How common is brief counselling in New Zealand?

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Abstract
Brief counselling is pervasive in the international counselling and therapy literature. Average sessions per client of fewer than ten are the rule, not the exception, and the modal number of sessions is most often one. Earlier data from New Zealand were consistent with these findings (Manthei, 2017), and more recent research has provided additional support. This additional research is summarised in this article and the implications for counsellor-educators and practitioners discussed.

Key words: brief counselling, single session therapy, number of sessions, Low Intensity CBT, outcome

How common is brief counselling in New Zealand?

The predominance of counselling and therapy of comparatively short duration reported in the literature should not be a surprise to anyone working in the field. Researchers have long been reporting the pervasiveness of briefer counselling interventions in multiple settings overseas. Over 30 years ago, Budman and Gurman (1988, p. 7) declared that "Virtually every major review of the efficacy of various individual therapies… has been an unacknowledged review of time-unlimited brief therapy." Four years later, Steenbarger (1992, p. 413) reported that "an interesting problem facing a reviewer of the literature [on brief counselling] is determining which investigations do not pertain to brief work". During the intervening years the same finding has emerged: a large proportion of counselling has been found to be brief (usually reported to be between three and eight sessions or accepted as lasting fewer than 10 sessions). This is true regardless of what theoretical approach was being used, or whether the counsellors expected and planned for briefer counselling interventions or not (Bloom, 1992; Draper et al., 2002; Gallagher, 2010; Hoyt, 2009; Lambert et al., 1998; Reimer & Chatwin, 2006). Closer to home, Young et al. (2012) found that in Australia over 60% of the 115,000 counselling contacts spanning six years at all Victorian mental health clinics were of one or two sessions in duration.

Single session counselling has also been found to be common (Cannistrà et al., 2020; Hoyt et al., 2020; Talmon, 1990; Young et al., 2012), and generally successful over a range of client problems (Budman et al., 1992; Hoyt et al., 2020; Miller et al., 2006; Pekarik, 1992; Perkins, 2006; Slive et al., 2008; Silverman & Beech, 1979; Steenbarger, 1992; Talmon, 1990). Because the modal number of sessions across many therapy forms and theoretical modalities has been found to be one (Hoyt, 2009; Hoyt et al., 2018; Talmon, 1990), "the challenge… is to learn how to be aware of it, plan for it, and maximize its unusual potential" (Talmon, 1990, p. 17).

The pervasiveness of brief counselling found by these studies, including single-session contacts, was clear, and suggested that:

- counsellors need to adopt a favourable attitude or orientation (called a mindset) toward brief counselling, one that accepts that change can be substantial and can happen in a few sessions;
- counsellors should be trained in and able to implement the principles of brief counselling whatever their preferred theoretical approach (such principles include the establishment a clear and consistent focus on progress; the flexible and conscientious use of time; the setting of clear and achievable goals; the regular assessment of progress toward those goals; and being active, questioning, educating and challenging with clients [Cameron, 2006]);
- employing an approach that automatically assumes counselling will necessarily be lengthy ignores the compelling evidence to the contrary, but may also represent unprofessional, and possibly unethical, practice; and
- presuming that counselling will be lengthy can result in excessive financial shortfalls for agencies and extra expenses for clients.

How would counselling in New Zealand be characterised? In 2016 I wrote that "Since these results [the average number of sessions is less than five and a mode of one] are derived from over 5,500 clients and span nine years, they cannot be easily discounted as just a random finding" (Manthei, 2016, p. 56). The results were based on a large number of clients from two Christchurch counselling agencies. Since then, additional evidence from a number of different settings in New Zealand has been published that supports that conclusion. To my knowledge there are no published New Zealand data that contradict it. This article summarises the data and indicates just how much stronger the case has become in the intervening five years for training all counsellors in the principles and processes of brief counselling.

What does recent New Zealand research show?

A search of the literature using PSYCHINFO, the *New Journal of Counselling, the New Zealand Journal of Psychology*, and the *New Zealand Medical Journal* issues from the last 10 years yielded several studies involving counselling or therapy that have reported the number of sessions clients received and a few that have also reported outcome data. Searching Google Scholar identified another two recent reports of counselling with problem gamblers that yielded similar information.

Table 1 summarises the eleven studies that reported length of counselling, as either an average or a mode, the number of clients involved, and in seven instances, estimates of counselling impact.

The total number of clients was approximately 20,000 and the number of counsellors involved was well in excess of 130. The latter figure is important because with such a large number of counsellors involved, it was highly unlikely that most of them were practicing one modality or were proponents of brief therapy. The weighted average number of sessions (based on the different numbers of clients in each study) across all of the studies was 4.7. A mode of one or two was reported in five of the studies, and in Bellringer et al. (2019) the median was three. With such a large range of sessions in that study (1–147), a median of three meant that at least half (probably more) of the 5895 clients had three or fewer sessions.

The studies in Table 1 reported counselling that was delivered in several different settings: agencies, schools, and private practice, and across a wide variety of ages (adolescents, adults, and the elderly). The total number of clients involved and the consistency of session averages in the studies being at or below five reinforce my earlier comment (Manthei, 2016) that both here and overseas, brief counselling is neither rare nor random. Furthermore, seven of the studies reported outcome data that suggested that this short-term counselling can have a positive impact on clients, as has been shown overseas (see, e.g., Bloom, 2001; Nai & Rodgers, 2017; Steenbarger, 1992). Four of the studies reported effect sizes that were close to or above the "large" indicator (see Cohen, 1988), where effect sizes of 0.2 are considered small, 0.5 medium, and 0.8 or more large. In contrast, the last column indicates that there was only a small percentage of clients (usually 5–10%) who were seen for more than about 10 sessions. Of course, there needs to be more research done on this topic, but the current data on their own are consistent and compelling and should be taken seriously by counsellor-educators and counsellors.

Table 1:

NZ counselling research reporting setting, number of subjects, age, gender, number of sessions, number of counsellors, and outcome data

	Study	Setting	Subjects	N	Ave. age
1	Manthei, 2005	Walk-in agency	Adults	31	--
2	Manthei, 2010	Walk-in agency	Adults	82	--
3	Manthei and Norse, 2012	Agency, special population	Elderly, 55+	635	73
4	Manthei, 2012	Walk-in agency	Mostly adults	916**	--
5	Manthei, 2016	Walk-in agency	Mostly adults	4625**	--
6	Bridgeman + Rosen, 2016	Problem Gambling Foundation	Problem gamblers	4055	41.5
7	Manthei, 2017	Private practice	All ages, but mostly adults	762	42.0
8	Bellringer et al. 2019***	Gambling treatment settings	Problem gamblers	5895	--
9	Hughes et al., 2019	11 secondary schools	Students	1596	13–19 (range)
10	Manthei et al., 2020	14 secondary schools	Students	490	14.9
11	Manthei + Tuck, 2021 (In preparation)	Private practice	All ages, but mostly adults	720	41.5
	Totals			**≈19807**	

* ES calculated for this article; not in original study.

** Clients deemed 'outliers' were eliminated from the calculation—less than 5% of totals, as per Simmons, Nelson, & Simonsohn, 2011.

*** This was an evaluation of the introduction and use of PCOMS into the work of the Gambling Foundation. Only the median number of sessions (3) was reported and by itself suggests that the average and mode would also be low.

▪ This figure is the weighted mean of all the studies except study 8, for which there was no mean reported.

▪▪ This is a very low estimate given studies 2, 3 and 8, which involved large numbers of clients; number of counsellors involved not given.

Gender	Sessions: Ave.(range)	Number of counsellors	Outcome measure	Effect size	% improved by # sessions
86% F 14% M	9.4 (3-20)	6	10 pt. scale	--	
--	5.2	Multiple	10 pt. scale	--	
77% F 23% M	4.3	Multiple	ORS (n= 204)	.73*	
66% F 34% M	4.8 (1-149) Mode=1	19	--	--	90% <10
63% F 37% M	4.5 (1-260) Mode=1	46	--	--	90% < 13
43% F 57% M	5.96	86	PCOMS	.69	75% < 7
54% F 46% M	3.1 (1-25) Mode=2	1	--	--	90% < 6
--	Median = 3 (1-147)	Multiple	PCOMS	Overall, positive gains in well-being	--
64% F 35% M 1% other	2.5	25			95% <10
70% F 28% M 2% other	4.0 Mode=2	30	ORS	.87	92% <8
56% F 44% M	2.4 (1-10) Mode=1	1	ORS	.9	92% <5
	Ave=4.7 ▪	**>128 ▪ ▪**			

A twelfth study (Barrett, Lapsley, & Agee, 2012) was not included in Table 1 because it did not contain sufficiently detailed information on the number and range of sessions and the total number of clients involved. Nevertheless, this study, a follow-up survey of 51 single-session, career-counselling clients, 85% of whom were female, reported that 97% of the 27 respondents said in quite specific terms that their one session had been helpful. These findings, and the first author's statement that in her practice single session career counselling was the most common type of interaction, lend further support to the information in Table 1, namely, that in New Zealand counselling tends to be brief but that it can be successful.

Limitations of these studies in Table 1:

The figures in Table 1 present an aggregated view, one that might obscure different session averages among different types of clients and counsellors using different modalities. Interestingly, this latter variable was examined by Manthei (2016, p. 64) who found that an agency's self-professed brief counsellors saw clients for fewer sessions, had fewer session cancellations and generated higher fees from their clients than did person-centred or long-term proponents—yet all three groups still had session averages of fewer than 10. The differences among the groups, however, were not large. In addition, three quarters of the clients in Table 1 are from three studies (14,500), two of which focussed on problem gamblers (studies 6 and 8 in Table 1). In future, detailed information about the type and severity of client problems would help to determine if the number of sessions varies with presenting problem, though Slive and Bobele (2012, p. 30) asserted that "There is no established direct correlation between the duration of the complaint or the severity of the complaint and the duration of the treatment." Calculating the average number of sessions for each counsellor along with details about each counsellor's orientation or mind-set toward counselling and preferred modality could reveal possible differences in session averages among counsellors. Finally, the studies reporting outcome data didn't always include a standardised assessment measure, and none of them included randomised control groups. While recognising the latter shortcoming, findings of this sort can still be considered a useful complement alongside evidence from randomised control trials (Cooper et al., 2013).

A second set of studies published in the *New Zealand Journal of Psychology* are summarised in Table 2. They are included here because they represent a recent trend in clinical psychology that acknowledges the wide-spread use and effectiveness of short-term therapeutic interventions. According to Haarhoff and Williams (2017),

Low Intensity CBT (LICBT) programmes that utilise effective, brief, accessible, low-cost, manualised CBT interventions targeting specific problems or conditions are being developed in response to the growing scarcity of specialist practitioners and fiscal restraints. They are designed to enable ". . . greater client access to evidence-based psychotherapies, more choices, less stigmatisation, and greater client control" (Haarhoff & Williams, 2017, p. 5). As can be seen in Table 2, the number of clients across the studies is relatively small (N = 91) and the number of sessions has been pre-determined by the programme developers. Each programme is delivered as a planned "course" (either by a trained facilitator or on a self-guided or self-help basis) and covers material that is considered essential and presented in a prescribed sequence. While the average number of sessions in the studies exceeded the average in Table 1 (9.2 vs 4.7, respectively), these studies represent the LICBT movement, which clearly acknowledges that brief, or time-limited, interventions are feasible and can be effective for many types of clients and their presenting problems. Taken as a whole, the LICBT movement provides further support for and recognition that brief counselling or interventions may be desirable and beneficial to many clients with various problems.

Limitations of these studies in Table 2:

Although their time-limited rationale is clear, the LICBT programmes use an "expert-based model" that prescribes content, sequencing of topics, and programme length, often with no justification for any of these factors. Why, for example, are 12 sessions over three months preferable to eight, six, or even four? However, since many of these programmes have been structured as client-guided, or self-help experiences, how they are implemented can often be controlled by the clients involved. Therefore, as the programmes become more extensively used, additional data might show ways in which clients have altered them—even by shortening the experience—without sacrificing effectiveness.

Implications

The implications of these findings are increasingly clear for counsellor-educators, counsellors and researchers: Firstly, that additional research should be conducted to see if the results confirm or disconfirm them, *and* secondly that it is important to teach or adopt an "each session could be the last session" mindset in counselling practice (Slive & Bobele, 2012; Talmon, 1990). Bobele and Slive (2014; in Hoyt, Young, & Rycroft, 2020, p. 224) listed a number of ideas that define such a mindset:

- clients know what works best for them;
- clients are far less interested in psychotherapy than are therapists and prefer brief
- therapeutic encounters;
- clients frequently choose to attend only one session and overwhelmingly express satisfaction with that session;
- research demonstrates that most change occurs early in therapy, followed by ever-decreasing improvements as sessions continue; and
- rapid change is not only possible, but also common in human experience.

In order for counsellors to become more accepting of short-term counselling, the first step is to recognise how common one- and two-session counselling really is. This can be done by reading the literature on brief counselling, of which there is a copious amount available, including those papers referenced in this article.

Table 2:
NZ manualised LICBT programmes reporting setting, subjects, age, number of subjects, gender, number of sessions, number of counsellors, and outcome data

Study	Setting	Programme	Subjects
Benton et al., 2012	Outpatient, drug and alcohol clinic	Seeking Safety (25 topics)	PTSD and substance abuse
Heywood & Fergusson., 2016	Community-based	Family Functional Therapy	Youth and families
Farrand et al., 2017*	Outpatient clinic	PROMOTE (self-help programme)	Mild dementia + depression
Lee & Williams, 2017	Guided/self-help programme	Living Life to the Full	Asian tertiary students
Montagu & Williams, 2017	Guided/self-help programme	Overcoming depression and low mood	Volunteers
Totals			

*Description of the protocol only; no actual data collected.

Failure to accept the prevalence of short-term counselling can result in the "clinician's illusion" whereby "the majority of a clinician's time can often be spent working with a few long-term clients, and the rest working briefly with a lot of clients" (Cohen & Cohen, 1984 in Young et al., 2012, p. 86).

When this happens, the real number of clients who attend few sessions can become "invisible" (Young, et al., 2012, p. 86–87).

Secondly, educators and counsellors need to educate themselves about what is involved in practising brief therapy. Although this can involve some time and effort, the rewards will be worth it. One can start by exploring the formal literature—two early and comprehensive articles are Steenbarger (1992) and Bloom (1992). If access to a tertiary institution's library databases is not possible, there is still a wealth of information available online. However, to get started, I recommend first reading Nai and Rodgers' (2017) useful review of brief therapy in the *New Zealand Journal of Counselling*. Accessing it is easy (https://www.nzac.org.nz/publications/new-zealand-journal-of-counselling/), and it can be downloaded free of charge.

Age	N	Gender	Number of sessions	Number of counsellors	Outcome
41yrs	20	100% F	Weekly for 3 months	1 for each group of 10	Overall positive effects
13.6 yrs	59	30% F 70% M	Ave. 10.4 (8–12 sessions over 2–4 months	10	Favourable overall
18+	--	--	12 max. over 3 months	One-on-one and face-to-face	No data collected
23.8	11	36% F 64% M	8 sessions over 8 weeks	None—self-help programme	Stat. sig. on all measures; 64%-73% had clinical improvement
33 and 51 yrs.	2 (case studies)	100% M	4 sessions over 6 weeks	1 support person	1 improved; 1 deteriorated
	91		**Ave=9.3**		

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