Substance Abuse and Mental Health Services Administration

Center for Substance Abuse Treatment

Brief Interventions and Brief Therapies for Substance Abuse

Treatment Improvement Protocol (TIP) Series

34

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3 Brief Therapy in Substance Abuse Treatment

Brief therapy is a systematic, focused process that relies on assessment, client engagement, and rapid implementation of change strategies. Brief therapy providers can effect important changes in client behavior within a relatively short period. The brief therapies presented in this TIP should be seen as contained modalities of treatment, not episodic forms of long-term therapy.

However, in the literature and in practice, the term "brief therapy" covers a wide range of approaches to treatment of varying lengths and with a variety of goals. Brief therapies usually consist of more (as well as longer) sessions than brief interventions. The duration of brief therapies is reported to be anywhere from 1 session (Bloom, 1997) to 40 sessions (Sifneos, 1987), with the typical therapy lasting between 6 and 20 sessions. Twenty sessions usually is the maximum because of limitations placed by many managed care organizations. Any therapy may be brief by accident or circumstance, but the focus of this TIP is on *planned* brief therapy. The therapies described here may involve a set number of sessions or a set range (e.g., from 6 to 10 sessions), but they always work within a time limitation that is clear to both therapist and client. In the following pages, all therapies described should be understood as planned or time limited.

Brief therapies differ from brief interventions in that their goal is to provide clients with tools to change basic attitudes and handle a variety of underlying problems. Compared with brief therapies, brief interventions are more motivational, seeking to motivate the client to make a specific change (in thought or action). (See Chapter 1 for more on how this TIP distinguishes brief therapies from brief interventions.)

Brief therapy differs from longer term therapy in that it focuses more on the present, downplays psychic causality, emphasizes using effective therapeutic tools in a shorter time, and focuses on a specific behavioral change rather than large-scale or pervasive change. A number of specific types of therapy are designed to be carried out in a brief period (e.g., cognitive–behavioral approaches are often designed to require fewer than 20 sessions). Many longer approaches have been or can be adapted; even lengthy psychodynamic approaches have been adapted for brief therapy with clear guidelines for their use (Davanloo, 1980; Luborsky, 1984; Mann, 1973; Sifneos, 1972; Strupp and Binder, 1984).

This chapter provides an overview of brief therapy in substance abuse treatment. First, the evidence for the efficacy of this approach is presented. The appropriateness of brief therapy is discussed next, and criteria are provided for determining duration of therapy. The components of all brief therapies are then discussed, including common characteristics

and steps in treatment. Finally, essential therapist knowledge and skills for conducting successful brief therapies are described.

The chapters following this present a cross-section of the approaches that are and have been used in brief therapy. No one approach is endorsed as the best or only approach for use with the range of persons with substance abuse disorders, nor are all of them considered by the Consensus Panel to be equally valid. Rather, the therapies in Chapters 4 through 9 were chosen because they either represent the most widely used brief therapies or they represent models that have good potential, are recommended by national experts, and will be of interest and assistance to providers who treat persons across the range of substance abuse disorders. Some of these approaches can be used with the whole range of people with substance abuse disorders; others are useful only for a smaller subset of that population. Each of the chapters that follows discusses a particular type of the individual therapies. However, each of the approaches described in Chapters 4 to 9 will provide useful techniques for the eclectic practitioner.

Research Findings

Research concerning the relative effectiveness of brief versus longer term therapies for a variety of presenting complaints is mixed. Some studies have found that planned, short-term therapies are as effective as lengthier (or unlimited) therapy (Koss and Shiang, 1993; Smyrnios and Kirkby, 1993). Other studies, such as the *Consumer Reports* mental health study (Seligman, 1995) and the National Institute of Mental Health (NIMH) Treatment of Depression Research Program (Blatt et al., 1995; Elkin, 1994), have found that longer term treatments generally lead to better outcomes as perceived by clients. Much depends on the modality being evaluated and the goals of the treatment. (More specific research evaluating different types of brief therapy is given in Chapters 4 to 9.)

There is, however, promising evidence that brief therapies as a treatment for substance abuse disorders are often as effective as lengthier treatments (Bien et al., 1993; Gottheil et al., 1998; McLellan et al., 1993; Miller and Hester, 1986a; Miller and Rollnick, 1991). These studies are positive but are primarily limited to program effectiveness studies with smaller sample sizes. Future research should both replicate previous work and use more rigorous designs that include experimental designs with randomization. Many of the fundamental questions about brief therapies—the optimum conditions under which they should be used, the economic cost-benefits, and level and type of provider, the most suitable types of clients—have yet to be studied.

The majority of clients in therapy (regardless of the modality) remain in treatment for between 6 and 22 sessions; 90 percent end treatment before completing 20 visits (Friedberg, 1999). The fact that many clients stay in therapy for relatively short periods of time suggests that brief therapy techniques should be much more common than they are in current clinical practice (Pekarik and Wierzbicki, 1986; Phillips, 1987). Many therapists trained in long-term treatment modalities choose not to use planned short-term therapies (Bloom, 1997). Alcohol and drug counselors often have to work with clients in a limited period of time, however, and could apply brief therapy techniques even when they are designed for treatment of different types of disorders and problems.

Because brief therapy is more effective than being on a waiting list, it could benefit many clients. Wolberg suggested that all clients seeking treatment be given brief therapy initially, before moving on to long-term treatments (Wolberg, 1980). Such an approach would help to reserve longer treatments for

clients with a greater need for them. However, there are clearly exceptions to this rule, such as clients who have a history of severe and persistent mental illness. Other criteria for assigning a client to longer term rather than brief therapy are presented in Figure 3-1.

Planned brief therapy can be adapted as part of a course of serial or intermittent therapy (Budman and Gurman, 1988; Cummings, 1990). When doing this, the therapist conceives a long-term treatment as a number of shorter treatments, which requires that the client's problems be addressed serially rather than concurrently. Because of insurance constraints, many therapists are now billing by episode and treating one problem at a time.

Brief therapy may prove to be a useful tool for reconceiving how therapy is delivered. For the treatment provider working with clients with substance abuse disorders, this means that a particular type of therapy could be applied to a specific problem associated with a client's substance abuse. By treating these allied problems, long-term goals, such as continued abstinence, may be more likely to be reached (Iguchi et al., 1997; McLellan et al., 1993).

When To Use Brief Therapy

Insufficient data are available to determine which populations would benefit most from brief therapy. Therefore, client needs and the suitability of brief therapy must be evaluated on a case-by-case basis. Some criteria for considering the appropriateness of brief therapy are presented in Figure 3-2. The American Society of Addiction Medicine (ASAM) client placement criteria for substance abuse treatment (ASAM, 1996) may also be useful for determining who could benefit from brief therapy (see discussion in Chapter 2).

Brief therapy may be appropriate for a moderate to heavy drinker such as a college student but inappropriate as the sole treatment for a commercial airline pilot who is alcohol dependent, no matter what the motivation is for treatment. Therapists must consider extenuating circumstances when recommending a particular course of treatment. In some programs, duration of therapy is determined mutually by the client and therapist; brief therapy may be the best option if the client objects to longer term treatment or if expense is an issue.

Research is needed to identify specific populations for which brief therapy would serve as the catalyst for resolution of substance abuse-related problems. The impact of brief therapy on chronically relapsing, substance-abusing persons has not been investigated. Because of these large gaps in research, therapists must rely on their clinical judgment to determine whether brief therapy is appropriate for a particular

Figure 3-1
Criteria for Longer Term Treatment

The following criteria can help identify clients who could benefit from longer term treatment:

- Failure of previous shorter treatment
- Multiple concurrent problems
- Severe substance abuse (i.e., dependence)
- Acute psychoses
- Acute intoxication
- Acute withdrawal
- Cognitive inability to focus
- Long-term history of relapse
- Many unsuccessful treatment episodes
- Low level of social support
- Serious consequences related to relapse

Figure 3-2
Selected Criteria for Providing Brief Therapy

- Dual diagnosis issues such as a coexisting psychiatric disorder or developmental disability
- The range and severity of presenting problems
- The duration of abuse
- Availability of familial and community supports
- The level and type of influence from peers, family, and community
- Previous treatment or attempts at recovery
- The level of client motivation (brief therapy may require more work on the part of the client but a less extensive time commitment)
- The clarity of the client's short- and long-term goals (brief therapy will require more clearly defined goals)
- The client's belief in the value of brief therapy ("buy in")
- Large numbers of clients needing treatment

The following criteria are derived from clinical experience:

- Less severe substance abuse, as measured by an instrument like the Addiction Severity Index (ASI)
- Level of past trauma affecting the client's substance abuse
- Insufficient resources available for more prolonged therapy
- Limited amount of time available for treatment (e.g., 7-day average length of stay in county–jail-level correctional facilities; 30- to 45-day limitation in Job Corps program)
- Presence of coexisting medical or mental health diagnoses
- Large numbers of clients needing treatment leading to waiting lists for specialized treatment

client and what kind of modality would be most effective.

The best outcomes for brief therapy may depend on the therapist's skills, comprehensive assessments, and selective criteria for eligibility. Using selection criteria in prescribing brief therapy is critical, since many clients will not meet eligibility. The Consensus Panel hopes that brief therapy will be adequately investigated before managed care and third-party payors decide it is the only modality for which they will pay.

Brief therapy for substance abuse treatment is a valuable but limited approach, and it should *not* be considered a standard of care for all populations. In fact, time in treatment has been found to be directly related to better outcomes within a range of modalities, including therapeutic communities, psychotherapy, methadone maintenance therapy, and extended detoxification (Hubbard et al., 1997). Therefore, although brief therapy is a useful tool in a portfolio of interventions, its use should be targeted to those clients who are most likely to benefit.

Determining when to use a particular type of brief therapy is also an important consideration for counselors and therapists. Counselors recognize that not all clients are at the same stage in their readiness for treatment. Currently, the most widely used model for understanding clients' readiness for change is Prochaska and DiClemente's stages-of-change model, which is discussed in Chapter 2. (For more information about this model, see also TIP 35, *Enhancing Motivation for Change in Substance Abuse*

Treatment [CSAT, 1999c].) Counselors who use this model will have to determine which therapy is compatible with the client's stage of readiness for change and the tasks needed to move forward in the change process and develop an overall understanding of the course of change (DiClemente and Scott, 1997).

Clinical interventions should be targeted to the client's stage of readiness for change to increase his motivation to change behaviors and to augment a sense of empowerment in recovery. Therapies that work with experiential processes (such as consciousness raising, self-reevaluation, and a cognitive restructuring) are more important for understanding and predicting transition from preparation to action and from action to maintenance (Prochaska et al., 1994). Seeking and processing information, observing others, and gathering useful information in light of the client's situation are the primary activities reported most frequently during the contemplation stage (Prochaska et al., 1992). Especially during this early stage the client should be provided with information regarding addiction as well as confronted with the short- and long-term consequences of continued use. Asking the client to perform a risk appraisal of continued use as well as a benefit/risk-reduction appraisal of achieving abstinence can facilitate sound decisionmaking that involves a comparison of all potential gains and losses (Janis and Mann, 1977).

Finally, it will be essential to learn the client's perceived obstacles to engaging in treatment as well as to identify any dysfunctional beliefs that could sabotage the engagement process. The basic assumption behind this approach is that the way individuals evaluate a situation and cope with it determines their emotional reaction to it (Ellis and Grieger, 1977). The critical factor in determining an individual's response is the client's self-perception and associated emotions. The therapist should help the client recognize the messages she gives herself and help her correct problematic thinking patterns and dysfunctional beliefs (Kendall and Turk, 1984). Often, dysfunctional beliefs lead to low levels of perceived self-efficacy and subsequent inability to adopt or maintain the desired behavior (Bandura, 1986). It is important to note that self-efficacy shifts in a predictable way across the stages of behavior change, with clients progressively becoming more efficacious as they move through the stages (Marcus et al., 1992; Prochaska et al., 1994).

Approaches to Brief Therapy

Brief therapy uses a selected process to change a specific problem based on an underlying theory about the cause of the problem or the best way to encourage positive change. Figure 3-3 lists several therapeutic approaches that are applicable to brief therapy. These approaches can be used with clients with different types of problems and varying degrees of substance abuse severity.

Components of Effective Brief Therapy

Although different models of brief therapy may stress certain goals and activities more than others, all brief therapies have common characteristics (see Figure 3-4). In addition, brief therapies should incorporate several stages, including screening and assessment, an opening session that includes the establishment of treatment goals, subsequent sessions, maintenance strategies, ending treatment, and followup. These stages are discussed below.

Screening and Assessment

Screening and assessment are critical initial steps in brief therapy. Screening is a process in

Figure 3-3

Approaches to Brief Therapy

Approaches	Description
Cognitive therapy	This therapy posits that substance abuse disorders reflect habitual, automatic, negative thoughts and beliefs that must be identified and modified to change erroneous ways of thinking and associated behaviors. The desire to use substances is typically activated in specific, often predictable high-risk situations, such as upon seeing drug paraphernalia or experiencing boredom, depression, or anxiety. This approach helps clients examine their negative thoughts and replace them with more positive beliefs and actions. Many relapse prevention strategies use cognitive processes to identify triggering events or emotional states that reactivate substance use and replace these with more healthful responses. (See Chapter 4 for more information.)
Behavioral therapy	Using this approach, which is based on learning theories, the therapist teaches the client specific skills to improve identified deficiencies in social functioning, self-control, or other behaviors that contribute to substance use disorder. Some of the techniques that are used include assertiveness training, social skills training, contingency management, behavior contracting, community reinforcement and family training (CRAFT), behavioral self-control training, coping skills, and stress management. (See Chapter 4 for more general information on behavioral therapy and Chapter 8 for more information on CRAFT and other behavioral family therapies.)
Cognitive–behavioral therapy	This approach combines elements of cognitive and behavioral therapies, but in most substance abuse treatment settings it is considered a separate therapy. This approach focuses on learning and practicing a variety of coping skills. The emphasis is placed on developing coping strategies, especially early in the therapy. Cognitive–behavioral therapy is thought to work by changing what the client does and thinks rather than just focusing on changing how the client thinks. (See Chapter 4.)
Strategic/ interactional therapies	These approaches seek to understand a client's viewpoint on a problem, what meaning is attributed to events, and what ineffective interpersonal interactions and coping strategies are being applied. By shifting the focus to competencies, not weaknesses and pathology, the therapist helps clients change their perception of the problem and apply existing personal strengths to finding and applying a more effective solution. (See Chapter 5.)
Solution-focused therapy	Using this approach, the therapist helps a client with a substance abuse disorder recognize the exceptions to use as a means to reinforce and change behavior. Future behavior is based on finding solutions to problem behaviors. Little or no time is spent talking about the problem; rather, therapy is focused on solutions that have already worked for the client in the past. (See Chapter 5.)

Figure 3-3 (continued)
Approaches to Brief Therapy

Approaches	Description
Humanistic and existential therapies	These therapies assume that the underlying cause of substance abuse disorders is a lack of meaning in one's life, a fear of death, disconnectedness from people, spiritual emptiness, or other overwhelming anxieties. Through unconditional acceptance, clients are encouraged to improve their self-respect, self-motivation, and growth. The approach can be a catalyst for seeking alternatives to substances in order to fill the emptiness experienced and expressed as substance abuse. (See Chapter 6.)
Psychodynamic therapy	The psychodynamic therapist works with the assumption that a person's problems with substances are rooted in unconscious and unresolved past conflicts, especially in early family relationships. The goal is to help the client gain insight into underlying causes of manifest problems, understand what function substance abuse is serving, and strengthen present defenses to work through the problem. A strong therapeutic alliance with the therapist assists the client to make positive changes. (See Chapter 7.)
Interpersonal therapy	This therapy, which combines elements of cognitive and psychodynamic therapies, was originally developed to work with clients with depression but has been used successfully with substance-abusing clients. It focuses on reducing the client's dysfunctional symptoms and improving social functioning by concentrating on a client's maladaptive patterns of behavior. It is supportive in nature, providing encouragement, reassurance, reduction of guilt, and help in modifying the client's environment. (See Chapter 7 for more information.)
Family therapy	While not a distinct "school" of therapy, family therapy is a modality that either treats the client as part of a family system or considers the entire family as "the client." It examines the family system and its hierarchy to determine dysfunctional uses of power that lead to negative or inappropriate alignments or poor communication patterns and that contribute to substance use disorder by one or more family members. The therapist helps family members discover how their own system operates, improve communication and problem-solving skills, and increase the exchange of positive reinforcement. (See Chapter 8.)
Group therapy	This modality (also not a distinct theoretical school) uses many of the techniques and theories described to accomplish specified goals. In some group therapy, the group itself and the processes that emerge are central to helping clients see themselves in the reactions of others, although the content and focus of the groups vary widely. (See Chapter 9.)

Figure 3-4

Characteristics of All Brief Therapies

- They are either problem focused or solution focused; they target the symptom and not what is behind it.
- They clearly define goals related to a specific change or behavior.
- They should be understandable to both client and clinician.
- They should produce immediate results.
- They can be easily influenced by the personality and counseling style of the therapist.
- They rely on rapid establishment of a strong working relationship between client and therapist.
- The therapeutic style is highly active, empathic, and sometimes directive.
- Responsibility for change is placed clearly on the client.
- Early in the process, the focus is to help the client have experiences that enhance self-efficacy and confidence that change is possible.
- Termination is discussed from the beginning.
- Outcomes are measurable.

which clients are identified according to characteristics that indicate that they are possibly abusing substances. Screening does not inform the therapist of the severity of the individual client's substance abuse, only its presence and, in some cases, broad indications of risk. Screening identifies the need for more in-depth assessment and is not a substitute for an assessment.

Assessment is a thorough, extensive process that involves a broad analysis of the factors contributing to and maintaining a client's substance abuse, the severity of the problem, and the variety of consequences associated with it. Screening and assessment procedures for brief therapy do not differ significantly from those used for lengthier treatments.

The assessment should determine whether the client's substance abuse problem is suitable for a brief therapy approach. The criteria for determining the appropriateness of brief therapy, presented in Figures 3-1 and 3-2, are first applied during the assessment stage.

It is reasonable to assume that brief therapies are most effective with clients whose problems are of short duration and who have strong ties to family, work, and community. However, limited client resources may also dictate the use of brief therapy. For example, if a client lacks the financial means to participate in a longer treatment process, a brief therapy approach is imperative. Some treatment is almost always better than no treatment. In addition, brief therapy may be indicated for clients who resist longer treatment, rather than risk the loss of an otherwise motivated client. (Technical Assistance Publication [TAP] 21, *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice* [CSAT, 1998a] contains further guidance on screening and assessment for brief therapy.)

Therapists should gather as much information as possible about a client before the first counseling session. One way to do this is to obtain copies of any notes taken by an intake worker or the referral source. However, when gathering information about a client from other sources, therapists should be sensitive to confidentiality and client consent issues (for more information see the section entitled "Confidentiality of Information About Clients" in Chapter 9 of the forthcoming TIP, *Substance Abuse Treatment for Persons With HIV/AIDS* [CSAT, in press]). Other options include asking intake workers to administer questionnaires, using computerized assessments, or asking the

client to complete an assessment form before the first session. The assessment instrument can be brief and informal, generating critical information in a short time. Although initial screening and assessment ideally should be conducted before the first therapy session, the process of assessment should continue throughout treatment.

A variety of brief assessment instruments, many of which are free, are available to clinicians. *Assessing Alcohol Problems* (National Institute on Alcohol Abuse and Alcoholism, 1995) is a useful source of research-validated instruments. Figure 3-5 provides a sample battery of brief assessment instruments that might be used in a brief therapy setting, ideally before the first counseling session. These instruments can provide the therapist with a quick assessment of the most critical domains about which clinical decisions should be made. In general, most clients can complete these instruments in less than 1 hour. These instruments should be supplemented in the first counseling session by a clinical assessment interview that covers the core areas outlined in the following section. For sample screening instruments and additional information on screening procedures see also TIP 24, *A Guide to Substance Abuse Services for Primary Care Clinicians*; TIP 26, *Substance Abuse Among Older Adults*; TIP 31, *Screening and Assessing Adolescents for Substance Use Disorders*; and TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (CSAT, 1997, 1998b, 1999a, 1999c).

For brief therapy, the setting in which treatment will occur frequently dictates the kind of assessment that can be conducted. Clients seek treatment in the type of agency they feel will best meet their needs (e.g., those who need to continue working while seeking treatment will likely enter an outpatient program). Constraints may be placed by insurance companies or other outside forces. For example, managed care environments generate their own assessment criteria. Assessment often must be conducted outside the treatment facility and may not qualify as a reimbursable visit. In addition, private practitioners often do not have easy access to background information

Figure 3-5
Sample Battery of Brief Assessment Instruments

Assessment Domain	Example Instrument(s)
Quantity/frequency of use	Timeline Follow Back Technique
Severity of dependence	Short Alcohol Dependence Data (SADD), Severity of Dependence Scales (SDS), CAGE
Consequences of use	Michigan Alcoholism Screening Test (MAST), Drug Abuse Screening Test (DAST), Substance Abuse Subtle Screening Inventory (SASSI), DRINK
Readiness to change	Commitment to Change Algorithm, SOCRATES
Problem areas	Problem Checklist from Comprehensive Drinker Profile, Problem Oriented Screening Instrument for Teenagers (POSIT), Adolescent Assessment/Referral System (AARS)
Treatment placement	Addiction Severity Index (ASI)
Goal choice and commitment	Intentions Questionnaire

Sources: Allen and Columbus, 1995; Miller, 1991.

regarding a potential client. In a primary care office, screening and assessment consist only of taking a client's history and conducting a physical examination.

Core assessment areas

Before proceeding with brief therapy for substance abuse disorders, a number of areas should be assessed, including the following:

- Current use patterns
- History of substance abuse
- Consequences of substance abuse (especially external pressures that are bringing the client into treatment at this time, such as family or legal pressures)
- Coexisting psychiatric disorders
- Information about major medical problems and health status
- Information about education and employment
- Support mechanisms
- Client strengths and situational advantages
- Previous treatment
- Family history of substance abuse disorders and psychological disorders

As mentioned earlier, assessment is critical not only before beginning brief therapy but also as an ongoing part of the process. Only by continually assessing the client's progress and problems can the therapist accomplish the goals of brief therapy in the limited timeframe. In addition, ongoing assessment can function as a therapeutic tool because it helps clients identify when they are at risk of using substances as well as other negative behaviors.

The Opening Session

In the first session, the main goals for the therapist are to gain a broad understanding of the client's presenting problems, begin to establish rapport and an effective working relationship, and implement an initial intervention, however small. The therapist must accomplish certain critical tasks during the first session, including

- Producing rapid engagement
- Identifying, focusing, and prioritizing problems
- Working with the client to develop possible solutions to substance abuse problems and a treatment plan that requires the client's active participation
- Negotiating the route toward change with the client (which may involve a contract between client and therapist)
- Eliciting client concerns about problems and solutions
- Understanding client expectations
- Explaining the structural framework of brief therapy, including the process and its limits (i.e., those items not within the scope of that treatment segment or the agency's work)
- Making referrals for critical needs that have been identified but can not be met within the treatment setting

Goals of treatment

Therapists should identify and discuss the goals of brief therapy with the client early in treatment, preferably in the first session. The client has a critical role in determining the goals of therapy, and the therapist might have to be flexible. The therapist can recommend treatment goals, but ultimately they are established through interaction and negotiation with the client. If a client has certain expectations of therapy that make it difficult for her to commit to the goals and procedures of brief therapy or to a particular therapeutic approach, other approaches should be considered or a referral made.

Treatment goals should focus on the central problem of substance abuse and may include the following:

- Making a measurable change in specific target behaviors associated with substance abuse
- Helping the client demonstrate a new understanding and knowledge of problems and issues related to substance abuse
- Improving the client's personal relationships
- Resolving other identified problems (e.g., work problems, support group attendance)

The goals of brief therapy may be more client driven than those developed in long-term therapies because, by design, the therapist does not have as long to shape these goals. A variety of goals besides those related to substance abuse disorders can be addressed effectively in a brief therapy modality, but given time constraints, therapists will have to limit the number of issues addressed. The key is to identify the goals most important to the client and to work with him to achieve those goals, keeping in mind the ultimate goal of sobriety or decreased use.

Although abstinence is an optimal clinical goal, it still must be negotiated with the client (at least in outpatient treatment settings). Abstinence as a goal is not necessarily the sole admission requirement for treatment, and the therapist may have to accept an alternative goal, such as decreased use, in order to engage the client effectively.

Subsequent Sessions

In subsequent sessions of brief therapy, therapists should

- Work with the client to help maintain motivation and address identified problems, monitoring whether any accomplishments are consistent with the treatment plan and the client's expectations
- Reinforce—through an ongoing review of the treatment plan and the client's expectations—the need to do the work of brief therapy (e.g., maintain problem focus, stay on track)
- Remain prepared to rapidly identify and troubleshoot problems
- Maintain an emphasis on the skills, strengths, and resources currently available to the client
- Maintain a focus on what can be done immediately to address the client's problem
- Consider, as part of an ongoing assessment of progress, whether the client needs further therapy or other services and how these services might best be provided
- Review with the client any reasons for dropping out of treatment (e.g., medical problems, incarceration, the emergence of severe psychopathology, treatment noncompliance)

Maintenance Strategies

Maintenance strategies must be built into the treatment design from the beginning. A practitioner of brief therapy must continue to provide support, feedback, and assistance in setting realistic goals. Also, the therapist should help the client identify relapse triggers and situations that could endanger continued sobriety.

Strategies to help maintain the progress made during brief therapy include the following:

- Educating the client about the chronic, relapsing nature of substance abuse disorders
- Developing a list of circumstances that might provide reasons for the client to return to treatment and plans to address them
- Reviewing problems that emerged but were not addressed in treatment and helping the client develop a plan for addressing them in the future (or identifying specific problems that might have emerged but were not dealt with in treatment)
- Developing strategies for identifying and coping with high-risk situations or the reemergence of substance abuse behaviors

- Teaching the client how to capitalize on personal strengths
- Emphasizing client self-sufficiency (encouraging the client to work through his own problems and stay focused on the goals that have been set in therapy) and teaching self-reinforcement techniques
- Developing a plan for future support, including mutual help groups, family support, and community support (e.g., religious or social service organizations), which can be done much earlier than in long-term therapy

In addition to routine progress assessments that are conducted throughout the therapy, midway through the agreed-upon number of sessions the therapist should formally review the client's progress. Particularly because of the time limitations of brief therapy, continuing assessments are essential to ensure that problems are addressed and that the client can recognize when she is most at risk of slipping into substance abuse or other negative behaviors. Assessments will also take into account the level of the client's progress. When the client has made agreed-upon behavior changes and has resolved some problems, the therapist should prepare to end the brief therapy. If a client progresses more quickly than anticipated, it is not necessary to complete the full number of sessions.

Ending Treatment

Termination of therapy should always be planned in advance. In many types of brief therapy, the end of therapy will be an explicit focus of discussion in which the therapist should

- Leave the client on good terms, with an enhanced sense of hope for continued change and maintenance of changes already accomplished
- Leave the door open for possible future sessions dealing with the client's other problems
- Elicit commitment from the client to try to follow through on what has been learned or achieved
- Review what positive outcomes the client can expect
- Review possible pitfalls the client may encounter (e.g., social situations, old friends, relationship issues) and talk about the likelihood of a good outcome and indicators of a poor outcome
- Review the early indicators of relapse (e.g., depression, stress, anger)

In brief therapy, issues regarding referral and followup are often different from those of longer term therapy because clients will not necessarily remain in contact with the therapist. If the goals of therapy have not been met, more intensive therapy may be suggested.

During continual assessment of the progress of the therapy, the therapist may decide that referral is appropriate before treatment ends. It is important to remember that referrals can be made at any time during treatment, not just at the end of the treatment process. Reasons for initiating referrals during or at the end of treatment include the following:

- The client needs ancillary services for other problems that have been recognized during therapy (e.g., medical or psychiatric problems).
- The client requires more intensive therapy.
- The client may benefit from involvement with a support group, such as Alcoholics Anonymous, Self-Management and Recovery Training (SMART), or Moderation Management (which may also be a part of the brief therapy process).

Followup

It is always advisable for the therapist to follow up with clients who have completed brief therapy. Followup reassures the client that the therapist is concerned about her progress. In addition, it is an effective way to gather much-needed data regarding treatment effectiveness. The therapist might obtain such data by conducting a client satisfaction survey via telephone or mail. Aftercare, when additional treatment is provided, is not part of the brief therapy process. However, followup activities such as offering reassurance and tracking client status are customary.

Therapist Characteristics

To successfully integrate different short-term therapies into practice, therapists benefit from a firm grounding in theory and a broad technical knowledge of the many different approaches available. When appropriate, elements of different brief therapies may be combined to provide successful outcomes. However, it is important to remember that the effectiveness of highly defined interventions (e.g., workbook-driven interventions) used in some behavioral therapies depends on administration of the entire regimen. The therapist must use caution in combining and mingling certain techniques and must be sensitive to the cultural context within which therapies are integrated. Therapists should also be sufficiently trained in the therapies they are using and should not rely solely on a manual such as this to learn those therapies. Appendix B provides some resources for further education.

Although therapists with many levels of training and experience can conduct brief interventions, certain skills and training are particularly important for conducting effective brief therapy. Those who specialize in providing brief therapy are likely to be more successful when grounded in a specific model of psychotherapy but possess a general understanding of other models from which appropriate techniques may be drawn. They should be adept at determining early in the assessment process the client needs or goals that are appropriate to address. Related to this, and equally important, therapists must establish relationships that facilitate referral when the client's needs or goals cannot be met through brief therapy. A comprehensive description of the professional and personal attributes that practitioners need to be effective providers of substance abuse treatment is provided in TAP 21, *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice* (CSAT, 1998a). TAP 21 emphasizes that practitioners should

- Be empathic
- Be able to integrate their training—whether in substance abuse treatment or other disciplines such as social work, medicine, nursing, or psychology—with experience, both professional and personal, to create the best therapeutic environment for the client
- Have a mature sense of personal and professional boundaries
- Be sensitive to the cultural and spiritual needs of the client
- Follow appropriate Federal, State, and agency regulations in the provision of substance abuse treatment services

Providers of brief therapy must focus effectively on identifying and adhering to specific therapeutic goals in treatment. They should be able to extract techniques from longer term therapies and adapt them within the parameters of brief therapy. The provider of brief therapy will have to focus on short-term change that can have long-term benefits and avoid issues that are more global. The therapist must be able to shift approaches depending on what is learned about the client during treatment.

Brief therapy is amenable to the use of a wide range of techniques from which the therapist can choose. It is therefore helpful for therapists to be aware of the broad range of therapeutic techniques available. Exposure to several psychotherapeutic approaches (many described in the following chapters) allows therapists to understand how other clinicians might approach the situation, what a client might have experienced in previous treatments, and how to build on these experiences.

Brief therapy for substance abuse disorders is often helpful, but should not be considered a standard of care for all persons or populations. Brief therapy, as presented in this TIP, can be a contained modality of treatment and not an episodic form of long-term therapy. In fact, successful brief therapy may be the only treatment some clients will require.

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