

From: Levenson, H., & Evans, S. (2000). *Professional Psychology: Research and Practice*, 31, 446-452.

The Current State of Brief Therapy Training
in APA-accredited Graduate and Internship Programs

Abstract

Did your graduate education include training in the types of therapy most in demand today? The present study surveyed training directors at APA-accredited graduate and internship sites to ascertain if their programs offered training in brief therapy. With response rates of 87% and 78%, respectively, we found that almost all internship sites and a simple majority of graduate schools provide some brief therapy training. The brief therapy teachers/supervisors in these settings were also surveyed with regard to course content, educational methods, amount of supervision, and problematic training issues. It is our position that given the nature of the emerging marketplace, clinical training programs should include brief therapy as part of their curricula. Specific recommendations for increasing trainees' and professionals' knowledge base in this area are presented.

The Current State of Brief Therapy Training
in APA-accredited Graduate and Internship Programs

Are students in graduate programs and internships receiving adequate and relevant training in the modes of therapy favored by managed care companies? Specifically, are training programs providing courses and/or supervised experiences in short-term theories and intervention strategies? Or are they “lagging behind society’s demands for the new professional psychologist” as suggested by Cummings (1995, p. 14)?

Many psychology training programs have neglected to train students in brief therapy, focusing instead on teaching long-term, individual psychotherapy to trainees who plan to enter solo practice (Levenson & Burg, 1999). A number of authors have lamented the dearth of psychologists who are adequately prepared to provide the time-limited, cost-effective therapy that is increasingly necessary for professional practice in today’s health care environment (Nahmias, 1992; Sherman, 1992). In a national survey (Davidovitz & Levenson, 1995) of 1,250 psychologists, 90% report using brief therapy in their practices, but *half* of these admitted that they have never had any course work in it.

A current report written by the American Psychological Association’s (APA) Education Directorate and Research Office under contract by the federal government’s Center for Mental Health Services, describes the need for changes in graduate training to prepare psychologists for the emerging marketplace (Spruill, Kohout & Gehlmann, 1997). The report concludes that “psychologists working in a health-care arena increasingly defined by managed care will require new skills, among them expertise in brief therapy” and notes that many training programs have not kept up with these changes in the field (Murray, 1998, p. 30).

Stedman (1997) opined that while some areas of training have been studied extensively, the types of psychotherapy taught in doctoral programs and internships (including brief therapy) have been less thoroughly investigated. Carleton (1998) surveyed the chairpersons of all APA-approved clinical, counseling and school psychology programs in 1996. She found that most programs required courses in the following modalities: cognitive-behavioral (81%), behavioral (79%), short-term psychodynamic (55%), and othr short-term therapies (62%).

The Surveys

The aim of the current study is to ascertain if doctoral-level training is preparing future psychologists to deal with today's demand for briefer interventions. We aspired to gain a representative and comprehensive picture of the current state of brief therapy training in APA-approved clinical psychology programs at the graduate and internship levels, by surveying instructors/supervisors in these settings with regard to their specific courses and training experiences, as well as training directors.

Surveys were mailed to the training directors of all clinical psychology graduate schools ($N = 165$) and internship programs ($N = 370$) approved by the American Psychological Association (APA). The half-page form (the Directors' Survey) asked training directors to identify their institutions and whether they were graduate or internship programs. Directors were also asked to indicate the predominant theoretical orientation of the training program and whether it offered brief therapy training. In keeping with past empirical and theoretical definitions (Koss & Shiang, 1993; Levenson, 1995), brief therapy was defined as *therapy that is designed to be limited in duration and/or focus, usually completed within ten to twenty sessions*.¹ If such brief therapy training were provided, the directors were requested to forward enclosed copies of a one-page questionnaire (the Educators' Survey) directly to a maximum of three individuals responsible for teaching brief therapy.

Current State of Brief Therapy Training

Brief Therapy Training in Graduate School: Directors

Two mailings of the Directors' Survey, and a final opportunity to complete the questionnaire by telephone yielded an excellent response rate of 87%. Graduate programs that responded to the survey were categorized by their location into seven geographic regions. Response rates were high (80% or greater) in all regions except the South (58%).

In terms of the major theoretical orientations of their programs, about half of the responding training directors indicated cognitive-behavioral (55%), followed by psychodynamic (30%), eclectic-integrative (29%), systems-strategic (12%), and other orientations (19%). About one-third of the directors (30%) endorsed multiple orientations.

Almost three-fifths of the responding graduate school training directors indicated that their

institutions offered brief therapy training (59%). This finding may be viewed as the glass being half-full or half-empty, depending upon one's perspective. The good news is that a majority of graduate schools offer brief therapy training; the bad news is that over 40% do not, an alarmingly high percentage considering that almost 90% of psychologists report using some brief therapy in their daily practices (Davidovitz & Levenson, 1995). Further analyses indicate that the preponderance of professional schools of psychology provide brief therapy training at a significantly higher rate than academic institutions (85% vs. 47%; $X^2(1, n = 140) = 10.09, p < .01$). This finding is consistent with the stated mission of professional schools to be more responsive to the clinical needs of the marketplace (Peterson, 1997). In addition, professional schools tend to be more recently established, allowing for the possibility that curriculum changes may be made more easily.

In addition, the prevalence of brief therapy training varied significantly by region, highest in the West (81%), compared to programs in the South (29%), Southeast (43%), Midwest (50%), or Northeast (52%). The regional differences found in this survey echo the findings of Kent (1995), who surveyed 233 psychology interns in 1993, and found that students in the Western states were significantly more likely to report exposure to brief therapy models. Kent hypothesized that this finding may reflect the more traditional approach of the Eastern schools, as well as the fact that the impact of managed care was initially greatest in the Western states.

Brief Therapy Training in Graduate School: Educators

This section describes the responses of 85 instructors from 75 graduate school programs, representing almost 90% of the graduate programs with brief therapy training. Data from the educators, therefore, may be taken as a reasonable attempt to capture the valuable perspective of the people who actually teach brief therapy. Among the graduate schools that offer brief therapy training, each training director reported that there was an average of two brief therapy instructors and four to five clinical supervisors.

A majority of graduate school educators indicated that their brief therapy course or supervision included a cognitive behavioral orientation (59%). One-third of the educators checked psychodynamic, and about one-quarter checked eclectic-integrative (27%), systems-strategic (26%), or "other" (24%). Approximately one-fourth of the educators indicated more than one theoretical orientation. Although

cognitive-behavioral was the most frequently mentioned orientation by both the training directors and brief therapy teachers, a wide range of theories is represented.

The responses from the educators indicate that brief therapy training had, on average, been offered at their institutions for under a decade, and that they had been teaching the subject for ten years or less. However, a closer inspection of the data indicate that this figure is skewed upward by the few who report having taught cognitive therapy for over 20 years. The majority of those teaching brief therapy have only two to five years experience. Thus it appears that brief therapy training is a relatively new phenomenon in graduate programs--new for students and teachers alike. This finding suggests, as noted by others (Levenson & Burg, 1999), that there may be difficulties locating faculty qualified to teach students how to practice in the era of managed health care.

There is almost an even split between trainings that are elective (55%) and those that are required (45%). According to the teachers, two-thirds to three-quarters of the students typically enroll in the brief therapy training. Thus, it seems that when brief therapy training is offered, students readily avail themselves of the opportunity. It is likely that such therapy training is popular with students because they perceive it as important for future practice.

With regard to special topics included in the training, approximately half of the educators reported that they cover crisis intervention or practice issues/managed care. Almost one-third included child and adolescent topics (31%), supportive therapy (31%) or brief group therapy (29%). More than one in five programs addressed single session therapy (22%), suggesting that some training programs are teaching what has been called "ultra brief therapy."

In order to understand how theoretical orientation might influence what special topics are taught, we compared the responses of graduate school educators who characterized their training as *purely* psychodynamic ($n = 9$) with the responses of educators who taught or supervised from a *purely* cognitive-behavioral framework ($n = 17$). Surprisingly, the topic of practice issues/managed care was covered by over three-quarters of the psychodynamic teachers compared to less than one-fifth of the cognitive-behavioral educators [$\chi^2(1, n=26) = 8.99, p < .01$].

These graduate school educators use a wide range of educational methods to teach brief therapy skills to their students. Role playing, used in 53% of the trainings, was the most common teaching method.

Other frequently used educational methods included audio- or videotaping of student cases (50%), demonstration tapes (46%), seminar-lecture (43%), and manuals (43%). Under “other,” educators wrote in topics such as live demonstration, co-therapy, and case conference. It is interesting that only half of the programs used audio- or videotaping, which are considered the “state-of- the-art” methods for teaching brief therapy (Levenson & Strupp, 1999). A number of factors might explain this finding. There may be concerns about confidentiality or the readiness of beginning students to interact with real patients; there may be a lack of access to videotaping equipment; students may not have patients who agree to taping; or there may be some resistances to exposing one’s work so openly.

We asked the graduate school brief therapy teachers to write in the authors and titles of their primary teaching material. Table 1 lists their most popular responses

 Insert Table 1 here

categorized by theoretical orientation. A complete listing of all authors and titles mentioned may be obtained from the second author.

The educators also reported the number of supervised brief therapy cases a student typically completes by the end of the course or training, including the number of individual, family or couple, group, and child cases. Educators estimated that students typically completed between three and six individual brief therapy cases. Among the graduate programs offering family and couple brief therapy, students typically completed two to four cases during the training. Training in brief child psychotherapy was rarely provided; when it was, students completed about two cases on average. Only six educators indicated a number for brief therapy groups, reporting that students in those programs would complete an average of less than two brief therapy groups in the course or training.

As part of the survey, the educators generated a list of the most difficult training issues from their own experience teaching brief therapy to graduate students. The most frequently cited issues were what instructors referred to as “shifting paradigms” or a “philosophical shift” that is necessary when moving from a long-term to a brief therapy focus (28%). This category includes such difficult training issues as helping students to focus on problem solving rather than on psychopathology, and to see therapy as a

catalyst for future change rather than expecting that change needs to take place within the therapy. One instructor characterized this attitudinal shift as “accepting that you [the therapist] will not get to see the results of your work-- that you get to be the tugboat; you don’t get to do the journey.” Other oft-cited difficult issues include: setting limited goals (24%) and adhering to a focus (20%).

Brief Therapy Training in Internship: Directors

Of the 370 surveys mailed to the internship training directors, 290 completed valid surveys (following two mailings and a telephone follow-up), yielding a high response rate of 78%. Response rates varied by region--lowest in the Mideastern states and highest in the Southwest.

Consistent with the graduate school findings, the most popular theoretical orientation among internship directors was cognitive-behavioral (42%), followed closely by psychodynamic (37%). More than one-quarter of the directors checked eclectic-integrative, and about one-fifth indicated developmental. One-quarter of the internship training directors endorsed more than one orientation.

An astounding 96% of responding internship directors reported that their program offered brief therapy training. This finding suggests that nearly all students completing an APA-approved internship will have at least some opportunity for brief therapy training at their APA-approved internships, compared to graduate programs, where over 40% reported offering *no* brief therapy training. The proportion of brief therapy training at internship sites varied little by region, with the exception of a somewhat lower percentage (83%) in the Southeastern region.

Brief Therapy Training in Internship: Educators

The internship directors indicated that an average of two instructors and five or six clinical supervisors were responsible for brief therapy training at each institution. This section describes the responses of 257 brief therapy educators, who represent approximately half of the internships with brief therapy training.

About half of the internship educators indicated that their brief therapy courses or supervision included a cognitive-behavioral orientation. The next most popular orientation was psychodynamic (42%), followed by eclectic-integrative (40%). Almost one-quarter of the educators checked systems-strategic (23%), followed by “other” (18%). Many educators checked more than one theoretical orientation.

Compared to the graduate school programs, internship training in brief therapy included

proportionately more psychodynamic and eclectic orientations, although cognitive-behavioral was numerically the most frequently indicated orientation in both. These findings lend “support to the notion that prospective psychotherapists are . . . being trained in programs where ideologies (i.e., cognitive-behavioral, behavioral) are consistent with the demands of contemporary mental health care delivery systems” (Carleton, 1998, p. 304).

In the internship settings, brief therapy seems to be a more recent phenomenon than in graduate school. The internship sites have offered brief therapy training for an average of only five to seven years, but the wide range (1 to 27 years) indicates enormous variability. Educators reported that students were required to do brief therapy training in two-thirds of the responding programs. Educators estimated that between 92% and 100% of students typically enroll in the brief therapy training. Extrapolating from the data on prevalence of brief therapy training and enrollment in the training, it follows that almost all students who complete an APA-accredited internship will have received some form of brief therapy training.

The most frequently mentioned special topics were similar to those taught in graduate school programs. Crisis intervention (42%) and practice issues/managed care (42%) were the most popular special topics in internship settings, just as they were in graduate programs. In internship programs, other frequently covered special topics included brief group therapy (34%), child and adolescent therapy (24%), supportive therapy (21%), and single session therapy (19%). Solution-focused therapy was the most frequently mentioned “other” topic. A number of educators commented that there is very little in the literature on training therapists in the special topic of brief therapy with children.

Compared to the graduate school educators, the internship educators reported using fewer didactic tools to teach brief therapy. It may be that internship educators focus more on students’ cases and less on didactic presentations or teaching methods. Audio- and videotapes of student cases were the most popular teaching methods (37%), followed by seminar-lecture (30%), demonstration tapes (27%), and role play (25%). While manuals were used by over 40% of the graduate program educators, the percentage dropped to half that amount for internship teachers/supervisors, where they were the least-used teaching method. This is a surprising finding, since many of the internships endorse a cognitive-behavioral orientation, which is quite compatible with manualized training (Dobson & Shaw, 1993; Levenson, Persons, & Pope, 2000). Also manuals are more commonly written for briefer therapies of various theoretical orientations. The

most popular manuals and texts used by brief therapy teachers at the internship level can be found in Table 1.

Internship educators indicated the number of supervised brief therapy cases a student typically completed by the end of the course or training. On average, students completed 10 to 18 individual brief therapy cases in their internship training, compared to three to six cases in graduate programs. In programs where specialized brief therapy supervision was offered, internship students typically completed three to six family or couple cases, four to five child cases, and two to six group cases. Given that graduate programs tend to focus more on theory and internship settings more on applied learning, it makes sense that students received more supervised casework in the internship programs. Nevertheless, it appears that even in internship programs, relatively few students are exposed to direct supervision in brief therapy with families, couples, children, or groups. Others have commented on limitations in clinical training in these areas (Butler & Fuhrman, 1986; Carmody & Zohn, 1980; Peterson, 1985; Sperry, 1989).

Training issues most difficult to teach students at the internship level included difficulties in setting limited goals (34%), attitudinal biases in favor of long-term therapy (33%), and inclusion/exclusion or selection criteria for brief therapy (20%). Setting limited goals appeared as one of the top three difficult training issues for both graduate and internship educators, and many wrote comments about how hard it can be to teach students about setting and keeping a focus on specific goals. In a previous study, two parameters--defined goals and a limited focus--emerged as the sine qua non distinguishing brief therapy from long-term therapy (Levenson & Butler, 1999). It thus appears what the teachers view as difficult to get across to their students is the very essence of what delineates a brief therapy. Educators were also especially expressive in their qualitative survey comments about difficulties overcoming attitudinal biases in favor of long-term treatment. As one instructor described it, the biggest problem is "convincing students that brief therapy doesn't mean inferior therapy;" another spoke of the difficulties of "unlearning passive, long-term ideology."

In order to understand how theoretical orientation might influence what is considered to be a difficult training issue, we compared the responses of internship educators who characterized their training as *purely* psychodynamic ($n = 30$) with the responses of internship educators who taught or supervised in a *purely* cognitive-behavioral framework ($n = 44$). Despite their differing theoretical positions, purely

psychodynamic and cognitive-behavioral educators independently identified remarkably similar training issues as most difficult to communicate to students. The psychodynamic and cognitive-behavioral educators agreed that attitudinal bias in favor of long-term therapy, setting limited goals, and selection criteria were three of the five most difficult issues in training students to conduct brief therapy. However, at the top of the list for the psychodynamic educators was forming a therapeutic alliance and shifting paradigms. In contrast, cognitive-behavioral educators mentioned termination and specific techniques (e.g., desensitization, homework).

The chief purpose of this survey was to determine whether clinical psychology graduate programs and internships typically offer training in brief therapy. Because of the high response rates obtained in this study, we feel fairly confident of the findings. The results make it clear that students receive near-universal exposure to brief therapy training in their internships, and to a lesser degree, in their graduate programs. The next step is to assess whether this training adequately prepares students to conduct brief therapy.

Recommendations

Based on our research, awareness of training options, and observations about the changing marketplace for clinical services, we offer the following suggestions:

1. Graduate schools (particularly the university-based programs) need to increase their brief therapy offerings (especially considering that some students will not go to APA-approved internships and therefore may not get exposure to brief therapy there). According to APA's recent doctorate employment survey (Wicherski & Kohout, 1997) new graduates said that they needed training to help them deal with the present realities of health care delivery systems.
2. We need training of the trainers. Given that most educators have only been teaching brief therapy five years or less, they may need help with the content and instructional process. As pointed out by VanDyke and Schlesinger (1997), when new modalities are needed, "faculty may not be equipped by background, level and nature of skills, or by inclination, to present the new material competently and to serve as teachers, trainees and mentors for the next generation of students" (p. 47). Perhaps faculty in academic institutions can co-teach with practitioners who have considerable experience conducting brief therapy in agencies and private practice settings.

A clearinghouse through which information about brief therapy programs, curricula, and materials

could be gathered and disseminated would provide a much needed resource so that each teacher would not have to deal with these issues de novo. APA and its various divisions (e.g., Divisions 12 and 29) are in the most appropriate position to facilitate such an undertaking. For example, educators who are interested in teaching about empirically supported treatments can request a sampling of existing graduate course syllabi on the topic by writing to Division 12 Central Office, POB 1082, Niwot, CO 80544-1082. In addition, use of current technology (E-mail, Internet, virtual classrooms) could encourage communication among teachers in geographically disparate programs.

For trainers, supervisors, and directors of training, a good place to start to become informed about various teaching options can be found in the Final Report of the American Psychological Association Working Group on the Implications of Changes in the Health Care Delivery System for the Education, Training and Continuing Professional Education of Psychologists (Spruill et al., 1997). This thorough treatise can be obtained through APA.

3. Clinical training programs should make greater use of videotapes for teaching and supervision.

Videotaping allows students to see what actually occurs in therapy. Focusing on specific therapist-patient interactions with stop-frame techniques can be particularly helpful. Students will gain from the opportunity to view themselves as therapists; they also profit from seeing their teachers/supervisors doing therapy on tape. The students' reluctance to expose their work to the close scrutiny videotaping allows must be addressed in the classroom (see Levenson, 1995). However, resistance to exposure is not just an issue for students. As a director of one brief therapy program commented, "If you think students are resistant to being taped, try asking a licensed professional to tape one of his/her sessions for teaching purposes." We encourage supervisors to begin taping their therapies and becoming comfortable with the process as a first step to using their own tapes in the classroom. It is reassuring for teachers to know that video vignettes of actual sessions do not have to be stellar examples of magnificent therapy to be extremely useful for neophytes in the field to see (see Levenson, 1995).

4. Internship sites should make greater use of treatment manuals. The infrequent use of manuals in internship is quite disturbing and surprising (especially in the case of cognitive-behavioral programs). We are in favor of using manuals to teach inexperienced trainees the fundamentals of various brief therapies (see Levenson & Strupp, 1999; Moras, 1993).

5. Brief therapy training cannot focus just on teaching skills and theory; it should address students' negative attitudes and biases about briefer interventions. Training needs to provide more opportunities that enable students to develop positive viewpoints; their preconceptions about short-term approaches need to be openly discussed. We have found that a collaborative and supportive supervisory style encourages trainees to challenge their assumptions and temporarily suspend their disbelief sufficiently to try on brief therapy models. Students' negative views are extremely important for instructors and supervisors to deal with, since such attitudes have been found to be inversely related to practitioners' skill in brief therapy (Davidovitz & Levenson, 1995; Levenson, Speed & Budman, 1992) and preference for short-term interventions (Bolter, Levenson, & Alvarez, 1990). Students who continue to hold beliefs that are antithetical to brief therapy will likely be impeded in effectively employing brief therapy methods. Fortunately, there are data indicating that negative attitudes toward brief therapy can be changed with training (Levenson & Bolter, 1988; Neff, Lambert, Lunnen, Budman & Levenson, 1996). To lessen the impact of negative attitudes, research suggests the best time to teach brief therapy is early in clinical training (Henry, Strupp, Binder, Schacht, & Binder, 1993) when students have not already been thoroughly indoctrinated in the belief that "more is better" (Hoyt, 1985).
6. There should be more specific training in brief group therapy at the internship level. Because it is cost-effective and has been shown to have therapeutic benefits (MacKenzie, 1997), brief therapy with groups is emerging as a favored mode of treatment among many managed care organizations.
7. The departmental chairs and training directors in the Southern states should convene a meeting to develop plans to expand the availability of brief therapy training in this region. The sparsity of brief therapy training in the Southern states deserves attention, especially since such programs often train therapists who practice in rural settings, where the demand for brief therapy is particularly high.
8. "The rush to acquire new therapy skills [is a] grassroots phenomena by psychologists who are in the trenches" (Cummings, 1995, p. 11). Psychotherapy Finances (1997) found a steady increase in the number of therapists taking brief therapy training and adopting its techniques into their practices. For those established practitioners, who feel unprepared to deal with present day clinical and economic challenges because they did not get formal brief therapy courses or practica during their predoctoral training, we urge continuing education. Since most of them have been trained in longer-term models, they should expect to

work on their own negative expectations about brief therapy's efficacy. Considering the fundamental and pervasive shifts necessary, a model of training that emphasizes immersion over a period of time (e.g., certification programs) is preferable to a one-shot workshops. When one does take a workshop, new learning can be bolstered by asking the workshop leader to provide follow-up consultations. Peer consultation groups can also provide an excellent format for wrestling with theoretical and practical issues in practicing brief therapy. In addition therapists might elect to enroll in trainings that make fundamental paradigm shifts more explicit and, therefore, less onerous (e.g., taking a course specifically designed to teach cognitive-behavioral techniques to dynamic psychotherapists).

9. Our last recommendation has to do with not overselling brief therapy to trainees or practitioners.

Training must help students deal with the major clinical conflicts and ethical dilemmas that are endemic in today's professional practice. We should not convince them or ourselves that what may be economically and/or administratively necessary in a specific clinical situation is what is necessarily best for the client.

References

- American Psychological Association, Division of Clinical Psychology, Task Force on Promotion and Dissemination of Psychological Procedures (1995). Training and dissemination of empirically validated psychological treatments: Report and recommendations. The Clinical Psychologist, 48 (1), 3-23.
- Austad, C.S., Sherman, W.O., & Holstein, L. (1993). Psychotherapists in the HMO. HMO Practice, 7, 122-126.
- Bolter, K., Levenson, H., & Alvarez, W. (1990). Differences in values between short-term and long-term therapists. Professional Psychology: Research and Practice, 4, 285-290.
- Butler, T. & Fuhriman, A. (1986). Professional psychologists as group treatment providers: Utilization, training, and trends. Professional Psychology: Research and Practice, 17, 273-275.
- Carleton, E. K. (1998). An examination of doctoral-level psychotherapy training in light of the proliferation of managed care. Professional Psychology: Research and Practice, 29, 304-306.
- Carmody, T., & Zohn, J. (1980). APA-approved group treatment internship training opportunities: Present status and future directions. Professional Psychology: Research and Practice, 11, 213-219.
- Cummings, N.A. (1995). Impact of managed care on employment and training: A primer for survival. Professional Psychology: Research and Practice, 26, 10-15.
- Davidovitz, D., & Levenson, H. (1995, August). A national survey on practice and training in brief therapy. American Psychological Association Convention, New York City.
- Dobson, K.S. & Shaw, B.F. (1993). The training of cognitive therapists: What have we learned from treatment manuals? Psychotherapy, 30, 573-577.
- Henry, W.P., Strupp, H.H., Butler, S.F., Schacht, T.E. & Binder, J.L. (1993). Effects of training in time-limited dynamic psychotherapy: Changes in therapist behavior. Journal of Consulting and Clinical Psychology, 61, 434-440.
- Hoyt, M.F. (1985). Therapist resistances to short-term dynamic psychotherapy. Journal of the American Academy of Psychoanalysis, 13, 93-112.
- Kent, A. J. (1995). A study of graduate and internship training in brief psychotherapy and

managed care. Paper presented at the meeting of the American Psychological Association, New York.

Koss, M., & Shiang, J. (1993). Research on brief psychotherapy. In A. Bergin & S. Garfield (Eds.), Handbook of psychotherapy and behavior change (4th ed.), New York: Wiley.

Levenson, H. (1995). Time-limited dynamic psychotherapy: A guide to clinical practice. New York: Basic Books.

Levenson, H., & Bolter, K. (1988, August). Short-term psychotherapy values and attitudes: Changes with training. In H. Levenson (Chair), Issues in training and teaching brief therapy. Symposium conducted at the convention of the American Psychological Association, Atlanta.

Levenson, H., & Burg, J. (1999). Training psychologists in the era of managed care. In A.J. Kent and M. Hersen (Eds.), A Psychologist's Proactive Guide to Managed Mental Health Care, Hillsdale, NJ: Erlbaum.

Levenson, H., & Butler, S. (1999). Brief psychodynamic individual psychotherapy. In R. Hales, S.C. Yudofsky, & J. Talbot (Eds.), American Psychiatric Press Textbook of Psychiatry, Washington, D.C.: American Psychiatric Press.

Levenson, H., Persons, J.B., & Pope, K.S. (2000). Cognitive and behavior therapies. In H. Goldman (Ed.), Review of General Psychiatry, Los Altos, CA: Lange Medical Publications (Fifth Edition).

Levenson, H., Speed, J., & Budman, S. (1995). Therapists' experience, training, and skill in brief therapy: A bicoastal survey. American Journal of Psychotherapy, *49*, 95-117.

Levenson, H., & Strupp, H.H. (1999). Recommendations for the future of training in brief dynamic psychotherapy. Journal of Clinical Psychology, *55*(4), 1-7.

MacKenzie, K.R. (1997). Time-managed group psychotherapy: Effective clinical applications. Washington, DC: American Psychiatric Press.

Moras, K. (1993). The use of treatment manuals to train psychotherapists: Observations and recommendations. Psychotherapy, *30*, 581-586.

Murray, B. (1998, January). Psychology trainers urged to update their programs. APA Monitor, *29*(1), 30.

Nahmias, V.R. (1992). Training for a managed care setting. Psychotherapy in Private Practice, *11*, 15-19.

Neff, W.L., Lambert, M.J., Lunnen, K.M., Budman, S.H., & Levenson, H. (1997). Therapist's attitudes toward short-term therapy: Changes with training. Employee Assistance Quarterly, 11, 67-77.

Peterson, D.R. (1985). Twenty years of practitioner training in psychology. American Psychologist, 40, 441-229.

Peterson, D.R. (1997). Educating Professional Psychologists. Washington, D.C.:American Psychological Association.

Psychotherapy Finances (1997). 23, 7.

Sherman, C.F. (1992). Changing practice models in managed health care. Psychotherapy in Private Practice, 11, 29-32.

Sperry, L. (1989). Training in time-limited group therapy. The Journal of Training & Practice in Professional Psychology, 3, 47-63.

Spruill, J., Kohout, J., & Gehlmann, S. (1997, July). Final report of the American Psychological Association working group on the implications of changes in the health care delivery system for the education, training, and continuing professional education of psychologists. Washington, DC: American Psychological Association.

Stedman, J.M. (1997). What we know about predoctoral internship training: A review. Professional Psychology: Research and Practice, 28, 475-485.

VanDyke, C., & Schlesinger, H. (1997) Training the trainers. Administration and Policy in Mental Health, 25(1), 47-69.

Wicherski, M., & Kohout, J. (1997). 1995 doctorate employment survey. Washington, DC:American Psychological Association.

Winokur, M. & Dasberg, H. (1983). Teaching and learning short-term dynamic psychotherapy. Bulletin of the Menninger Clinic, 47, 36-52.

References for Brief Therapy Texts

Barlow, D.H. (Ed). (1993) Clinical handbook of psychological disorders: A step-by-step treatment manual, 2nd edition. New York:Guilford.

- Bauer, G.P. & Kobos, J.C. (1987). Brief therapy: Short-term psychodynamic intervention. Northvale, NJ: Jason Aronson.
- Beck, A.T., Rush, A.J., Shaw, B.F., & Emery, G. (1979). Cognitive therapy of depression. New York: Guilford.
- Berg, I.K. (1994). Family based services: A solution-focus approach. New York: Norton.
- Bergin, A.E., & Garfield, S.L. (Eds.) (1994). Handbook of psychotherapy and behavior change, 4th ed. New York: Wiley.
- Beutler, L.E., & Clarkin, E. (1990). Systematic treatment selection: Toward targeted therapeutic interventions. New York: Brunner/Mazel.
- Bloom, B. (1992). Planned short-term psychotherapy: A clinical handbook. Boston: Allyn and Bacon.
- Budman, S.H., & Gurman, A.S. (1988). Theory and practice of brief psychotherapy. New York: Guilford.
- Davanloo, H. (Ed.) (1980). Short-term dynamic psychotherapy. Northvale, NJ: Jason Aronson.
- de Shazer, S. (1985). Keys to solution in brief therapy. New York: Norton.
- Ellis, A. (1962). Reason and emotion in psychotherapy. New York: Lyle Stuart.
- Furman, B., & Ahola, T. (1992). Solution talk: Hosting therapeutic conversations. New York: Norton.
- Gustafson, J.P. (1986). The complex secret of brief psychotherapy. New York: Norton.
- Haley, J. (1969). Strategies of psychotherapy. New York: Grune & Stratton.
- Klerman, G.L., Weissman, M.M., Rounseville, B.J., et al. (1984). Interpersonal psychotherapy of depression. New York: Basic Books.
- Levenson, H. (1995). Time-limited dynamic psychotherapy: A guide to clinical practice. New York: Basic Books.
- Lewinsohn, P.M., Munoz, R.F., Youngren, M.A., & Zeiss, A.M. (1978). Control your depression. Englewood Cliffs, NJ: Prentice Hall.
- Luborsky, L. (1984). Principles of psychoanalytic psychotherapy: A manual for supportive-expressive treatment. New York: Basic Books.

- Mann, J. (1973). Time-limited psychotherapy. Cambridge, MA: Harvard University Press.
- Messer, S.B., & Warren, S. (1995). Models of brief psychodynamic therapy: A comparative approach. New York: Guilford.
- O'Hanlon, W.H., & Beadle, S. (1994). A field guide to possibility-land: Possibility therapy methods. Omaha, NE: Center Press.
- Persons, J.B. (1989). Cognitive therapy in practice: A case formulation approach. New York: Norton.
- Sifneos, P.E. (1987). Short-term dynamic psychotherapy: Evaluation and technique, 2nd Edition. New York: Plenum.
- Strupp, H.H., & Binder, J.L. (Eds.). Psychotherapy in a new key: A Guide to time-limited dynamic psychotherapy. New York: Basic Books.
- Talmon, M. (1990). Single-session therapy: Maximizing the effect of the first (and often only) therapeutic encounter. San Francisco: Jossey-Bass.
- Watzlawick, P., Weakland, J.H., & Fisch, R. (1974). Change: Principles of problem formation and problem resolution. New York: Norton.
- Wells, R.A., & Giannetti, V.J. (Eds.) (1990). Handbook of the brief psychotherapies. New York: Plenum.

Table 1
 Authors of Most Frequently Used Brief Therapy Texts

Graduate Schools	Internships
Psychodynamic:	
Levenson	Klerman et al.
Luborsky	Systems/Solution Focused:
Mann	deShazer
Messer & Warren	Furman & Ahola
Strupp & Binder	O'Hanlon & Beadle
	Talmon
Cognitive/behavioral:	
	Watzlawick et al.
Barlow	
Beck et al.	
Ellis	
Persons	
Eclectic/integrative:	
Bergin & Garfield	
Beutler & Clarkin	
Bloom	
Budman & Gurman	

Bauer & Kobos

Davanloo

Levenson

Mann

Sifneos

Strupp & Binder

Barlow

Beck et al.

Ellis

Lewinsohn et al.

Persons

Beutler & Clarkin

Bloom

Gustafson

Klerman et al.

Wells & Giannetti

Berg

deShazer

Haley

O'Hanlon & Beadle

Talmon

Note. Texts are listed in alphabetical order within theoretical categories. Complete citations are provided in a separate reference section.

Footnote

1. Although HMO therapy (1-6 sessions; Austad, Sherman, & Holstein, 1992) is quite common in today's marketplace, we chose to use the more traditional time-span of brief therapy (10-20 sessions), because the so-called ultra brief therapies have come under attack by clinicians for lack of therapeutic utility and by researchers for lack of empirical validity.