

From: *Psychotherapy*, 2000, 37, 335-340.

Brief Therapy Prevalence and Training:

A National Survey of Psychologists

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Are you finding yourself ill-prepared to meet the increasing demand for briefer and briefer

therapies? If so, you are not alone. Members of APA Divisions 12 (Clinical Psychology) and 29 (Psychotherapy) were surveyed ($N = 1250$; return rate = 57%) regarding their practice of and training in brief therapy. Results indicate that almost all (89%) of the respondents perform some brief therapy and, on average, spend half their time doing it. With regard to training, however, half of those conducting brief therapy have never taken any brief therapy courses. Additional findings indicate theoretical orientation, gender, region, practice site, and setting are significantly related to the amount of brief therapy delivered. Overall, the amount and helpfulness of brief therapy training are significantly related to one's skill, satisfaction, and positive attitude toward brief therapy.

Keywords: brief therapy, managed care, training, attitudes, skill

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“In graduate school I received an excellent education in how to do long-term psychotherapy. Little did I know that brief therapy would become my bread and butter.” “After 25 years of being in practice, I have had to enroll in a number of CE courses to learn how to do brief therapy.” “When I tried to join a provider panel, the first question they asked me was did I have any brief therapy training.” “As a provider for [large health maintenance organization], I am required to do a lot of brief therapy. But I am ashamed to admit that I often don't know what I am doing, because I have never had any training in it!” These are some of the comments provided by psychologists in response to a national survey regarding their practice of and training in brief therapy.

Viewed for many years as a second-rate, “Band-Aid” treatment to be used only in cases of expediency, brief psychotherapy is now considered a common and even a treatment of choice for many clients (Levenson & Burg, 2000). In a recent report on the implication of changes in the health care delivery system prepared by the American Psychological Association for the Center of Mental Health Services, it was strongly recommended that in this era of managed care, therapists should be comfortable and competent with brief treatment modalities and the delivery of services in a time-limited context (Spruill, Kohout & Gehlmann, 1997).

To what degree have practitioners received adequate training in short-term theories and methods? Clearly, training is extremely important in preparing clinical psychologists to meet the needs of patients and third-party payers who are demanding time-efficient and effective treatments. The purpose of this present study was to develop a comprehensive picture of the current practice of brief therapy by conducting a nationwide survey including practitioners from the three major disciplines of psychiatry, psychology, and social work. This paper presents the

findings for the psychologists.

The goals of this survey are fourfold. The primary goal is to assess the degree to which psychologists are practicing brief therapy nationwide. The second set of goals seeks to identify factors related to the practice of brief therapy (e.g., geographical location, practitioner's theoretical orientation, gender). The third focus of the study is of critical importance concerning the quality of patient care--to document the amount and type of training brief therapy clinicians have received. And the last goal is to consider those factors related to skill in conducting brief therapy. Such information has significance for training institutions, practicing clinicians, consumers of mental health services, and managed care organizations.

The Brief Therapy Survey

A random sample of 1,250 members of Divisions 12 (Clinical Psychology) and 29 (Psychotherapy) from the American Psychological Association (APA) was mailed a cover letter, a one-page questionnaire, a return envelope, and a numbered postcard. The cover letter explained the purpose of the study and asked participants to complete anonymously a 15-item questionnaire based on an earlier survey (Levenson, Speed, & Budman, 1995). The questionnaire was divided into sections focusing on demographics, professional practice variables, amount and type of brief therapy done, and training experiences. In addition, respondents were asked to rate their experience and skill as a brief therapist as well as their attitudes toward the effectiveness of and satisfaction with doing brief therapy on a scale from 0 (not at all) to 4 (highly). In keeping with past empirical and theoretical definitions (Koss & Shiang, 1993; Levenson, 1995), brief therapy was defined as therapy that is designed and planned to be limited in duration and/or focus (usually completed in 10 to 20 sessions).

Participants were instructed to return their postcards after mailing in their completed questionnaires under separate cover. Five weeks after the first mailing, a second mailing was sent to those who had not responded to the initial solicitation. A copy of the questionnaire is available

to interested readers. Only the surveys of clinicians who indicated that they were currently conducting at least seven hours of therapy a week were used in the data analysis in order to ensure that the final sample comprised clinicians who spent a substantial amount of time in clinical practice ($N = 716$), resulting in a response rate of 57%.

An accurate assessment of the representativeness of the sample of the clinicians who returned their questionnaires was not possible because APA does not maintain records concerning demographic data. Using an approach developed by Pope, Levenson and Schover (1979), those who responded to the first mailing (early responders, $n = 535$) were compared with those who had to be prompted (late responders, $n = 181$). This analysis provides an indirect assessment of the representativeness of the sample, if it is assumed that the late responders are closer to those who did not reply at all because they did not reply to the initial request. Results of multiple one-way ANOVAs indicate no significant differences between early and late responders on any demographic, practice, or training questionnaire items.

The average respondent was a middle age male (42% of the sample was female) who was working 26 clinical hours a week in a metropolitan area. Almost 60% of those responding provided services under the auspices of a preferred provider organization (PPO); 48% did some work for a Health Maintenance Organization (HMO), and 37% for an Employee Assistance Program (EAP). The average practitioner was in practice 19 years and reported being most comfortable conducting moderately long-term, eclectic/integrative psychotherapy (39%). Psychodynamic (26%) and cognitive-behavioral (23%) comprised the two other popular predominant theoretical orientations.

Pertinent to the first goal of this study, respondents were asked to indicate how many brief therapy hours they conducted per week in various settings. Dramatically, results show that almost all psychologists ($n = 640$; 89.4%) are doing some brief therapy, and half (49.5%) of their clinical time is devoted to it, mostly in private practice settings. However, it should be noted that almost two-thirds of these clinicians who conduct brief therapies *actually prefer longer-term*

treatments.

Additional results show that 41% of a psychologist's time in private practice is spent doing brief therapy, while the percentage grows to 56% for those who work in agencies. The finding that psychologists in agencies do more brief therapy than their colleagues in private practice makes sense given agencies' commitment to serve a larger population, usually with meager resources. With waiting lists, consumer pressures, budgetary constraints, and financial incentives, agencies are under more pressure to do more with less. The length one has been in practice, however, is unrelated to the number of brief therapy hours a practitioner conducts, suggesting that neophytes to the profession as well as seasoned clinicians are equally involved in doing brief therapy. Compared to figures obtained in a survey of California and Massachusetts psychologists (Levenson et al., 1995), where approximately 80% of the respondents were doing brief therapy 40% of the time, the present data suggest that brief therapy is playing an even more dominant role in the practice of psychologists today.

According to a Psychotherapy Finances survey of their readers (1997), almost 70% of psychologists claimed they had shortened the length of their treatments, with 65% adopting time-limited techniques during the past year. In addition to the influence of managed care, there has been a confluence of factors promoting the use of brief therapy modalities, such as consumers' wish for quick results, the public's demand for accountability, rising costs of health care, and empirical findings regarding treatment outcome, to name a few.

Furthering the examination of factors related to the practice of brief therapy, a series of ANOVAs was conducted. The first of these suggests that one's theoretical orientation affects the amount of brief therapy conducted ($F(4,699)=20.9, p<.0001$). Post-hoc analyses reveal, as expected, that the cognitive-behavioral brief therapists did significantly more brief therapy per week (16.3 hours) than their psychodynamic (7.5), existential/humanistic (9.7), systems (11.0), and eclectic (11.9) colleagues. In addition, the psychodynamic brief practitioners saw significantly fewer brief therapy patients than those with systems and eclectic orientations. However, these brief therapists represent an overwhelming majority (82%) of all psychodynamic psy-

chologists. They spent almost 30% of their private practice time conducting brief therapy and more than 50% of their agency work. Furthermore, many psychodynamic brief therapists do work for a PPO (60%), HMO (40%), or EAP (30%), highlighting the considerable impact managed care has had on their clinical practices.

Theoretical orientation was also found to be significantly related to one's self-reported brief therapy experience ($F(5,627)=14.14, p<.0001$), skill ($F(5,633)=14.71, p<.0001$), satisfaction ($F(5,584)=16.59, p<.0001$), and positive attitudes toward brief therapy ($F(5,620)=19.73, p<.0001$). Here again, post-hoc analyses reveal the cognitive-behavioral psychologists rated themselves the highest (3.4, 3.3, 3.0, 3.2) and the psychodynamic therapists the lowest (2.6, 2.7, 1.9, 2.1, respectively). In addition, theoretical orientation is strongly related to one's preferred length of therapy ($\chi^2(10, N=667) = 235.93, p<.0001$). Over 60% of all cognitive-behavioral therapists preferred short-term treatments compared to less than 10% of the psychodynamic practitioners. All of these findings are in keeping with the theory and practice of cognitive-behavioral (and systems) orientations where focused, behavioral and pragmatic solutions are an integral part of the work (Levenson, Persons & Pope, 2000).

Other ANOVAs examined the relationships between brief therapy and region, practice site, and gender. What part of the country one resides in was found to be significantly related to the practice of brief therapy ($F(3,630)=3.11, p<.05$). Not surprisingly, brief therapists who practiced in the South spent the highest percentage of their clinical time conducting brief therapy (55%), while those in the Northeast spent the lowest (46%). Consistent with this regional finding, psychologists in rural settings do proportionately more brief therapy per week (61%) than their metropolitan (48%) and non-metropolitan (51%) counterparts. With regard to gender, male therapists devoted a significantly greater percentage of their clinical time to brief therapy (55%) than females (45%; $t(636)=4.07, p<.0001$), and were more likely to prefer therapies of a shorter duration (40% vs. 33%, $\chi^2(3, N=690)=27.65, p<.001$).

Lecours (1995) work underscores the importance of cultural expectations and social roles afforded to men and women in our society. Men more than women are expected to be the

more task-oriented problem solvers; women are expected to have expertise in the social- emotional realm. Even in a highly selected group of male psychologists (who are already focused on relationships), it makes sense that a problem-solving approach would lend itself to a brief therapy format, and a social-emotional focus would lead to forming (and keeping) relationships.

In an article on gender bias in short-term therapy, Edbril (1994) relates her personal experience working in the mental health department of a large health maintenance organization. "During that time, women therapists, women trainees, as well as women patients repeatedly expressed discomfort and/or dissatisfaction with the short-term format" (p. 602). From a developmental standpoint, Edbril comments on the need for women to have more of an ongoing therapeutic relationship than is usually provided in short-term therapy.

Those respondents doing brief therapy were asked to indicate the types of structured training experiences they had had in brief therapy from a list of eight, including a category for 'other.' All of the psychologists (99%) reported some brief therapy training. Not surprisingly, self-selected reading (88%), conferences (73%), and workshops (73%) were the most frequently utilized training modalities; the least frequently mentioned were consultation (44%) and audio-video tapes (35%). Approximately half the respondents said they had taken an academic course on brief therapy.

While we expected to find that psychologists were very involved in doing brief therapy, we were skeptical about the adequacy of their training. Since brief therapy is not simply a shorter version of long-term therapy, training in this modality is essential for the psychologist practicing short-term interventions (Koss & Shiang, 1993; Levenson & Butler, 2000). We were surprised (and delighted) to find that almost all brief therapists reported availing themselves of some additional brief therapy training. However, our criteria for what constituted training were quite liberal; all someone would have to have done was read an article on brief therapy to qualify. Inspection of the frequencies of various training modalities reveals that three-quarters of the

respondents participated in workshops and conferences to further their learning. One has only to count the number of brochures offering workshops on brief therapy to grasp this supply and demand relationship. "[T]he rush to acquire new therapy skills [is a] grass-roots phenomenon[on] by psychologists who are in the trenches" (Cummings, 1995, p. 11). As the impact of managed care continues to spread, we would expect to find even more adjunctive trainings to fill the need. In a survey of its readership, *Psychotherapy Finances* (1997) found that over half the responding psychologists indicated they had participated in a time-limited training for the first time in the past three years.

Consultation and audio-video tapes were not popular training experiences. At first, this finding was puzzling, until we considered the limited availability of quality tapes or consultants with brief therapy expertise. There are some indications that the situation may be improving with regard to multimedia. Data from a survey of APA-approved graduate and internship settings reveal that audio- and videotaping of students' cases are popular educational methods in the classroom (Levenson & Evans, 2000).

Considering the relatively recent impact of the managed care environment, it is perhaps not surprising that half of the psychologists who are conducting brief therapy today reported they have never had any course work in brief therapy. The average respondent in our study was in graduate school 25 years prior--a time when psychodynamic, open-ended therapy was the norm. Because graduate programs provide an excellent opportunity to train clinicians about time-limited models of psychotherapy, it might be expected that recent graduates are receiving more exposure to specialized academic training in brief psychotherapy resulting from the increased demand of brief therapy services. However, additional inspection of our data indicates that of the psychologists who graduated as recently as six years ago, more than half reported taking no graduate school brief therapy courses--the exact same percentage as those graduating more than twenty years ago. Similarly, Levenson and Evans (2000) found that 40% of APA-approved

graduate schools presently offer no courses in brief therapy training.

In addition, participants were asked to rate the helpfulness of the training they had received on a 5-point scale from 0 (not helpful at all) to 4 (extremely helpful). Those practicing brief therapy judged supervision to be the most helpful modality (3.1), followed closely by consultation (2.9) and workshops (2.9). The importance of supervision in brief therapy training has been specifically addressed (Bauer & Kobos, 1987; Levenson et al., 1995; Strupp & Binder, 1984; Strupp, Butler, & Rosser, 1988). Conferences, academic course work, and audiovisual materials received the lowest of the seven training types rated. Self-selected reading was the most frequently utilized training experience and was also ranked as very helpful. There is certainly a very large, accessible body of literature on brief therapy, and psychologists seem to make good use of this training modality.

A surprising and somewhat dismaying finding of this study was the relatively lower rating of the helpfulness of academic course work training. In fact, those who had academic courses in brief therapy found them to be the least helpful of their training experiences. Several authors have emphasized the importance of didactic training and the need to increase such offerings if clinicians are to meet the rising demand for brief services (Carleton, 1998; Constantine & Gloria, 1998; Levenson & Burg, 2000).

Relevant to the last goal, a multiple regression was conducted, regressing the participants' self-rated skill level in conducting brief therapy on amount of brief therapy training, the perceived helpfulness of that training, and the potentially confounding variables of gender, age, years of practice, and practice site (specifically, non-metropolitan and rural). This set of predictors accounts for a significant proportion of the variance in therapists' skill ($R^2 = .271$, $F(7,596) = 31.64$, $p < .0001$). Of the seven predictor variables, amount and helpfulness of training contribute independently to skill level (partial $F(1,596) = 79.89$ and partial $F(1,596) = 83.67$, respectively, both $p < .0001$). Years of practice (partial $F(1,596) = 7.01$, $p < .01$), is also a significant independent contributor to the explained variance, but training and helpfulness are still significant even when controlling for the potential confounds.

Of particular interest is the finding that clinicians who report that they have had more training and found those trainings to be helpful claim to be more skilled in the practice of brief therapy than their less trained peers. These findings are consistent with the Levenson et al. (1995) study which found that psychologists' self-ratings of skill were positively correlated with the amount of trainings in which they had participated. Although there is some controversy in the literature about the relationship between training and competency (Holloway & Neufelt, 1995; Shaw & Dobson, 1988; Stein & Lambert, 1995), the present study suggests that training in focused, short-term interventions will result in better treatment for the large number of people receiving brief therapy today. Studies need to be undertaken, however, to determine objectively if more brief therapy training leads to more competent practitioners, who can in turn deliver a higher standard of care.

Implications and Recommendations

1. Because of the large numbers of psychologists who do brief therapy, practitioners need to be aware of the legal, ethical, and clinical implications of such work. The impact of these factors for those employed by HMOs, PPOs, and/or EAPs, are even greater.
2. The results from this study clearly suggest that academic training opportunities are inadequate in both quality and quantity. Graduate programs must address this inadequacy if they are to meet the rising demand for brief therapy services. Wicherski and Kohout (1997) found that new graduates responding to a recent APA doctorate employment survey, wanted training to help them cope with the present realities of health care delivery systems.
3. Because brief therapy is an area of specialization, we urge those who practice brief therapy to take continuing education in the field to hone their skills and keep up-to-date with clinical and research advances. In particular, we encourage psychologists to avail themselves of ongoing supervision in brief therapy, as it was found to be the most helpful form of training.
4. We have coined the term, "therapists in conflict," to describe those practitioners who are not well trained in brief therapy and who do not believe in its efficacy, but who feel forced to do it because of economic and/or administrative constraints. We encourage psychologists who

experience this conflict to avail themselves of additional training opportunities in order to improve their skill and competency, and, therefore, hopefully feel less conflicted in meeting the needs of their clients seen in brief therapy.

5. Related to the point above, brief therapy training cannot focus just on teaching skills; negative attitudes toward brief therapy also need to be addressed. We fear that unexamined biases against

brief interventions may hinder a therapist's ability to deliver brief therapy competently. The present study suggests that training (e.g., supervision, CE courses) needs to take into account that some subgroups (e.g., female therapists, psychodynamic clinicians) may have particular difficulties making the paradigm shift to briefer interventions.

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