Brief therapy in adult psychiatry

Alasdair J. Macdonald*

Forty-one of forty-four referrals to a multidisciplinary team providing brief therapy in adult psychiatry were followed up after one year. Questionnaires were sent to attenders and their general practitioners. A good outcome was reported in 29 cases (70%) while four cases (10%) were worse. Good outcome was linked with more therapy sessions and having specific goals for treatment. Lower social class did not predict poor outcome, unlike other forms of psychotherapy. Benefit was not linked to age, sex, place of residence, duration of problem, source of referral, those attending, inpatient status or lapse from treatment. Long-standing problems did slightly less well. The 'worse' group were younger and all four were female. Training of the team took place during therapy at little extra cost without any detriment to outcome. These findings have implications for the team's approach and for the provision of psychotherapy services in general.

Introduction

Family therapy of all types is recognized as an effective treatment in child and adolescent psychiatry and in social work. Only a small number of reports exist of its use in adult psychiatric settings (see, for example, Bloch et al., 1991). In this era of community care, the need to assess and modify family interactions is an increasing part of all psychiatric services. Wilkinson and van Boxel (1992) have drawn attention to the importance of training in family work in general psychiatry for all professions involved with patients of all ages. In addition, financial and staffing limitations mean that all therapies are required to be cost-effective and short-term as far as this can be achieved. The study reported here describes our attempts to address some of these issues.

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Method

Therapy style

In the cases reported here, we used brief therapy of the type described by Fisch et al. (1982). The basic assumptions are that problems are many, but that unsuccessful solutions fall into a few recognizable types. Clients persist with unsuccessful solutions leading to a feedback loop which maintains the problem. We seek concrete descriptions of how the problem appears to the attenders. Goals and first steps towards them are then described. The team highlights the attenders' existing skills and recommends tasks which obstruct ineffective solutions. This allows patients to use their own problem-solving skills, usually to good effect. As a result, therapy requires limited data collection and is usually completed within a small number of sessions.

Case example. A young mother complained of obsessional handwashing. She fought constantly but unsuccessfully against this impulse and was regularly criticized by her husband for her failure to control it. Handwashing occurred about 30 times daily. Her goal was to reduce it to 10 times daily by gradual steps. The team reframed her behaviour as a maternal attempt to protect her child from infection and she was advised not to reduce below 25 times daily in the first month. Her husband agreed to supervise this task. When she was seen again four weeks later her anxiety and the handwashing were much reduced, as was her husband's criticism. Further similar advice was given and the couple regarded the problem as resolved after three months (four interviews in all). Handwashing at that time had reduced to about 10 times daily but they no longer bothered to count it or to talk about it.

Our Brief Therapy Team is made up of mental health professionals from several disciplines. We use a one-way screen and prefer to videotape all sessions. One team member acts as the key worker and makes all contacts with the attenders and outside agencies. The teams are anonymous, passing messages to the therapist via an earphone and meeting with the therapist for discussion during breaks. The structure of the clinic is described in more detail elsewhere (Macdonald, 1990; Bowditch, 1991). The team includes trainee therapists from several disciplines. Only one member (the author) had previous experience of this approach. The technique has proved easy to teach and applicable to work in other areas of the Mental Health Unit such as wards and day hospitals.

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The team receives referrals from general practitioners, consultant psychiatrists and other health care professionals. The Mental Health Unit of which our team is a part serves a scattered rural population and has a long history of traditional high quality hospital-based care. We exclude patients with acute psychosis but do not select referrals in any other way. Referring agents may select cases where they see family issues as relevant, but otherwise the range of problems referred is very wide.

Clients themselves decide who will come to sessions although we invite all family members. We assess motivation by looking for ‘customers’ who seek change, ‘complainants’ who seek change in others, and ‘visitors’ who do not wish change at this time. Tasks are modified according to our assessment of motivation on this basis. We will specifically invite other family members or significant others if we think this relevant. We rarely exclude anyone but may choose to see certain combinations of family members. Discharge may be negotiated or may be decided by the family.

Our attenders are sent a leaflet in advance outlining the basic structure for therapy. We include a detailed explanation of their rights in relation to videotaping along the lines recommended by Birch (1990), using this as a first step towards involving them in therapy and in decision-making about their own goals and plans.

Follow-up design

This is derived from the descriptions in Watzlawick et al. (1974) and de Shazer (1985). One year after their last session, all clients receive a postal questionnaire asking: Is the problem solved? Were your goals for therapy achieved? Have other problems been solved at the same time? Have new problems appeared? Has further involvement with mental health professionals been necessary? Comments on the therapy style and setting are also sought. At the same time we write to all the general practitioners asking if the problem is better, worse or the same. Again, any additional comments are requested. We chose one year for follow-up, as a shorter period might reflect a ‘honeymoon’ effect of therapy and over a longer period further life events might obscure the outcome.

The study had the approval of the Dumfries and Galloway Ethical (Research) Committee. Statistical calculations followed Swinscow (1983) and Siegel (1956).
Results

The study period covers three years. Forty-eight cases were referred, but four did not attend. Forty-three sets of questionnaires were sent out, one case having been lost to follow up. In two cases the patients had left the area and no information could be obtained. The sample is therefore based on the 41 remaining cases. Replies were received from 26 patients (63%) and 37 general practitioners (90%). In 15 cases, general practitioners replied but the patients did not.

The identified patients ranged in age from 20 years to 70 years (mean 37.32 years, SD 10.77). There was no significant age difference between male and female groups. The social class distribution of the sample differed from the local population as shown in Table 1.

The duration of the problem to be treated was classified as ‘short’: less than one year; ‘medium’: one to three years’ duration; ‘long’: over three years. In this series, 20 cases had a short history, nine cases a long history and 12 reported problems for one to three years.

The length of contact with the 41 cases ranged from one to 15 months (mean 3.84 months, SD 3.8). The number of sessions ranged from one to 13 (mean 3.71 sessions, SD 3.22). The length of treatment and number of sessions correlated well together ($r = 0.907$, significance $p < 0.001$).

In view of this close correlation, number of sessions has been preferred throughout the calculation of results as being a more accurate measure of treatment activity. Male and female groups differed significantly by number of sessions. The 14 male identified patients attended for one to five sessions (mean 2.00, SD 1.41) while the 27 female identified patients attended for one to 13 sessions (mean 4.59, SD 3.54). This difference is significant, $p < 0.001$ (standard error of means).

<table>
<thead>
<tr>
<th>TABLE 1 Social class distribution</th>
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<tbody>
<tr>
<td></td>
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<tr>
<td>Population %</td>
</tr>
<tr>
<td>Sample %</td>
</tr>
<tr>
<td>All sample</td>
</tr>
<tr>
<td>‘Good outcome’</td>
</tr>
</tbody>
</table>

Differences between ‘all sample’ and ‘good outcome’ not significant
(Wilcoxon rank sum test (unpaired))

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Outcomes

'Good outcome' means either that the patients themselves reported that the problem was solved or that the general practitioner reported that the problem was solved if information from the patient was not available. The patient's response was preferred in all cases if there was a choice. By this definition a good outcome was reported in 29 cases (70%).

Information from both patient and GP was available for 22 cases and the two sources agreed in 14 cases of whom 12 were described as 'better'. Of the 'good outcome' cases combined data were available for 17, of whom 12 (71%) were described as 'better'. The differences between these figures were not significant.

There were no significant differences between the 'good outcome' group and the total sample in terms of age, social class or district of residence. The duration of the problem in the 'good outcome' group was 'short' in 15 cases, 'medium' in seven cases and 'long' in seven cases. These figures are not significantly different from the main sample. Five of the nine 'long' cases had received further advice after leaving brief therapy, as against five of the 27 'short' and 'medium' cases. Similarly, five of the nine 'long' cases had developed new problems as against five of 27 'short' and 'medium' cases. These differences are significant, $p < 0.05$ ($\chi^2 = 4.1, df 1$).

The characteristics of the 'good outcome' group in terms of sex distribution, source of referral, those who attended, the existence of significant others who did not attend, whether the identified patient was in hospital at the time of referral and whether they were discharged or lapsed from treatment are summarized in Table 2. No significant differences were found on any of these variables.

The outcomes reported by patients and general practitioners separately are summarized in Table 3. The number of sessions did not affect outcome directly. Eight 'good outcome' cases and five other cases had only one treatment session; this difference is not significant.

Problems

Problems were defined in the clients' terms so are not easily summarized. A separate formal 'research' assessment was not feasible. Sixteen of the presenting problems could be regarded as linked to anxiety or tension. Eleven of the presenting problems were defined in terms of relationships and five in terms of eating or weight
<table>
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<th>Table 2: Between-group characteristics</th>
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<tr>
<td>Sex</td>
</tr>
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<tr>
<td>All sample 14 M 27 F</td>
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<tr>
<td>‘Good outcome’ 10 M 19 F</td>
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TABLE 3 Outcome and number of sessions

<table>
<thead>
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<th>N</th>
<th>Range</th>
<th>Mean</th>
<th>SD</th>
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<tr>
<td><strong>Patient</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>better</td>
<td>17</td>
<td>1-13</td>
<td>5.47</td>
<td>4.05</td>
</tr>
<tr>
<td>same</td>
<td>7</td>
<td>1-4</td>
<td>2.29</td>
<td>1.38</td>
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<tr>
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<td>3-5</td>
<td>4</td>
<td>1.41</td>
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<tr>
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<td>1-5</td>
<td>2.67</td>
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<td><strong>GP</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>better</td>
<td>27</td>
<td>1-12</td>
<td>3.3</td>
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<td>6.5</td>
<td>7.78</td>
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<tr>
<td>same/worse combined</td>
<td>10</td>
<td>1-13</td>
<td>5.4</td>
<td>4.14</td>
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</table>

(Patient—better vs. same/worse combined significant $p < 0.046$ (standard error of means))

preoccupations. Four patients reported depressed mood and two described sexual problems. Three patients, who were all male, mentioned alcohol as part of the problem, while one patient complained of excessive spending and another complained of persistent nightmares. A good outcome was reported in 13 of the patients with anxiety or tension problems, 10 of the patients with relationship problems and three patients with eating or weight concerns. Two depressed patients improved, as did all three drink-related problems. One patient with a sexual difficulty reported an improvement.

When asked to choose their goals 15 chose specific achievements such as weight targets or 'one day in a week without an argument', and 14 succeeded. Seventeen chose to stop specified unwanted behaviours and 12 succeeded. Nine could only identify general non-specific benefits to themselves or others and were successful in three cases. The increased achievement of goals by those who identified specific targets is significant at the 1% level ($\chi^2 = 7.11$, $df$ 1).

The replies from patients and general practitioners in terms of achievement of therapy goals are shown in Table 4. A difference in goal achievement between the 'good outcome' group and the remainder is significant at the 1% level ($\chi^2 = df$ 1). Additional problems were resolved in some cases and new problems also occurred in a number of cases. The differences between groups on these points were not significant. Some patients had received other advice or continuing support from other mental health professionals but again the differences between groups were not significant. A
<table>
<thead>
<tr>
<th></th>
<th>Goal achieved</th>
<th>Other problem solved?</th>
<th>New problems?</th>
<th>Other advice since?</th>
<th>Patient comment</th>
<th>GP comment</th>
</tr>
</thead>
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<tr>
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<td>Yes 14</td>
<td>Yes 5</td>
<td>Yes 4</td>
<td>Yes 7</td>
<td>Favourable 7</td>
<td>Favourable 8</td>
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<td>No 12</td>
<td>No 10</td>
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<td>Unfavourable 3</td>
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<tr>
<td></td>
<td>No 0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Others</td>
<td>Yes 13</td>
<td>Yes 2</td>
<td>Yes 5</td>
<td>Yes 3</td>
<td>Favourable 6</td>
<td>Favourable 3</td>
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<tr>
<td></td>
<td>No 9</td>
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</table>

Goal achieved yes/no: significant difference $p < 0.01$ ($\chi^2 = 5.61, df = 1$)
variety of comments were received from both patients and general practitioners.

Because the Brief Therapy team was a new development all the therapists were novices initially. We therefore analysed the cases to look for evidence of changes in effectiveness over time. However, no significant variations in our success rate emerged. Referrals came from general practitioners and consultant psychiatrists in equal proportions throughout the study period.

‘Worse’ group

Worsening of symptoms was reported by two cases while the GP reported a worse situation for one. In one instance improvement was reported by the client while the GP reported worsening: this occurred because of a wide time interval between the two replies, during which further treatment was received elsewhere. In this case the goal (weight gain) was reported to be achieved, unlike the others in the ‘worse’ group.

The four ‘worse’ cases were significantly younger (mean age 25.5 years, SD 5.88; \( p < 0.001 \) by standard error of means). All four identified patients were female and one was an inpatient when brief therapy began. The ‘worse’ group did not differ significantly from the main sample in relation to source of referral, those who attended, length of disorder, duration of treatment, choice of goals, lapse from treatment, development of new problems or need for other advice. These cases were evenly spread through the study. Two unfavourable comments about the therapy came from these patients out of four in total.

Discussion

In this study we found a good outcome in 65% of cases as reported by patients themselves. This appeared to be associated with longer attendance, the mean being 5.47 sessions against 3.71 in the unimproved group. This in turn may reflect greater motivation, known to be a critical variable in psychotherapy outcome.

General practitioners regarded the patients as better in 71% of cases. This is important because general practitioners are often the true ‘customers’ of the mental health services in the UK. They will direct their patients and their funds towards agencies or services which appear to provide good results at an acceptable cost.

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Combining reports from patients and general practitioners, we have an overall good outcome in 70% of cases. This is considerably better than average for most treatments available in general psychiatry.

Our results compare with a similar study of brief therapy in unselected referrals by Watzlawick et al. (1974). They reported results from 97 cases six months after completing treatment. Thirty-nine were recovered and 31 improved (72%); the remainder were treatment failures. In our study four cases were worse (10%) and eight cases were unchanged. Using brief therapy as intervention in a counselling service for police staff, Bodin (1981) achieved improvement in 30 of 34 cases closed in the first year (88%) and in 60 of 76 cases closed in the second year (79%). By definition his cases had short histories and occurred in a relatively able client group. In our study some attenders had lengthy histories but this did not seem directly related to outcome.

Chase and Holmes (1990) conducted an audit of family therapy in adult psychiatry over a two-year period. The treatment offered was a mixture of structural and strategic family therapy. They found symptomatic improvement in 23 of 34 families (68%) when reviewed after one to two years.

The presenting symptoms of our attenders were similar to those seen at local adult outpatient clinics. As in many other studies we have shown that outcomes are similar whether patients are formally discharged or simply choose not to attend further. This mirrors experience in general practice where a good outcome is assumed in most cases if the patient stops attending.

The social class distribution is of interest. Our sample did not differ significantly from the general population of this region and the ‘good outcome’ group did not differ from the main sample. To us this suggests that brief therapy is helpful to patients from all social classes, in contrast to most other forms of psychotherapy, which tend to favour the higher social classes and those of a higher educational level. Especially in a socialized medicine system, it is important to offer treatments which meet the needs of economically or socially disadvantaged groups.

We are assuming in this discussion that the outcome at one year is associated with having been in therapy. However, the link in our findings between specified goals and satisfaction with outcome overall does support this assumption. The effect was less for negatively defined goals and least for non-specific goals. There is increasing

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evidence from psychotherapy outcome research that goal-setting is helpful to outcome and that this effect is greater when the patient plays a major part in the selection and definition of goals. This is reviewed in detail by Koss and Butcher (1986), who also note the importance of keeping the focus of therapy on the goals chosen and of staying in the ‘here and now’ during therapy as far as possible. Our own therapy experience confirms these comments. Because therapy is brief and we do not select referrals in advance we can usually offer appointments quickly, which Koss and Butcher also identify as helpful.

We do not know whether other treatments given concurrently with brief therapy influenced the outcomes reported. For resource reasons it was not possible to collect this information as a part of the study. We do know that some of our clients had received many previous treatments without benefit. In some cases referrers clearly saw brief therapy as a last resort.

As well as the identified goals, other problems were reported to improve in five ‘good outcome’ cases and two other cases, a finding noted in other studies of brief therapy (Weakland et al., 1974; de Shazer, 1985). By contrast, new problems had appeared in four of the ‘good outcome’ cases and five of the remainder. Seven of the ‘good outcome’ group had received additional advice or help from other professionals during the follow-up period, as had three of the unimproved group. Long-standing cases were more likely to have received other advice since discontinuing brief therapy and to have developed new problems.

Our treatment package is economical to provide and does not lead to prolonged service use or therapist dependency. Outcome rates did not vary over time, suggesting that the team method described makes good use of scarce expertise. Experiential training in this fashion appeared both rapid and effective, the team offering support to novice therapists while simultaneously protecting the families from errors due to inexperience. It is encouraging for novice therapists to see rapid results. Training and treatment occurred together, so the costs of training were low.

Brief therapy is readily compatible with other treatments for those who require more than one approach. It often takes less time than the length of the waiting list for other forms of psychotherapy. Our work has attracted increasing interest (and referrals) from other staff within the Mental Health Unit. An ability to work confidently with families is essential to all staff who will be working outside traditional mental
health institutions. Given these various advantages and the results reported, we hope to see brief therapy being used more widely both locally and nationally in psychiatric services.

Acknowledgements

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References


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