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Intentionally brief therapy

A brief exploration of the literature

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Abstract

This thematic review aims to highlight some of the complexities and challenges that are present in the literature surrounding brief therapy. Specifically, the article looks at the diversity in definition of brief therapies, and the question of whether or not brief therapies work. Common themes across different types of brief therapy are explored. A tentative, integrative model of brief therapy is proposed consisting of a collaborative relationship, ready-and-willing clients, an active therapist, and a constant but not excessive pressure. Implications for offering "intentionally brief" therapy are discussed in relation to funding and service providers, practitioners, researchers, and educators.

Keywords: brief therapy, brief counselling, literature review, efficacy

> *…research showing the prevalence of brief therapeutic interventions suggests that agencies, individual counsellors, and funders of mental health services should plan for and deliver intentional brief therapy, and that such approaches should be a central part of any counsellor education programme. Perhaps it should be the approach of choice, not an optional extra. (Manthei, 2012, p. 53)*

As Manthei has indicated, there seems to be a growing case for counsellors in Aotearoa New Zealand to be able to offer "intentionally brief" therapy. By this, we mean that rather than therapy being "brief" by happenstance, or arbitrarily imposed due to funding limits, there is a conscious intention from initiation to ending that the work will be framed as "brief." Though this may seem obvious and of no particular significance, the following thematic review of the literature on brief therapy highlights several complexities and challenges. While this review is not systematic and does not

claim to cover all relevant perspectives on brief therapy, it poses some significant questions for service providers, practitioners and researchers. Note that throughout this article the terms *therapy*, *counselling*, and *psychotherapy*, as well as *therapist*, *counsellor*, and *psychotherapist* will be used interchangeably. It is acknowledged that there are numerous and significant differences between these; however, as this article will argue, there would seem to be important commonalities in the endeavour to offer "intentionally brief" therapy irrespective of specific professions.

Method

The review broadly followed the method outlined by McLeod (2015) as a "practice-friendly review" (p. 130). This type of review is differentiated from a systematic review in that its focus is not to arrive at any objective or definitive finding, but rather to explore the implications for practice of the published literature around a specific topic. Hence the intent of the review was not to provide an exhaustive coverage of the brief therapy literature, but rather to identify key concepts and points of interest that seemed to have relevance to the first author's counselling practice. Specifically, the review aimed to address the question: "What are the key elements and effective components of 'intentionally brief' therapy?" The review is termed a "thematic review" as the results are organised around key themes that emerged from the literature.

Search process

An initial search was conducted using an amalgamated university search engine of databases including Web of Science, Scopus, OVID, EBSCO, JSTOR, ProQuest, PsycInfo, and PEP. Search terms included "brief," "short term," and "time limited" in combination with "counselling," "counseling," "psychotherapy," and "therapy." From key articles, a "search back" was performed by looking through the reference list for any further relevant literature. Additionally, a "search forward" was conducted by searching the databases for any literature referencing the key article.

The search was specifically directed towards articles that discussed the efficacy of brief therapy, as this was the primary practice interest of the first author. Here it became obvious that most such discussions were based around different modalities of practice. Hence the decision was taken to seek literature that covered what we saw as representing the four core modalities, or schools of thought, around brief therapy practice: brief dynamic therapies, solution-focused brief therapy, brief cognitive behavioural therapy, and brief person-centred counselling.

In line with the practice-friendly approach, the decision was also taken to include only literature referring to face-to-face therapy and therefore exclude e-therapy, online therapies, phone counselling, etc. This was seen to be in line with current NZAC guidance for provisional membership (NZAC, 2017), and was also consistent with the first author's practice setting. Further, though there was no specific intention to focus on an Aotearoa New Zealand context, where local publications were found, these were seen to be of particular interest.

Thematic process

The process of identifying and organising key themes in the literature broadly followed Braun and Clarke's (2006) model. In this approach, themes are seen to represent "some level of *patterned* response or meaning within the data set" (p. 82). Further, how "key" a theme is to a study is not seen to depend on its numerical prevalence, "but rather on whether it captures something important in relation to the overall research question" (p. 82). This was seen as a good fit with McLeod's (2015) practice-friendly approach by allowing the researcher to discern what had most meaning for their practice.

Braun and Clarke (2006, p. 87) identified six phases of thematic analysis:

1. Familiarizing yourself with your data: Reading and re-reading the data, noting down initial ideas.
2. Generating initial codes: Coding interesting features of the data in a systematic fashion across the entire dataset, collating data relevant to each code.
3. Searching for themes: Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes: Checking whether the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic "map" of the analysis.
5. Defining and naming themes: Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
6. Producing the report: The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating the analysis back to the research question and literature, producing a scholarly report of the analysis.

From this process, the following themes emerged as being of significance to exploring the idea of offering "intentionally brief" therapy in practice.

What is brief therapy?

One complexity in the use of the term "brief therapy" constitutes the lack of agreement about what this actually means. Manthei (2016) has articulated that brief therapy is a conceptually planned undertaking distinct from "short term" therapy, that is, it is not simply defined by a duration of time. This is aligned with Steenbarger's (1992) assertion that "not all therapy of limited duration is 'brief therapy'" (p. 404). Early client termination, administrative restrictions, as well as unplanned therapist-initiated endings can all lead to short durations of "therapy without any intentionality for the 'work' to be completed in a time-limited fashion."

Even when there is an intentional framing of the therapy as brief, there is significant variance in the literature around what exactly this means. Steenbarger (1994) found a "surprising diversity" of treatment duration—some therapists offering up to eight sessions, others up to twenty sessions and yet others more than twenty. Significantly, within Aotearoa New Zealand there is evidence that "brief" therapy may be even briefer than international contexts. Manthei (2012, 2016) reported an average of around 4.7 sessions in agency settings, and as low as 3.1 sessions in the case of the private practice portrait presented in the current issue (Manthei, 2017).

This situation is confounded further by the variance over which cases are included in reported studies. Some studies include single-session treatments while others exclude cases with three or fewer sessions as "early terminators." Some include treatments offering flexible parameters while others require strict time-limited boundaries. A further complexity here is that the number of counselling sessions is not necessarily consistent with the time period taken. For example, are six sessions spread out over a six-month time period still to be considered "brief"? Conversely, are 24 sessions completed within six weeks of intensive therapy "brief" or "long term"? Unfortunately, these types of distinctions are seldom made in the literature.

Another way of framing brief therapy is by defining the scope of work to be done, or the intended outcome. Rather than undertaking the task of "counselling to the point of cure" (Manthei, 2016, p. 66), intentional brief therapy can be seen as focusing on collaboratively helping clients to address a discrete portion of a larger piece of work, or of getting them started on a longer journey. Quick and Gizzo (2007) remind us that "clients do not have to wait for problems to be fully resolved to create profound change" (p. 81). This is consistent with research that has found that counselling is not necessarily a one-off endeavour, but rather, people may seek counselling on many different occasions throughout their lifetime when the need arises (Manthei, 2016). Eckert (1993)

has conceptualised this intermittency as a developmental process such that clients may seek therapy at different stages in their lifetime as new issues arise for them in their life cycle. Similarly, McKenna and Todd (1997) have identified a number of distinct patterns of engagement with counselling, such as initial exposure to the possibility of help, "shopping around" to find the right counsellor, formation of a viable working relationship, along with seeking "booster sessions" to consolidate and reinforce previous episodes. This conceptualisation is similar to the stages of the change model of pre-contemplation, contemplation, preparation, action, and maintenance (Norcross, Krebs, & Prochaska, 2011; Prochaska, Norcross, & Diclemente, 2013). From this perspective, brief therapy can be framed as the intentional engagement with a defined "episode" or "stage" of a client's longitudinal therapeutic journey.

From the above discussion, it will be clear that there are no precise parameters in the literature about what constitutes "brief therapy." This is an important dilemma to keep in mind throughout the rest of the review. Rather than getting bogged down in attempting to explicitly resolve this, we have intentionally taken a broad perspective on this in order to include a diversity of conceptual and theoretical understandings of brief therapy.

Does brief therapy work?

Bloom (1992) asserted that "planned short-term psychotherapy is indistinguishable from time-unlimited psychotherapy in its effects" (p. 162). Similarly, Steenbarger (1992) found that "clients, observers, and standardized measures rate time-limited therapy as being as effective as time-unlimited treatment" (p. 414). Specifically, Steenbarger (1992) referred to research conducted in community clinics, college counselling centres, and private practice that demonstrated enduring change through brief therapy, including studies incorporating long-term follow-up.

Within these assertions can be found the complexity of the above discussion over what exactly it is that is being found equivalent. While Bloom (1992) refers to "planned short-term" therapy, Steenbarger (1992) instead refers to "time-limited" therapy. Are these the same or different? There has also been some debate on the full extent of this "equivalence" claim, with some authors such as Gelso (1992) arguing that there has been insufficient empirical evidence to justify these claims. We would agree that more research is necessary; however, the evidence is mounting.

For example, a systematic review of 63 controlled trials of brief psychological treatments for depression conducted for the NHS in the UK (Churchill et al., 2001) found that "patients receiving any variant of [brief] psychotherapy were significantly

more likely to improve to a degree where they were no longer considered clinically depressed…than those receiving treatment as usual" (p. iii). In this study, brief treatments included those within a "time-limited framework" of up to 20 sessions, with treatment as usual being defined as "usual care/management, waiting list and no treatment" (p. 7). While this study does not compare brief therapy to longer term work, it is compelling evidence for the overall efficacy of psychological treatments undertaken in a time-limited framework, at least for depression.

Likewise, Leichsenring, Rabung, and Leibing's (2004) meta-analysis of 17 studies of short-term psychodynamic psychotherapy (STPP) found that therapy yielded large effect sizes that "significantly exceeded those of waiting-list controls and treatments as usual," and that "no differences were found between STPP and other forms of psychotherapy" (p. 1208). Similarly, Gingerich and Peterson (2012) completed a systematic qualitative review of 43 controlled outcome studies of solution-focused brief therapy. Their findings indicated that nearly three-quarters of the studies reviewed (74%) reported significant positive outcomes, while 23% indicated positive trends, with one study reporting no observable benefit, leading them to conclude that "overall, evidence from the 43 studies suggests that SFBT consistently produces benefits to clients across fields of practice" (p. 279). From their analysis of comparative studies utilising alternative treatments such as medication, they further concluded that "not only does SFBT consistently produce positive outcomes, but those outcomes appear to be at least as good as those from a variety of alternative treatments, and better in some instances" (p. 279).

Overall, these systematic reviews would tend to support the assertion that brief therapy works. The studies also tend to support claims of greater cost-effectiveness with equivalence in outcome to longer term therapy or alternative pharmacological treatments (Churchill et al., 2001; Gingerich & Peterson, 2012). Interestingly, these systematic reviews also confirm the divergence in definition of "brief" as discussed above. Churchill et al. (2001) stated that "20 sessions in all models of psychotherapy constitutes a time-limited therapeutic framework" (p. 2), while Leichsenring et al. (2004) defined "short-term" therapy as encompassing from 7 to 40 sessions (mean of 20.97), and Gingerich and Peterson (2012) indicated the typical duration of SFBT was less than 10 sessions.

What works about brief therapy?

Several authors have attempted to articulate specific aspects that influence the efficacy of brief therapy. For example, Eckert (1993) conceptualised a model which includes

catalysts for change: "just as a chemical catalyst speeds the course of a chemical reaction, a therapeutic catalyst would hasten the rate of therapeutic progress. Consequently, effectively applying such catalysts to any therapeutic endeavour would produce more rapid results" (p. 242). The key factors within this model include "rapid early assessment, maintenance of a focus, selection of a limited goal, flexibility of treatment selection, high therapist activity, therapeutic alliance, promptness of intervention, and limitation of time" (Eckert, 1993, p. 242).

From a different perspective, Steenbarger (1994) identified client, therapist, and contextual mediators which are required for brief counselling to be effective. These are defined as the client's interpersonal functioning, capacity to form attachments, openness to therapeutic interventions, involvement, and client expectations, along with therapist influence and capacity for relatedness, client-therapist match, and post-therapeutic events. Here, Steenbarger (1994) proposed a continuum for determining the likely efficacy of brief therapy, with "clients who are highly aware of focal problem patterns and form a ready, involving alliance" (p. 116) at one end, while at the other end were "clients with broad, diffuse, and poorly understood patterns and who need considerable time to form a trusting alliance" (p. 116).

As well as these attempts to articulate the effective components of brief therapy in general, there have been several attempts to articulate the distinguishing features and effective components of different modalities of brief therapy. Following is an overview of these in relation to brief dynamic therapies, solution-focused brief therapy, brief cognitive behaviour therapy, and brief person-centred therapy.

Brief dynamic therapies

Steenbarger (1992) described brief interpersonal dynamic therapy as "a process of 'experiential learning' in which 'corrective emotional experiences', rather than verbal interpretations, are the crucial elements of change" (pp. 405–406). He explained that by using this approach, therapy becomes a place where maladaptive client patterns of relating to others are enacted and responded to in more helpful ways, such as with interpretation and challenge. Brief dynamic therapists actively use the counselling relationship as a change vehicle, through "non-judgmental exploration, the encouragement of affect, and direct behavior change techniques" (p. 406). Similarly, anxiety-provoking brief dynamic therapies (Steenbarger, 1992) put the emphasis on anxiety as the genesis of change. In this approach, the therapist is more active in "'exerting a constant but not excessive pressure' to catalyse client movement"

(Alexander & French, as cited in Steenbarger, 1992, p. 406). These brief dynamic approaches allow for relationship patterns, and patterns of defence or resistance, to be enacted, identified, and challenged within sessions.

Leichsenring and Schauenburg (2014) reviewed 14 randomised controlled trials, looking at the effective components of short-term psychodynamic therapy for the treatment of depression. Their findings indicated that effective components of this approach include a strong focus on goals, a more active therapist stance than in classical psychotherapy, encouragement of clients to be active in the working through of emotions both in sessions and between sessions, and an emphasis on the client's maladaptive interpersonal patterns that are experienced in their current relationships outside of therapy. They suggested a structured yet fluid process of working through three phases: 1) *Supportive interventions*, including the building of the alliance, education and empowerment, and the setting of goals; 2) *Expressive interventions* such as identifying and working through the core conflict, allowing expression of painful emotion, and modifying object relations; and 3) *Terminating interventions* such as reviewing what has been done and the milestones achieved, discussing termination, pointing out the client's contribution and activities and incorporating and maintaining gains.

Solution-focused brief therapy

In contrast to brief dynamic approaches, solution-focused brief therapy (SFBT) takes the emphasis away from problems and focuses on solutions. Quick and Gizzo (2007) investigated the "ingredients of change" as identified by clients in a brief solution-focused therapy group and found that having a focus on positives and away from the problem was considered a key ingredient for change. Other factors identified in the study were behaviours or attitudes of the clients themselves rather than therapist interventions, such as small and specific behaviours, socialisation, communication, and hope. "Acceptance—of setbacks, feelings, personal styles, ambivalence, and discomfort—also appeared to be an important component" (Quick & Gizzo, 2007, p. 81).

Franklin, Zhang, Froerer, and Johnson (2017) demonstrated that SFBT's specific questioning techniques, such as miracle questions and scaling, are important interventions for facilitating change. They also noted that clients' "increasing positive expectancies, and positive emotion, such as hope and optimism, may be associated with positive outcomes within SFBT" (Franklin et al., 2017, p. 17). Co-construction of meaning which helps clients build solutions is an important part of therapy, where

"clients are specifically asked to co-construct a vision of a preferred future and draw on their past successes, strengths, and resources to make that vision a part of their everyday lives" (p. 17). Only a small portion of the themes which were identified in the studies reviewed by Franklin et al. (2017) showed that the therapeutic relationship and the therapists' style had a positive impact and, in fact, one of the studies found that the therapeutic alliance was not actually associated with a positive outcome. This was in "contrast with the therapeutic literature that shows the significance of the therapeutic relationship as a common factor for therapeutic change and to the clinical literature on SFBT" (Franklin et al., 2017, pp. 26–27). This led Franklin et al. (2017) to conclude that there was not enough research into the effects of the SFBT therapeutic relationship on outcome.

Brief cognitive behaviour therapy

In brief cognitive behaviour therapy (CBT), the counsellor aims to identify "learned cognitive and behavioural patterns" (Steenbarger, 1992, p. 407) which are the primary sources of distress. When focusing on cognitive restructuring, the counsellor helps the client to assemble evidence which undermines negative worldviews or schemas. This involves helping clients to recognise automatic thoughts, and employ systematic hypothesis testing. Steenbarger (1992) described this as clients becoming their own "personal scientists" who are able to "empirically test" their own assumptions (p. 407). A study by Wolf and Goldfried (2014) into the effective elements of brief CBT for panic disorder found that therapists identified psychoeducation, cognitive restructuring, relabelling of sensations associated with panic, and the identification of emotional reactions to life situations as effective interventions, as well as the "simulation of panic sensations within the session" (p. 43), breathing retraining, and relaxation training. They also pointed out that patient expectations and motivation, and their social system, influence the effectiveness of treatment, as does the quality of the therapeutic alliance.

Barnes et al. (2013) found that clients viewed some elements of brief CBT negatively, such as homework between sessions, the painful revisiting of experiences or emotions, learning about aspects of self, having to think about negative issues in their life, rigidity in the therapy approach, and feeling "steered" by the therapist. There was also the finding that clients were dissatisfied with therapy if the main issue behind their seeking therapy was not adequately explored by the therapist. They claimed that "these difficult issues can be dealt with through the collaborative nature of the therapist/-

patient relationship" (p. 357). Despite these negative reactions to brief CBT, Barnes et al. (2013) found that those who attended more than one session "spoke about having learned to challenge their own negative thoughts and about CBT having given them the 'tools' to cope with or manage their condition" (p. 356).

Brief person-centred counselling

Timulak and Lietaer (2001) listed the "positively experienced moments" in brief person-centred counselling as being focused on two themes: 1) moments where the therapeutic alliance was strengthened, and 2) moments of empowerment of the client. The strengthening of the therapeutic alliance occurred through the counsellor's metacommunication and disclosure, interpersonal skills, congruence, transparency, and client-centeredness. Timulak and Lietaer (2001) explained that explicit communication about therapeutic intentions, the counselling process, and clarification of goals was considered important in establishing an alliance. "Our study shows that a negotiation of the therapeutic process and its goals has the potential of empowering the alliance" (p. 70). The client's interest in the counsellor's perspective, the client's sense of having an influence on the counselling process, and the client's felt sense of safety, peace, relaxation, trust, and freedom also contributed to the strengthening of the alliance. The empowerment of the client was demonstrated through an exploration of personal meaning, the counsellor's reflecting on and listening to their own inner experience, the clarification of the client's experiencing, and focusing on the client's felt sense and meaning. This was also apparent in the "aha" moments, and the client's growing sense of satisfaction in and enjoyment of the counselling process.

Emergent themes regarding effective components of brief therapy

This review of the literature is by no means exhaustive, and cannot be considered as representative of all approaches to brief therapy, or of all studies into the identified approaches. However, it has revealed several interesting findings that point to the need for further investigation and consideration. In line with Braun and Clarke's (2006) approach to thematic analysis, the following themes have been constructed both inductively (bottom up from the data) as well as theoretically (top down from pre-existing knowledge). Additionally, rather than attempt to ascribe specific themes to specific modalities, the intention has been to bring to awareness "possible" factors that span approaches and may be significant in an integrative approach to offering intentionally brief therapy. Within the following descriptions of each primary theme, subthemes from the literature are identified in italics.

Collaborative relationship

Interestingly, within the reviewed literature, some difference of opinion was apparent as to the significance of the therapeutic relationship in brief therapy. Studies on solution-focused brief therapy concluded that there was not enough reported evidence describing the effects of the therapeutic relationship on outcome (Franklin et al., 2017). In contrast, research on other approaches found that the therapeutic relationship did have a positive impact (Barnes et al., 2013; Franklin et al., 2017; Steenbarger, 1994; Wolf & Goldfried, 2014). Themes throughout this literature suggest that clients value a sense of *safety and trust* in their counsellor (Steenbarger, 1994; Timulak & Lietaer, 2001). A therapeutic alliance allows for *collaboration*, the ability to *openly talk about difficult feelings and experiences*, to *hear challenges and interpretations* and to effectively work through them. The use of psychodynamics as a change tool was shown as being useful for recognising *transference/countertransference*, reflecting on it and using it to facilitate understanding (Hofmann, Sperth, & Holm-Hadulla, 2015; Steenbarger, 1994). The SFBT research did find that *co-construction of meaning* was an effective component of therapy (Franklin et al., 2017), and it could be argued that this is only possible within a positive, collaborative, therapeutic relationship. Taken as a whole, the above indicates that a sound therapeutic relationship is a necessary component for therapeutic change in brief therapy. However, there appears to be more emphasis on the collaborative and co-constructive nature of the relationship rather than change happening *through* the relationship.

Ready and willing clients

The reviewed literature suggests that a number of client characteristics support the effectiveness of brief counselling. These include a *good level of interpersonal functioning* (Steenbarger, 1994) which allows for faster building of a therapeutic alliance, as well as *existing client strengths and resources* (Bloom, 1992; Franklin et al., 2017) including their social system which helps support the client during their counselling journey. The current review also identified the value of an *active engagement in the counselling process* (Barnes et al., 2013; Leichsenring & Schauenburg, 2014; Steenbarger, 1992) such as practising certain behaviours as intentional steps towards solutions both in therapy and outside of therapy, willingness to be challenged, acceptance of setbacks, and the willingness to experience and work through difficult feelings, discomfort, and contradictions (Quick & Gizzo, 2007). Additionally, clients who have *hope and positive expectations* before counselling has even begun are seen to make the best use of brief therapy (Franklin et al., 2017; Steenbarger, 1994; Taylor et al., 2017). This suggests that

clients who are generally higher functioning and primed to engage with a therapeutic process will benefit the most from brief counselling. The above also indicates that if a client has a poor level of interpersonal functioning, significantly lacks existing strengths and resources, or does not quickly engage in the therapeutic process, or has little hope or positive expectations of therapy, then brief counselling may be inappropriate.

Active therapist

The literature covered in this review has indicated that an active therapist is just as important as an active client for effective brief therapy (Bloom, 1992; Leichsenring & Schauenburg, 2014; Steenbarger, 1992). Themes such as *rapid early assessment* (Eckert, 1993) and *goal setting* (Eckert, 1993; Leichsenring & Schauenburg, 2014; Timulak & Lietaer, 2001) indicate the importance of immediate engagement with why a client is attending therapy, while *maintenance of a focus* (Eckert, 1993; Quick & Gizzo, 2007) suggests an active "shaping" of sessions. Similarly, *education and empowerment* (Leichsenring & Schauenburg, 2014; Timulak & Lietaer, 2001; Wolf & Goldfried, 2014), *questioning techniques* (Franklin et al., 2017; Wolf & Goldfried, 2014), and *emotion techniques* (Leichsenring & Schauenburg, 2014; Timulak & Lietaer, 2001; Wolf & Goldfried, 2014) indicate the value of therapists having a varied 'toolkit' of interventions, while *counsellor's use of self* (Timulak & Lietaer, 2001) reminds us of the value of therapists actively using themselves as the therapeutic tool. Taken together, these themes suggest a higher level of activity in counsellors compared to longer term therapies, and traditionally less directive modalities such as person-centred and dynamic approaches.

However, it needs to be noted that the current review highlights several cautions with a more active stance, such as the difficulty for clients of encountering *painful emotions, negative thinking, feeling* "*steered*", as well as *issues not adequately explored* (Barnes et al., 2013). While these potential difficulties were raised as concerns in relation to brief CBT in particular, they serve to warn us that the activeness of the therapist should not be limited to just implementing techniques and interventions. Rather, attention also needs to be given to being actively *transparent* and the use of *metacommunication* about the intent and purpose of the counsellor (Timulak & Lietaer, 2001), along with actively attending to any distress or discontent expressed by a client.

Constant but not excessive pressure

A tentative overarching conceptualisation can be seen to emerge from a combination of the previous three primary themes: *collaborative relationship*, *ready and willing*

clients, and *active therapist*. Here we have drawn on what Steenbarger (1992) has referred to as a *constant but not excessive pressure*. We conceptualise this as arising from the interaction of a *ready and willing* client with an *active therapist* working within a defined and delimited time boundary. Here, a dynamic of a constant pressure can be seen to be constructed which needs to be held by a *collaborative, transparent and sensitive therapeutic relationship* in order for this not to become excessive. This conceptualisation somewhat parallels Eckert's (1993) idea of a catalyst, where a therapeutic "substance" is introduced to speed up the process of therapy. A closer analogy is perhaps that of a pressure cooker, which likewise can be seen to speed up a process. This later analogy captures somewhat better the necessity to maintain a balance, and to not "overheat" the process.

The above findings can be seen to have a number of implications for funders, service providers, practitioners, and educators, and for future research. In the spirit of this exploratory review, the following implications are not a definitive list, but rather are intended to provoke and facilitate further discussion and consideration.

Implications for funders and service providers

The lack of clarity around the exact definition of what constitutes brief therapy can create significant confusion in terms of policy and service provision. For example, in their framing of a stepped care model, Te Pou o te Whakaaro Nui (2012) suggest six to eight sessions of low-intensity approaches such as "brief talking therapy," while 16 to 20 sessions should be allocated for the more severe cases of mental distress. Clearly there is the implication here that 16 to 20 sessions are not "brief," yet this falls into the definition used by a number of studies in this review, such as that undertaken by the UK National Health Service (Churchill et al., 20021). The significance here is that large systematic reviews such as these often become sources of evidence for guidance protocols for service providers (see, for example, the UK's 2004 National Institute for Clinical Excellence guidelines for depression; NICE, 2004). However, when it comes to implementing this guidance, there can often be a mismatch between the researched "brief" intervention (e.g. up to 20 sessions) versus the funding available to service providers for implementing the "brief" intervention (e.g. limited to between six and eight sessions).

This is further complicated by the way various funders finance practitioners to provide "brief" interventions. For example, in an Aotearoa New Zealand context, some Primary Health Organisations (PHOs) provide funding on a contracted "package-of-care" basis to external service providers and leave them to distribute this

funding as it suits, while other PHOs have stricter guidance on service delivery, and yet others deliver interventions "in house" by employed practitioners (Dowell et al., 2009). In the experience of the first author, this leads to some clients receiving a very delineated "brief" intervention over six consecutive weeks, while other clients may receive their "brief" treatment over a number of months. This resembles something of a "postal code lottery" as to which PHO clients are referred through, and results in significant variance in the implementation of "brief" interventions, even within the same agency and by the same practitioner. The issue here is that current approaches to conceptualising, reporting, and evidencing brief therapy practices seldom take into account these systemic issues around variance in implementation.

Similarly, current approaches to conceptualising, implementing, and evidencing practice typically do not differentiate between different episodes or stages of therapy. Here there would seem to be opportunities to differentiate more systematically between clients attending for initial exposure/contemplation, versus engagement/action, versus booster/maintenance sessions. It would be possible to intentionally allocate differentiated resources, depending on the stage of engagement. This could include different durations of intervention, different modalities and formats (e.g., CBT versus dynamic therapy, group versus individual), different assessments of successful resolution, and potentially even different counsellors who have a varying aptitude or specialisation in working with different stages. More broadly, the literature suggests that we can be more discerning about whether to even try a brief therapy approach. If clients are not "ready and willing," this review suggests that allocating clients to brief therapy may be inappropriate.

Implications for practitioners

Both Steenbarger (1992) and Manthei (2007) have found that despite findings of the equivalence of outcome, counsellors tend to be resistant towards working in a brief way. Steenbarger (1992) found that "therapists frequently resist the use of brief treatments even when these have been demonstrated to be effective, and underestimate the effects of those brief interventions they do undertake" (p. 404). Manthei (2007) has echoed Steenbarger, stating that "many clients expect and prefer briefer counselling than do their counsellors" (p. 277). There are significant issues here for practitioners in terms of privileging longer term work, not least the ethical question of either knowingly or unknowingly encouraging clients to stay in therapy longer than they need to be. This is confounded by the tendency of the profession to utilise indicators of outcome that focus on the absence of symptoms, improved life functioning, etc., rather than the

successful resolution of an episode or stage of therapy. Conversely, the finding regarding the importance of a ready and willing client to the success of brief therapy introduces the potential to dismiss any poor outcome cases as being due to a client being "unsuitable." Practitioners are hence encouraged to reflect carefully on their own biases, implicit agenda, and justifications when working within a brief therapy framework.

Possibly the most significant finding of this review for practitioners who aspire to offer "intentionally brief" therapy is that of the active therapist. This finding calls for therapists to generally be "more active" in their practice. A complexity here, however, is determining what "more active" entails. The current review gives some indicators of this, such as the need to be active not just in terms of interventions, but also in terms of the process of therapy. Being actively transparent, actively attending to distress or alliance ruptures, and the liberal use of metacommunication can all be seen as key components of offering intentionally brief therapy. In parallel with this activity, it can be seen that a collaborative, trusting, and sensitive therapeutic relationship is essential to maintain the "constant but not excessive pressure." This balance perhaps reflects a defining trademark of a practitioner who offers intentionally brief therapy—the capacity and willingness to actively engage while simultaneously supporting and attending.

A further complexity with this more active stance for practitioners is the potential pressure of the expectation to perform, from self, the agency, and also the client. Especially when working from an integrative framework, this active stance could easily lead to the expectation that the counsellor has lots of interventions or tools to draw on, in order to achieve results in a limited time. Likewise, the pressure to form a sound therapeutic relationship immediately could potentially lead to an artificially forced alliance, especially if limited funding implied that any change of therapist would also mean a reduction in available sessions. This pressure to "get it right" from the first session could readily introduce an unhelpful and potentially unhealthy dynamic for both client and practitioner. Similarly, the pressure to perform session after session, client after client, week after week could well take its toll on a counsellor's wellbeing. Here it would seem wise to have a mix of caseloads involving both brief and longer term work, as well intentionally attending to counsellor self-care.

Implications for researchers

The lack of a definition of brief therapy calls for greater transparency by researchers when reporting studies in published articles. In addition to the number of sessions,

indicators of frequency and duration of sessions would also be desirable, as well as the overall elapsed time since therapy. Further, indicators of planned versus unplanned endings would be helpful, especially with regard to outcome studies. Specifically, we would encourage the analysis and reporting of results which differentiate outcomes attributed to planned endings versus unplanned endings, such that a clearer understanding of the efficacy of offering "intentionally brief"' therapy can be established. Similarly, the acknowledgement that outcomes across different stages or episodes of therapy are not homogeneous indicates the need for more differentiated outcome measures. Here, there is potential to utilise individualised outcome measures such as the Personal Questionnaire (Elliott et al., 2015) which allow clients to articulate in their own words what they are wanting to work on in therapy.

More generally, additional research into discerning different stages, episodes, or phases of therapy would potentially assist in constructing a more nuanced view of the process of brief therapy, and assist with a more coherent conceptualisation of "intentional" brief work. This would also allow for further research into the significant relational, therapist, and client factors at different stages/episodes/phases of therapy. Unfortunately, the dominant paradigm of evidence-based practice tends to focus on a differentiation in terms of what interventions demonstrate a cure for which particular presenting issues. This presents a rather blunt tool in terms of clients' idiosyncratic and differentiated engagement with therapy services over time. Here it is important that research begins to be much more interested in the longitudinal process and outcome of clients' therapeutic journeys rather than focusing on one-off interventions.

Implications for educators

Returning to the beginning of this article, Manthei (2012) has challenged us to consider that training in brief therapy should be central to all counsellor education programmes. Reflecting on our own training experiences as both trainee and trainer, we can see that there is indeed a challenge here. The complexity of framing brief therapy in terms of our overarching theme of *constant but not excessive pressure* implies an advanced use of therapeutic skills. Is this too advanced for an initial counsellor training? Is this imposing too much pressure on trainee counsellors to perform consistently? There would seem to be potential for significant confounding between appropriate heightened activity and the need to "get it right" or to "fix" a client. On the flip side, if brief therapy is as effective as longer term therapy, it would seem to be ethically questionable to train future practitioners in anything other than brief therapy. Here

we agree with Manthei (2017) that "counsellor educators should ensure that the curriculum includes the teaching of the values, attitudes, procedures, and techniques of 'working briefly' with clients" (p. 34).

We would also urge further research and inquiry into what facilitates students to cultivate a positive attitude towards offering "intentionally brief" therapy. One possible avenue here is to frame therapy in terms of more differentiated "chunks" of work such as the Norcross et al. (2011) stages of change model. From this perspective, longer term work can be conceptualised as a contiguous sequence of these more differentiated chunks, while brief therapy can be seen as intentionally attending to a specific chunk of work. Different modalities or approaches to therapy might well conceptualise chunks of work in different ways, such as Rogers' (1958) seven-stage model, or Leiper and Maltby's (2004) dynamic spiral of change. The key here is that trainees are facilitated to conceptualise their work intentionally in more differentiated stages rather than "counselling to the point of cure" as Manthei (2016) intimates.

Conclusion

This review raises some important questions about how intentionally brief therapy is defined in the literature. At present, there would seem to be a lack of clear definition separating the different types of "short term" therapy, which inherently confounds any attempts to identify the efficacy of brief therapy. Further, different modalities articulate different views of "what works" about brief therapy. The findings of this review offer an integrative conceptualisation of effective brief therapy in the form of a "pressure cooker" where *constant but not excessive pressure* is exerted through the interaction between an *active therapist* and a *ready-and-willing client* supported by a *collaborative, transparent and sensitive therapeutic relationship*.

In the field of brief therapy, a key focus in the future is addressing the need for greater differentiation among the stages/episodes/phases of client change. This would enable more nuanced investigation into how clients can make best use of therapy of limited duration, rather than an undifferentiated attempt to "cure" all who attend counselling, whether or not they are ready for it. This is also seen as an important development for the training of future therapists, such that they are better positioned to meet the unique and particular needs of clients at different stages in their therapeutic journey.

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