Brief psychological treatment in mental care

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General discussion
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Introduction

In the late 80’s of the last century clinicians from Dutch Community Mental Health Centres (CMHC’s)\(^4\) started, for a variety of reasons, to experiment with brief treatments (BT’s) limited to five or six sessions (Van Buuren & Schouten, 1994; SOGG, 1995). Although at that time there was already quite some literature about short-term treatment at an international level, it seemed that the BT-programmes developed in CMHC’s were not a copy of a particular treatment approach already clearly described and investigated. Despite the fact that little was known about the effects of these BT’s and it was even questioned whether such BT’s should belong to specialised mental health care (Ministerie van VWS, 1998), implementation of BT programmes continued.

Given this situation, we did two studies that addressed four main questions regarding these BT programmes. First, what is the state of affairs involving BT in the CMHC’s in 1998 and in particular how can the nature of these BT-programmes be characterised? Second, what patient characteristics make clinicians recommend BT? Third, for which of these BT-patients is BT successful? Fourth, what is the relation regarding working alliance, between patient and clinician, and the outcome of BT?

In the first study semi-structured interviews were held with respondents of all 57 Dutch CMHC’s, in order to get information about their BT-programmes (see chapter two). Because this study only gives insight in what respondents said clinicians were doing, a second study was conducted within six CMHC’s. In this open and naturalistic study it was assessed which patients are actually allocated by clinicians to BT (see chapter three). By following patients allocated to BT over a period of eight months it was possible to assess for which of these patients BT is successful and to make prediction models on the basis of baseline patient characteristics and two months follow-up working alliance scores\(^5\) (see chapter four and five).

Since the primary aim of BT is often to help patients who are stuck in a changing process by offering them the right tools to continue and finish this process on their own, the ‘stages of change’ described by Prochask a and DiClemente (1982; 1983) seemed an interesting concept to evaluate treatment progress. This concept was, however, hardly ever used within longitudinal research and, to the best of our knowledge, stage specific transitions were never assessed within a heterogeneous sample of CMHC-patients. Because of this lack of research the ‘stages of change’ concept was not chosen as an outcome measure for this study. However, in chapter six the possibilities of this concept as a measure of (treatment) progress is evaluated. So our fifth and last main research question was: can the ‘stages of change’ concept be used within a BT-population and in particular can it be used to evaluate (treatment) progress?

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\(^4\) In 1982 57 Regional Institutes for Community Mental Health Care (RIAGGs) were established in the Netherlands to guarantee a diversified set of ambulatory services. In the second half of the nineties RIAGGs started mergers with other regional organisations like mental hospitals and sometimes also psychiatric departments of general hospitals and regional institutes of sheltered living. In this article we will refer to these former RIAGGs and the ‘new’ organisation in which they have been incorporated, as ‘Community Mental Health Centres’ (CMHC’s).

\(^5\) See chapter one; figure 1.1 and 1.2 with regard to information about number of patients and clinicians that completed baseline and follow-up questionnaires and table 1.8 to 1.12 for the content of these questionnaires.
Before discussing the results, two issues that might influence the way in which the results have to be interpreted will be mentioned. First, three important developments that took place during the study period within mental health care in the Netherlands will be described. Second, some main decisions regarding the study design will be mentioned. After discussing the results, some methodological issues will be addressed. This general discussion will finish with some future research suggestions.

**Developments within Dutch mental health care**

Between 1997 (the start of our study) and today, there have been some major developments in mental health care in the Netherlands (Schene & Faber, 2001). Three of these developments influenced the establishment of BT-programmes in specialised mental health care. Firstly, the increasing number of people using specialised mental health care services made the government stimulate the ‘gatekeeper’ function of the general practitioner. At the same time a growing number of psychologists started to work in primary care, helping patients with less severe psychological problems. Secondly, there was an increasing number of regional fusions of organizations like Regional Institutes for Community Mental Health Care (Riaggs), general psychiatric hospitals and sometimes also psychiatric departments of general hospitals and regional institutes of sheltered living. At the time of our national survey only a few of the 57 Riaggs had been merged with other organizations, nowadays almost 80% of these Riaggs are integrated into new organisations. Finally, in the past few years there is a growing interest for implementing special programmes for defined target populations with specific psychiatric diagnosis (e.g. psychotic, mood, anxiety or personality disorders). From the perspective of quality of care, one tries to make these programmes evidence based, meaning that they have to be in accordance with existing professional national guidelines and also based on the experiences of clinicians and patients (and their families). These three developments in mental health care each have their influences on aspects of BT in specialised mental health care.

With primary care taking over part of the patient population with the less severe psychological problems, it seems plausible that part of the population that was allocated to BT in the CMHC’s in the 90’s is now being treated in primary care. Regional fusions and the implementation of special programmes for defined target populations made many CMHC’s re-evaluate the implementation of BT-programmes. These developments lead to discussions about whether or not one should (again) implement an (already existing) BT-programme in the (new) organization and if so, they had to decide on the content of the BT-programme, the patient-population eligible for this programme and the place of such a programme within the organization. Should it be situated at the ‘front-door’, at the beginning of some (or all) of the special programmes for defined target populations, or should it be seen as an independent programme by itself. These developments in mental health care still continue and we hope that our studies will supply more information that will help clinicians as well as policy makers to make balanced decisions about who can or should be offered BT.
General discussion

Operationalisation of BT and BT-outcome and the selection of CMHC’s

Definition of brief treatment

A basic issue about the definition of BT is the number of treatment sessions. As in the international literature (Bloom, 1997), clinicians in the CMHC’s do not totally agree on an upper limit (Schaefer et al., 1999). After reviewing all treatment-programmes described by the respondents of all 57 CMHC’s as ‘brief’, a treatment programme was defined as ‘brief’ if the following criteria were met:

1. the treatment-programme itself must be clearly established within the CMHC and the clinicians providing it must constitute a separate team,
2. a clinician providing treatment within such a programme must start the treatment with the intention to end it within six or fewer sessions,
3. it should be neither a crisis intervention programme, nor some kind of group treatment programme.

This definition includes BT-programmes with an upper limit of six sessions (with no standard possibility of a prolongation within BT) as well as the ‘five-plus offers’ in which clinicians want to try to end BT within five sessions, but have the possibility to prolong the BT with three or five BT-sessions (Schaefer et al., 1999).

Assessing brief treatment success

A challenge was the way in which to assess whether or not the BT was successful. A successful BT had to be brief (≤ six sessions) and the outcome had to be rated (by the patient) as positive.

The six-session limit

Although the intention of the clinicians was to end BT within six sessions, the BT of some patients was prolonged. When a patient rated the result of a, for example, eight-session BT as positive, the BT can be seen as successful, but for this study the BT was assessed as unsuccessful because of the six-session limit. We chose for this specific and rather conservative cut-off point because the results of our nation-wide survey showed that about three quarters of the CMHC’s had a BT-programme in which the clinicians started the BT with the intention to end it within six sessions and we were curious with which patients they actually succeeded in doing so.

Assessing brief treatment outcome

The group of patients allocated to BT was quite heterogeneous in terms of patient characteristics. This made it impossible to use specific symptom severity measures (e.g. the Beck Depression
Inventories -BDI- from Beck et al., 1961 or the State-Trait Anxiety Inventory -STAI- from Spielberger et al., 1970) to assess BT-outcome. Measures that focus on assessing complaints/symptoms in different problem areas, like the Symptom Check List 90 (SCL-90; Derogatis, 1977) does, also have limitations. Although the SCL-90 was included in the test battery, it was not selected as an outcome criterion because the items comprising this questionnaire make it easier to assess progression of problems which symptoms are strongly represented in the SCL-90 than problems with symptoms less well represented in the questionnaire. Further the literature is not always clear on the issue of how much progress can be called 'successful'. Finally, the goal of BT in many cases was not primary focused on symptom reduction.

To evaluate the effect of BT a combination of treatment result and goal-attainment, as perceived by the patient, was used. Patients had to rate the treatment result on a 10-point scale. If they rated seven or higher the treatment outcome was scored positive. Treatment outcome was also rated positive if the patient scored six on the 10-point scale, but rated the most important goal as 'pretty much' or 'entirely' achieved.

Selection of the Community Mental Health Centres

All 57 CMHC's participated in our national survey which means that the results of this study give a detailed and representative view of the state of affairs regarding BT in the CMHC's in 1998. However, with this survey it was only possible to assess what the organizations said they did and not what they actually did. To assess the latter a new study was conducted within six CMHC's.

In selecting the CMHC's for our study we considered two main criteria. First, it was our aim to assess an as large and heterogeneous as possible group of adult patients with whom clinicians are willing to try to end treatment within six or fewer (50-minute) sessions. So we wanted at least include some CMHC's that in our nation wide study had shown to allocate as much patients as possible to BT (about 30-35% of new patients). Second, we also wanted to include CMHC's distributed over the Netherlands and situated in both rural and urban areas. This along with the number of centres involved in this study increases the generalisability of these study results. Because it is possible that the six centres differ with regard to specific BT-team aspects, the results were controlled for the multi-centre character of the sample.

Results

Nature of brief treatment in specialized mental health care

In 1998 almost all CMHC's lacked a specific theory, working method or protocol that described their BT properly. Consequently, the BT's provided within the CMHC's should not be characterised as a particular method, but more as a treatment given by clinicians who share the same basic BT-attitude. BT-clinicians hold that many patients are able to work most of their problems by themselves, but are demoralised at the time they ask for help. It is hold that these
patients 'only' need short-term treatment from a clinician who is able to quickly distinguish essentials from side issues and who helps the patient decide on how to (re)start working on the problems to restore autonomy. The goal of BT is therefore hardly ever 'total cure', but almost always to overcome demoralisation and providing the patient with the tools necessary to continue the process of change on his/her own.

The type of interventions BT-clinicians use can be quite different, probably depending on the type of patient (the nature of the problems, the kind of interventions they ask for, their competences, and their environment) and the type of interventions the clinician is familiar with. Some basic interventions many BT-clinicians use are:
- placing thoughts and feelings in a new kind of perspective,
- reminding patients of their (neglected) strengths and competences,
- stimulating a solution-focused orientation,
- creating an active working attitude and
- making patients more and more responsible for working on their problems.

The basic BT-attitude and the interventions mentioned above are not restricted to a particular therapeutic approach. Some BT-clinicians work quite mono-methodical (e.g. directive, behavioural) others more eclectic.

BT-clinicians believe that they are able to treat a large proportion of the CMHC-patients in only a few sessions. This raises two main questions. Firstly, which patients need only six sessions to get back on track and to manage their problems on their own again? Secondly, is it acceptable to work from such a 'basic attitude' without a clearly described working method or protocol? Regarding the second question it should be noted that in clinical practice, also in long-term treatment, many patients are treated without specific treatment protocols.

**Patients eligible for brief treatment**

The two studies within this thesis provided the opportunity to approach the question about the eligibility for BT from three different angles; firstly what respondents of the national survey reported about their allocation procedure, secondly the analysis regarding the comparison of patients allocated to BT with patients allocated to Unlimited or Long-term Treatment (ULT), and thirdly the analysis regarding BT-success within the sample allocated to BT.

The respondents of the national survey (see chapter two), consider BT contra-indicated for about 50% of their CMHC-population and a good alternative for 10%. There is less consensus about the feasibility of BT for the remaining 40% of CMHC-patients.

The following patients comprised the 50% considered unsuitable for BT:
- patients facing severe or acute problems (psychotic disorders, severe mood or eating problems, cognitive dysfunction, suicide risk),
patients with severe personality disorders (especially those of cluster A) combined with severe
behavioural difficulties and lack of skills to build an adequate therapeutic relationship with the
clinician in a limited amount of time,
- patients with multiple problems without the capacity to translate them (together with the
clinician) into clear and limited treatment goals.

The 10% patients found eligible for BT were those with less severe psychiatric disorders (primary
adjustment disorders, mild depression or anxiety disorders) and/or with more serious relational,
life-phase, occupational or study problems. Our survey also showed that eligibility was not only
related to the nature and severity of the problems but also to patient characteristics such as an
active working attitude, having strengths, being open for possible approaches to look at the
complaints/problems and to cope with them.

Whether the remaining 40% of patients (i.e. those CMHC-patients some clinicians considered
eligible for BT while others did not) were actually allocated to BT, depended on factors like:
characteristics of the BT-team, characteristics of the clinicians responsible for allocation, other
available treatment options within the centre, and regional factors (see chapter two). Although
most CMHC's allocate at least 10% to 15% of their population to BT, depending on the factors
mentioned above in some CMHC's this percentage was as high as 35%.

Next, within two CMHC's the patients who were allocated to BT were compared to those who
were allocated to ULT (see chapter three). Twenty six percent of the patients who were found
suitable for treatment within these two centres were allocated to BT. Patients with severe
problems, who were mostly allocated to ULT, were not included in this study because their
clinician considered them too ill to participate in the study. For the remaining patients BT
allocation was not related to severity of the problems, but was related to ratings regarding how
well the patient is integrated in life. That patients who have assets and a number of areas in their
lives in which they function well are considered to be better candidates for BT than patients who
have besides their target problems also weaknesses and problems in living is in line with the
results of our national study, literature about recommendations regarding selecting patients for
short-term treatments in general (see Bloom, 1997; Koss & Shiang, 1994), and literature about
variables that are related to treatment duration (e.g. Rijnders et al., 2002a; Rabinowitz & Renert,
1997). However, the present study was able to identify specific characteristics (e.g. self-esteem,
satisfaction with received emotional support when encountering problems, satisfaction with social
network, and enjoyment of leisure time) that make some patients more eligible for BT than others.

Two patient characteristics not specifically mentioned in literature as patient characteristics
associated with successful short term treatment in general; 'desire to ventilate one's feelings in
treatment' and 'avoidant coping', were found to be related to BT-allocation. The probability of
being allocated to BT decreased with a decreasing desire of the patient to ventilate one's feeling
in treatment (i.e. telling a professional about their problems and wanting to know what this
professional thinks about the situation to validate their own decisions). The probability of being
allocated to BT also decreased when patients had a more avoidant coping style. In BT the
patients are often asked to explore and confront their problem and to do homework which
probably is not easy for patients who most of the time avoid their problems.
Interestingly, there were also other variables found to be related to BT-allocation. It is hard, however, to give clear reasons why these factors are related. The probability to be allocated to BT was, for example, found to be higher for patients over 50 years of age and those with ‘only’ primary education or less. It is hard to tell whether these patients are allocated to BT because they specifically ask for BT or because clinicians consider them as the traditional ‘underprivileged’ psychotherapy patients (see also Rutgers & Duurkoop, 2001).

It is important to note that these predictors for selection to BT are assessed on the basis of the actual allocation process. It is possible that outside factors (e.g. organizational aspects or personal preferences of clinicians) have influenced the allocation to BT or ULT. That a patient is allocated to BT does not mean that BT will be successful (alternatively, this also holds for patients allocated to ULT). To investigate for which patients, allocated to BT, this type of treatment is successful, we followed BT-patients for eight months and assessed whether or not BT was sufficient (ended within six sessions with the patient rating the BT outcome as positive) for their problems (see chapter four).

For patients allocated to BT the kind of problems and symptom severity were not predictors of BT-success. However, the probability that BT was successful was greater for patients with a lower number of target complaints (< 4) and patients with higher baseline GAF-scores. In order to keep the treatment brief, it is often necessary that the clinician and the patient agree on a central focus for treatment (Koss & Shiang, 1994; Schaefer et al., 1999; Schaefer et al., 2003), which might be difficult when a patient has more than three target complaints. Because GAF-score is a combination of symptomatology and social and occupational functioning, it remains unclear whether the increased probability of a successful BT is caused by the symptoms (rated by the clinician), levels of functioning, or a combination of both.

In line with the finding that well integrated patients are often considered better candidates for BT, it was found more likely that BT is successful for patients who are more satisfied with the emotional support received and who are feeling more in control over their own life-chances (mastery).

The probability that BT is successful is higher for those patients that have a more problem-focused coping style when encountering problems (i.e. turning the matter over in one’s mind, line up the problems and possible solutions, start solving the problem or unpleasant situation purposeful and with confidence) which concur the idea that an active approach is a good

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6 With regard to some variables we found ‘U’ shaped relations that were difficult to explain.

7 It is for instance possible that some patients of which BT-clinicians think that they can probably be helped in BT, are nevertheless allocated to another kind of treatment (e.g. to a programme in which an evidence based treatment for a particular kind of problem can be given) or that patients are allocated to BT because of logistic reasons (e.g. waiting-lists in ULT or patient does ‘not fit’ in the treatments given in ULT) and not because BT is found to be the best treatment for the patient.

8 The six CMHC's of this study together allocated about 30% of their population to BT.

9 It is possible that number of complaints was not found to be a predictor with regard to BT-allocation because the maximum number of target complaints that patients could mention was three, while in the study regarding the prediction of BT-sufficiency the number of target complaints was rated by the clinicians and could add up over ten complaints.
selection criterion for brief treatment as proposed by other writers (Gelso & Johnson, 1983; Koss & Shiang, 1994; Heglend, 1996).

With regard to the kind of intervention that the patient requests, there were two predictors for BT-success found. Firstly, it was found that the probability that BT was successful was lower for patients who had a high request for structure in treatment. Patients who feel overwhelmed by feelings, not able to keep control over themselves, and wish that the clinician takes over responsibility are likely not good candidates for BT because it probably will take more than six sessions to reduce their helplessness, get them working on their problems and to stimulate them to take matters in their own hands again. Secondly, it was found that the probability that BT was successful was lower for patients who want relatively much psychological insight as an intervention in treatment. Patients who want to understand and search the subconsciousness and wanting to uncover problems that are believed to be rooted in youth, are probably also patients who do not expect their treatment to be brief.

Interesting were the results regarding age and education. For older patients (30 years or older) the probability regarding a successful BT was lower than for younger patients, although older patients (over 50 years of age) were more likely to be allocated to BT. With regard to education a trend was found that when the level of education decreased the probability of a successful BT decreased, although patients with ‘only’ primary education or less were more likely to be allocated to BT. Future research should corroborate these findings and give more insight in why these relations are found.

Summarising the results, one can conclude that when clinicians allocate patients to BT they first exclude patients with severe problems. It seems that within the remaining patient group symptom severity does not play a meaningful role in the decision, but the level of integration in life, regardless of present problems, (i.e. have competences and resources especially satisfaction with social support) does. However, to successfully end BT within six or fewer sessions, it appears that in addition to the factors mentioned above, one should pay special attention to the following five patient baseline characteristics. The probability that a BT approach is successful is lower for patients:
- with a less problem-focused coping style
- who are thirty years or older
- who have four or more target problems
- who feel more helplessness and desire to be dependent on a clinician
- who want more psychological insight as a treatment intervention

BT was successful, according to our criteria, for almost 50% of the patients that participated in the study and for whom it was possible to assess whether or not BT had been successful (n=176). It is difficult to say whether or not this percentage is representative for the total group of patients that was allocated to BT (n=594). However, it does appear that BT is not a sufficient treatment option for a relatively large group of these BT-patients. Does this mean that six-session BT is only successful for a small sample of CMHC-patients or that this estimate is too low because of study limitations? The success-rate partly depends on our outcome criterion. If a milder criterion was
used (e.g. using a limit somewhat higher than six sessions\(^{10}\)), BT becomes a successful treatment option for a larger proportion of the patients allocated to this treatment modality. It is also possible that a group of patients for whom BT was a successful treatment option was missed because they were not allocated to BT. Further, it may be that when clinicians were not able to prolong BT, they ended BT more often within six sessions. Furthermore, it is possible that clinicians can treat more patients successfully within six sessions when they are better trained to do BT. These are important research questions for future studies.

**Working alliance and brief treatment outcome**

Results regarding the question 'for which BT-patients is BT successful' focused exclusively on patient characteristics since our primary goal was to detect baseline predictors useful for clinicians who have to decide whether or not to allocate a patient to (six-session) BT. It is however common knowledge that treatment outcome is not only influenced by patient variables. A variable often found to be related to treatment outcome is the therapeutic relationship (Beutler et al., 2003). However, little is known about the therapeutic relationship in very brief psychological treatments. In *chapter five* the relationship between different aspects of working alliance and the BT outcome is assessed.

More agreement (according to the patient) between the patient and clinician on Tasks or Goals increases the probability that BT is a successful treatment offer. The amount of Bonding between patient and clinician (as rated by the patient) was not related to this probability. When all three variables Tasks, Goals and Bond were entered in a stepwise logistic regression procedure only agreement on Tasks remained significantly related to the probability that BT was a successful treatment approach. Agreement on tasks also improved the prediction models based on patient characteristics found in *chapter four*.

These findings show the importance of treatment alliance for BT to be related to the type of alliance. Clinicians should be aware of the fact that agreement on Tasks (and Goals) is important in treatment and perhaps especially in BT. Because agreement on Tasks improved the 'prediction model regarding BT-success' based on baseline patient characteristics, it is likely that more patients can be helped within a six sessions BT when clinicians pay more attention to agreement on Tasks (and Goals).

**Stages of change**

Frequently the primary aim of BT is offering patients, stuck in a process of change, the right tools to continue and finally finish this process on their own. From a 'stages of change' perspective this could be described as 'helping the patient to make a specific stage of change transition'. This suggests an alternative operationalisation of a successful treatment outcome that is especially useful within a patient population that is heterogeneous with regard to target problem and (limited)

\(^{10}\) Nearly 90% of patients within our study ended their BT within eight months, and 75% of this group ended their BT within six sessions. However, no more than 10% consumed ten or more BT-sessions.
treatment goal. The usefulness of ‘stages of change’ profiles and transitions in a BT-population is assessed in chapter six.

Patients completed the University of Rhode Island Change Assessment (URICA; McConnaughy et al., 1989) before the start of BT and four and eight months after this start. With our two-stage allocation procedure it was found that the overall majority of the BT-patients could be allocated to a stages of change profile (SOC-profiles). Although patients were allocated at baseline to five different SOC-profiles, most patients were assessed as ‘Contemplators, taking some action’ or ‘Action stagers, still contemplating’ (63% and 26% respectively). Although our ‘SOC-profile approach’ seems sensitive to change (compared to baseline more than half of the patients had a different SOC-profile at eight months follow-up) and predictors for change seemed of clinical value, using this instrument for (treatment) evaluation is not without problems. The relations found between (changes regarding) different outcome measures and patients who were assessed at the same SOC-profile versus patients who made a SOC-transition were not easy to interpret. However, the results of our study show that it is worthwhile to further investigate what is actually measured when patients are assessed with the same or different SOC-profiles over time and how this relates to other outcome measures.

Methodological issues

Naturalistic study design

A naturalistic study design makes it possible to assess what actually happens in the clinical practice setting, thus increasing the generalizability of the results of our study (external validity). However, when one wants to assess the effect of specific therapeutic techniques within a BT approach (in relation to other treatment possibilities or no treatment at all) for different patient populations, our study design falls short because this is probably better assessed with carefully controlled studies (Randomized Controlled Trail, RCT). On the other hand, the value for clinical practice of results regarding studies with therapy manuals for specific patient populations can be questioned because they often lack external validity (see Sigal et al., 1999; Stirman et al., 2003). In practice one simply has less control of variables found to be relevant for treatment result and many RCT’s test patient populations that are not representative of the patient population that clinicians meet in practice.

Patient attrition

We were dependent on the clinicians to ask their patients to participate in the study, on patients to actually participate in the study and complete a number of questionnaires a couple of times, and also on clinicians to complete some questionnaires. This had consequences for attrition, which might decrease the external validity of our study. For several reasons the baseline questionnaire from 56% of all patients allocated to BT were not received (see figure 1.1, chapter one). Some of the attrition is assumed to be random (e.g. attrition caused by logistic problems) and ‘only’
influenced the power of the statistical tests, however some attrition is probably not random and may cause selection bias.

A group of patients could not be asked to participate in this study, because clinicians found it unethical to ask them because they were considered too ill to complete questionnaires (this applied to the majority of these patients), or too distressed or emotional at intake, or too ambivalent about treatment and the clinician did not want to risk losing these patients by asking them to participate in the study. The loss of this group might cause some selection bias. Because these patients were not asked to participate in the study, there is no information about them or the results of their BT and they could not be compared with regard to baseline characteristics with the group that was included in the analyses. The same holds for the interpretation of results regarding the question; which patients are allocated to BT? The percentage of patients who were not asked to participate for ethical reasons was larger in the ULT-group than in the BT-group.

The attrition regarding the follow-up assessments within the group of patients that completed a baseline questionnaire was relatively low (27%) and a large part of this attrition was probably random and therefore it is not likely that this attrition led to selection bias.

Type I and type II error

The explorative character of our study resulted in a relatively large number of statistical tests. One can argue that adjustment of the $\alpha$ level was needed to account for the large number of significance tests made in the stepwise regression procedures (i.e. decrease the type I error; finding significant relationships by chance). It is, however, also important to keep the type II error within acceptable limits. Decreasing our type I error would, given the relatively low $n$, mean that our type II error would become unacceptable large and our study would not have sufficient power to identify predictors. Despite the fact that our sample size forced us to work with a relatively large family wise type I error we believe our results still to be of value, but further research including a replication study is needed.

Future research

The studies described in this thesis have answered a few questions about BT’s as practiced in the CMHC’s in the Netherlands. However, there are still questions regarding BT that require further investigation.

With regard to the question ‘what patient characteristics make clinicians recommend BT’, we do not know for sure whether outside factors (like organisational or personal preferences) had influenced allocation to BT in our study. So, it would be interesting to construct a number of cases and let these be rated by different clinicians regarding eligibility for BT.
Chapter 7

With regard to the question 'for which patients, allocated to BT, is BT successful' there are some possible predictors that were not, or not specific enough, assessed as possible predictors for BT-success, like for instance: expectations of treatment outcome, motivation to work on the target problem and specific personality characteristics. It is also recommendable to assess in future research whether same predictors are found when other criteria for BT-success are used (e.g. another limit regarding BT-sessions or other outcome measures completed by patients or clinicians).

Although there are nowadays much outcome measures available, more research regarding outcome measures that are useful in heterogeneous CMHC-samples is still very much needed. Further, more research regarding a 'stages of change' questionnaire seems recommendable. Research should also focus more on the sensitivity of different outcome measures on different moments in treatment and to possible influences of patient characteristics on rating of these outcome measures (Aarsse, 2003).

Furthermore it would be interesting to get more insight in the balance between number of treatment sessions, the time span over which these sessions were spread and the treatment outcome.

The national survey describes the state of affairs involving BT in the CMHC's in 1998. This is already some years ago and it would be interesting to see whether the situation in practice has changed. In the past few years more literature (e.g. Methorst et al., 1997; Stoffer, 2001; Cladder, 2002; Rijnders et al., 2002b; Rijnders, 2004) and courses on short-term treatment have become available in the Netherlands. However, it must be noticed that most of these short-term treatment approaches do not use a limit of five or six sessions. It would be interesting to see if one in practice also has stretched the limit over six sessions.

Although most described models and protocols did not use the six-session limit, they nevertheless provided more information about techniques that can be useful in BT's. Interestingly, most of these short-term treatment approaches refer to the importance of 'general principles' identified in all psychotherapies. It would be interesting to assess in future research whether the universalistic approach of Frank (see Frank & Frank, 1991), which applies to all kinds of psychotherapies, is especially relevant for BT as described in many of these approaches. Apart from 'general principles', further research should also focus on specific techniques that might be useful in BT. Are the techniques that are recently described in the literature also used in practice? Which are effective and for whom? Is it possible to devise more detailed BT-protocols or working methods that can be used in practice for a relative heterogeneous group of CMHC-patients? Perhaps BT-protocols for heterogeneous patient samples can never be very detailed, because it might be the freedom that the clinicians have in choosing what is best for a particular patient that makes that the treatment can be ended in a few sessions. However, when the 'diagnoses treatment combinations' are practised more often, it is also possible that BT for heterogeneous CMHC-samples will disappear slowly, and that short-term treatments will be implemented within special programmes for defined target populations. With more homogeneous samples it is possible to describe more detailed protocols and in the literature there is quite some research available about the effect of 'very' brief interventions for specific target problems.
However, regardless the way short-term treatment will be implemented in CMHC’s, the key question remains, how do we know whether a patient has had enough treatment (for the time being) and can work on their problems on their own again. It is clear that research should focus on this issue.

Lambert et al. (2003a) argue that it is no wonder that Hansen et al. (2002) found routine practice to be substantially less effective than clinical trials, because the efficiency of psychotherapy reported in clinical trials is based on an average dosage of 12 to 16 sessions, while the actual dosage in routine practice is closer to three to five sessions. So it seems that many patients terminate treatment too soon, and Lambert et al. argue that clinicians should encourage patients to stay in treatment until a reliable benefit has been achieved. On the basis of research from Haas et al. (2002), who found that early responders not only are overrepresented among those who attain clinically significant change at termination of psychotherapy but also tend to maintain their gains at follow-up, Lambert et al. (2003b) also argue that those patients who respond to treatment quickly can be terminated after a few sessions, but more slowly responding patients are in need of more sessions. This calls for clinicians to monitor progress more carefully and Lambert et al. suggest that third-party payers, government agencies, and clinicians should emphasize measuring response to treatment to optimize the outcome of treatment and to make it cost effective.

Monitoring progress during treatment by standard assessing patients at the beginning, after about five sessions and at the end of treatment (and at other moments during treatment if the treatment contains more than about 12 sessions), would not only provide meaningful information for the individual patient and clinician, but also for the particular organisation. The baseline assessments can provide important information about the incoming patient population and with the follow-up assessments one can evaluate (particular) treatment (approaches) for (different) patient-sample(s). When the assessment becomes a standard procedure one also might lose fewer patients as a result of logistic problems, and because the assessment becomes a part of treatment more patients are probably willing to complete the questionnaires (see also Bransen et al., 2003).
References


Genera l discussion


