

Effectiveness of Brief Systemic Therapy versus Cognitive Behavioral Therapy in routine clinical practice

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Abstract

Background: Combining strategies and techniques from different therapeutic approaches is a common procedure in routine mental health practice. It has been claimed that the integration of systemic brief therapies offers useful psychotherapeutic alternatives, especially in our overloaded public mental health services. However, this claim has rarely been put to the test, and comparison with well-established empirically-based treatments has been scarce. **Method:** Of 419 patients referred to an Adult Ambulatory Mental Health Service, 212 were allocated to Cognitive-Behavioral Therapy (CBT), and 207 to an integrative Brief Systemic Therapy (BST). Follow-up assessments of patients' status took place between one and three years later. **Results:** Both therapy models were found to be equivalent in their percentage of therapeutic discharges, drop-outs, relapses and in the use of other mental health services during the follow-up period. Although both treatments were cost-efficient, BST was not briefer than CBT. The between-group equivalence was also confirmed, analyzing the data by psychiatric diagnosis. **Conclusions:** This study provides some preliminary data that suggest that BST might be an effective and efficient treatment in public mental health practice, comparable to well-established treatments like CBT.

Keywords: Brief systemic therapy, cognitive behavior therapy, effectiveness, efficiency.

Resumen

Efectividad de la Terapia Sistémica Breve versus la Terapia Cognitivo-Conductual en la práctica clínica rutinaria. Antecedentes: la combinación de estrategias y técnicas de diferentes modelos psicoterapéuticos es un procedimiento común en la práctica habitual en salud mental. Se ha propuesto que la integración de terapias sistémicas breves ofrece alternativas psicoterapéuticas útiles, especialmente en nuestros sobrecargados servicios públicos de salud mental. Sin embargo, esta afirmación apenas ha sido investigada y la comparación con tratamientos empíricamente validados ha sido escasa. **Método:** de 419 pacientes adultos remitidos a un Servicio Ambulatorio de Salud Mental, 212 fueron asignados a Terapia Cognitivo-Conductual (TCC) y 207 a una Terapia Sistémica Breve integrativa (TSB). Las evaluaciones del estado de los pacientes tuvieron lugar entre uno y tres años más tarde. **Resultados:** ambos modelos terapéuticos resultaron equivalentes en términos de sus porcentajes de altas terapéuticas, abandonos, recaídas y uso de otros servicios de salud mental durante el tiempo de seguimiento. Aunque ambos tratamientos fueron coste-eficientes, la TSB no fue más breve que la TCC. La equivalencia entre grupos fue también confirmada analizando los datos según los diagnósticos psiquiátricos. **Conclusiones:** este estudio aporta datos preliminares que sugieren que la TSB podría ser un tratamiento efectivo y eficiente en servicios públicos de salud mental, comparables con otros tratamientos bien establecidos como la TCC.

Palabras clave: terapia sistémica breve, terapia cognitivo-conductual, efectividad, eficiencia.

Brief Systemic Therapy (BST) (Beyebach, 2009; García, 2013; Quick, 2008; Selekman & Beyebach, 2013) is the integration of Problem Focused Brief Therapy (PFBT) (Weakland & Fisch, 1992) and Solution Focused Brief Therapy (SFBT) (de Shazer, Dolan, Korman, Trepper, McCollum, & Berg, 2007). These two brief therapy approaches are relational and interpersonal in nature, sharing their basic assumptions about therapeutic change. However, they adopt complementary therapeutic strategies: while

PFBT focuses on interrupting the problematic "ironic processes" (Rohrbaugh & Shoham, 2001) that maintain problems, SFBT emphasizes exceptions to the problem patterns, the resources that clients possess and how they can be applied to reach their goals (de Shazer et al., 2007). Separately, both therapies have provided empirical evidence of their effectiveness (Franklin, Trepper, Gingerich, & McCollum, 2011; Gingerich & Peterson, 2013; Kim, 2008; Rohrbaugh & Shoham, 2001), demonstrating they can be used successfully in the treatment of a variety of behavioral and psychological problems. They have also been compared with other well-established therapies in a small number of randomized controlled trials (Boyer, Geurts, Prins, & Van der Oord, 2014; Castelnuovo, Manzoni, Villa, Cesa, & Molinari, 2011; Cohen, O'Leary, & Foran, 2010; Knekt et al., 2008). However, the integration of SFBT and PFBT (Geyerhofer & Komori, 2004;

Quick, 2008; Saggese & Foley, 2000), with its promise to increase the clinical range of PFBT and SFBT applied separately, has so far only produced limited research evidence (Beyebach et al., 2000; Carrera et al., in press; López & Muñoz, 2014; Rodríguez-Arias, Otero, Venero, Ciordia, & Vázquez, 2004) and has yet to be compared with well-established alternative treatments.

Cognitive Behavioral Therapy (CBT) is one of the therapeutic approaches of choice for the treatment of most of the mental disorders usually referred to Clinical Psychology from Primary Care services, such as anxiety disorders (Otte, 2011), depression (Driessen & Hollon, 2010) or personality disorders (Matusiewicz, Hopwood, Banducci, & Lejuez, 2010). Therefore, it can be considered a golden standard with which to compare BST.

The aim of this study was to test the potential of BST as an effective and efficient treatment in a public mental health setting by comparing it to CBT in routine clinical ambulatory practice. To this end, a controlled, non-randomized design was used on a well-defined participant sample. The primary goal of the study was to compare the outcomes of these two treatments in terms of their percentages of therapeutic discharges, dropouts, relapses, and use of other mental health services during the follow-up period. A secondary aim of the study was to determine whether BST was briefer than CBT in this sample.

Method

Participants

The sample of this naturalistic study consisted of 422 adult patients who were referred to the *Mental Health Support Program to Primary Care* by the General Practitioners (GP) of six Primary Care units in Catalonia, Spain, that cover a population of approximately 125.000 inhabitants. The only exclusion criteria were a diagnosis of moderate or severe mental retardation or of a substance dependence disorder. Sample homogeneity was demonstrated in a previous study (Barcons et al., 2014).

The average age of the sample was 38 years, with a majority of women (73%). Concerning marital status, 47% of the patients were married, 12% divorced and 30% single. Regarding education, 42% of the patients had completed at least secondary school. 28 % were unemployed, 10% on sick leave and 7% retired. From a clinical point of view, 65% of the patients had a history of psychiatric disorders and 7% also a history of suicide attempts, and 87% of the sample had been prescribed psychiatric medication by their GP or by other mental health professionals.

From the mental health point of view, 37% of the sample received a DSM-IV-TR adaptive disorder diagnosis, and 29% of the sample an anxiety disorder diagnosis; 14% were diagnosed with depressive disorder, and 8% personality disorders. Less frequent (less than 10 cases per diagnostic category) were somatoform disorders, psychotic disorders, impulse-control disorders, sexual disorders, eating disorders, and attention-deficit disorders.

Instruments

Recruitment of patients took place from 06/2011 to 06/2013. Data collection complied with data protection required by the Spanish Ministry of Health especially in terms of confidentiality and consent. In the first session, the therapists established a mental health diagnosis according to DSM-IV-TR criteria.

The follow-up assessment of patients' status took place between August and September 2014; therefore, patients' follow-up period was variable, with a minimum of one year. Clinical administrative data were registered as outcome measures: case situation at follow-up (discharge, in treatment, dropout), number of relapses (number of new therapeutic processes initiated by discharged patients), number of admissions to Acute Psychiatric Units, number of referrals to Drug Abuse Treatment Units, and number of referrals to a Day Psychiatric Hospital unit.

Procedure

After being admitted to the *Mental Health Support Program to Primary Care*, 212 patients were allocated to CBT and 207 to BST. Three patients were dismissed from the sample because they received both CBT and BST. The allocation to treatments was not random, being determined according to the geographical location of the patient's Primary Care unit of reference.

CBT as applied in this study focused on modifying patients' dysfunctional emotions, maladaptive behaviors and dysfunctional cognitive processes and contents through a number of goal-oriented, explicit systematic procedures. Homework assignments were used in most cases. Although the treatment was not applied according to a closed manual, it followed the guidelines proposed for CBT for different disorders (Labrador, Cruzado, & Muñoz, 2001; NICE, 2007, 2011; Williams, 2009). The CBT therapists were two female clinical psychologists with ten and twelve years of experience in using CBT.

BST was applied in a goal-directed and collaborative way, following the general guidelines for the integration of PFBT and SFBT (Beyebach, 2009; Geyerhofer & Komori, 2004; Selekman & Beyebach, 2013). General problem-focused interventions included: defining the complaint in specific behavioral terms; investigating unsuccessful attempted solutions to the problem; and using client position to interdict problem-maintaining solutions (Weakland & Fisch, 1992). The solution-focused component included: negotiating specific and positive goals; identifying exceptions to the problem sequences; discussing possible pretreatment improvements; using scaling questions to encourage small next steps; and giving clients credit for their improvements (de Shazer et al., 2007). All clients received compliments at the end of each session and homework assignments based on what had been discussed during the session. No closed treatment manual was used, but the decision process was based on the available treatment manuals (Beyebach, 2009; Quick, 2008). The therapist was a male clinical psychologist with three years of experience using BST.

In both treatment conditions, the first session focused on diagnosis and case planning; with a maximum of one hour for the first and 30 minutes for the follow-up sessions. Time between sessions varied from 2 weeks to 2 months. Therapeutic discharges were decided by the therapists when symptom remission and a functional improvement of the patients were reported. Patients who unilaterally abandoned therapy and did not return for more than 6 months were considered dropouts.

Data analysis

Sample characteristics were described calculating medians and inter-quartile ranges (IQR) for numerical variables and absolute and relative frequencies (%) for binary and categorical variables.

Differences between intervention groups were tested with the Wilcoxon rank sum tests for numerical variables and Fisher's exact test for categorical variables.

In order to estimate the differential effect of BST *versus* CBT treatment on the main outcome variables adjusting for other confounding variables, multivariate regression models were used. To assess the effect of treatment type on the number of psychotherapy sessions, a negative binomial regression model was adjusted; a logistic model was regressed to estimate the effect of therapy on relapse rates. These effects were adjusted taking into account the following variables: personal history of psychiatric disorders, family history of psychiatric disorders, personal history of suicidal attempts, anxiety disorder, depressive disorder, adjustment disorder, personality disorder, receiving psychiatric treatment, and not taking psychiatric medication. Final models were obtained by consecutively introducing significant two-way interactions and removing non-significant terms according to the Akaike Information Criterion.

All statistical tests were conducted using the R Development Core Team software (2011). Standard significance level of 5% was interpreted as statistically significant.

Given that first sessions were primarily focused on case assessment and planning, re-analyses of only of those patients who had received more than one psychotherapeutic visit was conducted. Patients with only one visit tended to be wrong referrals, as their clinical and functional deficits were insufficient to require therapy proper.

Results

Pretest data

Both treatment groups were homogeneous in terms of patients age ($p = .687$) and sex ($p = .441$). There were also no statistically significant differences between therapy groups in participants civil status ($p = .540$) and labor status ($p = .096$). A statistically significant difference was observed in the level of schooling ($p < .001$), although the high number of missing data in this last variable in the CBT group (32%) makes this difference difficult to interpret.

In relation to DSM-IV-TR diagnoses, significant differences between CBT and the BST groups were found. The percentage of anxiety disorders was higher in the BST group (CBT = 24%; BST = 35%; $p = .014$), adaptive disorders were more frequent among the CBT patients (CBT = 48; BST = 24%; $p = .001$), and personality disorders were more frequent among the BST patients (CBT = 4%; BST = 13%; $p = .002$).

At pretest, the percentage of patients with a personal history of psychiatric disorders was significantly higher in the BST than in the CBT group (CBT = 51%; BST = 79%; $p < .001$), and also the percentage of patients with a family history of psychiatric disorders was higher for the BST condition (CBT = 35; BST = 77%; $p < .001$). No statistically significant differences among groups were found with respect to the number of other medical diseases that the patients presented (current comorbidity with other medical diseases $p = .401$), the history of suicidal attempts ($p = .051$), or the type of mental health setting attended by those patients with a history of personal psychiatric disorders ($p = .262$).

As displayed in Table 2, some statistically significant inter-group differences in medication prescription were also found.

More patients in the BST group were taking benzodiazepines than patients in the CBT group (CBT = 34%; BST = 48%; $p = .004$). Regarding non-psychiatric medication, BST patients were also taking more medications ($p < .001$).

Results at follow-up

As shown in Table 3, at follow-up, 8% of the patients in our sample were still in treatment, 52% had been therapeutically discharged, 38% had dropped out, and 2% had been referred to other services. Comparing patients treated with BST with those treated with CBT, no statistically significant inter-group differences were found in the case situation at follow-up ($p = .90$), with a similar percentage of therapeutic discharges (CBT = 52%; BST = 52%) and dropouts (CBT = 37%; BST = 39%). There were

Table 1
Clinical variables at baseline (N = 419)

Clinical variables	Global	CBT	BST	P ^a
1. P.H. ^b of suicidal attempts	28 (6.68%)	9 (4.25%)	19 (9.18%)	.051
2. P.H. of Psychiatric Disorders				***
No	147 (35.08%)	103 (48.58%)	44 (21.26%)	
Yes	271 (64.68%)	108 (50.94%)	163 (78.74%)	
Unknown	1 (0.24%)	1 (0.47%)	0 (0.00%)	
3. Type of Mental Health Professional				***
Psychologist	71 (16.95%)	34 (16.04%)	37 (17.87%)	
Psychiatrist	86 (20.53%)	42 (19.81%)	44 (21.26%)	
Not specified	1 (0.24%)	1 (0.47%)	0 (0.00%)	
Primary care physician	92 (21.96%)	66 (31.13%)	26 (12.56%)	
Psychologist and psychiatrist	67 (15.99%)	11 (5.19%)	56 (27.05%)	
Unknown	2 (0.48%)	2 (0.94%)	0 (0.00%)	
4. Family History of Psychiatric Disorders				***
No	136 (32.46%)	98 (46.23%)	38 (18.36%)	
Yes	235 (56.09%)	75 (35.38%)	160 (77.29%)	
Unknown	19 (4.53%)	11 (5.19%)	8 (3.86%)	
Note: Median and 1st and 3rd IQR are reported for numerical continuous variables and absolute and relative frequencies are presented for categorical variables				
^a p -values corresponding to Wilcoxon Test for numerical variables and Fisher's exact tests for categorical variables				
^b Personal History				
* $p < .05$; ** $p < .01$; *** $p < .001$				

Table 2
Use of medication at baseline (N = 419)

Use of medication	Global	CBT	BST	P ^a
Receiving Psychiatric treatment	141 (33.65%)	81 (38.21%)	60 (28.99%)	.050
Prescribed Antidepressants (SSRIs)	192 (45.82%)	87 (41.04%)	105 (50.72%)	.050
Prescribed Benzodiazepines (BZDs)	173 (41.29%)	73 (34.43%)	100 (48.31%)	.004
Other medication (not Psychiatric)				***
No	270 (64.44%)	158 (74.53%)	112 (54.11%)	***
Between 1 and 3	103 (24.58%)	36 (16.98%)	67 (32.37%)	***
Between 4 and 6	28 (6.68%)	11 (5.19%)	17 (8.21%)	
More than 6	18 (4.30%)	7 (3.30%)	11 (5.31%)	
^a p -values corresponding to Fisher's exact test				
* $p < .05$; ** $p < .01$; *** $p < .001$				

also no statistically significant differences in the percentage of relapses (CBT = 9%; BST = 11; $p = .639$), or in the percentage of patients with Emergency Psychiatric Units admissions (CBT = 0.94; BST = 0.97; $p = .983$), Psychiatric Day Hospital Unit admissions (CBT = 1.42; BST = 0.48; $p = .328$) or Drug Abuse Treatment Unit admissions (CBT = 0.94; BST = 1.45; $p = .632$).

Table 3
Treatment outcome measures at follow-up (N = 419)

Follow-up Measure	Global	CBT	BST	P^a
Case situation at follow-up				.900
Engaged only with Psychotherapy	10 (2.39%)	4 (1.89%)	6 (2.90%)	
Engaged only with Psychiatry	8 (1.91%)	5 (2.36%)	3 (1.45%)	
Engaged with both Psychotherapy and Psychiatry	16 (3.82%)	10 (4.72%)	6 (2.90%)	
Therapeutic discharge	218 (52.03%)	111 (52.36%)	107 (51.69%)	
Dropout	158 (37.71%)	78 (36.79%)	80 (38.65%)	
Engaged with Drug Abuse Treatment Unit	3 (0.72%)	1 (0.47%)	2 (0.97%)	
Engaged with Elderly Psychiatric Units	1 (0.24%)	0 (0.00%)	1 (0.48%)	
Engaged with Psychiatric Day Hospital	1 (0.24%)	1 (0.47%)	0 (0.00%)	
Discharge for transfer	4 (0.95%)	2 (0.94%)	2 (0.97%)	
Relapses	41 (9.79%)	19 (8.96%)	22 (10.63%)	.639
Individuals with Emergency Psychiatric Units admissions	4 (0.95%)	2 (0.94%)	2 (0.97%)	.983
Individuals with Psychiatric Day Hospital Unit admissions	4 (0.95%)	3 (1.42%)	1 (0.48%)	.328
Individuals with Drug Abuse Treatment Unit admissions	5 (1.19%)	2 (0.94%)	3 (1.45%)	.632

^a p -values corresponding to Fisher's exact test
* $p < .05$; ** $p < .01$; *** $p < .001$

As shown in Table 4, initially a small but significant difference favoring CBT was found between treatments, both in the number of therapy sessions for the whole sample (CBT = 3.71; BS = 3.80; $p = .005$) and in the number of therapy sessions for those patients receiving therapeutic discharges (CBT = 3.47; BST = 4.16; $p = .001$). However, reanalyzing data to include only those patients who had more than one session, these differences disappeared both overall (CBT = 5.25; BST = 4.58; $p = .788$) and for the cases with therapeutic discharge (CBT = 5.22; BST = 4.45; $p = .540$).

Differences between the CBT and BST groups were also analyzed within the most frequent psychiatric disorders in our samples (adaptive disorder, anxiety disorder, depression). No significant differences were found in the percentage of therapeutic discharges, the percentage of dropouts, the percentage of relapses, or the number of therapy sessions within any of these diagnostic categories.

Regression analyses

The negative binomial regression model (Table 5) revealed that for those patients with neither family nor personal history of psychiatric disorders, successful BST involved more sessions than CBT. However, this effect inverted among those patients with both a family and a personal history of psychiatric disorders, for which BST was shorter than CBT. The rest of the variables present in the model, although influencing the number of sessions, had no differential effect for CBT versus BST.

The final logistic regression model found no significant differential effects of treatment on the percentage of relapses. Presenting an anxiety disorder was associated with a lower propensity to relapse in comparison to other diagnoses, but this was the case for both for CBT and for BST patients: COEF = 3.73 (-6.81, -1.71); OR = 0.02 (0.00, 0.18); $p = .002$. Although not statistically significant, patients with a family history of

Table 4
Number of sessions according to type of treatment

Variable	Min	1 st Q	Median	Mean	Sd	3 st Q	Max	Total	W^a
N° Therapy Sessions (overall)									
Global	1	1	3	3.75	3.71	5	25	1573	.005
CBT	1	1	2	3.71	4.15	4	25	786	
BST	1	2	3	3.80	3.20	5	22	787	
Overall, excluding those patients with only 1 session									
Global	2	2	3	4.89	3.87	6	25	1451	.788
CBT	2	2	3	5.25	4.53	7	25	709	
BST	2	3	3	4.58	3.21	5	22	742	
Overall for discharged patients									
Global	1	1.25	3	3.81	3.58	5	25	830	***
CBT	1	1	2	3.47	4.12	4	25	385	
BST	1	2	3	4.16	2.88	5	14	445	
Overall for discharged patients, excluding those with only 1 session									
Global	2	2	3	4.76	3.68	6	25	775	.740
CBT	2	2	3	5.22	4.67	7	25	339	
BST	2	3	3	4.45	2.83	5	14	436	

^a p -values corresponding to Wilcoxon Test
* $p < .05$; ** $p < .01$; *** $p < .001$

psychiatric disorder also tended to relapse more, both in the CBT and in the BST conditions.

Discussion

Our findings show that, in our sample, patients treated with BST reached the same outcomes as patients treated with CBT. Therapeutic outcomes for CBT and BST were equivalent in terms of percentage of therapeutic discharges, percentage of dropouts, and percentage of relapses. The equivalence between the CBT and the BST treatments was also confirmed analyzing the data by clinical diagnosis, where no differential effectiveness was found.

Before discussing these findings further, we need to acknowledge a number of important limitations of our study. Given that it is a naturalistic comparison study, patients were not randomly assigned to treatments and in fact the two groups showed some demographic and clinical differences at pretest. As a result, BST patients were initially more disturbed than CBT patients: they were taking more medication and presented a higher percentage of cases with a personal history of psychiatric disorders and with a family history of psychiatric disorders. Multivariate regression models were adjusted in order to control for the differential effect of these possible confounding factors.

Another important limitation is that only three therapists participated in the study, in the double role of both diagnosing patients at onset and conducting the CBT and BST therapies. Finally, the outcome measures, of a clinical-administrative nature (therapeutic discharges, dropout, relapses and number of sessions), are very relevant from a public mental health perspective, but only provide limited clinical information and do not allow to compare the degree of improvement of the patients in the two therapy conditions.

As strengths of our study, we would like to emphasize its external validity. The study was conducted with broad patient inclusion criteria in a real public outpatient mental health unit, with all its accompanying constraints: high service demand, work overload, restrictions to the frequency of follow-up meetings, and so on. The fact that the BST and CBT treatments were not conducted in a manualized way and without measuring treatment integrity is an obvious limitation, but can also be seen as an asset, given that a flexible delivery of treatments is in fact typical of how psychotherapeutic treatments are actually practiced. This is especially the case in public mental health contexts, where case management with other professionals takes place, pharmacological treatments are often used concurrently, and comorbidity is frequent.

Within the context of these limitations and strengths, our data suggest that in our sample, BST was as effective and as cost-efficient as the comparison CBT treatment. In both conditions, the percentage of dropouts was slightly above one third of the sample, but over 50% of the cases were successful therapeutic discharges. For both therapies, this outcome was achieved after a rather low number of sessions, with an average of around 5 sessions. The percentage of relapses was below 10% in both treatment conditions, and the number of cases that had to be referred to more intense care (Day Hospital, Emergency Psychiatric Units or Drug Abuse units) was negligible, below 3% for both conditions.

In our view, these findings are especially relevant from the point of view of BST, given that in our study it successfully withstood the comparison with a “golden standard” therapy like CBT in routine clinical practice. Both therapies tended to be brief, with a median of 3 and an average below 5 sessions for successfully treated cases, and the percentage of relapses and of referrals to more specialized units was very low. In our view, these data suggest that CBT and

Table 5
Negative binomial regression on the number of Psychotherapy Sessions

Variable	Coef. ^a	Exp. Coef. ^b	P
Intercept	1.91 (1.19, 2.69)	6.74 (3.28, 14.67)	***
BST Therapy	1.25 (0.06, 2.52)	3.50 (1.06, 12.44)	*
Personal History of Psychiatric Disorders	-0.16 (-0.95, 0.64)	0.85 (0.39, 1.90)	.684
Family History of Psychiatric Disorders	-0.79 (-1.66, 0.10)	0.46 (0.19, 1.10)	.061
Personal History of Suicidal Attempts	-1.08 (-2.12, -0.02)	0.34 (0.12, 0.98)	*
Anxiety Disorder	-0.66 (-1.32, -0.03)	0.52 (0.27, 0.97)	*
Depressive Disorder	-0.54 (-1.26, 0.16)	0.58 (0.28, 1.18)	.122
Adjustment Disorder	-0.49 (-1.15, 0.14)	0.61 (0.32, 1.15)	.128
Not taking psychiatric medication	-1.42 (-2.35, -0.53)	0.24 (0.10, 0.59)	***
(Inter) ^c Family history of Psychiatric Disorders with Not taking psychiatric medication	1.50 (0.47, 2.58)	4.50 (1.59, 13.20)	*
(Inter) BST with Family history of Psychiatric Disorders	-1.26 (-2.37, -0.21)	0.28 (0.09, 0.81)	*
(Inter) Personal History of Psychiatric Disorders with Familiar history of Psychiatric Disorders	1.26 (0.23, 2.33)	3.53 (1.25, 10.24)	*
(Inter) BST with Personal history of Psychiatric Disorders	-0.85 (-1.88, 0.16)	0.43 (0.15, 1.17)	.078

^a Coefficients and 95% confidence intervals of a Negative Binomial regression model predicting the number of Psychotherapy Sessions

^b Regression adjusted on the logarithm of the number of sessions minus two, so that Exp. Coef. is interpreted as the multiplicative effect on the number of sessions of the reference group

^c Indicates that the coefficient is an interaction between two variables (variables that, when presented simultaneously, they do have a different effect than the sum of their separate effects)

* $p < .05$; ** $p < .01$; *** $p < .001$

BST, as applied in our study, were both effective and cost-efficient, fulfilling their role in the context of the needs and constraints of a public mental health service. It should be noted, however, that in our study, a solution-focused treatment like BST had, in fact, no fewer sessions than CBT, in spite of the claims made about solution-focused therapy as probably being briefer than other treatments (Franklin et al., 2011; Gingerich & Peterson, 2012).

Our findings can also be taken to provide some provisional support to the feasibility of integrating different brief solution-focused and systemic therapies, as proposed by the clinical literature (Chang & Phillips, 1993; Quick, 2008; Selekman &

Beyebach, 2013). The findings of this study provide some evidence that integrative brief systemic therapy approaches can be effective and efficient in routine clinical practice, as recent research on integrative solution-focused group therapy also suggests (Carreras et al., in press). We expect that future and better controlled studies will allow more robust claims to be made as to the effectiveness of BST for different disorders and settings. In this way, the repertoire of available evidence-based therapeutic tools for therapists would be enlarged, contributing to help patients who might not profit from the most commonly used therapeutic approaches (Hays & Iwamasa, 2006; Roth & Fonagy, 2005).

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