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COUNSELING AND CLINICAL PSYCHOLOGY PROGRAMS

A Dissertation

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By

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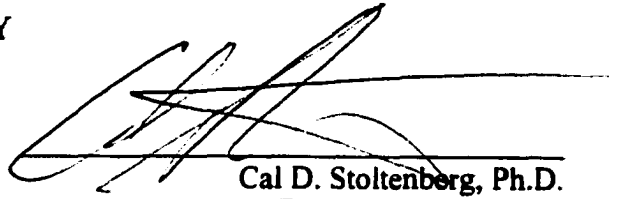
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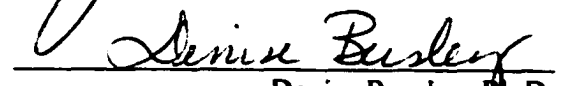
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ABSTRACT

The practice of brief psychotherapy has increased dramatically during the last two decades. Although practicing psychologists report spending a substantial proportion of their time conducting brief psychotherapy, up to one third of them report having little or no training in how to conduct brief psychotherapy. The current study examined standard practices of APA accredited Clinical and Counseling psychology programs with regard to their brief therapy training. Training directors of all accredited programs in the United States and Canada were surveyed, and a 40% response rate overall was obtained. The results indicate that 81% of programs provide their students with some form of brief therapy training, but the depth of that training varied tremendously, ranging from a one-hour seminar to 750 hours of supervised practica training. The results of the survey were integrated with extant literature on brief therapy training in order to develop training recommendations appropriate for APA Accredited Clinical and Counseling psychology programs to consider.

CHAPTER I

INTRODUCTION

Prior to World War II, mental health services were delivered primarily in state hospitals to the severely and chronically mentally ill. Outpatient therapy was a service provided primarily to the elite who could afford to pay for psychotherapy out of pocket, and was mostly long-term in nature (Garfield, 1989). In the later half of the century, however, the primary site of service delivery shifted from the in-patient hospital to the outpatient mental health center. This shift occurred due to several major social factors, including the passage of the Community Mental Health Center Construction Act put forth by President Kennedy and passed by congress in 1963 (Vanderbos, Cummings, & Deleon, 1992). A greater focus on the role of the family and the environment also contributed to a decrease in the acceptance of the medical disease model of mental illness. Today, mental health treatment is seen as being appropriate for any individual or family experiencing distress, rather than only for the rich or the seriously mentally ill (Garfield, 1989).

Between the 1950's and the 1990's, there was an explosion in the number of mental health services and treatments available, and in the number of providers. In order to meet growing clinical demands, therapists began experimenting with the development of shorter-term therapeutic techniques (Austad & Berman, 1991). Early attempts focused on reducing the length of traditional long-term psychodynamic therapy. Later, innovations

in cognitive and behavioral treatments were developed and were often inherently brief. The advent of managed care and increased examination of therapeutic efficacy by funding agencies further pushed the development of effective treatments that were brief in duration. (Austad & Berman, 1991). The current trend in psychotherapy seems to be an emphasis on more active forms of treatment, brief intervention, and targeted, problem-specific intervention (Watkins & Watts, 1995). Today there are over 50 different modalities for conducting brief psychotherapy (Cooper, 1995).

Research consistently shows brief therapy to be more effective than no treatment, and as effective as long term therapy for many client problems (Koss & Shiang, 1994; Barber, 1994). In fact, the field of brief therapy seems to be gaining the characteristics of a professional subfield in it's own right (Bloom, 1992).

Brief psychotherapy is argued to be substantially different from long term therapy in both values and orientation, rather than simply a truncated version of long-term therapy (Budman & Gurman, 1988). Training is an essential part of developing the clinical skills specific to brief therapy (Austad & Berman, 1991). Psychologists in practice report spending a substantial portion of their time conducting brief psychotherapy, however many do not receive any training or supervision in how to conduct brief therapy (Levenson & Strupp, 1999). For example, in one recent survey psychologists reported spending 40% of their time doing brief therapy, but one third of those psychologists had little or no training in brief therapy (Levenson, Speed, & Budman, 1995).

Previous research has documented that although psychologists are spending more and more of their time providing brief therapy, they often do not feel well trained in the area

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of brief therapy. However, only one study to date (Levenson & Strupp, 1999) has examined the actual training in brief therapy provided by doctoral programs. This study focused on programs with a psychodynamic orientation, and only reported whether programs provided some form of training or not; it did not explore the depth of that training or the methods used in training students to conduct brief psychotherapy.

The purpose of the current study was to examine the standard practices of doctoral programs in clinical and counseling psychology, accredited by the American Psychological Association (APA), with regard to training students to conduct brief psychotherapy. Both the prevalence of training and methods used to train students were examined in some depth, and extant literature was integrated in order to develop training recommendations appropriate for APA accredited programs to consider. It is hoped that these recommendations could assist programs in providing their students with high quality training in brief therapy, an area that is likely to account for a major portion of their time as professionals.

CHAPTER II

REVIEW OF THE LITERATURE

The History of Brief Psychotherapy

The traditional psychoanalytic model of therapy dominated the clinical practice of

psychology for decades. The model of long-term therapy was the accepted norm, and it

was widely believed that in order for personal change and character reconstruction to

occur, the therapeutic process must be lengthy. The psychoanalytic model held that since

a person's problems developed over the course of many years, effective treatment would

necessarily take several years. It was accepted that only by helping the patient gain

insight into the unconscious conflicts causing his or her problems, could he or she be

helped (Garfield, 1989).

Freud himself envisioned therapy as requiring six months to a year to complete,

although he hoped that as psychoanalysis became perfected the required time might be

shortened. Just the opposite occurred, however, and the length of individual therapy

continued to increase, sometimes reaching 5 to 10 or even 15 years (Garfield, 1989).

Some of Freud's followers, such as Ferenczi and Rank (1925), began to experiment

with reducing the time required for therapy, but these attempts were not well accepted by

most psychoanalysts. A later attempt at abbreviating psychoanalysis was developed by

Alexander and French (1946). They argued that significant improvement can occur as the

result of just a few interviews in which a significant emotional experience occurs and

insight is gained. They also criticized psychoanalysts for excusing lack of effectiveness

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and progress in therapy as resistance on the part of the client. Also in 1946, Herzberg advocated active psychotherapy, in which the therapist plays a more active role and assigns certain tasks for the patient to perform, thus fostering the patient's independence. Another attempt at reducing the duration of therapy was made by Frohman in 1948. He advocated an eclectic approach directed by the needs of the individual patient, and suggested that therapy should last between 20-30 sessions. However, none of the attempts at reducing the duration of therapy gained mainstream acceptance, and brief therapy continued to be viewed as superficial and ineffective in creating meaningful change (Garfield, 1989).

A little more than a decade later, in the 1960's, brief therapy began to be viewed more positively. Garfield (1989) outlined social factors that, together, have created a significant shift in how brief therapy is viewed. First, Garfield stated that psychotherapy has been popularized and made more available to populations other than the very wealthy, who could afford to pay for individual therapy for years. The need to make therapy more widely available became apparent in the post-World War II period. The Joint Commission on Mental Illness and Health (1961) published a report highlighting the inadequacies of mental health services available at the time. They were particularly critical of psychoanalysis. Both the length of time required to train analysts and the length of time required for therapy put major limitations on the services psychoanalysts were able to provide. The Joint Commission (1961) called for the development of more efficient methods of treatment in order to better meet the nation's mental health needs.

The need for effective interventions in times of crisis also encouraged the development of brief therapy. During World War II, large numbers of soldiers developed psychological difficulties. The treatment resources and techniques that were available at the time were not sufficient to handle such a great demand for services (Koss & Shiang, 1994). This prompted the development of early forms of short-term crisis intervention. This intervention was designed to provide help as soon as possible after the initial trauma, and aimed at stress reduction, symptom relief, and the prevention of further breakdown by restoring self-esteem (Koss & Shiang, 1994).

Another social factor that positively influenced the mainstream view of brief therapy was the passage of the Community Mental Health Center Construction Act put forth by President Kennedy and passed by congress in 1963 (Vanderbos, Cummings, & Deleon, 1992). This community mental health movement made many creative contributions to the mental health field, including ideas such as crisis intervention, para-professional counselors, and a greater emphasis on relatively brief therapy (Garfield, 1989). This movement also changed the population of clients seeking therapy. Therapy came to be seen as a potential treatment for everyone, not just for the wealthy or the seriously disturbed. This change in population also encouraged the development of brief therapy modalities (Garfield, 1989).

Over the next several decades, the proliferation of brief therapy was encouraged by several factors. First, research consistently showed brief therapy to be as effective as long-term therapy (Koss & Shiang, 1994). Second, brief psychotherapy has also become increasingly requested by clients, as most are seeking alleviation of a relatively specific

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problem and do not want long-term therapy (Koss & Shiang, 1994). Finally, there has been a move toward greater accountability and increased examination of therapeutic efficacy by therapists, insurance companies, and other funding agencies (Budman & Gurman, 1988).

Beginning in the mid 1970's the effectiveness of psychotherapy has been increasingly scrutinized, and greater efficiency and accountability has been demanded of therapists (Budman & Gurman, 1988). Unlimited funding of long-term therapy is no longer unquestioningly accepted by insurance companies, particularly HMO's, legislators, employee assistance programs, and other funding agencies (Budman, 1992). Managed health care and other third-party payment structures often place a limit on the number of therapy sessions that they will reimburse. Because many clients are unable to afford to pay for private therapy, especially long-term therapy, the length of therapy is being determined by managed health care programs for more and more clients (Bergin & Garfield, 1994).

Managed mental health care tends to emphasize short-term psychotherapy and community-based, rather than hospital-based, treatment (Sauber, 1997). In response to pressures by such funding agencies and with a desire to provide better and more efficient services to their clients, many practitioners have embraced the practice of brief psychotherapy. For example, Austad (1996) surveyed 294 mental health professionals who had made the transition from fee-for-service practices to working in a managed care setting. They reported that as a result of the transition they used brief therapy models much more frequently, developed a stronger belief in the effectiveness of brief therapy,

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and became more active and directive as therapists (Austad, 1996). The rise of managed care has clearly had a significant impact on the prevalence of brief psychotherapy.

Defining Brief Psychotherapy

According to Bloom (1992), brief therapy lasts between a minimum of one session and a maximum of 20 sessions, with an average duration of about six sessions. Bergin and Garfield (1994) expand this range a bit, reporting that most models of brief psychotherapy last between one and 15 to 30 sessions. Koss and Shiang (1994) report that there is a general agreement in the literature that 25 sessions is the upper limit for brief therapy. However, brief therapy is more meaningfully defined in terms of a set of limitations that are placed on service delivery systems, than by a specific number of sessions.

Many mental health professionals initially viewed brief therapy as an abbreviated version of long-term therapy, as opposed to a qualitatively different approach. However, as brief therapy became increasingly accepted and developed as a therapeutic modality, it became clear that there were differences in the values held by traditional, long-term therapists and brief therapists. Budman and Gurman (1988) outlined the values that were held to be central to long-term therapists. First and foremost, the goal in traditional long-term therapy was basic character change, rather than the alleviation of a specific symptom. Presenting problems were viewed as being indicative of a deeper pathology, rather than taken at face value. Second, long-term therapists believed that for character change to occur therapy was required, because such change would not occur in everyday life. In keeping with this view, the long-term therapist views therapy itself as the most

important part of the client's life. Third, the long-term therapist views therapy as having a "timeless" quality, and is unconcerned if change takes a great deal of time. Fourth, therapy is seen as benign and helpful, regardless of length. Finally, and perhaps unfairly, long-term therapists have been accused of unconsciously recognizing the financial benefits of keeping each client in therapy for an extended period of time.

In contrast to the values held by long-term therapists, Budman and Gurman (1988) discuss the values that are widely shared by brief psychotherapists. First, contrary to the long-term therapist's goal of character change, therapists utilizing brief therapy models target the client's presenting problem. Second, they adhere to an adult developmental perspective, and view psychological change as an inevitable part of everyday life. Furthermore, they view the client's world as being more important than therapy itself, and acknowledge that change will continue even after therapy has ended. Third, in brief therapy approaches, therapists do not adhere to the notion of a "cure" in therapy. Rather, they emphasize the patient's own strengths and resources, and use the least radical intervention that is also efficient and practical. Fourth and perhaps most importantly, brief therapy models do not accept the traditional "timeless" model of therapy in which the therapist is unconcerned if change takes a great deal of time. Brief therapy approaches even view therapy as capable of doing harm to the patient. Finally, as a result of these other values, financial issues are muted and are often dictated by the structure of reimbursement that is in place in that particular therapeutic setting.

In order to explore the differences in values held by long-term versus brief therapists, Bolter, Levenson, and Alvarez (1990) surveyed 222 licensed psychologists who were

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selected at random. They found that 34% of their sample favored brief approaches to therapy, 54% favored long-term therapy, and 12% indicated no preference. The results of the survey provided support for the differences in values proposed by Budman and Gurman (1988). For example, brief therapists valued a time-limited model of therapy, whereas long-term therapists preferred a "timeless" model. Furthermore, long-term therapists viewed the personality as static and needing therapy to overcome resistance to change, whereas brief therapists viewed the personality through an adult developmental perspective, and supported therapy as an intervention to help resume normal growth.

Offering a dissenting opinion, Miller (1996) asserts that "short-term therapy values" are used as a justification for rationing mental health treatment without the client's knowledge. He points out several fallacies in Budman and Gurman's (1988) arguments. First, Miller (1996) argues that Budman and Gurman have created a false dichotomy between the values of long-term and short-term therapists. He points out that therapists do not have to choose one value system or the other; in reality there are many more than two choices. Miller (1996) also argues that in delineating long-term therapists' values, Budman and Gurman have created a caricature of values that are not supported by any theory of psychotherapy. For example, Miller states that although some therapists may act as if therapy is a "timeless" endeavor, timelessness is not a value espoused by any theory of psychotherapy. In addition, Miller (1996) states that although change does occur without treatment as brief therapists point out, research suggests that both the quality and quantity of improvement resulting from therapy are different from and superior to change that occurs in normal development or spontaneous remission. Finally,

Miller (1996) takes issue with Budman and Gurman's (1988) assertion that financial issues are muted for brief therapists. He points out that just as long-term therapists stand to gain economically by keeping clients long term in a fee-for-service environment, in a managed care environment short-term therapists stand to gain by keeping treatment duration brief. Such covert incentives as bonuses, referrals, or continuation on a provider panel may be linked to keeping treatment length short (Miller, 1996). Clearly, the increasing prevalence of brief therapy has not been universally welcomed or received without controversy.

Models of Brief Therapy

As the practice of brief psychotherapy has grown in popularity and gained greater acceptance, there has been a proliferation of theories about how brief therapy should be conducted. Cooper (1995) reports that there are currently over 50 specific models for conducting brief therapy.

Koss and Shiang (1994) classify the numerous models of brief therapy into five broad categories. The categories include 1) psychodynamically oriented brief therapies, 2) brief behavioral, cognitive, and cognitive-behavioral therapies, 3) eclectic brief therapies, 4) crisis-oriented therapies, and 5) all other miscellaneous brief verbal therapies.

The first category includes the psychodynamically oriented brief therapies. These systems seek to develop at least a limited psychogenic-based understanding of the presenting problem. They continue to emphasize insight, but focus on the present rather than on childhood experiences. Interpretation is still a major therapeutic technique, and

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positive transference is generally thought to be essential to successful treatment outcome. Once transference has occurred, the central issue or conflict can unfold.

The second major category suggested by Koss and Shiang (1994) includes brief behavioral, cognitive, and cognitive-behavioral therapies. Treatment length is not of primary concern in these orientations, but they can generally be completed within the time limits of brief therapy. Cognitive and behavioral therapies have become increasingly popular, and have been shown to be especially effective for patients diagnosed with agoraphobia, social anxiety, obsessive-compulsive disorders, weight problems, and somatic disorders. These therapies are more focused on matching diagnoses and interventions than are most other orientations (Koss & Shiang, 1994).

The third major category of brief psychotherapy modalities includes the eclectic psychotherapies (Koss & Shiang, 1994). The underlying philosophy of the eclectic therapist is that human problems are complex, and must be addressed using a variety of techniques and an integration of approaches. Technical eclecticism refers to simply borrowing therapeutic techniques from various orientations, whereas theoretical eclecticism refers to the attempt to integrate underlying theoretical orientations. Brief eclectic therapies may use behavioral techniques, focused problem solution, problem-solving methods, and family techniques in order to achieve successful therapeutic outcome (Koss & Shiang, 1994).

The fourth category of brief psychotherapy modalities, according to Koss and Shiang (1994), includes the crisis-oriented therapies. Crisis intervention is usually provided when the client has experienced a traumatic event, such as a rape, death of a loved one, or

a natural disaster. Crisis intervention can involve referring the client to needed resources, providing general support, or helping the client to find meaning or gain personal insight into their response to the crisis. Such intervention is generally by nature brief.

The fifth and final category of brief psychotherapies includes all other miscellaneous brief verbal therapies. This category includes hypnosis, hypnoanalysis, and narcoanalysis. These techniques are usually used as a treatment for a target symptom in conjunction with other techniques. Cathartic psychotherapy is also included in this category, and aims at creating an emotional catharsis for the client through the use of role playing, repetition of emotion-laden phrases, and expressive movements such as striking a couch to release anger.

Koss and Shiang (1994) emphasize that all of the brief therapy modalities in these categories share in common a core set of principles. First, therapeutic goals are based on the assumption that patients are capable of making changes throughout their life span. Second, the time allotted to achieve these goals is limited. Finally, a working alliance develops between the therapist and the client in order to achieve the therapeutic goals within the limited time frame.

Cooper (1995) reports that as brief therapy continues to develop, strategic-structural and cognitive-behavioral approaches are becoming more widely accepted and popular than dynamic approaches. He postulates that this may be because brief dynamic approaches place an emphasis on selecting motivated, functional clients who are capable of insight, thus limiting their application to a narrow population.

Bloom (1992) reviews several brief dynamic approaches. He reports that Malan (1963) has had a pervasive influence on dynamic brief therapy. Malan emphasizes working with limited treatment goals, and identifying a "focal conflict" which will then become the focus of therapy. He also offers guidelines for selecting appropriate patients. He states that motivated persons who have the capacity to think in feeling terms and are not severely disturbed are good candidates for brief therapy. However, Malan's definition of brief therapy is 40 sessions, which is not generally accepted in the literature.

Mann (1973), another brief psychodynamic therapist, adheres strictly to a 12 hour limit in order to facilitate the client's confrontation of reality. Each patient is allowed to determine how he or she would like to allot that time: for example, 12 hour-long sessions, or 24 half-hour sessions. Mann also emphasizes the identification of a central issue which reoccurs over time, and relates to the individual's development or adjustment to his or her environment. In order to resolve the central issue within the 12 hour limit, Mann states that clear goals must be maintained and the therapist must remain very active.

Davanloo (1979) uses traditional psychoanalytic principles including interpretation of dreams and transference material. His confrontations and transference interpretations tend to provoke anger in patients because they are used to elicit the patient's true feelings and to confront their defenses. Such confrontations are designed to limit transference neurosis, which is seen as undesirable in brief therapy. Davanloo states that a strong patient-therapist relationship is needed because of the strength of these confrontations.

His goal is character change through the resolution of core neurotic conflicts. Davanloo considers his approach to be broadly applicable, even in patients with severe pathology.

Finally, Sifneos (1992) advocates "anxiety-provoking therapy," which he also considers to be applicable even in cases of severe pathology. Sifneos uses direct confrontation of the patient's defense mechanisms to clarify issues from the patient's childhood. He then makes interpretations of how those early conflicts impact the patient's current circumstances.

Cooper (1995) reports that there are commonalties across the various brief psychodynamic approaches. Specifically, all these methods of brief dynamic therapy emphasize transference and countertransference, confrontation and interpretation of intrapsychic conflict, and the psychological importance of termination.

According to Cooper (1995) strategic-structural and cognitive-behavioral models of brief therapy are growing in favor over dynamic models of brief therapy. Cooper reports that cognitive-behavioral theories emphasize assessment, relief of current problems, and use empirically-based techniques to reach mutually-determined goals.

Strategic-structural therapy, as proposed by Haley (1991) and Minuchin (1981) both de-emphasize pathology and use a directive therapist style. Haley further emphasizes a pragmatic, problem-solving approach to reach therapeutic goals. Minuchin uses a structural approach to family therapy that focuses on solving immediate family problems by changing the family structure that creates and maintains them.

In Walter and Peller's solution-focused brief therapy (1992), the emphasis is placed on building upon exceptions to the presenting problem. They assert that very little

problem   information is necessary for effective therapy, and advocate rapid

identification or development of solutions that are intrinsic to the problem or to the client.

Finally, Beck's (1976) cognitive therapy and Ellis's (1992) rational-emotive therapy

are both inherently brief. They emphasize that changing the client's cognitive processes

is effective in order to achieve a wide variety of treatment goals, including successful

treatment of mood disorders and even personality disorders. Cognitive therapy

emphasizes the identification of cognitive errors or irrational thoughts, and then

challenges them in order to replace them with healthier cognitions.

Behavioral therapies also tend to be inherently brief. According to O'Leary and

Wilson (1987), they emphasize early and continuing assessment, and the goal is to

extinguish maladaptive patterns of behavior and to replace them with more adaptive

patterns. Behavior therapists make use of such techniques as systematic desensitization,

assertiveness and communication skills training, contingency management and

contracting, and token economies.

Yalom and Yalom (1990) suggest that similar dynamics exist in the provision of brief

group therapy. In brief group psychotherapy, the therapist must also be very active and

directive, help individuals establish limited and attainable treatment goals, and maintain a

focus on the goals as the group progresses. They assert that it is also important for each

individual within the group to take personal responsibility regarding his or her own goals.

Efficacy of Brief Psychotherapy

Once thought to be appropriate for only minor problems, brief psychotherapy is

proving to be as effective as long-term therapy in treating a wide range of psychological

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and health-related problems. For example, brief therapy has empirically shown to be effective in treating depression, panic disorders, phobias, compulsions, post-traumatic stress disorder, poor interpersonal relationships, test anxiety, social skills deficits, and job-related stress (Koss & Shiang, 1994; Steenbarger, 1992). Brief therapy has also been shown to be effective with severe and chronic problems when therapeutic goals are reasonable (Budman & Gurman, 1988). For example, brief therapy has shown some success in clients with personality disorders (Koss & Shiang, 1994), and highly disturbed clients appropriate for psychiatric hospitalization (Steenbarger, 1992). Furthermore, manualized brief therapies have been shown to be as effective as other forms of psychotherapy, and to be more effective than no treatment (Barber, 1994). Changes produced in brief therapy hold up remarkably well over time, documented in follow-up periods of one year and longer (Steenbarger, 1992). The conclusions that planned brief therapy is largely indistinguishable from time-unlimited psychotherapy in effectiveness and that clients are satisfied with brief episodes of treatment are consistently found in the literature (Bloom, 1997).

The literature comparing short-term and long-term therapy has essentially shown no difference in effectiveness (Austad, 1996). However, the debate about whether long or short-term psychotherapy is more effective rages on. In the first large-scale study to lend support to the claims that long-term therapy is more effective, Seligman (1995) published a Consumer Reports survey on the effectiveness of psychotherapy. Of the 22,000 people who completed the annual Consumer Reports Survey, 7,000 responded to the mental health section of the survey and 4,100 reported seeking help from some mental health

professional. Their responses indicated that the longer people stayed in therapy, the more

they improved. In addition, no specific modality of psychotherapy was shown to be

better than any other, and clients were equally satisfied with all mental health

professionals with the exception of marriage counselors. However, Seligman's (1995)

study is criticized for being retrospective, using overly gross measures of outcome, and

for lacking a control group. In addition, the sample was largely educated and middle-

class, and therefore not representative of all therapy clients (Austad, 1996). Finally,

Seligman's (1995) study is criticized for being essentially a survey of satisfaction with

therapy, and it is questionable as to whether satisfaction is equivalent to effectiveness

(Austad & Morgan, 1998).

Bloom (1997) interpreted the results of Seligman's (1995) Consumer Reports study as

supporting the efficacy of brief therapy. Seligman asked respondents if they were

currently seeing a therapist, and if not, why not. One response choice was because "my

problems were resolved or significantly improved," or due to clinically significant

improvement. Bloom (1997) points out that 68% of respondents whose treatment was

longer than two years in duration checked this alternative, while 60% of respondents

whose treatment was less than one month in duration checked the same alternative.

Bloom (1997) asserts that this data reaffirms previous findings that psychotherapy is

efficacious, has a remarkably low threshold (the amount of treatment necessary to

produce a discernible effect), and an extremely short latency (the speed at which a

discernible effect is produced).

Studies of brief psychotherapy have revealed several important variables that seem to moderate outcome in brief therapy. One such variable is time (Steenbarger, 1992). Studies that have examined brief therapy interventions at termination and at a follow-up period generally find that change occurs rapidly over the treatment period and levels off after treatment. However, studies of outcome in brief dynamic therapy reveal that changes on personality dimensions continue to expand over the course of follow-up. These studies find that change is a function of time, not number of therapy sessions, leading some to suggest that fewer sessions spaced over a greater period of time would have greater impact than do a larger number of sessions massed within a time frame (Steenbarger, 1992).

Clients variables such as an acute onset of a behavioral problem, the ability to relate well to others, and high levels of motivation for treatment seem to predict a favorable outcome in brief therapy (Koss & Shiang, 1994). Other factors that have been shown to be related to positive outcomes in brief psychotherapy include the formation of a positive working alliance with the therapist, high levels of pretherapy adjustment, and high levels of client involvement at both the affective and behavioral levels (Steenbarger, 1992).

Several client variables have also been linked to poor outcomes in short-term therapy. Piper, DeCarufel, and Szkrumelak (1985) found that the use of more sophisticated defensive styles, such as sublimation and humor, predicted a more favorable treatment outcome for inpatients treated with short-term therapy than did less-sophisticated defensive styles, such as projection, massive denial or depersonalization. They suggest that in brief therapy, the assessment of defensive style could save time and increase

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efficiency. Holmes (1995) reports that clients with a history of childhood abuse showed no improvement after brief therapy, whereas clients with no history of childhood abuse showed clinically significant reductions in depression and anxiety following brief therapy. He suggests assessing for a history of childhood abuse as a key variable for predicting client response to short-term therapy. Finally, Franko (1997) reports that readiness for change was a predictor of client response to brief group therapy for bulimia nervosa. Results showed that clients who were in the action stage of readiness for change, as opposed to the pre-contemplation or contemplation stages, showed the greatest reduction in binge frequency. He suggests assessing clients' readiness for change as an indicator of whether brief therapy will be effective or not. The above three studies present interesting hypotheses about client variables that may predict poor response to brief therapy, but all three need to be replicated in additional studies before more than cautious interpretations are made.

Koss and Shiang (1994) report that some clients are better candidates for brief therapy than others. Clients who are psychotic, desire personality reconstruction, are deeply dependent, act out persistently, are unrestrainably anxious, have less than a fifth-grade education, or are mentally deficient are unsuitable for brief therapy (Koss & Shiang, 1994). Other authors have recommended that clients be excluded from brief therapy if they have shown serious suicide attempts, chronic schizophrenia, drug or alcohol addiction, organic impairment, severe personality disorders, severe cognitive defects, somatoform disorders, or severe bipolar disorder (Peake, Meyers, & Duenke, 1997). Steenbarger (1992) notes that psychodynamic modalities of brief therapy tend to set the

most restrictive criteria for client inclusion, limiting treatment to individuals who are higher functioning and have problems of recent onset. Cognitive-behavioral and structural modalities are often applied to a wider range of client populations (Steenbarger, 1992). Regardless of symptom severity, clients with a good ability to relate to others are considered to be better candidates for brief therapy than those who have difficulty forming relationships (Koss & Shiang, 1994).

Thinking on the issue of client selection for brief psychotherapy has traditionally been dichotomous: if the client is seen as high functioning he/she is assigned to short-term therapy, but if the client has more substantial deficits, he/she is assigned to long-term therapy. However, Steenbarger (1992) points out that this dichotomous thinking excludes a large group of clients who have been shown to benefit from brief therapy, but who may be at increased risk for relapse. Steenbarger (1992) suggests that clinicians use a three-tiered model of client selection: clients at low risk for relapse after brief therapy, clients at high risk of relapse after brief therapy, and clients who are not suitable for brief therapy. The first group, clients at low risk for relapse after brief therapy, includes clients who desire focal symptom relief as opposed to broad personality change, clients who have a history of positive adjustment and form rapport with the therapist at intake, clients who's presenting problem has a recent onset, and who express motivated interest in brief, active involvement in counseling (Steenbarger, 1992).

The second group is comprised of clients who can benefit from short-term intervention but are at high risk of relapse after brief therapy. These are clients have the ability to form rapport with the therapist at intake but have chronic, long-standing problems, have

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personality-centered problems rather than focal symptomatic problems, may have

difficulty sustaining a positive alliance with the counselor over the course of therapy, and

have multiple distressing symptoms. These clients can be provided with additional

"inoculation training" against relapse, long term follow-up sessions to consolidate

changes, and can be encouraged to return as needed for additional episodes of brief

psychotherapy (Steenbarger, 1992).

The third and final group is comprised of clients who are not suitable for brief therapy.

These clients cannot form a working alliance with the therapist, have a history of chronic

maladjustment, have presenting symptoms so severe (such as psychosis or severe major

depression) that they require hospitalization and/or medication before engaging in

interpersonal change efforts, and clients who clearly express a need and desire for

ongoing therapy and actively reject the notion of brevity (Steenbarger, 1992).

The Practice of Brief Therapy

As a part of role induction in the initial phase of therapy, Koss and Shiang (1994)

report that most brief psychotherapists inform their clients at the outset of any time limits

for therapy. The ability to directly address the issue of termination is an important

characteristic for a successful brief therapist. Furthermore, brief therapists view the

establishment of a therapeutic relationship as a important factor, and are both active and

directive in that relationship, preferring prompt and early interventions during a crisis.

Additionally, brief therapists set limited and attainable goals, maintain those goals as the

focus of therapy, and focus on the present rather than the past (Koss & Shiang, 1994).

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Budman and Gurman (1988) point out that due to the smaller number of sessions in brief psychotherapy, it is even more critical than in long-term therapy for the therapist to determine the salient issue and to maintain that focus until the therapeutic goals have been achieved. Together, the therapist and client must develop a shared value system and, based on that, agree on what therapy can and cannot accomplish. Such a working alliance is critical if the therapeutic goals are to be achieved in a limited period of time.

Budman and Gurman (1988) suggest that the therapist be aware of the most commonly presented foci, including losses, developmental dysynchronies, interpersonal conflicts, symptomatic presentations, and personality disorders. They further suggest that the therapist consider why the client is seeking therapy at this particular time, and whether the client's age, date of birth, developmental stage, or a particular event or crisis could have precipitated the entry into therapy at this particular time.

In a 1988 article, MacKenzie outlines three methods that can be used for establishing time limits in brief psychotherapy. First, the therapist or treatment center can set a specific number of sessions available per client, regardless of the client's issues. Second, a specific date of termination can be established, without specifying the number of sessions that will occur. This alternative allows for more frequent sessions at the beginning of therapy than at the end, if necessary. Finally, there can simply be a clear agreement between the therapist and client that therapy will be brief and that they will work rapidly, without setting a termination date or a specific number of sessions.

In order to explore the optimal number or "dose" of therapy sessions for clients, Howard, Kopta, Krause, and Orlinsky (1986) conducted a meta-analysis of fifteen studies

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conducted over a period of thirty years examining 2,431 patients in individual, outpatient therapy. They found that 10 to 18% of patients reported improvement in their conditions before therapy even began, simply as a result of contacting the therapist. Between 48% and 58% of the patients showed improvement by the eighth session. Finally, 75% of patients showed marked improvement by the twenty-sixth session (six months), and 85% improved by the end of fifty-two sessions (one year of treatment). The authors point out pharmacological studies define efficacy as the dose at which 50% of patients show some improvement. Using this criteria, eight sessions is an effective dose of therapy. Otherwise, twenty-six sessions might be used as a reasonable time limit, since the vast majority of patients improve within that time frame.

Research on How Clients Use Therapy

As computer technology has evolved, aggregate information and epidemological data about how clients actually use psychotherapy has become more readily available. The results from one such study, the 1987 National Medical Care Utilization and Expenditure Survey, were summarized by Austed (1996). According to this national survey, in 1987 3.1 percent of the outpatient population went for a psychotherapy session. Thirty-four percent of all patients appeared for one or two visits (very short-term users), 37 percent appeared for three to ten visits (short-term users), 13.4 percent appeared for eleven to twenty visits (intermediate users), and 15.7 percent appeared for twenty-one or more visits (longer term users of psychotherapy). The majority of people seeking outpatient treatment expected and received short-term therapy. The median duration of therapy was

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four to eight sessions. A small percentage of clients accounted for the bulk of therapy visits and cost expenditures (Austed, 1996).

Phillips (1985) was the first to describe the "attrition curve," the naturally occurring pattern of psychotherapy utilization. He combined data from international, national and local data bases resulting in a total sample of over a million cases. He then plotted the number of therapy sessions on the X axis and the number of clients remaining after each session on the Y axis, illustrating the topography of psychotherapy use. Phillips (1985) reports that regardless of the practice setting or the therapist's theoretical orientation, the average number of therapy visits is four to eight. Between one-third and one-half of patients who come for psychotherapy did not return after the first session. With each additional session, fewer and fewer clients remained in therapy. Only 8 to 10 percent continued therapy beyond ten or fifteen sessions (Phillips, 1985).

Summarizing epidemological research on psychotherapy use, Austad and Morgan (1998) conclude that up to one half of people who initiate mental health treatment do not return after one session. By the 5th or 6th sessions, only 10-15% of patients continue. The national average or mean number of session is 5 to 6 (Austad & Morgan, 1998).

In their 1986 meta-analysis, Howard, Kopta, Krause, and Orlinsky noted that the median number of sessions was actually higher for time-limited therapies than for time-unlimited therapies, suggesting that greater structure in therapy may help prevent clients from dropping out of therapy prematurely. In fact, in an archival study of 149 new clinic patients, Sledge, Moras, Hartley, and Levine (1990) found that the dropout rate for subjects in brief therapy in which the length of therapy was specified at the outset was

about half the dropout rate for subjects in long-term therapy and therapy in which the length was not specified at the outset.

It is clear that most clients who seek therapy want alleviation of a specific symptom, and neither want nor expect to be in therapy for a long period of time (Koss & Shiang, 1994). Garfield (1986) reports that most clients expect therapy to last between six and eight sessions. Clients' expectations about therapy are shaped by previous experiences with therapy as well as by their own implicit view of psychological health (Garfield, 1986).

Implications for Clinical Work

In spite of a lack of empirical support for the position, many practitioners maintain "long-term bias," or a belief in the superiority of long-term over short-term psychotherapy. Long-term therapy is seen by many clinicians as the gold standard of treatment, while brief therapy is seen as a lesser-quality treatment (Austad, 1996). While most clients receive brief psychotherapy, much of what we know about psychotherapy comes from studying the small percentage of clients who remain in therapy long-term. Cohen and Cohen (1984) called this "the clinician's illusion." There is disparity between the beliefs of long-term therapists and the reality supported by epidemiological data because therapists attribute the characteristics of long-term patients, who are seen more and are thus more memorable, to all patients. Generalization from the small percentage of clients who remain in therapy long term to the population of all therapy clients is not appropriate (Cohen & Cohen, 1984).

Regardless of therapists' own expectations about the length of time their clients should remain in therapy, it is important for clinicians to be aware of and sensitive to client's expectations about therapy, and the reality of how most clients will actually use therapy. Based on research and epidemological data, Austad (1996) concludes that brief therapy should be the treatment of choice for the majority of clients. She points out that the effectiveness of brief therapy has been demonstrated, that most clients expect brief therapy, and that there are strong economic pressures to use cost-effective treatments. She asserts that brief therapy should be considered the best choice unless otherwise indicated. Therapists should assume that brief therapy is the treatment of choice and if it does not work, then switch to a more intensive method. For the small percentage of clients who do need long-term treatment, additional services can then be provided (Austad, 1996).

Training in Brief Psychotherapy

Surveys of practicing psychologists consistently reveal two themes: psychologists are practicing brief therapy at a high rate, and many of those practicing brief therapy have little or no training in that modality. Levenson, Speed, and Budman (1995) surveyed licensed psychologists in California and Massachusetts (N=850) and found that over 80% were conducting some type of brief therapy, averaging 40% of their time per week. Ninety-five percent of the respondents reported doing some brief therapy now or in the past. Psychologists reported that about one-third of their private practice therapy hours were devoted to doing brief therapy, and the majority of agency hours were devoted to brief therapy. More than one-third of the psychologists indicated that brief therapy was

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their dominant treatment mode (Levenson, Speed, & Budman, 1995). However, of the respondents who reported doing brief therapy, one-third had little or no training in short-term interventions. Psychodynamically oriented psychologists evaluated their skills in brief therapy the lowest of any group, while cognitive-behavioral therapists rated their skills most positively. Of those who had training in brief psychotherapy, respondents ranked supervision first in effectiveness, followed by consultation and workshops. Self-selected reading was the most commonly used training method, used by 79% of all respondents, but was ranked fourth in effectiveness. Interestingly, recent graduates had not had more exposure to academic courses in brief therapy than older graduates. This finding raises the question of whether training programs are beginning to address the needs of students to become more skilled and knowledgeable in brief therapy (Levenson, Speed, & Budman, 1995).

Levenson and Strupp (1999) report that 82% of psychodynamically-oriented psychologists surveyed conduct some planned brief therapy. In their private practices, 30% of their time is spent conducting brief therapy, while in their agency work over half of their time is devoted to brief therapy. Again, however, psychodynamically-oriented psychologists reported that they do not feel very skilled or experienced in conducting brief therapy. More than 40% reported that they have not even had a course in brief therapy. Almost twenty percent of the psychologists who conduct brief therapy had not even read a brief therapy book of their choosing. Of those who reported having some training in brief therapy, the most common method was self-selected reading (82%), followed by supervision, workshops, conferences, and academic courses. Respondents

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rated supervision to be the most helpful training experience, and academic courses to be the least helpful. Although psychodynamically-oriented psychologists are doing a great deal of brief therapy work, 65% reported preferring long-term therapy (greater than one year), 25% preferred moderately long-term therapy (20-52 sessions), and only 7% prefer short-term therapy. Levenson and Strupp (1999) state that without proper training and positive attitudes toward brief therapy, poorer therapeutic outcomes are likely.

Davidovitz (1997) conducted a national survey of the practice and training in brief therapy of psychologists, psychiatrists, and social workers. The sample included 716 psychologists, 690 social workers, and 487 psychiatrists. The results indicated that 84% of all practicing therapists provide some brief therapy. An average of 40% of all therapists' clinical time was spent conducting brief therapy. All three disciplines reported using self-selected readings on brief therapy, attending conferences, and report that supervision was the most helpful form of training. Psychiatrists take more academic courses in brief therapy than do psychologists or social workers. Interestingly, whereas academic training of psychiatrists in brief therapy has increased over the past 20 years, this is not the case for psychologists and social workers. Half of the psychologists who reported doing brief therapy report never having course work in brief therapy. Psychodynamically-oriented therapists reported having less training in brief therapy, and practiced fewer brief therapy hours than those with cognitive-behavioral or systems orientations. Clinicians who had training in brief therapy reported greater effectiveness, skill and satisfaction in the practice of brief therapy. Davidovitz (1997) concludes that while the practice of brief therapy has increased rapidly due to the expansion of managed

care and other factors, a large number of clinicians do not have adequate training to practice brief therapy successfully.

It is now widely accepted that brief therapy is not simply truncated long-term therapy, but is qualitatively different. The adage "the shorter the therapy, the longer the training" reflects the view that training in brief therapy is paramount (Levenson & Strupp, 1999). Brief therapy is a complex endeavor in which every session counts, and it requires specialized training in its own theory, methodology, and techniques (Levenson, Speed, & Budman, 1995). In their extensive review of psychotherapy survey research studies, Watkins and Watts (1995) conclude that the need for students and professionals alike to be more informed about how to treat clients with brief therapy is one of the most pressing training issues in the current mental health care marketplace.

Perhaps the most compelling argument in support of the need for brief therapy training is the Ethical Principles of Psychologists and Code of Conduct of the American Psychological Association (1992). The ethical principle of Competence states that psychologists should recognize the boundaries of their competencies and provide only those services and use only the techniques for which they have been qualified through education, training, and experience (APA, 1992). Yet recent survey data suggests that many psychologists are not living up to this principle. For example, psychologists report spending 40% of their time doing brief therapy, but one third of those psychologists had little or no training in brief therapy (Levenson, Speed, & Budman, 1995). Small and Barnhill (1998) point out that the principle of competency and the principle of obtaining adequate training are taken for granted and seldom provoke discussion. They assert that

it is time for psychologists to re-examine these principles with regard to training in brief therapy (Small & Barnhill, 1998).

Therapists who are trained in brief therapy and follow a specified method of brief therapy have better outcomes than those not following such a model (Levenson, Speed, & Budman, 1995). Koss and Shiang (1994) report that increased levels of systematic training on the part of the therapist have been shown to enhance treatment outcome, lower rates of attrition, and decrease recidivism. For example, Pekarik (1994) randomly assigned 22 clinician volunteers to brief therapy training and control group conditions. Pretraining assessments found no differences between training and control group therapists or their clients (n=176). The training group then attended a ten hour brief therapy training program. Results indicated that compared to the clients of control group therapists, trained therapists' clients received more brief therapy, reported greater treatment satisfaction, had lower client-reported dropout rates, and obtained better therapeutic outcomes (Pekarik, 1994).

In a similar study, Burlingame, Fuhriman, Paul, and Ogles (1989) randomly assigned 12 therapists to treat 57 pre-selected clients. Therapists who participated in a 12-hour training program on brief therapy were compared with non-trained and self-trained therapists. Results showed that increased levels of training were associated with lower rates of attrition and recidivism and clinically significant positive change for clients (Burlingame, Fuhriman, Paul, & Ogles, 1989).

Therapists values and attitudes toward brief therapy are also important and influence the therapists' approach to providing therapy (Koss & Shiang, 1994). Systematic

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training has been shown to change therapsits' attitudes concerning brief therapy (Koss & Shiang, 1994). For example, Neff, Lambert, Lunnen, Budman, and Levenson (1996) administered the Beliefs and Attitudes Toward Therapy Questionnaire to 167 experienced therapists before and after workshops on brief therapy techniques. Following training, clinicians had more positive attitudes toward brief therapy. The most significant changes occurred in attitudes regarding the overall goals of psychotherapy and the value of brief therapy techniques in the treatment of serious long-standing psychopathology. The authors state that such attitude and value changes are critical in helping clinicians make the transition from being long-term to short-term therapists (Neff et. al, 1996).

Recommendations for Training

Given the growing demand for psychologists to practice brief therapy and the clear need for students to be trained in brief therapy, several authors have made training recommendations. Koss and Shiang (1994) state that training, supervision, and treatment manuals provide important guidelines for the practice of brief therapy, and point out that research has shown that adherence to the technical aspects of brief therapy is not always stable over time and requires ongoing supervision. However, Binder (1993) points out that manualized training is most effective at increasing technical procedure skills, and that there is little evidence that other skills related to therapeutic competence are acquired or enhanced through manualized training. He stresses the need to train therapists who are competent overall, then it will be easier to train them to be competent brief therapists (Binder, 1993).

Levenson and Strupp (1999) make recommendations specifically for training students in brief psychodynamic therapy. They state that brief psychodynamic training needs to move away from models that hold a "cure" to be a reasonable goal, and recognize that clients may need recurrent help or intermittent brief therapies throughout the life span. They also recommend that trainers assume that even experienced therapists are novices in brief therapy, use manuals in teaching brief dynamic therapy, and use videotapes for teaching and supervision. They also assert that training need to address therapists attitudes and values toward the practice of brief therapy, as a positive attitude is a significant predictor of skill in brief therapy (Levenson & Strupp, 1999).

Levenson and Strupp (1999) state that the ideal time to teach brief dynamic therapy is when the trainees have some clinical experience in doing longer-term therapy, but are not so indoctrinated as to believe that long-term therapy is better. Weiss and Marmar (1993) take a more extreme position, suggest teaching students brief dynamic therapy after they have had a minimum of two years of training in psychodynamics and psychopathology, supervised long-term dynamic therapy experience, and some familiarity with other brief therapy approaches.

Conversely, Lopez (1985) recommends introducing brief therapy model early in the process of training novice counselors. He suggests that supplementing conventional training in basic listening skills with a brief problem-focused model in order to teaching specific verbal skills and structuring methods. He teaches novice counselors to, over the course of 10 sessions, develop a concrete description of the problem, investigate previous client attempts at problem resolution, obtain a clear definition of the change to be

achieved, then formulate and implement a plan to produce change. He reports that the use of this model in early counselor training inhibits counselor anxieties about "what to do next" and helps prevent inefficient counselor management of interview time, inadequate problem clarification, and premature intervention and prescription. This brief therapy training model also emphasizes the development of effective questioning or probing, behavioral contracting, rationale-building and intervention development (Lopez, 1985).

In order to adapt to and be successful in a managed care environment, it has been recommended that practicing clinicians develop competence in short-term therapies, develop crisis management skills, and seek out training and supervision in the new models they are learning (Austad, 1996). Nahimas (1992) recommends that a comprehensive training program for a managed care setting include three components. First, clinicians should be introduced to brief therapy models and the unique demands of the managed care setting. Then, clinicians should begin practicing brief therapy while under close supervision. Finally, ongoing supervision, consultation, and continuing education should be included in any professional training program (Nahimas, 1992).

In addition to training in brief therapy and techniques, it is essential to address students and/or therapists values and attitudes about brief therapy (Levenson, Speed, & Budman, 1995). Research has demonstrated that psychologists do change their attitudes and values after training, and that such attitudes impact brief therapy outcomes. Since many practicing clinicians work from theoretical orientations that value long-term therapy, they need experiences that demonstrate what can be accomplished

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therapeutically in a short period of time and training that addresses any attitudinal biases. Novice therapists without such attitudinal biases need more training in brief therapy models and techniques, as well as experience in conducting brief therapy (Levenson, Speed, & Budman, 1995).

Stern (1993) asserts that training in brief therapy should include two components: attitudinal and technical-theoretical. The attitudinal component should address student's biases about brief therapy, point out that brief therapy will constitute a significant portion of their work as psychologists, and that brief therapy is a highly effective treatment modality for many clients. The technical-theoretical component of training should minimize the differences between brief and long-term therapy models with regard to theoretical and clinical complexity, minimizing the misconception that brief therapy is somehow simpler. Then, specific training should be provided in interview and therapeutic techniques. The emphasis should remain on integration of theoretical principles and flexible application of them in individual cases (Stern, 1993).

The Current State of Affairs

While several surveys have attempted to examine brief therapy training by asking mental health professionals to report retrospectively on their own training, only one study to date has addressed the issue directly to training programs, and this study focused on psychodynamically oriented programs. Levenson and Strupp (1999), in a survey of graduate training programs and internships in psychology, asked programs their theoretical orientation and whether or not they provide training in brief psychotherapy. The authors then reported the results of programs espousing a psychodynamic orientation

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(33% of graduate programs that responded, 42% of internship programs that responded). They report that 60% of graduate programs and 81% of internships with a psychodynamic orientation provide some form of brief therapy training. The most common methods used in teaching students brief psychodynamic therapy included video taping (30%), treatment manuals (30%), and role playing (30%). When programs were asked to identify the most difficult issues that arose in teaching brief therapy to students, they indicated that overcoming students' attitudinal bias in favor of long-term therapy, along with the need to set limited goals, adhere to a focus, and develop an alliance quickly were most difficult for students to grasp (Levenson & Strupp, 1999). Levenson and Strupp did not report data from programs with orientations other than psychodynamic, did not specify what programs were surveyed (clinical, counseling, or school psychology), and did not report more detailed information concerning the depth or methods of training.

The purpose of the current study is to examine what percentage of APA accredited doctoral programs in clinical and counseling psychology, including programs of all theoretical orientations, are providing their students with training in conducting brief psychotherapy. For the programs that do provide some training, the level and type of training provided will also be assessed. Once standard practices in brief therapy training have been identified, extant literature will be integrated in order to develop training recommendations appropriate for APA accredited programs to consider. It is hoped that

these recommendations can assist programs in providing high quality training for their students, thus enhancing the competency of practitioners providing brief psychotherapy services.

CHAPTER III

METHOD

Participants and Procedures

Using a roster of accredited programs that appeared in the American Psychologist

(American Psychological Association, 1999) research packets were mailed to training

directors of the 267 APA accredited clinical and counseling psychology programs across

the United States and Canada. Full research packets were again sent in follow-up

mailings to those who did not respond to the first mailing. One hundred six training

directors returned useable surveys, representing a 40% return rate overall. The return rate

for each geographic region as defined by the United States Census Bureau, according to

the proportion of programs in that region, was calculated. In the Northeast, 41% of

training directors responded, 38% responded in the South, 38% responded in the

Midwest, and 48% responded to the survey in the Western United States. Only 21% of

training directors in Canada responded.

Of the training directors who responded, 76% were from clinical psychology

programs, whereas 24% were from counseling psychology programs. The majority of

programs offer Ph.D. degrees (78%) with a smaller number offering Psy.D. degrees

(22%). Sixty-two percent of respondents indicated that their programs are part of public

institutions, with the remainder being private institutions. University or institution-wide

enrollment ranged from under five thousand students to over 55,000 students (M=7000,

SD=17,000, Mode 5000 or less, Median 22,000). The majority of programs reported being housed in colleges of Liberal Arts (51%) or Education (25%), with others reporting being housed in Professional Schools (10%), Free-Standing Programs (6%), or other types of schools such as medical schools (8%). Training directors reported an average of 13 full time faculty (SD=11.8) with an average of 10 part-time or adjunct faculty (SD=13). Student enrollment in this sample of APA accredited psychology programs ranged from 20 to 400 students, with a mean enrollment of 71 (SD=68). Seventy-five percent of programs reported that their students gained practica experience from a program-run clinic, and 80% of programs report that their students gain practica experience from external practica sites, either exclusively or in addition to the program-run clinics.

In order to gauge representativeness of this sample when compared to the population of all APA accredited clinical and counseling psychology programs, population parameters were calculated based on data published in Graduate Study in Psychology (APA, 1999). Table 1. below illustrates the population parameters as compared to the current sample's statistics:

Table 1.

Population Parameters of APA Accredited Clinical and Counseling Psychology Programs as Compared to the Current Sample:

Variable	Population Parameter	Sample Statistic
Clinical Programs	75%	76%
Counseling Programs	25%	24%
Ph.D. degree	83%	78%
Psy.D. degree	16%	22%
Ed.D. degree	1%	0%
Western U.S.	20%	24%
Southern U.S.	28%	27%
Midwestern U.S.	27%	26%
Northeastern U.S.	19%	20%
Canada	5%	3%

As Table 1 illustrates, the current sample matches the population closely in terms of percentages of clinical and counseling programs represented. The sample also matches the population closely in terms of representation of the various geographic regions, with only the Western region being slightly over-represented. The sample is most different from the population in terms of representation of the various degree types. In the current sample, Ph.D. programs are slightly under-represented and Psy.D. programs are slightly over-represented. Neither of the two Ed.D. programs responded to the survey, so the results cannot be generalized to those programs.

Training directors were asked to indicate the predominant theoretical orientation of their programs. Some training directors indicated that their programs do not have a predominant orientation, some indicated just one predominant orientation, and some indicated multiple orientations. Therefore, due to multiple responding on this item, a

clear picture of this variable was difficult to obtain. Table 2. below summarizes the

responses to this item:

Table 2.
Percent of Programs Indicating Each of the Following as a
Predominant Orientation:

Orientation	Percent
Cognitive-Behavioral	47%
Eclectic or Integrative	40%
Psychodynamic	29%
Systems	14%
Cognitive	9%
Behavioral	9%
Humanistic	9%
Interpersonal	2%
Biopsychosocial	1%
Experiential	1%

Note: The above percentages total to more than 100 due to single programs indorsing

multiple orientations.

Instruments

The research packets contained a cover letter, an author-devised Brief Therapy

Training questionnaire, and a stamped return envelope (see Appendix). All research

materials were coded to ensure confidentiality. Respondents are traceable only to their

institutional affiliation and have not been personally identified.

The author-devised Brief Therapy Training questionnaire asked participants for data

related to demographics and their academic program. The main focus of the survey,

however, was the nature and extent of brief therapy training provided to their students.

Training directors were asked to indicate whether their programs provide students with

any training in conducting brief psychotherapy. If so, they were asked to respond to several questions designed to determine their standard practices for teaching brief therapy. Specifically, the survey explored: whether students take a course in brief therapy, whether workshops or seminars in brief therapy are offered, whether practicum experience in brief therapy is offered, what sorts of readings on brief therapy students are required to complete, what approaches/models of brief therapy are taught, what specific therapeutic skills related to brief therapy are emphasized, and what the most difficult issues are in training students to provide brief therapy.

Data Analyses

Analyses for this exploratory study were largely descriptive statistics used to describe the current state of brief therapy training. A chi square analysis was conducted in order to determine whether clinical or counseling programs provide brief therapy training at different rates. Other chi square analyses could not be conducted due to missing data in some of the cells. Correlational analyses were conducted in order to examine the relationships between training institution variables, including the student population of the university or institution, number of students in the APA accredited program, number of full-time faculty, and number of part-time or adjunct faculty. Finally, a logistic regression analysis was conducted in order to determine those particular variables that might help to explain why certain programs may offer training in brief therapy while others do not.

These results were compared to the body of literature related to training students to conduct brief therapy, and the research reflecting the actual practice experiences of

licensed psychologists in employing brief therapy. Based on the data from the current study and on the extant body of literature, a set of training recommendations appropriate for APA accredited programs were developed. These recommendations seek to focus upon what academic programs can do in training their students to best meet the reality of practice in the field with regard to the use of brief therapy approaches. It is hoped that these recommendations can assist programs in adequately training psychologists to conduct brief therapy, an activity that will likely account for a large percentage of psychologists' professional time. In providing better instruction in brief therapy for their students, programs will ultimately produce better-trained, more competent practitioners.

Research Questions

The following research questions were examined in this study:

1) What percentage of this sample of APA accredited programs provide their students with training in how to conduct brief psychotherapy?

2) Do clinical or counseling programs provide training at different rates?

3) What methods are typically being used to train students in brief psychotherapy?

4) What do training directors report as the most difficult issues facing programs in training students to conduct brief therapy?

5) What recommendations appear in order regarding how programs can strengthen the academic preparation of their graduates regarding training in brief psychotherapy?

CHAPTER IV

RESULTS

Fully 81% percent of training directors reported that their programs provide some form of training in brief psychotherapy. Of the programs that did provide training, 65% report that brief therapy is covered in at least a portion of a required course, and 31% report that it is covered in an elective course. The mean number of course credits earned was three (SD=2), with a range from 2 to 9. Not all programs that reported covering brief therapy in course work reported the title of that course. However, of the programs who cover brief therapy in at least a portion of a course, Table 3 lists the course titles that were provided and the percent of programs reporting each title:

Table 3.
Titles of Courses Covering Brief Therapy

Course Title	Percent Of Programs Reporting Each Title
Brief Psychotherapy	11%
Cognitive-Behavioral Therapy	9%
Family Therapy Models	9%
Time-Limited Dynamic Therapy	4%
Treatment with Children and Adolescents	4%
Systems of Psychotherapy	4%
Advanced Theories of Counseling	2%
Psychotherapy for Adults	2%
Empirically Validated Treatment Techniques	2%
Intervention Strategies	2%
Behavioral Marital Therapy	1%
Medical Psychology	1%
Behavior Change	1%

Note. Percentages in Table 3 do not total to 100 due to the fact that many programs did not report the title of their course covering brief therapy.

Similarly, not all programs that reported covering brief therapy in a course reported the titles of the texts or treatment manuals used in that course. However, of the programs who cover brief therapy in at least a portion of a course, Table 4 lists the text books or treatment manuals that programs reported using, and the percent of programs using each text:

Table 4.
Text Books and Treatment Manuals Used in Brief Therapy Course Work

Text or Treatment Manual	Percent of Programs Using that Text
Budman & Gurman (1988), Theory and practice of brief therapy	6%
Levenson (1995), Time-limited dynamic psychotherapy: A guide to clinical practice	4%
Barlow (Ed.) (1993), Clinical Handbook of Psychological Disorders	4%
Beck (1995), Cognitive therapy: Basics and beyond	4%
Nathan & Gorman (1998), A Guide to Treatments That Work	1%
Walter & Peller (1992), Becoming Solution Focused in Brief Therapy	1%
Strupp & Binder (1984), Psychotherapy in a New Key: A Guide to Time-Limited Dynamic Psychotherapy	1%

Note. Percentages do not total to 100 due to the fact that most programs did not report which texts are used in their brief therapy courses.

Several respondents listed authors that are covered in their courses on brief therapy without specifying which text or publication of that author they used. These authors

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include DeShazer, Davanloo, Ellis, Meichenbaum, Linehan, Haley, Melan, Sifenos, Magnavita, and Berg.

Only 4% of programs who provided brief therapy training reported requiring their students to attend a seminar or workshop on brief psychotherapy. However, 40% reported offering elective seminars or workshops in brief therapy. The mean number of hours per seminar was six (SD=5), with a range from 1 to 20 hours.

Of the programs that provide training in brief therapy, training directors estimate that 80% of the students in their programs receive practica training in brief therapy. Fifty-six percent of training directors report that all of their students receive practica training in brief psychotherapy. Training directors further estimate that of the students who receive practica training in brief therapy, they receive an average of 141 hours of training (SD=179). The range in hours of training that these students receive was large, ranging from 3 hours to 750 hours total.

Training directors were asked to report which approaches to brief therapy are taught in their programs. The results are presented in Table 5 below:

Table 5.
Approaches to Brief Therapy Taught in APA Accredited Programs

Approach to Brief Therapy	Percent Teaching Approach
Brief Cognitive-Behavioral Therapy	62%
Brief Psychodynamic Therapy	55%
Solution-focused Brief Therapy	54%
Brief Crisis-Oriented Therapy	40%
Strategic-Structural Brief Therapy	24%
Interpersonal Therapy	4%
Emotionally-focused Couples Therapy	1%
Systems Theory	1%
Hypnotherapy	1%
Behavioral Medicine Interventions	1%
Gestalt Therapy	1%
Humanistic Therapy	1%

Note. The above percentages total to more than 100 due to the fact that an individual

program may teach more than one approach.

Training directors were also asked to indicate which therapeutic skills were

emphasized in their program's brief therapy training. The results are summarized below

n Table 6:

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Table 6.
Skills Emphasized in Brief Therapy Training

Therapeutic Skill	Percent Emphasizing That Skill
Formulation/ implementation of a plan to produce change	90%
Rapid development of a treatment focus	88%
Ongoing assessment of progress/change	80%
Rapid development of the therapeutic alliance	70%
Maintenance of focus	70%
Rapid assessment /diagnosis	59%
Addressing termination	51%
Confrontation of resistance	41%
Accurately/thoroughly identifying diagnosis to best determine treatment focus	1%

Note. The above percentages total to more than 100 due to the fact that each program

emphasizes more than one skill in its' brief therapy training.

Finally, training directors were asked to indicate which issues seem to be most

difficult in training students of conduct brief psychotherapy. The results are summarized

in Table 7 below:

Table 7.
Most Difficult Issues in Brief Therapy Training

Training Issue	Percent Reporting Difficulty
The need to set limited goals	72%
The need to rapidly develop a focus in brief therapy	53%
The maintenance of that focus	33%
Overcoming students' attitudinal bias favoring long-term therapy	33%
The need to rapidly develop a therapeutic alliance	27%
Addressing termination	17%
Other issues (see below)	12%

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Note. The percentages in Table 7 total to more than 100 due to the fact individual

programs identified more than one difficult issue in training.

Other issues that training directors identified as difficult when training students to

conduct brief psychotherapy include: reconciling students' differing training experiences,

having access to appropriate cases for short-term intervention, helping students

conceptualize well so that they can design a manageable piece of work that creates a

mastery experience and a good ending, overcoming students' desire to simplify the world

by seeing short or long-term treatment as either all good or all bad rather than seeing that

each has its' place, and avoiding students' tendency to practice brief therapy regardless

of approprietness by case. One training director wrote that the most difficult issue in his

program was overcoming supervisor resistance to brief therapy. Another training director

accurately pointed out that the survey question made an assumption that students would

have a bias in favor of long-term therapy, whereas he sees students having a bias in favor

of brief therapy models. Several respondents commented that their students like and

respond well to the brief models.

A chi-square analysis was conducted in order to determine whether there is a

relationship between program type (clinical or counseling) and likelihood of providing

brief therapy training. The results were not significant ($X^2=.02$, p .86), indicating that

clinical and counseling psychology programs provide brief therapy training at

approximately equal rates. Due to missing data in some cells, additional chi-square

analyses could not be conducted.

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Correlational analyses using Pearson's r procedure were conducted in order to examine

the relationships between training institution variables including the student population of

the university or institution, number of students in the APA accredited program, number

of full-time faculty, and number of part-time or adjunct faculty. The results are presented

in Table 8.

Table 8.
Correlations Between Institutional Variables

Variable	Student Pop.	Students in Program	Full-time Faculty	Part-time Faculty
Student Population of Institution	---	-.488*	.002	-.209
Number of Students in Program		---	.023	.335**
Number of Full-time Faculty			---	.015
Number of Part-time Faculty				---

Note. * $p<.000$, ** $p<.005$

Not surprisingly, the results indicate that there is a significant positive correlation

between the number of students in the APA accredited program and the number of part-

time or adjunct faculty used by the program. There is also a significant negative

correlation between the number of students enrolled in the APA accredited program and

the total student population of the university or institution. This may be a reflection of

the fact that free-standing Psy.D. programs enroll large numbers of students in their

programs, while the total population of the institution remains small compared to a

traditional university. Psy.D. programs make up 22% of the current sample.

Interestingly, there was not a significant relationship between the number of students in

the APA accredited program and the number of full-time faculty employed. The

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correlations between the student population of the institution and number of full-time faculty, between the student population of the institution and number of part-time faculty, and between the number of full-time and the number of part-time faculty were all non-significant.

Finally, a logistic regression analysis was conducted to examine the contribution of training variables to the prediction of whether or not programs offer brief therapy training. Logistic regression analysis was selected rather than discriminant analysis because the procedure is more flexible concerning statistical assumptions (Tabachnick & Fidell, 1996). For example, logistic regression analysis does not assume homogeneity of variance among predictor variables, and predictors do not need to be normally or linearly related to each other or to the dependent variable (Tabachnick & Fidell, 1996).

One logistic regression analysis was conducted utilizing a backward procedure. The geographic area of a training program, it's college affiliation, its public or private status, its status as clinical or counseling program, its use of in-house clinical training or external clinical training, and the type of degree it grants were used as predictor variables. The dependent variable for this analysis was the training director's endorsement of whether or not the program actually offers any training in brief therapy. The analysis examined the reclassification of programs into groups based on the presence or absence of brief therapy training. Table 9 below summarizes the results.

Table 9

Results of Logistic Regression Analysis for Factors Associated with Training
In Brief Therapy

(Initial Model: Constant Only)
-2 Log Likelihood 101.83
% Correctly Classified 80.77
Wald (1)= 33.27, p<.001

(Full Model)
-2 Log Likelihood 91.14
Improvement X^2 (df 13) 10.69 (not significant; p=.64)
% Correctly Classified 79.81

Unique contributions of variables in the model:

In-house clinical training	Wald (1) = .92, p<.34
External clinical training	Wald (1) = .06, p<.81
College affiliation	Wald (4) = 2.50, p<.65
College 1	Wald (1) = .94, p<.33
College 2	Wald (1) = 2.41, p<.12
College 3	Wald (1) = .08, p<.78
College 4	Wald (1) = .15, p<.70
Degree granted	Wald (1) = .31, p<.58
Public or private status	Wald (1) = .10, p<.76
Geographic region of training program	Wald (4) = 1.45, p<.84
Region 1	Wald (1) = .39, p<.53
Region 2	Wald (1) = .06, p<.80
Region 3	Wald (1) = .58, p<.44
Region 4	Wald (1) = .13, p<.72
Constant	Wald (1) = .06, p<.81

As Table 6 illustrates, the results of the logistic regression analysis indicate that the

geographic area of a training program, its college affiliation, its public or private status,

status as a clinical or counseling program, use of in-house clinical training or external

clinical training, and the degree type offered did not help to significantly predict over the

baseline constant whether a training program will offer instruction in brief therapy or not. Upon employing a backwards selection procedure, no variables were retained in the model.

CHAPTER V

DISCUSSION

The purpose of the current study was to examine the standard practices of APA accredited clinical and counseling psychology doctoral programs in training students to conduct brief psychotherapy. In addition, due to practitioners' concerns about the adequacy of their training in brief therapy (Davidovitz, 1997; Levenson, Speed, & Budman, 1995; Levenson & Strupp, 1999), extant literature has been integrated in order to develop training recommendations appropriate for APA accredited programs to consider.

However, the current findings must be understood in the context of certain limitations. First, although 40% of the population of training directors in APA accredited clinical and counseling doctoral programs responded to the survey, the response rate was lower than had been hoped, which limits generalization of the findings. The poorest response rate was obtained from training directors in Canada, making generalization to those programs particularly problematic. While the current sample matches the population closely in terms of percentages of clinical and counseling programs represented, and in terms of representation the of various geographic regions, the Western region of the U.S. was slightly over-represented. In addition, Ph.D. programs are slightly under-represented and Psy.D. programs are slightly over-represented in the current sample. Neither of the two Ed.D. programs responded to the survey, so the results cannot be generalized to those

programs. Furthermore, since only APA accredited clinical and counseling doctoral programs were surveyed, other types of programs that train mental health practitioners cannot be accounted for. These included non-accredited doctoral programs, school psychology programs, masters-level therapist and social work programs, and medical school training for psychiatry students. Thus it is unknown what if any differences in brief therapy training exist between these programs as compared to the ones sampled for this study.

Research Questions Addressed

Although the vast majority of programs (81%) expose their students to the concept of brief psychotherapy, the depth of that training varied tremendously. What programs labeled as "training" their students in brief psychotherapy ranged from a one-hour seminar on brief therapy, to a semester-long course coupled with a year-long practicum focused on the provision of brief psychotherapy. The total hours of brief therapy training students received ranged across programs from one hour to 750 hours. This enormous range in depth of training may partly account for the findings of other studies indicating that more than a third of psychologists who practice brief therapy report having little or no training in that modality (Levenson, Speed, & Budman, 1995). A one-hour seminar is simply not enough training to help a practitioners feel competently trained in a modality.

Clinical and counseling psychology programs appear to provide training at approximately equal rates. This suggests that although clinical and counseling programs tend to have differing emphases in some areas, the majority of both types of programs

seem to regard brief therapy as an issue that should be addressed, at least briefly, in the training of their students.

Unfortunately, due to multiple responding by participants on the theoretical orientation survey item, the question of whether programs with different theoretical orientations provide training at different rates could not be directly answered. However, some inferences can be drawn from the frequency with which training directors report that their programs train students in various models of brief therapy. For example, the most commonly taught model or theoretical orientation of brief therapy is brief cognitive-behavioral therapy (62%), whereas half of programs report training their students in brief psychodynamic therapy. This may suggest that programs with a primarily cognitive-behavioral orientation may be slightly more likely to train their students in brief therapy than programs with a primarily psychodynamic orientation. On the other hand, this finding may simply be an artifact in that many cognitive-behavioral therapies are inherently brief in nature, where as psychodynamic therapy is traditionally more long-term in nature. Either way, this finding is consistent with self-report from practitioners in previous surveys stating that therapists with cognitive-behavioral orientations feel more competent in practicing brief therapy and tend to practice brief therapy more often than therapists with a psychodynamic orientation (Davidovitz, 1997; Levenson, Speed, & Budman, 1995).

The most common method of training students to conduct brief psychotherapy was through the use of clinical practica, with training directors estimating that 80% of the students in their programs receive some practica training in brief therapy. Fifty-six

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percent of training directors report that all of their students receive practica training in brief psychotherapy. This is an encouraging finding given that psychologists consistently report that clinical practica and supervision are the most helpful forms of training (Levenson, Speed, & Budman, 1995; Levenson & Strupp, 1999).

Course work in brief psychotherapy is the second most common method used by programs to train their students in this modality. Of the programs who do provide training, 65% report that brief therapy is covered in at least a portion of a required course, and 31% report that it is covered in an elective course. As Tables 3 and 4 illustrated in the previous chapter, there is very little consistency across programs in terms of the focus of the course in which brief therapy is covered, or in terms of the text books used in those courses. In fact, many programs appear to expose students to specific brief therapy models, for example Parent-Child Interaction Therapy, without addressing the unique methodology and assumptions of brief therapy, or the value differences between brief therapy and more traditional long-term therapy. Without addressing the commonalities between all brief therapy models, students may not recognize training in specific models as brief therapy training, and may not feel prepared to function as a short-term therapist with a wide variety of clients.

While brief therapy is frequently covered as a portion of a course, it was rarely the focus of a course. Only eight programs, or 8% of the sample, report having an entire course focused solely on brief therapy. Again, one wonders if this finding partially accounts for the fact that while most programs report providing at least some training in brief therapy, 30 to 40 percent of psychologists practicing brief therapy report that they

have little or no training in brief therapy (Levenson, Speed, & Budman, 1995; Levenson & Strupp, 1999). For example, a student who was in a class in which brief therapy is covered in one chapter and discussed at one class meeting may retrospectively report that he or she had little or no training in brief therapy, while at the same time his or her training director reports on a survey that brief therapy training is provided. Clearly, there is a gap between exposure to the concept of brief therapy as opposed to training students to competently practice brief therapy.

Training directors reported that they face many difficult issues in training students to conduct brief psychotherapy. The most difficult issues were helping students to understand the need to set limited goals (72.2%) and the need to rapidly develop a focus in brief therapy (52.8%). One-third of training directors also indicated that the maintenance of focus in brief therapy and overcoming students' attitudinal bias favoring of long-term therapy were difficult issues. Training directors also experience difficulty with the fact that even when students understand brief therapy conceptually, as novice counselors they often do not possess the technical skill to implement components such as rapidly developing a therapeutic alliance, rapidly determining focus, or maintaining that focus. In addition, training directors face several practical obstacles in training their students to conduct brief therapy. These include having difficulty obtaining appropriate cases for training students to conduct brief therapy, resistance among supervisors to the concept of brief therapy, and the fact that many supervisors are themselves not well trained in brief therapy. For programs in which supervisors are not trained or familiar

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with brief therapy, instituting a brief therapy training component may need to be two tiered, first training clinical supervisors, who in turn provide training to students.

<u>Recommendations for Training</u>

Based on the data from the current study, as well as previous surveys of mental health practitioners who practice brief psychotherapy, several recommendations seem appropriate. First, since psychologists consistently report this modality of training to be the most helpful (Davidovitz, 1997; Levenson, Speed, & Budman, 1995; Levenson & Strupp, 1999), a practicum model that combines both didactic training and clinical experience is recommended. Given that brief therapy is not simply a truncated version of long-term therapy, but is qualitatively different (Levenson, Speed, & Budman, 1995), it is recommended that the didactic portion of the practicum training begin by educating students about the unique methodology, values, and assumptions that are common to all models of brief therapy. For example, illustrating the value of brief therapy in the treatment of serious long-standing pathology, and addressing the fact that brief therapy models do not hold the notion of a "cure" or major personality reconstruction to be a reasonable goal, but rather recognize that clients may need recurrent help or intermittent doses of therapy throughout the life span (Levenson & Strupp, 1999; Neff, et. al, 1996). Therapists' attitudes toward brief therapy have been shown to improve significantly following training in brief therapy, and a positive attitude is a significant predictor of skill in brief therapy (Levenson & Strupp, 1999; Neff, et. al, 1996). The didactic component should also present empirical literature related to the efficacy of brief therapy,

demonstrating, for example, that brief therapy has been shown to be as effective as long-term therapy and is frequently preferred by clients (Koss & Shiang, 1994).

Following the education of students on the general values, assumptions, and efficacy of brief therapy, it is recommended that programs train their students in (at least) one specific model of brief therapy. This portion of the training should make use of a treatment manual or other in-depth readings on that model. It has been shown that therapists who are trained and follow a specified method of brief therapy have better outcomes than those who do not follow a specific model, including lower attrition rates and decreased recidivism (Koss & Shiang, 1994). No specific model or orientation is being recommended, thus allowing programs to adapt the training to their predominant orientation and focus. Given the recent focus in the field on empirically validated and supported treatments, programs who chose to do so could incorporate such treatments into this phase of the training. In fact, many empirically supported treatment are inherently brief in nature and would fit well into a brief therapy training module.

The most important aspect of this practicum-model of training is the component of clinical experience coupled with supervision. Students should be supervised in the implementation of the specific model of brief therapy in which they are being trained. Clinical supervision should incorporate preferably videotapes, and at least audiotapes, of the students' therapy sessions in order to provide students with detailed feedback about their implementation of brief therapy skills, such as the maintenance of treatment focus. One real-world factor that complicates this suggestion is the fact that many supervisors

themselves are unfamiliar with brief therapy. Supervisors may need to first seek out their own training in order to appropriately guide students in this area.

The above model would provide systematic and in-depth training to students in brief therapy. However, it is recognized that there are practical difficulties in implementing such a training model, such as finding clients appropriate for practica training in brief therapy. In spite of such real-world constraints, brief therapy is clearly an area in which students should be competent and well-trained given the reality of the current practice in psychology. If programs were to implement such a training model, their students would be more fully prepared and competent to practice brief psychotherapy, which is likely to account for an average on 40% of their clinical time as psychologists (Levenson, Speed, & Budman, 1995).

The current examination of brief therapy training brings to light multiple directions for future research. Additional studies are needed in order to determine what impact the theoretical orientation of a program has on it's brief therapy training. In addition, the variables that predict which programs are likely to provide brief therapy training and which are not remain unknown. Finally, future research should examine the brief therapy training provided by internship sites of all theoretical orientations in order to obtain a more complete picture of the training being offered currently to doctoral psychology trainees.

There may be no other area of clinical practice that demands 40% of psychologists' time, and in which 30% of psychologists report having little or no training (Levenson, Speed, & Budman, 1995). That discrepancy should inspire training programs to prepare

their students for the realities of modern practice, help their students to live up to the

Competency standard set forth in the Ethical Principles of Psychologists and Code of

Conduct of the American Psychological Association (1992), and ultimately to positively

impact the care received by the future clients of these clinicians-in-training.

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APPENDIX

MATERIALS USED WITH PARTICIPANTS

Dear Director of Training,

Your program has been specifically selected as a part of a sample designed to best represent all APA accredited Clinical and Counseling Psychology programs. My name is Schelle Cody and I am a doctoral candidate in Counseling Psychology at the University of Oklahoma. For my dissertation I am conducting a survey in order to examine the types of academic training currently provided to graduate psychology students in the area of brief psychotherapy. This data will be compared to empirical research concerning the actual practices of licensed psychologists with regard to brief therapy, so as to develop preliminary recommendations for training in brief psychotherapy. It is hoped that such recommendations can assist educators in providing quality instruction for their students.

I would like to enlist your assistance with this project by asking you to complete the enclosed survey regarding the academic training in brief therapy provided by your program. The survey is very short and should require no more than 15 minutes of your time; a stamped return envelope is enclosed for your convenience. I would greatly appreciate your help in acquiring information on what training in brief therapy is provided in your program. Even if your program provides no training in brief therapy, this is valuable information and your response would be appreciated. Again, your particular program has been specifically selected as a part of a sample designed to best represent all APA accredited Clinical and Counseling Psychology programs, so your response is very important to the study. Of course, you may decline participation in this study with no penalty whatsoever.

All research materials sent to participants are coded to ensure confidentiality. Respondents will be traceable only to their institutional affiliation, and will not be personally contacted. Please note that all data will be reported only in aggregate form. No specific training programs or institutions will be identified in any written report or presentation of this research. Should you decide to return syllabi or other materials that illustrate your training practices in brief therapy, you can either 1) mask these materials before sending them, or 2) I will, immediately upon receipt of such materials, remove all identifying information from them and code them similar to all other research materials.

If you have any questions about the materials or the study, please feel free to contact either me at the address/phone listed below, my research advisor Dr. Loreto Prieto at (405/325-1506), or if you have questions about your rights as a research participant please call the Office of Research Administration at the University of Oklahoma (405/325-4757). I hope that you will elect to participate in this study as I believe this study will contribute to our knowledge of the current state of training in the area of brief psychotherapy. **If you are willing to participate in this study, please indicate your consent by signing below. Feel free to make a copy of this letter for your records, then return the original with your signature and the completed survey in the enclosed return envelope.** *Thank you* for your time and participation.

_____   _____
                Signature   Date

Sincerely,

M. Schelle Cody, Doctoral Candidate
University of Oklahoma
8 Keene St. A5, Columbia, MO 65201
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email: scody@webchoice.net

Survey of Brief Therapy Training
in APA-Accredited Clinical and Counseling Psychology Programs
Please check or write in the appropriate response to each question.

Institution/Program Information:

1. Is your institution a public_____ or private_____ institution?

2. What is the approximate total student population at your institution?

Under 5,000 _____	5,000 to 9,999 _____	10,000 to 14,999 _____
15,000 to 19,999 _____	20,000 to 24,999 _____	25,000 to 29,999 _____
30,000 to 34,999 _____	35,000 to 39,999 _____	40,000 to 44,999 _____
45,000 to 49,999 _____	50,000 to 54,999 _____	55,000 or more _____

3. What graduate degree does your program offer?

Ph.D.___ Psy.D.___ Ed.D.___

4. In what College/School at your institution is your program housed?

Liberal Arts____ Education____

Professional School____ Free-Standing Program_____

5. Approximately how many faculty members does your program employ?

_____ full-time faculty   _____ part-time faculty or adjunct faculty

6. Approximately how many students are currently enrolled in your APA psychology program?____

7. Does your program run a training clinic through which your students gain practica experience, or do they use external practica sites?

program-run clinic_____ external practica sites_____

8. Does your program have a predominant theoretical orientation?

Cognitive _____	Psychodynamic_____	Eclectic_____
Behavioral _____	Humanistic _____	Other_____
Cognitive/Behavioral _____	Systems _____	

<u>Information on Training in Brief Therapy in Doctoral Programs:</u> (For the purposes of this study, brief therapy is defined as therapy intentionally limited to 25 sessions or fewer)

9. Does your program provide coursework, seminars, clinical practica, or <u>any</u> training related to brief psychotherapy?

_____Yes. (Please continue with the survey)   _____ No. (This is valuable information too. Please return the survey; thanks for your time!)

10. Please indicate which type(s) of training in brief psychotherapy you employ and whether these training activities are required of students in your program:

a. <u>Coursework covering brief therapy:</u> elective_____   required_____
number of credit hours_____
(Please specify course names or provide syllabi):_____

b. <u>Seminar/workshop(s) in brief therapy:</u> elective _____ required_____
number of hours _____

c. Approximate percentage of students in your program who are trained in brief therapy during <u>clinical practica:</u> _____

  <u>Approximate number of hours</u> of brief therapy training those students receive:_____

11. Please check which approaches to brief therapy are taught in your program:

Brief Psychodynamic therapy   _____   Brief Cognitive-behavioral therapy _____
Solution-focused brief therapy   _____   Brief Crisis-oriented therapy   _____
Strategic-structural brief therapy _____   Other (please specify):_____

12. If known, please specify which texts, treatment manuals, or other readings on brief therapy are used in your program (or provide syllabi if you wish):_____

_____

_____

13. Please check the skills that are emphasized in your program's brief therapy training:

Rapid development of the therapeutic alliance _____

Rapid assessment/diagnosis _____

Rapid development of a treatment focus _____

Maintenance of focus _____

Formulation/implementation of a plan to produce change _____

Confrontation of resistance _____

Ongoing assessment of progress/change_____

Addressing termination_____

Other _____

14. Please check which issues seem to be most difficult in training students to conduct brief psychotherapy:

Overcoming students' attitudinal bias in favor of long-term therapy_____

The need to rapidly develop a therapeutic alliance_____

The need to rapidly develop a focus in brief therapy_____

The maintenance of that focus_____

The need to set limited goals_____

Addressing termination_____

Other:_____

_____

Thank you for your time in completing this survey!