chronic self-harming and suicidal clients. Relating to doing brief therapy, the more therapists deliberately bring these process-of-change concepts into focus, the more efficient and effective their therapy

becomes. In essence, the process of change view suggests that problems are described across all approaches as solution-generated vicious cycles where clients become trapped in repeated efforts to resolve difficulties which only make them worse. All effective psychotherapies intervene to interrupt and redirect these vicious cycles, thus initiating new virtuous cycle patterns for clients. In a manner of speaking, all effective therapy changes the way clients are attempting to change. These two interrelated elements of change are referred to as first-order and second-order change, and may be defined as follows:

- **First-order change** is a change within the common assumptions and related interactions of a given system. It may be a change in intensity, frequency, duration, location, etc. yet these changes do not change the system and, in fact, serve to perpetuate the system itself.

- **Second-order change** is a change *of* the common assumptions and rules of a given system and usually results in strikingly different interactions and resolutions within the system. It is a change of the system itself.

Without going much further on this, suffice it to say that most all approaches to effective therapy, explicitly or implicitly, view problems in line with the definition of first and second-order change. We further propose that second-order change is at the heart of each approach that we reviewed. From this perspective, then, we might offer the following brief descriptions of various commonly encountered clinical problems and their resolution:

> **Anxiety** is typically seen as the result of trying to master anxiety by avoiding it. The first-order vicious cycle is the result of hyper-vigilance and sensitivity to anxiety cues, which only provokes more anxiety and prevents mastery. Second-order interventions offer rationales explaining the cycle and the difference between fear and anxiety. They then prescribe reversals in the pattern by moving clients toward their anxiety to master it.

Depression is commonly seen as a vicious cycle of attempts to cope with overwhelming stress through self-disconfirmation, over-simplifying complex situations, and withdrawal. The first-order vicious cycle results in self-doubt, blame, and withdrawal from life situations that only get worse. Negative cognitions become self-fulfilling. Second-order interventions offer various rationales to affirm clients' depression as appropriate to context and to their habitual solutions. They then reverse the pattern through exercises in checking out their assumptions and addressing their challenges.

Parent/Child Problems are widely viewed as the result of vicious cycles where parents try to force compliance to their demands and children and adolescents resist. Second-order interventions reverse the change sequence for parents by offering rationales for why the escalating battles happen, then having parents de-escalate their demands by connecting and validating their children first before gradually shaping collaboration.

Couple Difficulties are typically described as vicious cycles where partners try to force change on each other. These conflicts become polarized and erode positive feelings within the couple making it harder to tolerate common couple conflicts. The more they try to fix the relationship, the worse it gets for the fixing. Second-order interventions first offer rationales to affirm the universal and more unique reasons for conflict. Reversals include asking partners to go toward conflicts, develop dialogue around and accept those irresolvable differences, and evolve positive experiences and futures with each other.

Chemical Dependency and alcohol problems have also been broadly described as the result of mastery through avoidance. The person does not properly attend to addictive behavior or take other necessary actions for change. One vicious cycle is between the person and their chemical where the more they deny addiction or dependence, the more they are drawn into addiction. The other cycle is triggered as significant others try to coerce the addict out of his or her addictive behaviors. A second-order intervention of AA and similar 12 step programs is to have the addict win over their addiction by admitting defeat. Significant others are encouraged to reverse their positions, stand aside, and allow the addict to seek their own resolution. The other major second-order interventions are reversals for therapists. Therapists reverse their attempts to have the addict acknowledge and change their addiction. Instead they validate the addicted person's position on change and collaborate with them on what they might decide to change, if anything.

Chronically Suicidal and Self-Harming client problems are described as vicious cycles of clients struggling with their own emotions and views of themselves and between them and significant others. Extremely dangerous actions become reinforcing for these clients and draw others to the rescue in an affirming way. Vicious cycles of emotional reactivity in historically invalidating relationships are repeated with significant others as well as with therapists. The

> second-order interventions revolve around therapists affirming their clients' distress and wish to self-harm while simultaneously working to build new skills to master such distress personally and interpersonally. Therapists provide second-order relationships for these clients through this position. Second-order reversals have clients go toward distress to practice new skills.

Describing how psychotherapy works from this level of abstraction has an additional advantage. Once it can be established that problems have common patterns and solutions, it becomes clear that a wide variety of methods can achieve the same result. For example, once it is understood that anxiety is maintained by avoidance and that solutions involve engaging the symptom, we can more easily understand how many different approaches might accomplish this task. We do not need to prove that one method is better than another. The same is true for the other problems noted. We contend that such a more deliberate view of the nature of problems and their resolution using this process of change model is the next step to becoming more efficient and effective brief therapists. It also offers therapists more flexibility in integrating approaches and adapting them to themselves and the uniqueness of each client.

Based on the above, second-order change can be operationalized in the following ways for therapists. The term "something to do with" is used out of respect for the many ways that exist for bringing about second-order change. Because change is so complex many of these elements may be observed in any given case.

- If the first-order solution is *to go away from the problem* the second-order solution will have something to do with *going towards it*.
- If the first-order solution is *to over-pursue the problem* the second-order solution will have something to do with *stopping and reversing the pursuit*.
- If the first-order solution is *to not attend to the problem*, the second-order solution will involve *acknowledging the problem* and *taking necessary problem solving action*.

- If the first-order solution involves *making the problem overly complex*, the second order solution will involve *simplifying the problem* and *narrowing problem solving efforts* down to the problem at hand and clarifying the problem's parameters.

- If the first-order solution is *to over-intervene* with normal ups and downs of daily living second-order solutions will involve *tolerating and accepting* the amount of unpleasantness that is a natural part of the human condition.

- If the first-order solution *reads too little into the difficulty*, or *simplifies the problem so much as to trivialize it*, the second-order solution will *honor the complexity of the problem*. To honor complexity entails both respecting and assisting the problem solver with building an understanding that clarifies the problem and its parameters in a way that is understood by the problem-solver.

The common interventions employed to achieve these ends usually include such things as: blocking and acceptance strategies; reversals of client strategies; restraints from change strategies; normalizing; framing, reframing and deframing strategies; positioning strategies; prescribing symptoms; predicting or prescribing difficulties or relapses; and adopting a goal-oriented future position. Several of these strategies usually are combined in most treatment approaches, and variations of all of them are employed throughout each approach to effective brief therapy. Nevertheless, effective brief therapy always involves a combination of these generic interventions along with a collaborative relationship, therapeutic rationale and an agreed upon contract to structure treatment in the most efficient way to achieve those ends. In addition to the characteristics of good brief therapy, the elements of all effective therapy, and the key components of Frank's contextual model, focusing on critical vicious cycles around identified problems and designing interventions to achieve desired second-order change is at the heart of all effective and brief therapy. Specific approaches will design their interventions from

different rationales and use different procedures, and yet the focus for change will be similar.

Episodes of Care and the Process of Change

The purpose of this paper was not to describe how to do brief therapy per se. Many clinical updates will tell clinicians "how to do" a given practice. To have done so this in this article would defeat its purpose. We could have outlined how to do strategic brief therapy, or solution focused brief therapy, or cognitive behavioral brief therapy, dynamic brief therapy, and so on. Yet this would have perpetuated the current problem where each of these various views lays claim to effectiveness through its own particular rationales and procedures. Few practitioners of each view relate to one another or acknowledge the potential effectiveness of alternate approaches. Instead they often jealously guard their own claims to being the best. Our view is that there are a number of very effective specific approaches to brief therapy, including those mentioned, among others. Clinicians interested in learning these various approaches have no lack of treatment manuals and training opportunities to learn them. Practitioners should pursue these. In the larger scheme, however, most effective brief therapy will come from clinicians knowing the key elements covered in this brief update, and then organizing their practice using the process of change model highlighted here.

From this view, doing brief therapy is first a product of a set of assumptions on the nature of change. Seeing change as an inevitable process where clients routinely get stuck in the process of negotiating difficulties leads to brief, focused episodes of intervention. Resolving these solution-generated vicious cycle problems frees clients to evolve their

life with the benefit of this new shift. They can always return at another juncture, in keeping with the "family doc" model of another episode of care. It is also a product of how a therapist organizes and engages in the process of treatment. Being active in maintaining a clear and specific focus, collaborating on goals, and explicitly using homework and outside systems will facilitate effective brief therapy, no matter what approach is used to do this. Gaining collaborative goal consensus in an empathic working alliance further maximizes key factors common to all effective therapies. It is important to remember that our clients co-create their world views as they negotiate their lives and these varied world views need to be understood and honored. They are the very views that often channel and direct these clients' well-meaning and yet often self-defeating efforts to resolve their problems. Collaborating with our clients within their world view to help foster change from within is one of the surest ways to enhance many of the elements common to all effective therapy. We must also remember that our own therapeutic perspectives co-create and shape our approach to treatment with clients. Frank's contextual model suggests that flexibly fitting these therapeutic rationales to achieve client-therapist buy-in is a sure way to enhance hope and accelerate change. The process of change model suggests that, while a first-order change sometimes is sufficient for brief therapy, most often the focus and the outcome of all efficient and effective brief therapy is second-order change. Beyond all of these important factors, at the highest level, we believe that doing brief therapy begins and ends with adopting the perspectives embodied in the process of change model briefly highlighted here. This should enhance selective integration of the many wonderful approaches that have been developed over the years. In these ways, doing brief therapy will not just be a product of responding to the current

press for quick-fix approaches to psychotherapy. It will flow instead from a perspective on simply doing effective therapy--which in fact is most often brief.

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