

**“Fast Therapy, Slow Healing? "A Critical Theoretical Exploration of Brief Therapy in
Contemporary Adolescent Mental Health Services”**

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Abstract

This thesis critically examines the rise of brief therapy within contemporary mental health systems, arguing that its widespread adoption reflects not only service-level efficiency demands but deeper cultural anxieties surrounding distress, diagnosis, and therapeutic containment. While often dismissed as a product of neoliberal managerialism, brief therapy has historical and theoretical roots within psychoanalysis—particularly in the work of Ferenczi, Rank, Malan, and Davanloo—who demonstrated that time-limited therapy can retain relational depth and emotional transformation. The thesis contrasts these models with current applications in youth mental health services, where brief interventions are often driven by outcome-based funding models, digital scalability, and a cultural climate of ‘prevalence inflation’ and diagnostic overreach. Rather than rejecting brief therapy outright, this thesis argues for its reclamation as an ethically grounded, developmentally attuned modality. When supported by clinical integrity and theoretical rigour, brief therapy can serve not as a shallow stopgap, but as a meaningful encounter capable of supporting genuine psychological change.

Introduction

The proliferation of brief therapy models has reshaped contemporary child and adolescent mental health care, particularly within public systems under economic strain. Advocates highlight their accessibility, cost-effectiveness, the potential for rapid symptom relief, especially for adolescents, when interventions are developmentally and contextually attuned (Bloom, 2001; Eapen et al., 2024). Typically grounded in cognitive-behavioural or solution-focused approaches, these models have gained traction in systems increasingly driven by short-term, measurable outcomes, that strive to prove the model as both effective and efficient (Hofmann et al., 2012; Norcross & Wampold, 2011).

However, others caution against this uncritical adoption of brief therapy as increasingly the default approach. There is growing concern that such models represent the only available option and are inadequate for young people with complex mental health difficulties, particularly those with entrenched relational disturbances that require sustained, in-depth therapeutic engagement (McWilliams, 2011; Orange, 2010). More broadly, the evidence base to support brief therapy has been subject to increasing scrutiny, particularly in relation to potential conflicts of interest. Critics argue that many of the studies promoting their efficacy have been produced, funded, or disseminated by the very organisations responsible for delivering these services, raising questions about selective reporting, publication bias, and methodological rigour (Dalal, 2018; Moloney, 2016).

As brief therapy is applied today—tracing its trajectory from psychoanalytic origins to its now-dominant but often unacknowledged forms—it warrants critical reflection, not only in terms of clinical efficacy but also in relation to the broader therapeutic culture of which it is both a casualty and a vehicle. As Furedi (2004) and Samuels (2015) argue, the rise of brief therapy and its instrumental models, is shaped not merely by economic constraint but by a deeper

cultural alignment with managerialism, risk aversion, and the standardisation of care. Within this paradigm, psychotherapy is increasingly framed as a set of technical procedures aimed at behavioural regulation rather than a relational process of meaning-making and ethical engagement.

Psychoanalytic thinkers such as Orange (2010) and Leader (2011) have warned that the erosion of therapeutic depth, ambiguity, and emotional complexity—long seen as central to transformative healing—risks reducing psychotherapy to a form of behaviour management. As traditions grounded in a freedom of duration, relational depth, and the co-construction of meaning are displaced, there is a growing concern that the foundational ethos of psychotherapy may be irreparably compromised (Safran & Muran, 2000; Orange, 2010).

Drawing on the work of Donald Winnicott (1960), one might argue that meaningful therapeutic work, that depends on the creation of a “holding environment”—a relational space that allows for regression, vulnerability, and the emergence of the true self—is under threat, if not already extinct, particularly in adolescent psychotherapy. Such holding is inherently time-bound and relationally attuned, requiring a consistency and presence that cannot be easily replicated in fragmented or accelerated formats. When therapy is restructured around immediacy and instrumental outcomes, it risks depriving clients of the relational and temporal space essential for processes of integration and lasting transformation. As Benjamin (1995) argues, genuine psychological change arises within an intersubjective space of mutual recognition, which cannot be hurried or predetermined without flattening the complexity of the therapeutic encounter. Similarly, Orange (2010) cautions that when psychotherapy is reduced to technique and outcome, it forfeits the ethical presence and attuned responsiveness that make healing possible.

Contrarily, a substantial body of research demonstrates that brief therapy can lead to clinically significant improvements in mental health outcomes, particularly for individuals experiencing mild to moderate psychological distress. Meta-analyses have shown that time-limited interventions—such as those based on Cognitive Behavioural Therapy (CBT), Brief Solution-Focused Therapy (BSFT), and other brief interpersonal models—can be as effective as longer-term treatments in reducing symptoms of depression and anxiety (Cuijpers et al., 2010; Barkham et al., 2006). For many clients—particularly those experiencing situational stressors or seeking rapid relief—brief therapies that provide timely access to focused, goal-oriented interventions can be highly effective (Cape et al., 2010).

Chapter One will begin by tracing the historical foundations of brief therapy from its psychoanalysis origins to the behavioural movement. While today, brief therapy is often associated with contemporary behavioural and cognitive approaches, brief therapeutic interventions have roots that extend back to the early days of psychoanalysis.

This historical overview aims to establish brief therapy as a legitimate and substantive psychotherapeutic modality, rooted not solely in pragmatic adaptations or managerial imperatives, but in a lineage of clinically and theoretically rigorous developments. It challenges the prevailing perception that brief therapy is merely a time-efficient offshoot of behaviourist and cognitive models that gained prominence in the 1960s (Bauer & Kobos, 1984; Levenson, 1995). By foregrounding its psychoanalytic and relational origins, this chapter asserts that brief therapy need not be synonymous with theoretical superficiality or historical rupture but can instead be re-situated within a tradition that values emotional depth, therapeutic alliance, and unconscious process—even within constrained formats.

Chapter Two explores the development and clinical application of psychoanalytically informed brief therapy, focusing on the foundational contributions of David Malan, Habib

Davanloo, Peter E. Sifneos, and Lester Luborsky. Working primarily in the mid-20th century, these clinicians challenged orthodox psychoanalytic assumptions by demonstrating that meaningful therapeutic change could occur within a condensed timeframe—once the therapeutic relationship was intensified rather than diluted (Malan, 1976; Davanloo, 1980; Sifneos, 1987).

Central to their approaches was the strategic use of transference, countertransference, and unconscious affect to accelerate emotional insight and transformation. Malan, in particular, advanced brief therapy from a conservative analytic stance toward a more radical model, emphasising early transference activation, confrontation of defences, and the working-through of resistance to facilitate depth-oriented change within a limited number of sessions.

The chapter also traces how this psychoanalytic formulation of brief therapy was later adapted by behaviourist and cognitive theorists, leading to a significant theoretical and clinical shift. Unlike their psychodynamic predecessors, behaviour therapists such as B.F. Skinner (1953) employed brief formats primarily for symptom relief and behavioural modification, drawing on principles of operant conditioning and a focus on observable change. This trajectory laid the groundwork for the emergence of CBT, formalised by Aaron Beck (1976), who introduced cognitive restructuring as a central mechanism for alleviating emotional distress. While CBT retained the time-limited structure of earlier models, it diverged sharply in its emphasis—toward structured, manualised interventions, goal-setting, and the modification of distorted thinking patterns—rather than the exploration of unconscious conflict or relational dynamics.

As Kazdin (2000) observes, this transition reflected a broader epistemological shift toward empirical validation, efficiency, and standardisation—aligning CBT with the operational demands of public mental health systems, increasingly driven by outcome measurement and cost-effectiveness. This divergence marks a significant clinical and ideological fault line, one

that reflects broader shifts in the ethics and aims of psychological care. These tensions, originating in mid-century debates, continue to shape contemporary practice and underpin the critical argument of this thesis: that brief therapy has evolved in multiple, often competing directions, shaped as much by institutional and cultural forces as by clinical innovation.

Chapter Three explores the escalating crisis in adolescent mental health, often referred to in popular and academic discourse as the rise of “*Generation Anxiety*” (Cook, 2024). Recent research highlights significant increases in anxiety, depression, self-harm, suicidal ideation, and suicide among young people, trends exacerbated by the COVID-19 pandemic and broader socio-cultural stressors (Twenge, 2017; WHO, 2021; Loades et al., 2020). This chapter examines the sociocultural, developmental, and systemic factors contributing to these patterns, while critically analysing how the crisis is framed in policy and service responses that deploy brief therapy models as the solution.

Further, mental health policy, as it prioritises prevention and early intervention, is inclined towards brief therapy models—particularly those grounded in solution-focused and cognitive-behavioural paradigms. Promoted as efficient, scalable, and cost-effective, these approaches have received significant public investment and are now widely implemented through schools, digital platforms, and primary care-level services (Weisz et al., 2017; Clark et al., 2018). However, this shift has occurred alongside the persistent under-resourcing of secondary mental health services such as CAMHS, which continue to experience chronic staffing shortages, long waiting lists, and limited capacity to support young people with complex, comorbid, or developmentally embedded needs (Mental Health Commission, 2023; Health Service Executive, 2019). The result is a service architecture where brief interventions are deployed not necessarily because of clinical fit, but as a pragmatic response to systemic constraint—raising

critical questions about access, equity, and the dilution of therapeutic depth in contemporary youth mental health care.

Chapter Four examines the sociopolitical context in which brief therapy has gained prominence, particularly within publicly funded mental health systems. It critically explores how economic austerity, managerialism, and “payment by results” frameworks have reshaped therapeutic practice, incentivising short-term, outcome-focused interventions at the expense of longer-term, relationally oriented care (Rose, 1999; Moloney, 2016). In such systems, the appeal of brief therapy lies not only in its clinical claims but in its compatibility with metrics-driven service models that prioritise efficiency, accountability, and throughput.

The chapter also considers the rise of diagnostic desire—a cultural phenomenon in which growing societal discomfort with emotional ambiguity has contributed to increased vigilance around children’s and adolescents’ mental states. Within this context, everyday distress is increasingly medicalised, and therapeutic intervention is sought even for normative developmental experiences (Brinkmann, 2016; Timimi, 2014). This has helped propagate a therapeutic culture where, as Furedi (2004) describes, “no problem is too small for therapy,” fuelling the expansion of brief interventions as first-line responses to a wide spectrum of psychological and behavioural concerns.

Together, these developments point to a broader transformation in how mental health is understood and managed: not merely as a clinical issue, but as a site of cultural, political, and economic negotiation. This chapter argues that the dominance of brief therapy reflects—and reinforces—a model of care shaped as much by system imperatives and cultural anxieties as by therapeutic effectiveness (Rose, 1999; Ehrenberg, 2010; Davies, 2017).

Chapter Five critically examines the ethical, philosophical, and relational implications of the widespread institutional adoption of brief therapy models. It explores how short-term,

symptom-focused interventions, now standard across many service contexts, introduce significant tensions between therapeutic depth and procedural efficiency, symptom relief and self-understanding, and accessibility and clinical integrity. Drawing on philosophical critiques (e.g., Foucault, 1963; Han, 2017), the chapter interrogates how brief formats risk reducing therapy to a form of technical problem-solving that pathologizes normative emotional experiences and reinforces cultural imperatives of productivity, recovery, and emotional control.

Central to the chapter is a critical analysis of how time constraints reshape the therapeutic relationship, limiting the space for complexity, ambiguity, and the unfolding of transference processes (Gelso & Hayes, 2007). The ethical challenges of practicing within time-limited models are further elaborated through discussions of consent, autonomy, and duty of care, particularly in systems driven by managerialist and outcome-oriented logics (Rose, 1999; Orange, 2010).

The chapter also considers the lived experience of therapists working under these conditions, highlighting the emotional labour, boundary complexities, and heightened risk of burnout and role strain (Maslach & Leiter, 2016; Figley, 2002). It argues that the compression of core therapeutic processes—such as alliance-building, assessment, and endings—can generate clinical and ethical dilemmas that are often under-acknowledged within service settings.

Ultimately, the chapter positions the therapist not merely as a deliverer of brief interventions, but as a moral agent navigating complex systemic, relational, and ethical pressures. In doing so, it calls for a re-engagement with the foundational values of psychotherapy—attunement, containment, and care—even within models increasingly shaped by imperatives of efficiency and standardisation.

Chapter Six synthesises the thesis' central arguments and proposes future directions for the practice, theory, and policy of brief therapy. Revisiting the core question—whether brief therapy can be reclaimed as a valid and meaningful psychotherapeutic modality—the chapter draws together the historical, clinical, ethical, and sociopolitical analyses developed in previous chapters. It critically examines the possibility of brief therapy operating beyond its current institutional framing, which is often shaped by imperatives of cost-efficiency, symptom management, and system throughput.

The chapter argues for a reimagining of brief therapy as an ethically grounded, relationally attuned practice capable of supporting emotional complexity and transformative engagement. Emphasising the importance of therapist training that fosters attunement and clinical reflexivity (Orange, 2010), it also highlights the need for service structures that allow for flexibility and discretion in therapeutic work (Safran & Muran, 2000). Drawing on relational theorists such as Benjamin (1995) and critical perspectives from Davies (2017) and Rose (1999), the chapter critiques neoliberal and managerialist reductions of therapy to procedural outcomes. Instead, it proposes a vision of brief therapy that resists such reductionism and affirms the possibility of depth, responsiveness, and moral intentionality within time-limited formats.

Chapter One – Historical Evolution of Brief Therapy

1.1 Introduction

Over time, two distinct applications of brief therapy have emerged, each rooted in differing theoretical, historical, and institutional contexts. The first is grounded in the psychoanalytic tradition, originating with Freud and further developed by figures such as Sándor Ferenczi, David Malan, and Habib Davanloo. In this lineage, brief therapy is not a compromise imposed by time constraints but rather an intensification of the analytic process—an accelerated form of psychoanalysis. Models such as Malan’s *Focused Dynamic Psychotherapy* (1976) and Davanloo’s *Intensive Short-Term Dynamic Psychotherapy* (1980) aim to swiftly challenge defences and facilitate emotional breakthroughs through transference work. In these approaches, the number of sessions remains flexible, subordinated to the depth and urgency of the therapeutic task rather than external pressures.

By contrast, the second application of brief therapy emerges from the cognitive-behavioural tradition, particularly through models such as CBT and SFBT. These approaches gained significant traction from the 1970s onward, especially within public mental health systems that seek more accessible, scalable, and cost-efficient interventions (Norcross & Karpiak, 2012). Unlike their psychodynamic counterparts, these models typically define success in terms of symptom reduction and goal achievement within a fixed number of sessions—commonly between six and twelve. The emphasis is on structure, measurable outcomes, and goal-oriented work, aligning closely with service-level performance targets and outcome accountability.

While psychoanalytic approaches show that brief therapy can be both relationally rich and deeply transformative, the cognitive-behavioural models often function within systems that

risk reducing psychotherapy to symptom-focused intervention and throughput optimisation (Shedler, 2010; Holmes & Lindley, 1989).

Nevertheless, it is important to acknowledge that cognitive-behavioural therapies remain among the most empirically validated modalities. Meta-analyses consistently demonstrate that CBT produces moderate to large effect sizes for a range of common mental health difficulties, including depression, anxiety, and post-traumatic stress disorder (Butler et al., 2006; Hofmann et al., 2012). These approaches are particularly suited to mental health systems that prioritise evidence-based practice and quantifiable outcomes, such as the UK's Improving Access to Psychological Therapies (IAPT) programme (Clark, 2018). The challenge, therefore, lies not in discrediting brief therapy, but in interrogating the systems and assumptions under which it is practiced, and considering whether current applications retain fidelity to the ethical, relational, and transformative aims of psychotherapy.

1.2 Psychoanalysis Formed Brief Therapy

Psychotherapy as a professional practice, has its historical roots in the psychoanalytic tradition, now more commonly referred to as psychodynamic psychotherapy. This tradition was profoundly shaped by pioneering figures such as Sigmund Freud, Alfred Adler, Karen Horney, and Harry Stack Sullivan, who collectively laid the foundations for a form of therapeutic work focused on unconscious processes, early developmental experiences, internal conflicts, and the dynamics of interpersonal relationships (McWilliams, 2020; Lemma, 2016). This tradition emphasised the subjects' unconscious motivations, early life experiences, repressed conflicts, interpretive dialogue, and the role of defence mechanisms (Lambert, 2023, p. 8). Levenson et al. (2002) note that the foundational structure of psychotherapy stems from Freud's lifelong concern with distancing psychoanalysis from the charge of mere suggestion—an accusation that today might be equated with psychoanalysis lacking empirical validity. Freud was keen to

differentiate true psychoanalysis, which he likened to “gold,” from the “copper” of suggestion (Freud, 1919/1955, as cited in Levenson et al., 2002, p. 15).

Freud’s emphasis on the role of the unconscious and transference, Adler’s concern with inferiority and social embeddedness, Horney’s critique of cultural and gender influences, and Sullivan’s interpersonal theory all contributed to a model of therapy that was depth-oriented, exploratory, and typically long-term in nature (Mitchell & Black, 1995). These early psychoanalytic approaches privileged the slow unfolding of insight through a consistent therapeutic relationship, with minimal structuring of session length or frequency—reflecting a belief that genuine psychic transformation required sustained emotional engagement over time. The very structure of open-ended therapy, with its tolerance for ambiguity and resistance, mirrored its aims: not merely symptom reduction, but fundamental changes in personality, relational patterns, and meaning making (Gabbard, 2017). As such, the early psychoanalytic model established a therapeutic ethos centred on introspection, complexity, and the co-construction of insight, which continues to inform critiques of time-limited approaches today.

By the 1920s, early optimism surrounding psychoanalysis had begun to wane in the face of growing concerns about the length and diminishing efficacy of traditional analytic treatment (Thompson, 1952). Key figures within Freud’s circle, particularly Sándor Ferenczi, responded to this disillusionment by proposing more active and responsive therapeutic methods that challenged the rigidity of classical analysis. Ferenczi, who had undergone his own analysis with Freud, pioneered what became known as “active therapy.” In his influential paper *The Elasticity of Psycho-Analytic Technique* (1918), Ferenczi argued for a flexible approach to psychoanalytic work, adapting technique to the specific emotional and developmental needs of the patient. This included a greater degree of therapist activity and, notably, the possibility of time-limited treatment (Demos & Prout, 1993).

Ferenczi's emphasis on empathy, relational responsiveness, and mutuality laid the conceptual groundwork for what would later be formalised as the therapeutic alliance—now considered a cornerstone of all psychotherapeutic practice. This contribution is particularly relevant to brief therapy, where trust and emotional engagement must be established swiftly and maintained effectively within a compressed timeframe. In this sense, Ferenczi's innovations represent an early and ethically grounded precursor to contemporary models of time-limited psychotherapy.

Ferenczi's contribution—articulated in his writings throughout the 1920s and especially in collaboration with Otto Rank (Ferenczi & Rank, 1923/1925)—laid critical groundwork for what would later be termed '*brief dynamic psychotherapy*'. His method was defined by its opposition to passivity, which Ferenczi identified as a primary cause of therapeutic stagnation and excessive treatment length. Instead, he introduced an “active” therapeutic stance, aimed at intensifying the transference and accelerating insight.

Key features of Ferenczi's active technique included:

1. **Taking a more engaged role** in the therapeutic relationship to elicit neurotic patterns more vividly in the transference.
2. **Time-limited interventions** or treatment constraints designed to intensify the emotional and relational aspects of the work.
3. **Mutuality and empathy**, which anticipated later relational and intersubjective paradigms in psychotherapy.

Ferenczi's work prefigures many of the principles seen in modern brief therapy, particularly those that emphasise the therapeutic relationship, focal conflict exploration, and emotional immediacy. His challenge to therapeutic passivity not only foreshadowed later developments in short-term dynamic psychotherapy (e.g., Davanloo, Sifneos, Malan) but also remains

relevant to contemporary debates about the depth and relationality possible within brief treatment models.

Otto Rank, (1884–1939), a prominent psychoanalyst and former colleague of Freud, is a significant figure in the history of psychotherapy, and a contemporary of Ferenczi in experimenting with short-term treatment. He was the first to use time limits to specifically address his patient's separation problems. Significantly, unlike traditional psychoanalysis, which often delved deeply into the past, Rank encouraged focusing on the present moment and the client's immediate experiences and emotions (Lieberman, 1985). The ideas of Ferenczi and Rank, were, however, strongly opposed in analytic circles of the time and were seen as a threat to Freud. The reactions eventually led to a halt in the development of short-term dynamic therapy until sometime after World War II (Bauer & Kobos, 1984). Franz Alexander (1891–1964), a Hungarian American psychoanalyst resumed the experimentation of session length in psychoanalysis. Working in Chicago, he adjusted treatment length to the patients' needs, along with a focus on a current life problem; minimised regression and emphasized reality, problem solving and new learning (Gabbard, 2004). His principles are widely used by many therapies, particularly short-term psychoanalytic psychotherapy (ibid, p4).

Milton H. Erickson, M.D. (1901–1980) an American psychiatrist, is legendary for his creative uses of communication and hypnosis that disrupt symptoms and evoke clients' resources to bring about therapeutic change. He is considered the “spiritual father” of various brief therapy approaches, including Solution-Focused Brief Therapy (SFBT), (Hoyt & Cannistrà, 2022 p.15).

Although short-term brief therapy is often dismissed as less legitimate than "real therapy," the literature reveals its deep roots in psychoanalytic tradition—having been practiced, endorsed, and adapted by key figures in early psychoanalysis who also shaped the broader field of

psychotherapy (Lambert & Archer, 2006). Rather than being a recent managerial innovation, time-limited therapy can be seen as a strategic adaptation of psychoanalytic principles aimed at intensifying therapeutic work. Ferenczi's active technique, Rank's time-limited focus on separation and individuation, and later developments by David Malan and Habib Davanloo all exemplify efforts to condense the therapeutic process without sacrificing its depth or relational integrity. These early contributions challenge the binary view that only long-term therapy allows for meaningful psychological transformation, instead illustrating that brevity and depth are not mutually exclusive when approached with clinical precision and relational attunement.

1.3 Brief Therapy – Critical Voices from Psychoanalysis

Other key psychoanalytic practitioners and theorists voiced strong reservations about the limitations and ethical compromises of brief therapy. Fromm (1941), for instance, cautioned that reducing psychotherapy to a technical process risked stripping it of its humanistic and existential dimensions. Karen Horney, writing in the 1950s, questioned whether the pragmatic focus of brief therapy—such as resolving immediate or surface-level problems—might undermine the deeper aims of emotional growth and self-realisation (Sayers, 1991). Wilhelm Reich similarly doubted whether brief interventions could ethically address the therapist's responsibility to engage with enduring characterological patterns and somatic defences. Harry Stack Sullivan, whose interpersonal theory emphasised the primacy of relational dynamics, warned that time-limited work may not adequately explore long-standing maladaptive relational patterns or affective difficulties (Shedler, 2010).

These critiques highlight that while brief therapy has identifiable roots in psychoanalytic practice—particularly through the innovations of Ferenczi, Malan, and Davanloo—it has long elicited ambivalence and resistance from within the psychoanalytic community itself. Critics such as Fromm (1941), Rado, and Eissler (as cited in Malan, 1975) feared that an overemphasis

on brevity, utility, and efficiency could compromise the core ethical and clinical aims of psychotherapy: namely, psychic transformation, emotional depth, and the slow co-construction of meaning. Their concerns are echoed in contemporary critiques from relational and depth-oriented clinicians, who argue that brief models, even when effective in symptom reduction, risk being subsumed by a medicalised, outcome-driven ethos that prioritises service throughput over therapeutic integrity (Moloney, 2016; Shedler, 2010).

The tension between these perspectives reveals a longstanding anxiety about the future of psychotherapy when shaped by institutional logics of productivity, standardisation, and cost-efficiency. While brief therapies offer undeniable pragmatic value in resource-limited contexts, its critics argue that they may inadvertently reinforce a reductive model of mental health treatment that sidelines the complex, relational, and existential dimensions of human suffering and growth.

Chapter 2 Psychoanalysis & Brief Therapies-Modern Theorists

2.0 Introduction

While early critiques of brief therapy focused on concerns about depth, ethics, and relational integrity, the 1960s and 1970s marked a pivotal shift. During this period, several psychoanalytically trained clinicians began developing structured short-term interventions designed to retain the depth of psychoanalytic insight while responding to increasing demands for time-limited therapy. What emerged was a body of work that sought to reconcile brevity with therapeutic depth, challenging the notion that short-term work must be superficial.

One of the most influential figures in this movement was Dr. Habib Davanloo, who pioneered Intensive Short-Term Dynamic Psychotherapy (ISTDP). Drawing on Freudian theory, Davanloo (1978, 1980) developed a technique aimed at rapidly accessing repressed emotions and unconscious conflicts through an active, often confrontational stance by the therapist. Central to ISTDP are the principles of resistance work, emotional breakthrough, and a strong therapeutic alliance—all conducted within a compressed timeframe. Davanloo's goal was to achieve the depth of long-term analytic work in a fraction of the time by intensifying the emotional engagement early in treatment (Hickey, 2017).

Peter E. Sifneos, a colleague of Davanloo, developed Short-Term Anxiety-Provoking Psychotherapy (STAPP), which similarly emphasised emotional activation but focused more explicitly on careful client selection. Sifneos (1972, 1979) argued that brief therapy was most effective for clients who were psychologically minded, highly motivated, and presenting with focused, circumscribed problems.

David Malan, working at the Tavistock Clinic, made a significant contribution through his model of 'Brief Psychotherapy' (1963, 1976). He introduced two conceptual frameworks—the

"*triangle of conflict*" (impulse–anxiety–defence) and the "*triangle of person*" (past relationships, current relationships, and the therapeutic relationship)—to help clients reach insight more efficiently. Malan argued that brief therapy could achieve depth, provided that the client's core emotional conflict was clearly identified, and interventions were timed precisely. (See Appendix B for an outline of Malan's triangle of conflict and of the person).

Another important contribution came from Lester Luborsky, who developed Supportive-Expressive Therapy (SET). Luborsky (2014) integrated traditional psychodynamic elements such as transference with supportive techniques aimed at strengthening ego functions and symptom relief. SET was deliberately designed to be adaptable across varying timeframes and clinical settings, making it particularly relevant for use in public health systems and research contexts.

Together, these theorists demonstrated that brief therapy could retain analytic integrity and depth when grounded in coherent theory and delivered with clinical precision. Rather than abandoning psychoanalytic principles, they reformulated them within structured, time-sensitive models that enabled meaningful therapeutic change in fewer sessions. Their innovations laid the groundwork for subsequent integrative approaches and serve as a counterpoint to assumptions that brief therapy must be shallow or purely pragmatic.

(See Table in Appendix A for an overview of each theorist's model and theoretical orientation.)

2.1 Influence of Malan's Radical Position on Brief Therapy

David Malan's landmark publication '*A Study of Brief Psychotherapy*' (1976) provides one of the most comprehensive theoretical frameworks for understanding the spectrum of brief therapy practice. Malan situates brief psychotherapy within two fundamentally opposing viewpoints—the *conservative* and the *radical*—each reflecting distinct clinical assumptions about client suitability, therapeutic depth, and expected outcomes.

The conservative position maintains that brief therapy is suitable only for individuals with recent-onset, mild disorders. From this perspective, therapy is largely symptom-focused and superficial, aiming for palliative results. Proponents such as N.C. Lewis and Rado viewed brief interventions as inherently limited, unable to generate meaningful structural personality change. Eissler went so far as to suggest that therapeutic outcomes from brief interventions might constitute "*an exchange of illusions*" rather than genuine transformation.... '*Deeper changes in the personality are neither attempted nor possible.*' (Brief Psychotherapy Council (quoted by Gutheil, op. cit. 1945 cited in Malan, 1976).

In contrast, the radical position posits that brief psychotherapy can produce substantial change, even in complex and longstanding neurotic conditions. Advocates of this view argue that techniques traditionally reserved for long-term psychoanalysis—such as transference interpretation, dream analysis, and the exploration of early relational dynamics—can be effectively utilised within short-term frameworks when applied with precision and emotional intensity. Franz Alexander and Thomas French (1946) were among the first to show that focused interventions in the transference relationship could catalyse significant therapeutic change. Later, Malan (1976) advanced this argument by demonstrating that brief psychodynamic interventions could address deep-seated conflicts, provided that therapy maintained a clear focus on a central dynamic issue. His work illustrates that durable

improvements are possible even with patients who present with chronic or complex neuroses, challenging the assumption that only long-term analysis can bring about meaningful change. This radical perspective reframes brevity not as a limitation, but as a method of distilling and intensifying therapeutic work.

As Malan concluded, psychoanalytically informed brief psychotherapy can facilitate significant change even in moderately severe and chronic cases, provided the approach is focal, emotionally engaged, and technically flexible (Malan, 1976; Malan, Osimo, 1994).

In the context of what Malan considered to constitute 'brief therapy', he describes this as therapy planned with a specific time limit from the beginning, even if it ran to 40 sessions, was still regarded as 'brief' within the context of that plan (Malan, 1976). However, typically he considered brief therapy to involve fewer than 40 sessions, with many of his clinical studies focusing on treatments ranging between 12 to 30 sessions, as he states, "*so far no attempt has been made to define any arbitrary point at which therapy ceases to be 'brief' and becomes 'long-term'...the definition of brief psychotherapy must depend on experience of what gives satisfactory results...[and] a study of those 'successful' cases of which some details have been actually published allows only the following generalizations to be made.*" (Malan, 1976, p. 9).

Rather than proposing a fixed session count, Malan's contribution was to shift the definition of "brief" from its time relevance alone, to a combination of structural, technical, and relational factors that allow depth within a time-limited frame (Malan, 1976).

Malan's work remains foundational for contemporary brief dynamic therapies, offering a framework that fundamentally challenges the dichotomy between therapeutic depth and duration. His model demonstrated that meaningful psychological change could occur within a limited number of sessions, provided the therapy is anchored by a clearly defined focus, emotional intensity, and the strategic use of transference. Rather than treating brief therapy as

inherently superficial, Malan (1976) argued that its effectiveness hinges on the depth of the focal conflict being addressed and the therapist's capacity to skilfully engage unconscious material. This perspective affirms that brevity need not come at the expense of complexity, and that the efficacy of psychotherapy lies not in its duration alone, but in the precision, intensity, and relational attunement of the therapeutic encounter.

2.2 *Psychology's adoption of Brief Therapies*

Although early brief dynamic therapies, developed by figures such as Malan, Sifneos, and Davanloo, retained their psychoanalytic foundations (Malan, 1976; Davanloo, 1980), the emergence of behaviourism in the mid-20th century marked a significant turning point in the evolution of brief therapy. Behaviourism, rooted in the work of Watson (1913), prioritised observable behaviour and empirical validation over introspection, aligning well with increasing demands for accountability, efficiency, and cost-effectiveness in public health systems (Kazdin, 2000; Norcross & Karpiak, 2012).

This scientific and outcome-focused orientation paved the way for the rise of cognitive approaches, particularly through the work of Aaron Beck and Albert Ellis in the 1960s. Beck's *Cognitive Therapy and the Emotional Disorders* (1976) marked a clear methodological break from psychoanalysis, shifting focus from unconscious meaning to cognitive restructuring and behavioural activation. While Beck retained some psychodynamic sensitivities from his early training, CBT evolved into a model characterised by structure, brevity, and outcome measurability—qualities that gained institutional favour in health systems under pressure following World War II (Dobson & Dobson, 2018).

In contrast to psychoanalysis—which was seen as elite, inaccessible, and open-ended—CBT was framed as practical, affordable, and results-oriented, reflecting broader post-war social and economic imperatives for scalable, standardised models of care (Clarke, 2020).

The rise of CBT marked a significant departure from psychoanalytic traditions, aligning brief therapy with the operational priorities of modern healthcare systems, including efficiency, standardisation, and cost-effectiveness (Fonagy, 2015). Behavioural theorists such as Joseph Wolpe and Hans Eysenck rejected the exploration of unconscious processes in favour of goal-directed interventions grounded in observable behaviour and environmental contingencies (Kazdin, 1978; Skinner, 1953). These developments were not purely clinical but emerged in response to broader socio-political pressures, including the post-war expansion of welfare states, rising mental health service demands, and the growing imperative for evidence-based, cost-efficient care. Collectively, they support the view that CBT's rise was influenced by its compatibility with post-war demands for therapies that are efficient, standardized, and scalable within public health frameworks.

The dominance of the randomised controlled trial (RCT) as the gold standard in evaluating treatments further marginalised psychoanalytic approaches, whose subjective and relational complexity resisted standardisation (Deacon, 2013). As a result, the institutionalisation of brief therapy—particularly in its CBT form—reflects a broader cultural shift towards neoliberal ideals of productivity, quantifiability, and symptom management (Rose, 1999; Timimi, 2015). While CBT gained legitimacy and scalability, it also signalled a philosophical turn away from depth-oriented, exploratory work towards problem-focused, time-bound interventions aimed at restoring functionality rather than understanding meaning.

While proponents of CBT argue that it delivers significant therapeutic benefits—particularly for individuals experiencing mild to moderate distress—critics have questioned its broader implications. Specifically, they argue that CBT's alignment with neoliberal ideals of productivity, self-management, and quantifiable outcomes may undermine the relational depth and existential nuance of traditional psychotherapy (Miller & Rose, 2008; Moloney, 2016).

From this perspective, CBT risks reducing therapy to a form of psychological training aimed at producing functional, self-regulating individuals, potentially neglecting the complexities of meaning, emotion, and relationality that underpin enduring psychological change. Nevertheless, advocates of brief therapy have demonstrated its potential for profound transformation, especially when applied with clinical sensitivity and informed by relational and psychodynamic principles (Abbass, Town, & Driessen, 2012).

The development of CBT is commonly described as occurring in three distinct “waves,” each reflecting shifts in theory, technique, and clinical emphasis (Hayes, 2004; Hofmann et al., 2010). The first wave emerged from classical behaviourism in the mid-20th century, focusing strictly on observable behaviours and the application of conditioning principles derived from figures such as Pavlov, Skinner, and Watson. The second wave, led by Beck and Ellis introduced cognitive elements into behavioural frameworks, giving rise to CBT in its more recognisable form. This iteration centred on identifying and restructuring maladaptive thought patterns as a means of alleviating emotional and behavioural symptoms (Beck, 1976; Ellis, 1962). At its core, this wave reflects a logic of cognitive correction: teaching clients to detect “negative” automatic thoughts and replace them with more rational or adaptive alternatives.

In contrast, third wave CBT represents a more substantive shift in ethos and therapeutic method. Approaches such as Acceptance and Commitment Therapy (ACT), Mindfulness-Based Cognitive Therapy (MBCT), and Dialectical Behaviour Therapy (DBT) emphasise acceptance, mindfulness, and psychological flexibility over symptom eradication (Hayes, Strosahl & Wilson, 1999; Segal, Williams & Teasdale, 2002; Linehan, 1993). Drawing on contemplative traditions, particularly Buddhist and Hindu philosophies, these therapies incorporate practices such as meditation, non-attachment, and self-compassion into clinical work. The therapeutic language of the third wave reflects this philosophical shift, privileging

concepts like “presence,” “acceptance,” “self-as-context,” and “values-based living” over the direct challenge or restructuring of cognitions. Rather than aiming to control inner experience, third wave approaches foster a more experiential, process-oriented, and relational engagement with psychological suffering.

2.3. CBT – Meta-Analyse that supports CBT effectiveness

A defining feature of CBT is its robust empirical foundation, which has contributed to its status as one of the most widely implemented psychotherapeutic modalities. Numerous meta-analyses and systematic reviews consistently support its efficacy in reducing symptoms and improving functioning across a wide range of psychological disorders. For instance, Cuijpers et al. (2023), in a meta-review of over 400 RCTs with more than 52,000 participants, found CBT to yield moderate to large effect sizes ($g = 0.79$) for depression, establishing its efficacy as comparable to pharmacological treatments. Similarly, Hofmann et al. (2012) reported large effect sizes for CBT in treating panic disorder, social anxiety, and GAD, attributing its effectiveness to its structured, problem-focused approach.

CBT’s transdiagnostic flexibility further enhances its utility. A review by Butler et al. (2006) concluded that CBT is effective for a range of conditions including somatoform disorders, bulimia, anger control issues, and stress. Innovations such as internet-based CBT (iCBT) have also shown comparable outcomes to face-to-face therapy, expanding access, especially for underserved populations (Andersson et al., 2014). Moreover, transdiagnostic protocols, which target core emotional processes across disorders, have gained empirical support, with studies by Newby et al. (2015) and Reinholt et al. (2023) demonstrating sustained therapeutic gains across various emotional disorders.

2.4. Psychological V Psychoanalytical – Proving Effectiveness in Brief Therapy

Although brief therapy may exhibit structural similarities across modalities—such as time-limited sessions and goal-oriented frameworks—the epistemological assumptions underpinning cognitive-behavioural and psychodynamic approaches remain fundamentally divergent. While not all brief therapy services adopt a CBT model, many are grounded in positivist and empirically driven traditions. Within these frameworks, psychological distress is typically conceptualised as the result of distorted cognitions and maladaptive behaviours, which can be alleviated through targeted interventions. Change is pursued through structured, often manualised techniques, designed to reduce symptoms and enhance functional outcomes (Beck, 1976; Dobson & Dobson, 2018).

In contrast, brief psychodynamic therapies—though similarly constrained in duration—are grounded in an interpretive epistemology. These models emphasise unconscious processes, relational dynamics, and the therapeutic relationship as central mechanisms of change (Malan, 1976; Gabbard, 2010). Rather than focusing solely on symptom elimination, they aim to facilitate emotional insight, expression, and intrapsychic restructuring, even within a brief frame (Leichsenring et al., 2004; Shedler, 2010). As such, the divergence between cognitive-behavioural and psychodynamic approaches lies not only in method but in their foundational assumptions about the nature of the mind, the purpose of therapy, and the process of psychological transformation.

The early hostility toward psychoanalysis from proponents of behaviourism is captured vividly in Salter's (1952) declaration: "*It is high time that psychoanalysis, like the elephant of fable, dragged itself off to some distant jungle graveyard and died. Psychoanalysis has outlived its usefulness. Its methods are vague, its treatment is long drawn out and more often than not, its results are insipid and unimpressive.*" This critique exemplifies the broader epistemological

rupture that underpinned the behavioural movement and later informed the development of CBT. Salter’s stance underscores a historical shift toward models of therapy that prioritise efficiency, structure, and measurable outcomes—hallmarks of CBT and key influences on many contemporary brief therapy models.

2.5 Risks and Limitations of CBT based Brief Therapy

Critics argue that brief therapy models—particularly those grounded in second-wave CBT—risk reducing complex emotional and psychological struggles to a series of cognitive or behavioural “errors” requiring correction (Dahl, 2018). This reductionism may inadvertently invalidate the lived experiences of young people whose distress is deeply embedded in broader social, familial, or cultural contexts. Further, Dahl’s (2018) critical examination of the UK’s Improving Access to Psychological Therapies (IAPT) programme reveals the tensions between therapeutic integrity and institutional performance demands. While IAPT is predicated on the structured delivery of manualised, evidence-based CBT interventions, practitioner interviews uncovered a stark disjuncture between formal protocols and real-world practice. Clinicians frequently emphasised that empathy, attunement, and therapeutic presence were more impactful than strict adherence to CBT frameworks. However, these relational values were often subordinated to satisfy key performance indicators—such as session completion rates and symptom-reduction scores—that dominate service accountability frameworks. Some therapists reported ‘managing’ documentation to present compliance with these metrics, thereby shielding therapeutic practice from systemic constraints (Dahl, 2018). These findings expose how audit culture and managerialism can distort the practice of brief therapy, reducing it to a performance-oriented façade that conceals deeper systemic contradictions.

Furthermore, for young people experiencing moderate to severe psychological distress—particularly those with developmental trauma, neglect, or attachment disruptions—short-term

interventions may not provide the relational consistency needed to foster safety, trust, and emotional integration. Without adequate time to establish and sustain therapeutic alliance, brief therapies may fall short of addressing core relational vulnerabilities (Fonagy et al., 2015).

Chapter 3 The Adolescent Mental Health Crisis

3.0 Introduction

Children and adolescents today are navigating a convergence of global stressors—what UNICEF (2025) has described as a “polycrisis”—encompassing the aftermath of COVID-19, climate change, geopolitical instability, digital saturation, and demographic shifts. The pandemic has had a profound psychological impact. A major global meta-analysis found that rates of depression and anxiety among children and adolescents had doubled by 2021 (Racine et al., 2021). In Ireland, this mental health surge was mirrored by a 30% increase in the number of young people seeking treatment and being hospitalised for eating disorders, as reported by the Health Service Executive (HSE) in the same year (Irish Times, 2021).

Compounding these pressures is the erosion of predictable developmental milestones. Young people face increasing delays in accessing stable employment, secure housing, and financial independence—factors that traditionally marked the transition to adulthood. This extended and uncertain life stage, conceptualised by Arnett (2004) as “emerging adulthood,” is now characterised by heightened psychosocial vulnerability. As McGorry et al. (2024) note, the cumulative impact of delayed transitions, social disruption, and service bottlenecks has significantly elevated the risk of mental health difficulties during this already fragile developmental period.

This demographic shift coincides with epidemiological findings indicating that mental illness now constitutes nearly 45% of the global disease burden among those aged 10–24 (Lancet, 2024). This has triggered widespread international concern, exemplified by the U.S. Surgeon General’s formal declaration of a youth mental health crisis (Office of the Surgeon General, 2021). Contributing factors include academic pressure, climate anxiety, digital

hyperconnectivity, and economic precarity (Patel et al., 2018; Twenge et al., 2017), all of which have been exacerbated by the social isolation and disruption caused by the COVID-19 pandemic (Loades et al., 2020; Lee, 2020).

In response, public health policy in many high-income nations has shifted toward prevention and early intervention, grounded in the assumption that early support can reduce long-term distress and alleviate future demands on healthcare and welfare systems (Patel et al., 2007; McGorry et al., 2014). Scalable, low-intensity interventions—often delivered through schools, primary care, and digital platforms—have been embraced as cost-effective strategies under the widely accepted adage that ‘prevention is better than cure’ (Clark et al., 2018).

However, while these approaches may align with public health imperatives, critical scholars warn that they risk oversimplifying the nuanced and contextual nature of adolescent distress. There is concern that the emphasis on scalability and early-stage symptom management may inadvertently divert resources and focus away from those already experiencing severe or complex mental health challenges (Foulkes, 2024; Wilson & Richardson, 2023).

There is growing consensus in both research and policy that integrated approaches—those that combine early therapeutic support with enhanced accessibility and continuity of care—are essential for effective youth mental health intervention, particularly within primary care settings where help-seeking commonly begins (McGorry et al., 2024). Such approaches are not only about streamlining service delivery but also about embedding mental health support within the everyday contexts of young people's lives. Importantly, international research highlights the need to move beyond narrow, individualised treatment paradigms to address broader structural determinants of mental health. These include socioeconomic inequality, educational stressors, digital exposure, and the need for culturally responsive services that reflect the lived realities of diverse populations (Patel et al., 2018; Rutter & Smith, 1995).

While prevention continues to be a dominant policy goal, the success of such initiatives ultimately rests on their capacity to engage young people in ways that are developmentally attuned, socially grounded, and psychologically meaningful. However, critics argue that the growing policy emphasis on early intervention and integration can unintentionally divert attention and funding away from secondary and tertiary mental health services—those designed to support young people with more entrenched, complex, or enduring difficulties. This concern has been raised in both academic and policy literature, with some warning that a focus on preventive and primary-tier services can mask systemic underinvestment in specialist care and lead to increased pressure on community-based providers ill-equipped for high-risk cases (Mills & Singh, 2020; Timimi, 2011). While prevention remains a policy imperative, the effectiveness of such initiatives ultimately depends on their capacity to engage young people meaningfully and respond to the depth, diversity, and contextual embeddedness of their mental health challenges.

3.1 Adolescent Mental Health in Ireland

Unsurprisingly, Ireland has not escaped the international-wide youth mental health crisis. Even prior to COVID-19, mental health problems such as anxiety and depression among children and adolescents were on the rise (Dooley et al., 2019). The *My World Survey 2*—a major national study of youth mental health—reported that 40% of young people experience symptoms of depression and 49% experience symptoms of anxiety outside the normal range (O’ Reilly et al., 2019). An earlier study by Cannon et al. (2013) found that one in three young people had a diagnosable mental health disorder by age 13, rising to over half by the age of 24. However, the framing of such findings warrants critical scrutiny. The terms “normal range” or “disorder”—and their softer derivative, “challenge”—have been questioned within critical and developmental frameworks. Scholars such as Brinkmann (2016) and Davies (2017) argue that

much of what is captured in prevalence data may reflect what is normative developmental distress rather than clinical psychopathology and may also be influenced by young peoples' growing fluency in the language of mental health discourse.

3.2. Child and Adolescent Mental Health Services

Despite widespread agreement on the importance of early intervention, Ireland's Primary Care Mental Health Services—responsible for addressing mild to moderate distress—remain underdeveloped, with waiting lists stretching up to seven years in some regions (Finnerty, 2023; Mark Ward TD, 2024; CPI, 2025).

CAMHS (Child and Adolescent Mental Health Services), Ireland's specialist service for young people with moderate to severe mental health difficulties, remains under significant strain. Access to CAMHS is tightly gatekept by General Practitioners (GPs), who often report systemic barriers to securing assessments. These include restrictive referral criteria, inconsistent thresholds across regions, lack of feedback from CAMHS, and prolonged waiting times (O'Keeffe et al., 2015). Regional disparities in service provision, coupled with chronic staffing shortages and fragmented care pathways, contribute to a system that is overstretched and uneven in its capacity to respond (HSE, 2019; MHC, 2023).

In 2024, the HSE launched a new policy initiative through its Child and Youth Mental Health Office (CYMHO), aiming to improve service integration and provide earlier intervention. Central to this strategy is the development of new 'CAMHS Hubs'—specialised multidisciplinary units designed to offer intensive brief interventions for young people in acute psychological distress (Butler & Hardiman, 2023). The model reflects a growing institutional interest in brief therapy as a scalable, efficient response to rising demand. These hubs represent a formal endorsement of brief therapy principles within specialist services, proposing time-

limited interventions as a front-line response even for young people experiencing moderate to severe presentations.

However, this proposed shift raises significant clinical and ethical concerns. While the intention to relieve pressure on core CAMHS teams and expand access is commendable, the specifics of the rollout remain ambiguous. Evidence for the long-term efficacy of intensive brief interventions in high-risk adolescent populations is limited, particularly regarding their capacity to address complex developmental, relational, or trauma-related presentations. In the absence of clearly defined service structures, sustained inter-agency collaboration, and rigorous outcome evaluation, there is a substantial risk that CAMHS Hubs may replicate—rather than remedy—the systemic shortcomings of the current model.

Alongside statutory services, a substantial proportion of therapeutic support for adolescents is delivered by voluntary and community organisations. These include Jigsaw, which provides brief early intervention to young people (aged 12yrs–25yrs) in 15 services around Ireland. Over 60% of the young people that engaged for support with Jigsaw are reported to show measurable reductions in their mental health distress post Jigsaw supports (Jigsaw, 2023; Barry et al., 2010).

Pieta provides free, crisis-focused psychotherapy for those at risk of suicide or self-harm (Corcoran et al., 2015; University of Limerick, 2022). Family Resource Centres, which operate under a community development model can deliver low-threshold counselling and wellbeing initiatives (Family Resource Centre National Forum, 2023; All-Ireland Social Prescribing Network, 2021).

3.3 Systemic Mismatch and the Burden on Brief Therapy Services

The rising identification of youth mental health difficulties has not been matched by adequate investment in specialist services, leading to severe strain on Ireland’s CAMHS and prompting families to turn to primary care-level supports like Jigsaw and Pieta House (Mental Health Commission, 2023; Barry et al., 2010; O’Keeffe et al., 2015; Pieta, 2022). These services, originally intended for mild to moderate issues, are increasingly managing complex cases by default, creating clinical and ethical tensions. Social factors such as academic pressure, digital saturation, and pandemic-related disruptions continue to escalate demand (Twenge et al., 2017; Patel et al., 2018; Loades et al., 2020), while desperate families often “shop around” for services, undermining coherent triage and tiered care systems (Finnerty, 2023). As a result, brief therapy has become a default rather than a deliberate choice—raising concerns about its suitability for those with complex needs. To be effective, brief therapy must be embedded within a stepped-care model that ensures access to long-term, relational interventions and addresses broader structural determinants of youth mental health (Patel et al., 2018; Rutter & Smith, 1995).

3.4 Potential Benefits of Brief Therapy in a Resourced Model

International research demonstrates that brief therapy can play a crucial role within tiered and integrated mental health systems, alleviating pressure on specialist services like CAMHS by addressing situational or early-stage distress at the primary care level (Weisz et al., 2017; Bower & Gilbody, 2005). This stepped care model improves service efficiency by matching intervention intensity to individual need and has been shown to enhance accessibility in youth mental health settings (Clark et al., 2018; van Straten et al., 2015). In the context of prolonged waiting times, early-access interventions—such as those offered by Jigsaw or school-based services—can help prevent the escalation of difficulties and promote timely support when

integrated into broader referral systems (Barry et al., 2010; O'Reilly et al., 2022; Cannon et al., 2013; Mental Health Commission, 2023).

3.5 Implications for Mental Health Services

Mental health services that rely heavily on brief therapy models—particularly those grounded in solution-focused techniques and second-wave CBT—risk failing to meet the needs of their most vulnerable and complex service users, especially when therapeutic practice is driven more by institutional targets than by clinical judgment (Timimi, 2015; Fonagy & Clark, 2015). While brief interventions can be effective for some young people, particularly those experiencing mild to moderate distress, their utility is significantly limited when applied as a universal solution across diverse presentations (Kazdin & Rabbitt, 2013).

To be clinically effective and ethically sound, brief therapy must be embedded within a stepped-care framework, where it serves as one component of a broader continuum of care—including access to long-term psychodynamic, systemic, and trauma-informed therapies (NICE, 2019; Patel et al., 2018). Without such flexibility and integration, services risk prematurely discharging young people or offering insufficient support for enduring or complex difficulties.

This concern is reflected in service data. In Ireland, the Mental Health Commission's (2023) interim report highlighted alarmingly high re-referral rates to CAMHS, indicating that many children and adolescents are not receiving effective or sustained intervention during their initial engagement. Similarly, a study across eight NHS trusts in England found that 35% of children aged 5 to 17 required re-referral to CAMHS, suggesting that early interventions often fail to resolve core issues or ensure ongoing care when needed (Wilkinson, 2025).

These patterns point to the need for greater flexibility in treatment planning, allowing for extensions, stepped-up interventions, or re-engagement when clinically appropriate. Yet

services remain caught in a resource dilemma: extending care for one individual often comes at the expense of access for others. This tension highlights a deeper systemic issue—how to balance efficiency and access with clinical depth and continuity, particularly in a context of rising demand and finite resources.

Chapter 4 - The Cultural Politics of Diagnosis

4.0 Introduction

Contemporary mental health policy and service delivery operate within a cultural landscape shaped by two converging dynamics. On the one hand, there is an increasing societal tendency to seek professional intervention for emotional and developmental difficulties—particularly among children and adolescents—driven by what Suzanne O’Sullivan (2025) terms *diagnostic desire*. In *The Age of Diagnosis*, O’Sullivan characterises a cultural condition in which discomfort, ambiguity, and interpersonal struggle are swiftly reframed as clinical problems, reinforcing a pathologizing framework for normative distress. On the other hand, we are witnessing a rapid proliferation of brief therapy models, single-session interventions, and digital, self-directed platforms—strategies aimed at managing rising demand within overstretched systems. This dual trajectory produces a paradox: as the threshold for defining distress as pathological lowers, the system’s responses become increasingly standardised, decontextualised, and time limited. In effect, the complex needs of many young people are forced into formats engineered for efficiency and scalability, rather than therapeutic depth or developmental appropriateness.

The increasing visibility of mental health in public discourse has undoubtedly played a vital role in reducing stigma and encouraging help-seeking behaviours, particularly among young people. Over the past decade, there have been extensive efforts in the Western world to improve public understanding about mental health problems. For example, in the UK, there have been charity campaigns promoted on television, radio and online (Sampogna et al., 2017), alongside interventions within schools, universities and workplaces (Bolinski et al., 2020; Wagner et al., 2016; Werner-Seidler et al., 2017). In Ireland, similar trends are evident. National campaigns such as "See Change" and the "Green Ribbon" initiative have sought to tackle stigma and

promote open conversations around mental health, while programmes supported by organisations like Jigsaw and Mental Health Ireland have introduced structured wellbeing and resilience curricula into schools (Jigsaw, 2024; Mental Health Ireland, 2023). These efforts reflect a wider cultural shift toward normalising psychological distress and encouraging early help-seeking across all age groups.

However, there is growing concern among scholars that these awareness efforts may also be contributing to a form of diagnostic expansion or "concept creep", whereby normative emotional fluctuations—such as sadness, anxiety, or stress—are increasingly interpreted as symptoms of diagnosable mental disorders. Foulkes and Andrews (2023) articulate this concern in what they term the '*prevalence inflation hypothesis*', suggesting that widespread mental health campaigns, though well-meaning, may lead individuals to over-pathologize normal experiences, thus inflating the perceived prevalence of mental illness. This cultural dynamic intersects with broader critiques from Brinkmann (2016) and Davies (2017), who argue that Western societies have become increasingly primed to medicalise discomfort and frame identity through psychiatric discourse. Within this context, the rise in reported mental health conditions among adolescents must be understood not only as a reflection of genuine distress, but also as a by-product of shifting cultural narratives that blur the boundaries between clinical pathology and everyday suffering. While this does not invalidate the real psychological pain that many young people experience, it does raise important ethical and clinical questions about how we define mental illness, allocate resources, and design services—particularly in under-resourced systems where access is often contingent upon diagnostic categorisation.

4.1 Navigating Demand: Transferring Pressures and the Digital Turn in Youth Mental Health

These shifting cultural narratives have profound implications for youth mental health policy and service delivery, particularly in the context of an increasing reliance on digital brief therapy platforms. In systems already under pressure—such as CAMHS in Ireland—diagnostic expansion contributes to increased demand for services without a corresponding expansion in capacity. As argued elsewhere, policy responses have leaned heavily on brief therapy models and early intervention strategies, particularly those grounded in solution-focused and cognitive-behavioural frameworks. While these approaches can be effective for certain presentations, they are increasingly used as default responses to a wide spectrum of referrals, including those that may not reflect enduring or severe pathology. In this context, mental health triage risks becoming less about matching treatment to need, and more about managing access thresholds—with young people often required to frame their distress in diagnostic terms to be taken seriously (O'Sullivan, 2021; Johnstone & Boyle, 2018). The ethical tension here is acute: on the one hand, services are tasked with responding quickly to prevent escalation; on the other, they must ensure that interventions are proportionate, meaningful, and not inadvertently reinforcing pathologisation. Without a more nuanced understanding of developmental, cultural, and contextual factors, brief therapy risks being reduced to a kind of emotional gatekeeping, offering surface-level containment rather than substantive care. What is needed is a more integrated, ethically reflexive model of care—one that recognises both the structural pressures on each service and the broader cultural forces shaping how distress is recognised, named, and treated as a mental health system.

Paradoxically, as brief therapy models have expanded—often positioned as a pragmatic response to the pressures facing under-resourced child and adolescent mental health services—they have themselves become entangled in the very dynamics they were designed to alleviate.

Amid rising demand and the cultural inflation of mental health prevalence, these services now face growing waiting lists, staff retention challenges, and escalating pressure to deliver results. In response, many brief therapy providers are increasingly turning to digital self-help platforms and AI-powered therapeutic tools as stopgap solutions—tools that, while offering scalability and immediacy, risk further distancing therapeutic care from its relational and reflective foundations.

Interventions are now frequently delivered through smartphone applications, online self-help portals (such as SliverCloud) and, more recently, AI-powered therapeutic tools. These developments instantiate what might be termed the “24/7 virtual therapist”—a model of care that is always available, continually responsive, and optimised for accessibility, speed, and user convenience (Mulligan, 2025). This transformation reflects broader public health imperatives for cost-efficiency, technological scalability, and alignment with the digital habits of younger users.

Recent studies highlight both the promise and the limitations of these technologies. For example, Fitzpatrick et al. (2017) found that automated conversational agents such as *Woebot* can lead to statistically significant reductions in symptoms of depression and anxiety among young adults in the short term. Similarly, a meta-review by Hollis et al. (2017) concluded that digital interventions for children and adolescents show potential in improving mental health outcomes, particularly in increasing accessibility. However, the authors also caution that many interventions remain under-evaluated, and questions persist about safeguarding, relational depth, and the long-term effectiveness of these tools.

In addition, platforms such as guided CBT apps, symptom trackers, and AI-driven chatbots promise immediate relief, behavioural advice, and structured interventions, effectively extending the logics of brief therapy into digital space (Topol, 2019; Lupton, 2016).

This development reflects a broader shift in how psychological wellbeing is conceptualised and managed in late-modern societies. In line with Rose's (1999) notion of the '*psychological society*' and extended by thinkers like Cederström and Spicer (2015), the individual becomes the site of continuous monitoring, optimisation, and moral evaluation. Digital mental health tools, marketed as empowering, often place the burden of emotional regulation squarely on the user, reinforcing the neoliberal logic of 'responsibilisation' and self-surveillance (Davies, 2015; Gill & Orgad, 2018). Moreover, these tools are not neutral. At the same time, they operate within an epistemological framework that privileges standardisation, quantification, and scalability. As Lupton (2016) and Zuboff (2019) argue, the user is transformed into a data subject—an individual whose symptoms, moods, and behaviours are parsed by algorithms and monetised within broader regimes of surveillance capitalism. This transformation is more than technical; it is ontological. As Foucault might put it, we are witnessing an extension of *biopower*, where technologies govern not just conduct, but the affective and cognitive interiority of subjects (Foucault, 1991; Cheney-Lippold, 2017). What emerges is not only a new form of therapeutic access, but a new configuration of therapeutic subjectivity: one that is always on, always available, and always expected to self-correct.

As referenced, SilverCloud is a widely used digital mental health platform in Ireland. It is first presented to the user as a non-neutral platform but is typical of the commercial nature of the emerging digital therapeutic ecosystems. Promoted as an evidence-based tool to expand access to care, SilverCloud's acquisition by U.S. telehealth giant Amwell and its links to venture capital—including investors implicated in social media's negative mental health impacts—reflect a broader commodification and financialization of care (Irish Times, 2021).

The platform's referral-based payment model, where institutions pay per user, raises ethical concerns about how profit motives may shape service delivery—prioritising volume over

therapeutic depth. Scholars like Zuboff (2019) and Fullagar & O'Brien (2019) caution that such platforms often align with surveillance capitalism and therapeutic governance, transforming care into a tool for data collection, behavioural monitoring, and market optimisation.

While such platforms may help bridge service gaps, they risk reinforcing a reductive, efficiency-driven model of mental health that undermines the relational depth of traditional therapy. Ultimately, the rise of digital brief therapy is not just a technological evolution, but an ideological shift in how care is conceptualised, delivered, and monetised.

What emerges from the proliferation of digital brief therapy is not merely a more accessible or efficient form of care, but a reconfiguration of subjectivity and distress that aligns with the broader cultural logics of control, commodification, and self-governance. As Rose (1999) has argued, therapeutic practices in neoliberal societies increasingly frame individuals as entrepreneurs of the self—responsible for managing their own optimisation, emotional regulation, and productivity. Cederström and Spicer (2015) extend this critique by describing how the wellness industry transforms care into a moral obligation, where failure to thrive psychologically is interpreted as personal failure. Within this framework, digital therapy tools such as *SilverCloud* are marketed as empowering and user-driven yet often operate to support institutional priorities around risk containment, efficiency, and scalability (Fullagar & O'Brien, 2019; Zuboff, 2019).

Rather than engaging with the relational, social, or systemic roots of distress, these platforms encourage users to internalise responsibility and self-monitor through behavioural prompts and cognitive tracking systems—reifying the logic of self-surveillance embedded in digital capitalism (Morozov, 2013; Lupton, 2016). In this light, the expansion of digital brief therapy reflects not just a transformation in how therapy is delivered, but in what therapy is understood to be, and who it is ultimately designed to serve. This development raises urgent ethical and

political questions about the future of therapeutic care, particularly within under-resourced public mental health systems, and invites a critical reassessment of how psychological support is conceptualised and enacted in a digital age.

4.2 From Care to Containment: The Systemic Pressures Reshaping Youth Mental Health

This section summarises how Ireland’s youth mental health system has become, most likely unintentionally, shaped by a convergence of cultural, institutional, and systemic pressures that now prioritise efficiency, risk management, and diagnostic clarity over relational depth and developmental sensitivity. Within a system where DSM-based thresholds determine access to care, young people and their families are often compelled to present distress in diagnostically legible terms to gain entry, reflecting broader cultural dynamics of performative help-seeking (O’Sullivan, 2021; Rose, 1999).

Brief therapy, while originally intended as a pragmatic response to service overload, has increasingly become a default triaging mechanism, applied not necessarily based on clinical suitability but rather due to capacity constraints and institutional priorities (Timimi, 2011; Bury et al., 2021). Young people often engage with services like Jigsaw or digital platforms such as *SilverCloud* not because these are the most appropriate interventions for their needs, but because they are the only accessible entry points into an overstretched and under-resourced system (O’Keeffe et al., 2015; Barry et al., 2010).

This dynamic has led to what scholars describe as the ‘instrumentalization’ of therapy—where care is reduced to short-term, protocol-driven interventions that prioritise efficiency, throughput, and auditability over relational depth or therapeutic responsiveness (Dahl, 2018; McGorry et al., 2022). Digital platforms reinforce these tendencies by embedding self-tracking, standardised symptom metrics, and algorithmic prompts into care processes, aligning therapy delivery with the logics of surveillance capitalism and technocratic governance (Lupton, 2016;

Zuboff, 2019). As a result, services risk becoming sites of containment rather than care—managing psychological risk and service flow, rather than fostering genuine transformation (Rose, 1999; Fullagar & O'Brien, 2019).

Drawing on theorists such as Foucault (1991) and Fricker (2007), it is argued that more broadly, youth and mental health services now operate within a framework of governmentality and epistemic injustice, where help-seeking is governed by institutional logics that favour speed, standardisation, and quantifiable outcomes. This creates a paradox in which services both medicalise suffering and ration care—reinforcing inequities in access and recognition. Clinicians are caught in ethical and clinical dilemmas—expected to stretch their remit to meet unmet needs or else deny care entirely—within systems more concerned with risk aversion than relational depth (Moloney, 2013). In such contexts, mental health services increasingly manage rather than meaningfully engage with suffering, reflecting what Davies (2017) terms a culture of '*emotional austerity*', where transformation is sacrificed to control. As Rose (1999) and Timimi (2011) argue, this shift reflects a broader cultural rationality in which the aims of therapy are subordinated to institutional imperatives of containment, documentation, and throughput.

Chapter 5.0 The Constraints and Possibilities of Brief Therapy

5.0 Introduction

This chapter draws on qualitative research, clinical case material, and practitioner literature to explore how psychotherapists navigate the tensions and possibilities of practising within brief therapy models in Ireland’s contemporary mental health landscape. While brief interventions are often advocated on the grounds of pragmatism, accessibility, and cost-effectiveness—especially in services such as Jigsaw and CAMHS—their application frequently places clinicians in conflict with the ethical commitments and relational depth traditionally associated with psychotherapeutic practice (O’Keeffe et al., 2015; Barry et al., 2010).

In the Irish context, services are increasingly structured around throughput, session limits, and outcome metrics. This reflects a wider policy shift towards early intervention and prevention, but also reveals a system under acute pressure, with long waiting lists, chronic understaffing, and rising referral rates (Mental Health Commission, 2023; HSE, 2019). Psychotherapists working in these environments must contend with complex institutional imperatives—such as time constraints, risk-management protocols, and diagnostic thresholds—that often constrain therapeutic flexibility and limit opportunities for meaningful relational engagement (Finnerty, 2023).

However, this chapter also examines how therapists working within brief therapy models seek to reclaim clinical discretion and therapeutic depth. Some practitioners draw on integrative and psychodynamic frameworks to embed brief work within a relational, developmentally sensitive frame (McMahon, 2018). Others adopt reflective and ethically attuned stances that challenge the transactional logic of managerialism, resisting the reduction of therapy to short-term symptom reduction alone (Cullen, 2021; Timimi, 2011).

By exploring these adaptive strategies and ethical tensions, this chapter contributes to a growing body of Irish and international scholarship that interrogates how depth-oriented practice can survive—and potentially flourish—within constrained service structures. It argues that rather than dismissing brief therapy as inherently reductive, the challenge lies in disentangling its clinical utility from the systemic forces that risk distorting its therapeutic potential.

5.1 Therapeutic Alliance in Time-Limited Work

The therapeutic alliance is a consistent predictor of outcome across modalities (Norcross & Wampold, 2011), yet forming a meaningful alliance within a restricted number of sessions can be challenging. Studies show that therapists working in brief frameworks often report pressure to establish rapport quickly, sometimes at the expense of deeper attunement (Muran et al., 2009). In public systems where session caps are rigidly enforced, the alliance risks becoming transactional—focused on agenda-setting and “goal alignment” rather than relational depth (Swift & Greenberg, 2015).

5.1.2. Transference, Countertransference, and the Compressed Frame

Psychodynamic literature has long emphasised the therapeutic potential of transference and countertransference dynamics (Gabbard, 2004), but these processes are often truncated in brief work. Practitioners report dilemmas around whether to engage these dynamics or bypass them in favour of solution-focused strategies (Rober et al., 2012). The compressed frame may force therapists to adopt a more “managerial” stance—regulating emotion rather than exploring it—which can compromise the emotional authenticity of the encounter (Cooper, 2009).

5.1.3. Assessment and the Therapeutic Encounter

Brief therapy often places assessment and intervention within the same session, collapsing the distinction between understanding and doing. This shift can hinder complex formulations, particularly in cases involving trauma, dissociation, or developmental disturbance. As Timimi (2015) argues, standardised assessment tools—while efficient—can obscure the subjective, embodied dimensions of distress and reinforce a pathologizing narrative. Therapists may be left with insufficient time to develop a nuanced understanding of the client’s world before “treatment” begins.

5.1.4 Endings, Abruptness, and Incomplete Closure

Brief therapy models, especially when implemented in under-resourced public services, frequently rely on scheduled endings that can feel abrupt and ethically unsettling for both therapists and young clients. Knox (2015) highlights the emotional strain practitioners face when therapeutic work is truncated prematurely, particularly when the developmental needs of the client are ongoing. Young people, many of whom may already carry histories of attachment disruption, often experience these time-limited engagements as re-enactments of relational abandonment (Mason, 2012).

A growing body of evidence suggests that these constraints do not merely reflect individual practice choices but are embedded in systemic pressures. For example, Wilkinson (2025) reports that within some Irish primary care services, therapists describe between 20%–40% of their caseload as re-referrals—clients returning due to unresolved issues from initial brief engagements. This cyclical care dynamic, also described by Coles et al. (2020), indicates that brief therapy is sometimes being used in ways that circumvent rather than address developmental and clinical complexity.

The Irish context reflects these international trends with added urgency. The Mental Health Commission's (2023) review of CAMHS noted re-referral rates of over 32%, with some children referred multiple times for the same concerns. These patterns raise important questions about the adequacy of brief therapy in responding to the needs of young people with chronic, relational, or trauma-based difficulties. Rather than offering a sustained developmental trajectory, the system risks providing episodic containment with limited psychological integration (Shedler, 2010).

As Finnerty (2023) observed in the analysis of Ireland's CAMHS audit, these re-referral patterns are symptomatic of a broader systemic dysfunction: young people are discharged too early due to service pressures, only to return when their difficulties remain unresolved or escalate. This undermines both the therapeutic alliance, and the broader goals of continuity, trust, and emotional development that effective adolescent mental health care should support.

5.1.5. Emotional Labour, Burnout, and Systemic Pressures

Therapists working in brief frameworks within public systems often experience burnout, moral distress, and emotional fatigue. The demand to meet productivity targets, manage clinical risk, and deliver measurable outcomes within rigid timeframes erodes professional autonomy and creates tension between institutional expectations and therapeutic integrity (Maslach & Leiter, 2016; Figley, 2002). As Feltham (2010) notes, the emotional labour involved in containing others' distress—particularly in bureaucratically regulated and target-driven environments—can result in vicarious trauma, emotional numbing, and a diminished capacity for reflective practice.

This erosion of reflective space is particularly concerning in mental health systems that prioritise throughput over therapeutic process. In such contexts, supervision may become another administrative checkpoint rather than a supportive, exploratory process (Ruch et al.,

2010). Therapists report feeling pressured to prioritise documentation, scoring tools, and key performance indicators over relational presence and emotional attunement (Moloney, 2016; Dahl, 2018). This creates what Waddington (2020) describes as a form of “professional alienation,” where clinicians are simultaneously accountable to systems and estranged from their own clinical instincts.

Moral distress arises when therapists recognise what is clinically or ethically appropriate but are unable to act on this knowledge due to institutional constraints (Austin et al., 2005). Over time, this dissonance can lead to emotional exhaustion, cynicism, and even attrition from the profession altogether. In youth mental health, where relational trust and developmental sensitivity are critical, such burnout carries significant consequences—not only for therapists' wellbeing but for the consistency and quality of care offered to young people.

Moreover, practitioners may engage in forms of quiet resistance or ethical subversion—such as unofficially extending contact, bending service protocols, or prioritising relational work over prescribed manualised content (Wilkinson, 2025; Dartington, 2010). While these strategies can preserve therapeutic integrity in the short term, they also reflect the chronic tension between relational ethics and institutional governance. Without adequate structural reform, therapists risk becoming what Cooper (2022) terms “emotional functionaries”—a dispenser-technician within systems increasingly defined by risk-aversion, standardisation, and emotional efficiency.

5.1.6 Trauma and Complexity

For those with complex trauma, personality disorders, attachment disruptions, or comorbid conditions, brief models may fail to address underlying relational patterns and long-term developmental needs (Midgley et al., 2017). This can result in only temporary symptom relief or therapeutic disengagement. A focus on short-term intervention can lead to a systemic misalignment, where services are structured to deliver what is efficient, not necessarily what is clinically appropriate (Rose, 2018). This is particularly problematic when services are pressured to demonstrate quick outcomes within rigid frameworks.

6. Recommendations: Reclaiming Brief Therapy for Depth-Oriented Care

6.0 Introduction

This thesis has shown that while brief therapy is often promoted as an efficient and scalable response to rising mental health demand, in its current implementation environment, it frequently compromises the relational, developmental, and ethical integrity of care. Within services shaped by managerial logic and diagnostic culture, brief therapy is often reduced to a triaging mechanism—used to process demand rather than respond meaningfully to complex psychological needs. These recommendations aim to reclaim brief therapy as a relational and clinically rigorous modality, proposing adaptations to service delivery, training, and policy that align therapeutic care with human complexity, rather than bureaucratic expedience.

6.1 *Depth Within Limits: Creative Adaptation and Ethical Resistance*

Despite structural constraints, many clinicians demonstrate creativity and resilience. Rather than treating brief therapy as a purely technical procedure, they reframe it as a potential ‘holding environment’—a relational space where containment, presence, and emotional resonance can still occur. Some therapists intensify attunement, working with unconscious process and relational dynamics even within short formats (Cushman & Gilford, 2000). This may involve deep listening, focusing on non-verbal cues, or responding empathically to emotional themes that arise spontaneously, rather than rigidly adhering to manualised techniques.

Others engage in subtle forms of resistance: reframing time limits, advocating for additional support, or bending institutional rules to protect therapeutic integrity (Moltu et al., 2010; Brodwin, 2013). These actions demonstrate a commitment to the ethics of care, rather than to the logic of metrics. Such resistance is not about insubordination but about protecting the

relational and developmental needs of young people within systems that may not be designed to hold them.

These practices suggest that brief therapy can support meaningful change when clinicians are supported by reflective supervision, organisational flexibility, and a culture that values complexity over output. Investing in clinician wellbeing and autonomy is crucial for sustaining these ethically grounded adaptations. Services and policymakers must listen closely to clinicians working in brief frameworks—often evidenced through low uptake or high staff turnover—and use their experiences to redesign systems that allow for clinical judgment, relational continuity, and therapeutic integrity. Without this feedback loop, services risk prioritising expediency over efficacy.

6.2 Depth with Limits: Brief, but Not Superficial

Empirical evidence consistently underscores that the quality of the therapeutic relationship—not duration—is the strongest predictor of positive outcomes (Wampold & Imel, 2015). However, this understanding is often sidelined in service environments dominated by outcome measures and session quotas. Reclaiming brief therapy as a relational and ethically grounded modality involves disentangling it from performance metrics and throughput targets.

Clinicians must be empowered to centre emotional engagement, narrative meaning-making, and developmental understanding in their brief work. This could mean shifting from protocol adherence to formulation-based practice, in which each brief therapy engagement is tailored to the client's context, history, and presenting distress. Time-limited work can still be deep work, but it requires clinicians to be relationally present, emotionally attuned, and supported by their institutions to prioritise therapeutic quality over efficiency.

Services should reduce the surveillance culture that constrains clinicians' work by de-emphasising rigid outcome metrics in favour of reflective, process-based supervision. The emotional depth of therapeutic encounters cannot always be quantified in six-session formats, nor can meaningful change be measured solely through symptom reduction scales. Clinicians should be encouraged—and not dissuaded—from building emotional depth with clients. When professional autonomy is supported, brief therapy can serve as a flexible, humanising intervention rather than a mechanised solution to systemic overload.

6.3 Depth Within Limits: Reclaiming Brief Therapy Through Psychoanalytic Practice

Unlike more manualised brief approaches rooted in second-wave CBT or solution-focused techniques, psychoanalytically informed brief therapy maintains a commitment to emotional depth, unconscious process, and relational integrity. These models resist the flattening of therapeutic encounters into quantifiable outcomes and instead promote genuine relational work, even when time is limited.

David Malan's Brief Dynamic Therapy, Habib Davanloo's ISTDP, and Lester Luborsky's Supportive-Expressive Therapy (SET) show how short-term work can still engage transference, facilitate affective insight, and access core relational conflicts. These models treat time as a container for intensity, not a barrier to transformation. Sessions are structured but not rigid, focused but still responsive to what emerges in the therapeutic encounter.

These approaches remind us that the challenge is not time, but how time is used. When therapists have the training and permission to work with unconscious dynamics and emotional truth, brief therapy can foster lasting change.

Appendix C outlines possible psychoanalytic based training for clinicians based on Luborsky's SET model.

6.4 Systemic Alignment: Bridging Brief Therapy and Structural Realities

For brief therapy to function effectively within the adolescent mental health system, it must be embedded within a well-integrated, stepped-care model that includes both short-term and longer-term interventions. This begins with investment in comprehensive, formulation-based assessments that move beyond symptom checklists and diagnostic categories. Such assessments should attend to the young person's developmental history, relational patterns, socio-cultural context, and current life stressors. This allows services to allocate clients more appropriately ensuring that those with complex, entrenched difficulties are not inappropriately assigned to time-limited care, which risks therapeutic rupture, re-referral, or premature disengagement.

Inappropriate triage is not a trivial administrative issue; it is a clinical and ethical failure that undermines the continuity of care. Therefore, services should ensure that clinicians have the autonomy and clinical discretion to tailor interventions, advocate for clients, and—where necessary—extend therapeutic work beyond the arbitrary endpoint of brief protocols. This is especially important in cases involving complex trauma, disrupted attachment, neurodivergence, or comorbid conditions, where relational continuity is often foundational to therapeutic progress.

Crucially, brief therapy must not become a substitute for more comprehensive care where it is clearly needed. Rather, it should be positioned as a potential entry point within a broader continuum of mental health support—one that includes clear, flexible, and timely pathways to ongoing or stepped-up care. Achieving this requires more than just referral mechanisms; it demands integrated communication across service tiers, adaptability in service delivery, and a professional culture that prioritises clinical judgement over algorithmic triage. In the Irish context, serious consideration should be given to a structural merger—or at minimum, a formal

integration—between CAMHS and Jigsaw. Such a move could streamline transitions between early intervention and specialist care, reduce duplication, and improve continuity for young people whose needs span both domains. Without this level of coordination and shared governance, the risk remains that brief interventions will function as a holding pattern rather than a bridge to meaningful, developmentally attuned therapeutic work.

Furthermore, the emotional labour of providing brief therapy under conditions of constraint must be recognised and supported. Many clinicians experience moral distress when systemic pressures prevent them from offering the depth of engagement, they know their client’s needs. Institutions must create policies that promote clinical supervision, reflective practice, and staff wellbeing. This includes protected time for debriefing and consultation, opportunities for peer support, and a service culture that acknowledges the relational intensity and ethical complexity of working in brief formats.

When held within relationally intelligent systems—those that listen to clinicians, respond to complexity, and prioritise human connection—brief therapy can become more than an expedient intervention. It can serve as a holding environment that fosters safety, emotional resonance, and momentum for further therapeutic work. But this is only possible when brief therapy is scaffolded by structures that value containment over throughput and meaning over metrics.

6.5 Balancing Flexibility with Clinical Integrity in a Digital Era

Younger generations increasingly seek flexible, digital access to mental health support. Services must accommodate this shift without sacrificing the relational and temporal conditions essential for psychological change. Hybrid models—blending digital platforms with therapeutic relationships—must be designed with clinical nuance, not just technological convenience.

Clinicians should be trained to integrate digital tools without defaulting to protocol-driven care. For example, asynchronous platforms should include reflective prompts, narrative engagement, and opportunities to transition to live support. Services must ensure that brief digital interventions are not substitutes for care but steps on a continuum of support.

This also means resisting the overuse of digital tools as stand-alone solutions for complex distress. Instead, they should be integrated into stepped-care models that preserve continuity, emotional safety, and human contact—particularly for those with relational trauma or developmental vulnerability.

6.6 Reframing Distress: From Diagnostic Inflation to Contextual Understanding

Mental health services must critically engage with cultural dynamics that shape help-seeking behaviours—particularly the growing trend of interpreting normative distress through diagnostic frameworks. The expansion of mental health awareness—while important—has also led to an inflation of perceived psychopathology among adolescents. This phenomenon, compounded by social media, parental anxiety, and shifting cultural scripts around vulnerability, contributes to service overload and risks pathologizing ordinary developmental struggles.

To address this, services should embed psychoeducational and community-facing components into their early intervention pathways. These should help young people and families distinguish between transient, situational stress and more persistent clinical need. Practitioners must also be supported to explore contextual, social, and relational dimensions of distress—not just symptoms—in assessment and treatment planning.

Policy should prioritise training for clinicians in formulation-based approaches that resist premature diagnosis and foster a more nuanced understanding of psychological suffering.

Assessment frameworks must be developed to incorporate not only symptom checklists but also narrative, developmental, and socio-cultural factors that shape distress. This will help reduce inappropriate referrals to brief therapy services, lower re-referral rates, and preserve specialist capacity for those with enduring or complex needs.

In short, mental health systems must move away from reflexive diagnostic labelling toward a more contextualised, developmentally attuned approach to adolescent care. By doing so, they can better align the use of brief therapy with clinical appropriateness rather than cultural expectation

7.0 Conclusion

Fast Therapy – Slow Healing argues that the current expansion of brief therapy reflects not merely clinical pragmatism, but a deeper recalibration of how mental health is conceptualised and operationalised in contemporary society. While brief therapy need not equate to shallow therapy, its dominant forms often risk just that. Psychoanalytic innovations—such as those developed by David Malan and colleagues—offer a blueprint for sustaining therapeutic depth even within time-limited formats. However, this potential remains largely unrealised so long as brief therapy continues to serve as the system’s default response to chronic under-resourcing and escalating demand. To move beyond this impasse, brief therapy must be reclaimed as a purposeful modality, not a stopgap measure for structural failure.

A meaningful future for brief therapy depends on structural investment, ethical commitment, and theoretical clarity. Services must be resourced to support therapist autonomy, supervision, and flexibility. Policies must value depth over speed, presence over protocol, and care over compliance. The success or failure of brief therapy is not merely a function of model fidelity or clinical expertise, but how therapists are positioned within systemic constraints. The therapeutic alliance, emotional labour, and ethical tensions embedded in this work reveal that brief therapy is not just a mode of care—it is also a site of negotiation, where values, power, and practice intersect. Therapists are not passive implementers of protocol, but active agents navigating the contradictions between healing and governance.

In closing, this thesis calls for a reimagining of how we understand and deliver brief therapy—not as a shortcut to resolution, but as a context-sensitive practice embedded in broader therapeutic, social, and political frameworks. Brief therapy must be reclaimed from the logics of speed and standardisation and reintegrated into a pluralistic system that values containment,

complexity, and care. Only then can it serve its original promise—not as a default response to scarcity, but as an intentional, relational act of healing.

When brief therapy is held with skill, attunement, and institutional support, it can be not only fast—but also healing.

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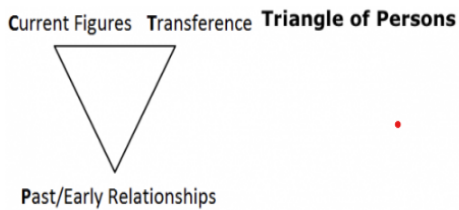
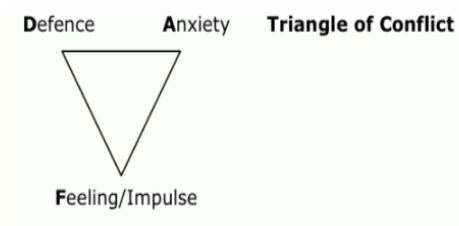
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Appendix A

Theorist/Model	Typical Session Count	Theoretical Orientation	Core Features / Aims
David Malan Brief Psychodynamic	12–30 sessions	Psychodynamic / Psychoanalytic	Unconscious conflict, transference, focal conflict, rapid emotional engagement
Habib Davanloo Intensive Short-Term Dynamic Psychotherapy (IS- TDP)	Up to 40 sessions (often <25)	Dynamic Psychotherapy	Break resistance, mobilize unconscious emotion, emotional breakthroughs
Peter Sifneos (S- TAPP) Short-Term Anxiety-Provoking Psychotherapy	12 sessions	Short-Term Anxiety- Provoking Psychotherapy	Rapid access to affect, anxiety regulation, diagnosis-driven selection
Lester Luborsky (Supportive- Expressive) Psychodynamic Core conflictual	16–40 often <20 sessions	Psychodynamic	Core conflictual relationship themes (CCRT), balance of support and interpretation

relationship themes (CCRT)			
Michael Balint (Brief Psychotherapy)	6–20 sessions Variable	Psychoanalytic (Doctor– patient relationship focus)	Focused on doctor- patient dynamics, especially for GPs and psychosomatic patients
CBT (Standard models)	6-20 sessions	Cognitive-Behavioural	Symptom reduction, skills training, problem-focused
Solution-Focused Brief Therapy	1-10 sessions	Postmodern / Constructivist	Focus on solutions, future orientation, client strengths
Brief Strategic Therapy (Haley, MRI)	6–10 sessions	Systemic / Strategic	Focused interventions to disrupt dysfunctional patterns

Appendix B:



Feelings and impulses that early caregivers did not tolerate, evoke anxiety and are avoided by the use of defenses. As illustrated by Malan's (1979) Triangle of the Person, core emotional conflicts from the patient's early relationships are re-enacted with others in the patient's current life, including the therapist.

Like any dynamic treatment, faulty cognitions are not viewed as an end in themselves as they are in cognitive-behavioural therapy (CBT), but as defenses against unconscious feelings and anxiety. If the defenses work well, little or no anxiety is experienced. If the defenses fail in keeping the feelings well-hidden, anxiety rises at the prospect of the feelings rising to the surface.

Appendix C – Brief Therapy Models based on Psychoanalytic Principles

Lester Luborsky’s Supportive-Expressive Therapy (SET) is a time-limited psychodynamic approach developed in the 1970s to offer a structured, researchable form of psychoanalytic therapy that retained both depth and adaptability.

- Expressive techniques, which focus on identifying and interpreting repetitive relational patterns (the Core Conflictual Relationship Theme, or CCRT).
- Supportive techniques, which aim to bolster ego functioning, reduce distress, and strengthen the therapeutic alliance.
- SET operates within a brief timeframe (typically 16–20 sessions) and is well-suited to research settings and public mental health contexts.

The balance between support and expression allows SET to be tailored to client readiness, making it particularly valuable for those with moderate difficulties or limited psychological resilience.

This dual emphasis allows SET to preserve psychodynamic depth while remaining clinically focused and adaptable—key advantages in resource-limited settings like CAMHS and IAPT.

Relevance to Public Mental Health Services (e.g., CAMHS, IAPT)

SET was designed to be scalable, manualised, and empirically testable, which makes it highly relevant to contemporary service settings increasingly reliant on brief interventions. Unlike CBT, however, SET preserves a psychodynamic emphasis on relationship patterns, emotional meaning, and unconscious conflict, offering an alternative route to depth within brief formats.

In services like CAMHS, SET could be used:

- With adolescents who have recurring relational difficulties or identity issues.
- To offer psychodynamic therapy within session limits, while building long-term psychological understanding.
- As a bridge model—between supportive care and more intensive relational work—especially for young people not ready for more exploratory long-term therapy.

Luborsky’s SET model strengthens an argument that brief therapy need not be shallow or symptom-focused. It offers a clear example of a time-limited approach that balances relational depth and system constraints. Unlike many CBT-based interventions, SET does not reduce therapy to symptom management, but instead maintains a commitment to narrative, insight, and therapeutic alliance—even within bureaucratic limits.

4. The Ethical Value of SET in Brief Work

SET’s balance of containment and exploration aligns well with ethical critiques of current brief therapy trends. It offers a model that:

- Avoids superficial symptom management by engaging the client’s internal world.
- Maintains therapeutic depth while respecting the time constraints of contemporary practice.
- Upholds relational ethics, allowing the therapist to remain attuned and reflective, even in short-term work.