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B R I E F D Y N A M I C P S Y C H O T H E R A P Y

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A Short Report submitted to the Faculty of Medicine, University of the Witwatersrand, Johannesburg in fulfilment of the requirements for the degree of Master of Medicine (Psychiatry)

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ABSTRACT

In this short report I shall first discuss the history of brief dynamic psychotherapy.

I will then compare short term and long term dynamic psychotherapy: What are their aims; can short dynamic therapy bring about lasting structural changes in the personality; and the impact of short term therapy on the therapeutic relationship.

I will look into the concepts of enthusiasm and expectation of the therapist as they apply to short term therapy.

Other factors important to short term psychotherapy are selection of patients, technique and matching the patient to a particular technique.

I shall also deal with the concept of interpretation, transference and keeping to a consistent focus throughout therapy.

The length and termination of brief therapy, the concept of time, and the activity of the therapist as opposed to the passivity of psychoanalysis, are other essential features of short-term therapy. I shall compare the results of brief behavioural therapy with brief analytical therapy and finally mention the implications of one-session analytical psychotherapy.

DECLARATION

I declare that this short report is my own, unaided work. It is being submitted for the degree of Master of Medicine in the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination in any other University.

Ronald Doctor
30th day of May, 1982

To my wife Avril and daughter Bonita.

PREFACE

The idea for this short report came after working at Tara H. Moross Centre, where patients were given a time limit as to their stay in hospital. I would like to acknowledge the help given by Dr. George Warren, who introduced the idea of Brief Psychotherapy. My thanks also to Shelley Eppel who typed this short report.

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INTRODUCTION

My fantasy of analytic psychotherapy was of a passive therapist sitting behind a couch, listening to an interminable account of the patient's life. The very history of analysis from hypnosis, to suggestion, to free association has been toward an increase in the length of therapy.

Gillman[1] noted that "brief psychotherapy usually connates an opposition to psychoanalytic theory, a substitute for psychoanalysis, a better psychoanalytic concepts. On the other hand, psychoanalytic orientation usually implies lengthy treatment, exploration in depth, therapeutic passivity, - because successful psychoanalysis requires them to achieve its goals".

Actually, an incisive intervention in a single interview can contain more psychoanalytic orientation than a protracted series of sessions that merely imitate the external trappings of psychoanalysis but contains little of its essence. It is no contradiction to apply psychoanalytic theory to the encounters of brief therapy.

Franz Alexander[2] observed that the intricate procedure of psychoanalytic treatment has undergone very few changes since its principles were formulated by Freud. Is it due to the perfection of the standard procedure which, because of its excellence, does not require improvement, or does it have some other cultural rather than scientific reasons?

Malan[3] noted that anyone who tries to develop a technique of brief psychotherapy is trying to reverse an evolutionary process impelled by powerful forces, and it is as well that he should first identify these forces, and specifically try to

oppose them. To identify these forces let us look at the history of psychoanalysis.

Thus, to begin, Breuer[4] used hypnosis to enable the patient to relive painful memories and feelings that had been forgotten or repressed.

Freud[4] replaced hypnosis with suggestion but found that suggestion was insufficient to overcome a marked resistance by the patient against recovery of these memories. To overcome this resistance he used free association, thus forcing the therapist into an increasingly passive role.

It was later found that a single symptom was usually found to have its roots in many quite separate memories and feelings, each of which had to be uncovered before the symptom could be relieved (over determination) and that each root often had to be uncovered many times in different contents, before relief was permanent (working through).

Patients inevitably began to have intense feelings (transference) about the therapist. Freud interpreted to the patient that these feelings were not about the therapist at all, but of some important person in the patient's childhood (or early childhood). Relapse often occurred at the threat of termination of therapy and could only be reversed by interpreting the patient's anger (negative transference) at being abandoned.

There usually develops a state known as transference neuroses in which the patient's whole neurosis is expressed in his relation to the therapist, on whom he becomes extremely dependent.

Therefore, to summarise Malan's[3] factors leading to longer analysis:

(1) Resistance
(2) Overdetermination
(3) Necessity for working through
(4) Roots of neurosis in early childhood
(5) Transference
(6) Dependence
(7) Negative transference connected with termination
(8) The transference neurosis

The above are factors occurring in the patient.

There are also lengthening factors in the analyst which may be summarised as follows:

(9) A tendency towards passivity in the analyst - the willingness to follow where the patient leads.
(10) The "sense of timelessness" conveyed to the patient
(11) Therapeutic perfectionism
(12) The increasing preoccupation with ever deeper and earlier experiences.

Robert Gillman[1] and Richard Serba[13] noted that the first recorded examples of brief psychotherapy were those of Freud. Bruno Walter, the famous conductor, reports in his autobiography that in 1906 after the birth of his first child, he developed partial paralysis of his right arm. After medical consultation failed to help, he went to Dr Freud prepared to talk about infantile sexuality. Treatment consisted of six interviews in which Freud first prescribed a short vacation, then insisted that Walter try conducting anyway. Freud used his authority, over Walter's

objection, to take responsibility that his performance would succeed. Walter had no further difficulty throughout his long career.

Freud's second case is that of Little Hans whose phobia was two months old when his father began analytically-oriented therapy under Freud's guidance. Halfway through the two month therapy Freud met with Hans on one occasion. On the basis of his analytic knowledge Freud was able to connect for the little boy his fear and hostility to his father and their relation to the phobic object. Freud added that he understood how the boy's natural fondness for his mother would make him think his father was angry, but that actually his father was fond of him. The next day marked the first real improvement in the phobia.

In Freud's Studies on Hysteria[4], 1895, we find another short-term analytically orientated psychotherapy in a patient, Katarina. Freud constructed the events and psychic processes leading to the hysterical anxiety symptoms.

Freud[5], recognising the need for brief therapy, stated in 1918: "It is very probable, too, that the large scale application of our therapy will compel us to alloy the pure gold of analysis freely with the copper of direct suggestion. But whatever form this psychotherapy for the people may take, whatever the element out of which it is compounded, its most effective and most important ingredients will assuredly remain those borrowed from strict and untendentious psychoanalysis".

However, as psychoanalysis became more complex, analytic treatments began to lengthen to such an extent that Freud concluded that some of them were becoming interminable.

The first analyst to explore modifications of psychoanalytic technique for the purpose of shortening the length of classical analysis was Sandor Ferenczi who in 1918 began to experiment with what he called "active therapy".

Ferenczi[6] claimed that he was merely following Freud's ideas, who had stated that in certain instances of phobia or obsessional neuroses, it is sometimes necessary to use active measures to induce the patient to face the phobia or anxiety.

Ferenczi[6] also pointed out that activity was inherent in the psychoanalytic process, because even interpretation constitutes an interference with the patient's psychic transactions of that moment and thus facilitates the appearance of thought that otherwise might not have become conscious. Ferenczi[6] tried various types of activity in the psychoanalytic situation in an effort to overcome what he called "stagnation of the analysis".

Some of his techniques were restrictive or pressuring e.g. forbidding masturbation or insisting that patients control certain body movements. Ferenczi[6] deemed it to be in the service of unconscious resistance.

Other interventions were loving or indulgent, based on the theory that the analyst as a parent surrogate was thus making amends for the rejection and tramata that the patient may have suffered from his own parents. Ferenczi's reparative efforts included hugging, kissing and non-erotic fondling of his patients.

When Freud[7] heard of these, he wrote Ferenczi the now famous letter expressing his very dim view of these activities and predicting prophetically that they would eventually lead to greater excesses on the part of the other therapists.

"A number of independent thinkers will say to themselves, why stop at a kiss. Bolder ones will come along who will go further ... The younger of our colleagues will find it hard to stop at the point that they originally intended, and God the Father Ferenczi, gazing at the lively scene he has created will perhaps say to himself: 'Maybe after all I should have halted in my technique of motherly affection before the kiss'".

Other particular techniques of Ferenczi[6] were:

(1) Playing a definite role in relation to the patient, of a kind intended to bring out more intensely the patient's neurotic reactions in the form of transference.

(2) Setting a time limit to treatment - used also by Freud (1910) in the case of Wolf Man.

(3) "Forced Fantasies" - asking the patient to make up fantasies on certain chosen themes in order to speed the exposure of hidden conflicts.

Innovations in psychoanalytic technique produced some early success but later became increasingly unreliable. Ferenczi[6] subsequently abandoned these particular techniques but he never gave up his efforts to develop a more active approach to analytic therapy.

Ferenczi's efforts brought him into early collaboration with Rank[8] who had been pursuing similar approaches independently..

They[8] pointed out that early in the history of psychoanalysis "splendid cures were effected, sometimes in a few days or weeks but that as analytic theory and knowledge expanded, analyses became longer and longer". They attributed this to a need for discovering afresh in every single case the psychological and theoretical knowledge derived from analyses and to turning every analyses into a proving ground for analytic theory.

Ferenczi and Rank[8] characterised this as making the disastrous mistake of neglecting the actual task for the sake of psychological interest. They criticized an undue preoccupation in therapy with the historical past, and emphasized the importance of focusing on the present analytical situation and its transference implications. They also asserted that the goal of psychoanalysis is to substitute affective processes for intellectual processes.

Ferenczi and Rank[8] placed the greatest importance on the patient's emotional experiences in analysis, as an attempt to correct the still prevailing emphasis upon cognitive insight through genetic reconstruction. They felt that the re-experiencing of infantile conflicts in the transference neurosis was enough. They felt that a greater understanding of these principles of technique would shorten and simplify psychoanalytic treatment.Marmor[14] suggested that Otto Rank may well be the most important forerunner of the brief dynamic therapy movement. His[9] concept of the trauma of birth laid the foundation for the subsequent recognition of the importance in personality development of the pre-oedipal years, particularly of the early mother-child relationship.

When Rank[9] published his views, however, the primary emphasis in psychoanalytic theory was on the oedipal period and castration anxieties, rather than on the pre-oedipal period and the more basic separation anxieties. Marmor[14] noted that Rank's views were vigorously attacked by Freud's contemporaries because they were perceived as threatening Freud's theories at that time. It is unfortunate that the issue of disloyalty to Freud has discredited the value of Rank's work.

Looking back from the vantage point of our present knowledge of the importance of pre-oedipal relationship in personality development and of separation and individuation in emotional maturation, we can now see that Rank was the prime theoretical precursor of these developments. Rank[9] made the "working through" of the separation and individuation the central focus of psychotherapeutic method.

It is not surprising therefore that Rank[9] was the first analyst to attribute major importance to the setting of a time limit to focus on the problem of separation and individuation which he considered critical to all human existence.

Rank[9] also emphasized the importance of mobilising the patient's "will" or motivation in the course of therapy and claimed that by doing so the therapeutic process could be faciliated. The concept of "will" is comparable to the present concept of motivation which has a bearing on a favourable outcome and the selection of patients for short-term therapy.

Twenty years later Alexander and French[11] came out with a volume which was a continuation of the work of Ferenczi and Rank. It was the culmination of seven years work into the development of shorter approaches to psychotherapy carried out at the Chicago Institute of Psychoanalysis. They recommended the "conscious use of varying technique in a flexible manner" - a revolutiorary idea in an era dominated by the standard psychoanalytic method.

Among the modifications of the standard technique they proposed were:

(1) Using not only the method of free association but interviews of a more direct character

(2) Manipulating the frequency of the interviews

(3) Giving directives to the patients concerning his daily life

(4) Employing interruptions of long or short duration in preparation for ending the treatment

(5) Regulating the transference relationship to meet the specific needs of the case

(6) Making use of real life experiences as an integral part of the therapy.

Like Ferenczi and Rank, Alexander[11] placed great emphasis on the emotional experiences of the patient in relatior to the therapist, which he called the "corrective emotional experience". The patient is re-exposed under the more favourable circumstances of the transference relationship to emotional situations that he could not handle in the past.

Although Alexander's[11] views were violently attacked by most of the classical psychoanalysts of his time, the principles he elucidated have today become part of the technique of almost every analyst. It is fair to say that Alexander[11] more than any other analyst, is responsible for leading the way towards the application of psychoanalytic principles to more active and shorter dynamic psychotherapy. Analysts began to see their patients less frequently than the traditionally four or five times weekly, and often working with them face to face and in general entering into more active, communicative transactions with them than the more passive, classical model required.

Alexander[11] felt at this time that some analysts were still working on the assumption that the curative process mainly takes place on the couch and maintained that the consequences of the assumption , that the therapeutic process is confined to the interviews, is enormous , viz, that it is responsible

for many prolonged treatment, for the unnecessary insistence on daily interviews, for our fear of interrupting treatment and for our not clarifying one of the most general experiences of psychoanalytic therapy - the mysterious post-analytic improvement.

Alexander was also of the opinion that the analytic session may be considered catalytic agents, speeding up and making possible new relationships and experiences. The influences upon the ego of these experiences of daily life are as great as, and often much greater, than that of the interview.

Balint, Ornstein and Balint[12] maintained that Alexander and his co-workers demonstrated the effectiveness and the considerable value of their shortened therapies. Had Alexander not claimed that his method improved the standard procedure - which it did not - the heated controversy he aroused might have taken a very different turn. Rather than examining the manipulative recommendations, the argument shifted to the question of whether the new techniques constituted psychoanalysis or merely a form of psychotherapy. The majority of psychoanalysts rejected the idea that Alexander's recommendations improved the standard procedure. They felt that the attempts to introduce or to impose upon the analytic process certain arbitrary activities, that go beyond the interpretative interventions and manipulate the interpersonal climate, could not be absorbed into the mainstream of psychoanalysis.

To conclude, Alexander[2] put forward some interesting views: To be a reformer of psychoanalytic treatment was never a popular role. The need for unity among the pioneer psychoanalysts, who were universally rejected by outsiders, is one of the deep

cultural roots of this stress on conformity. The majority of those who had critical views became "deserters" either voluntarily or by excommunication. Some analysts jocularly expressed the view that the stress on conformity was a defence against the analyst's unconscious identification with Freud, each waiting to become himself a latter day Freud and founder of a new school. Conformity was a defence against too many prima donnas.

Another important factor is the bewildering complexity of the psychodynamic processes occurring during treatment. It appears that the insecurity which this intricate field necessarily provokes, creates a defensive dogmatism which gives its followers a pseudosecurity.

SHORT-TERM VERSUS LONG-TERM PSYCHOTHERAPY

What are the essential differences between long and short-term therapy? Various writers have attempted to answer this question.

Malan[3] wrote a very extensive review on brief dynamic psychotherapy in which he asked three questions:

(a) Which patients are suitable and how is it possible to recognise them?

(b) What technique should be used?

(c) What kind of therapeutic results can be achieved?

Malan[3] studied the literature and found that the answers to the above questions were completely contradictory. The answers given were essentially the degree to which brief psychotherapy resemble or differ from long-term therapy.

On the question of selection criteria, the one view was that

only acute illness, in basically well adjusted personalities, are suitable. The other view point was that good results can be achieved in severe long standing illnesses.

On the second question of technique some writers had avoided dream transference and childhood origins of neurosis while other writers felt there was no essential difference between brief and long-term methods and in fact dreams, transference and childhood origins of neurosis may be interpreted freely where appropriate.

On the question of outcome the point is made that results are essentially palliative and consist of symptom removal only, while other workers feel there is no essential difference between the therapeutic results of brief and long-term methods; quite far reaching changes are often possible in short-term therapy.

Thus these contradictory messages seem to indicate that there may be no essential difference between long- and short-term psychotherapy.

Marmor[14] looked at short- and long-term therapy and found that there were factors common to both therapies, and factors specific to short- term therapy. The common denominators in all psycho-dynamic therapies are:

(a) A release of tension - catharsis in a setting of hope and expectation of help;

(b) A constructive patient/therapist relationship (therapeutic alliance) based on both unconscious factors (transference factors) as well as the real qualities that both patient and therapist bring to their transactions;

(c) Cognitive learning based on interpretations (insight);

(d) Operant conditioning based on overt and/or covert indications of approval or disapproval from the therapist;

(e) Identification with the therapist in which the patient models himself, often the therapist, incorporating some of the latter's value systems and/or behavioural patterns;

(f) Elements of persuasion and suggestion;

(g) Some aspects of practice and rehearsal of new adaptive techniques and their generalization (working through) all in a setting of consistent emotional support from the empathic therapist.

Marmor's[14] factors specific to short-term therapy are:

(a) The patient is always seem sitting up, facing the therapist.

(b) Brief therapy always involves setting a time limit.

(c) Persistent focus throughout therapy on the core conflict and the refusal to permit defensive digressions from the central focus.

(d) Activity of the therapist, i.e. persistent confrontations and interpretations.

I shall look further into these last four factors at a later stage.

McGuire[15] compared brief and long-term therapy and found that they differ in their aims.

To draw only one comparison, an aim of lengthy therapy is a thorough understanding of the patient's motivations, in brief work the aim is an understanding of a few expectations and recognition of certain motivations.

Having different aims, the value the therapist places on certain ego functions automatically changes. In analysis the patient's desire to solve his own problems without discussing them is a resistance and interpreted as such to the patient, whereas in short work, the same desire, while still a resistance, is often encouraged.

Thus the therapist with short-term objectives tries to denote and examine a selected area of intrapsychic emotional conflict in a limited time, to integrate healthy ego functions and to avoid interfering with otherwise semi-healthy ego functions.

Sifneos[16] defined the aims of brief psychotherapy as 'The aims of such therapy involve the choice of, and concentration on, one of the predicted areas of emotional conflict and the avoidance of conflicts involving character problems'.

Thus the aims seem to be more limited in brief therapy.

Another issue of short-term versus long-term psychotherapy is: Can a short psychoanalytic therapy bring about lasting structural changes in the personality and if so, how much and of what kind?

This question usually causes a parting of the way - on the one hand there are those who argue that there is no short cut to affecting a structural change, for such change needs time for the development of transference neurosis, and for the process of working through, for without such time, any ensuing change cannot be but superficial.

On the other hand there are others who argue that such a long time spent in analysis is often unnecessary and not seldom harmful. For it causes the patient to get stuck in a regressive rut while his analyst deludes himself about the possible value of such regression.

Malan[3] has stated that in the early pioneering times psychoanalysis was short. Yet, despite its short duration, (not exceeding 6 - 9 months) or because of it, it led normally to quick and dramatic uncovering and seemingly successful reso-

lution of a basic conflict where several themes were prominent.

From 1914 psychoanalyses tended to last longer and longer, so that now 3-4 years are not considered an excessively long time by many psychoanalysts.

Malan has described factors which he felt accounted for the lengthening of psychotherapy (these were mentioned in the introduction).

Malan then went on to list shortening factors which nonetheless appear to facilitate a deep and lasting structural change.

(a) An active focal approach which directs itself to what is assessed as the patient's core problem or basic conflict.

(b) The therapist's ability and courage to get involved with the patient to bear what Balint has called 'the tension of involvement'.

(c) A resolute tackling of the negative transference by the therapist.

(d) Interpretation about termination.

(e) A patient's capacity to mourn.

(f) The therapist permitting an interpersonal climate wherein the patient can express himself freely.

(g) The therapist's enthusiasm.

Malan[3] seemed to be of the opinion that structural changes in brief therapy was possible using his shortening factors.

Stierlin[17] puts forward a theory of human relationship to explain that short-term psychotherapy can indeed cause personality change.

Each human relationship can be seen as having in its individual life a beginning and an end.

He lists five perspectives which bring to light what is important in the life of a relationship:

(a) moment duration
(b) sameness - difference
(c) stimulation - stabilization
(d) gratification - frustration
(e) closeness - distance

It is the first one, moment - duration, which has relevance to short-term psychotherapy.

The importance of the moment in psychoanalysis is revealed in the importance of the concept 'timing'. The concept refers mainly to the psychoanalyst's contribution.

The analyst when making an interpretation must catch the right moment, neither too early nor too late.

Stierlin[17] stated that:
'In order that the analyst can time his contribution correctly, he must make use of what transpired in the past of this relationship which he shared with his patient. But he must also take into account what he hopes for and expects for the future - i.e. the future of the patient and of the relationship. Thus in the analyst's well-timed contribution and in the patient's reaction thereto, moment and duration are effectively reconciled'.

Along with this expectation for a shared relational future goes a commitment to the patient and to the relationship. This in turn, sets the stage for the working through in depth, which characterizes psychoanalysis. The analyst makes himself available for the unhurried internalization as a good object.

Similar considerations apply to the mother-child relationship. However the mother-child relationship is in many respects unique. Owing to the infant's initial extreme undifferentiation, helplessness and prolonged dependency on his mother, the moment duration dimension gains a specific quality and significance.

The mother's preformed image of her child's growth and of the future of the relationship will have a determining influence precisely because the infant has no such image.

This difference in capacities and expectations then structures the setting, within which the relational drama between these two people will unfold.

In order that a positive mutuality can develop, the moment-duration balance must reflect mother's deep commitment to the child's future but also her ability and willingness to let her image of this future be influenced by the needs and developmental potentials of her child.

The psychoanalytic and the mother/child relationship of Stierlin present two examples of typically but differently constructed moment-duration balances.

As such they offer a view of all human relationships wherein the time-dimension offers the crucial differentiating criterion. (There are mothers who are committed to making their children in their image which invites symbiotic entanglements and precocious development. There are mothers with a lack of caring and future orientated commitment who let their children run loose without much concern for a tomorrow which leads to an uncaring and ruthless impulsivity).

Thus short-term as well as long-term psychotherapies would have to be seen as instances within a panorama of possible relationships. Within this panorama we would have to distinguish between enduring future bound relationships on the one side and casual momentary relationships on the other.

In the enduring future bound relationship (mother/child, husband/wife, analytic relationships) the moment duration balance is structured in such a way as to make for a shared future and a commitment to the relationship. The partners appear committed to the working through of difficulties that will arise. They allow for a common path to emerge, thereby gaining a dimension of depth and become dependent on each other. They can dare to reveal themselves freely to each other and share regressive experiences.

In deep relationships, between committed partners, growth may occur, as these depend on the ongoing internalization and inner processing of the other's image and values. In these relationships both partners contribute to the other's growth and to his integration of inner objects and therefore the loss of the other is bound to become painful and shattering. This loss exposes patient and therapist to the work of mourning, which stimulates growth and ego change in the manner which Freud had in mind when he described the ego as a precipitate of past relationships.

Casual momentary relationships are found on the other end of the scale and would appear to lack the elements just described. Yet at close inspection, relationships of casual appearance may show features of depth and intensity and have a formative impact that may even be deeper than in enduring future-bound

relationships. This may seem paradoxical but Stierlin[17], using the concept of moment-duration, explains further. In those relationships which stand out on account of a 'seemingly unsurpassed sharpness, freshness and intensity of experience and yet are unenduring affairs ... we seem to feel the unmitigated impact of the moment'. He talks about a relationship which owes its intensity and meaningfulness for both partners to the fact that it has no future, they are unburdened by the troublesome prospect of having to work through their difficulties nor coping with the routine of everyday living, nor correcting the illusions they have of each other. They will be spared the task of an ongoing and laborious inner object-processing and integration.

In many psychotherapeutic relationships of the casual type - one consultation interviews, short-term psychotherapies, 'our perceptions are often unusually sharp, fresh and intense'.

Another phenomenon is that of the most intimate and best guarded aspects of one's private life which one dares to and seeks to reveal in the absence of a future bound relationship. A person might tell a chance acquaintance on a train what he would not dare to tell his wife.

It is not simply a matter of obtaining 'a temporary catharsis but rather an attempt at self-revelation and self-confirmation under conditions of controlled interpersonal distance'.

Thus we must allow for experiences of great intensity and emotional impact which result from relationships that are short and basically non-committal.

In these relationships a therapist's emotional responsiveness

and perceptual acuity find their counterpart in a patient's willingness to reveal himself and let himself be moved.

We must allow for relationships wherein the moment becomes enduring or becomes transformed into duration, where short relationships tend to live on in one or both partners, the indi idual continues to carry such a relationship with himself after it has ended. The inner dialogue with the lost partner goes on.

Secondly, the formative impact of short-term psychotherapy must take into account the fact that both therapist and patient know the relationship will not and cannot last.

As mentioned earlier, Malan[3] listed a shortening factor of Balint's, i.e. 'the tension of involvement' which reflects a needed engagement, on the part of the therapist, and his enthusiasm and commitment to the task. It makes for a controlled intensity of the relationship and this intensity in turn, might contribute to the transformation of the moment into duration. This engagement however is conceived to end soon, which appears to contribute to the intensity of involvement but also makes this involement more bearable, its end is in sight.

The same seems to hold true for the tackling of the negative transference: such negative transference will be experienced as less of an insidious burden by the partners when they know the relationship will not last.

ENTHUSIASM AND EXPECTATIONS

Malan[3] points to the fact that each psychoanalyst seems to repeat in his individual career what characterizes the psychoanalytic movement as a whole. In the earlier stages of his career he usually achieves some quick and dramatic successes which later seem to become unreachable. "The ontology of psychoanalysis thus seems to recapitulate its phylogeny". Malan[3] offers the explanation of the above concept in the therapist's enthusiasm. Perhaps the intense interest of any worker new to the field engenders a corresponding heightened excitement in the patient, with the result that repressed feelings come easily to the surface and are experienced with such intensity and completeness that no further working through is necessary. Subsequently this excitement can never be quite recaptured, nor can its effects.

This interesting observation suggests the possibility that the emotional conditions within the therapist may be even more important than has yet been realized and may sometimes make the whole difference between an interminable failure and quick success.

Malan[3] says that waning enthusiasm in the therapist may be the one lengthening factor that may well prove to be the most difficult of all to counteract.

H Stierlin[17] also noted that there is little doubt that enthusiasm sharpens the therapist's focal empathy and perception and that enthusiasm is infectious thus heightening the patient's responsiveness to the contributions of the therapist.

Enthusiasm is difficult to sustain and only exceptional people seem able to sustain it for long.

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The early enthusiastic psychoanalysts defied, so to speak, the whole existing psychiatric past with its established notions about the nature of neurotic disturbances.

Stierlin[17] noted that, "In this context we might wonder as to how much a project of the type Malan initiated was bound to stir up and sustain enthusiasm. It challenged part of the established psychoanalytic past: as a group project it could feed on a feeling of shared excitement; it could benefit from an inspired if not charismatic leadership as apparently afforded by Balint and Malan himself; and perhaps most important it was limited by its nature; its end was clearly in sight and the future was therefore not allowed to stretch forbiddingly on".

Besides enthusiasm, there appears to be another aspect of the therapist that might contribute to the shortening of psychotherapy i.e. the therapist's expectations.

Aldrich Knight[18] explored Johnson and Szurek's concept of parental expectations and the superego lacuna as determinants of behaviour disorders in upper and middle class children and its practical application in shortening the duration of psychoanalytically oriented psychotherapy.

Johnson and Szurek[19] postulated that 'acting out' in children of customarily non-deliquent families is due to a 'superego lacuna', or defects in behaviour controls unconsciously sanctioned by parents in order to gratify their own forbidden impulses. They believe that the sanction is communicated to the child of parental expectation of a specific type of delinquent behaviour, and that the parent selects a scapegoat from among his children to express for him the behaviour in question.

Not only parents, but schoolteachers and scoutmasters' capacity to control the behaviour of their charges seems to be primarily a function of their expectations. Even lower animals respond to expectations; eg. the frightened postman gets bitten by the dog.

Society in general communicates its expectations of behaviour through its mores but may expect different behaviour from different sectors.

The extension of the superego lacunae hypothesis has definite implications for therapists.

Frank[20] maintains that therapists' expectations affect patient behaviour. He points out that 'those who practised long-term psychotherapy find that their patients take a long time to respond; those who believe that good results can be produced in a few weeks claim to obtain them in this period of time and considers that 'length of treatment probably reflect in part, the therapist's and patient's expectations'.

Frank[20] states that therapeutic hope or optimism is an important ingredient in effective psychotherapy. 'Optimism' means optimism that is informed about the patient diagnosis, including the strength of his ego and the extent of his self destructive tendencies.

Informed optimism communicates a valid expectation that improvement for whatever reason can persist rather than collapse. The therapist's optimism or pessimism adds one more expectation to the existing combination of parental and societal expectations.

Thus if the therapist expects that the patient's capacity to

respond favourably to short-term symptomatic treatment, it is evidence of his capacity to cope autonomously with residual unresolved conflicts.

Aldrich Knight[18] was of the opinion that the results of short-term psychotherapeutic repair of ego defects of 'closure of superego lacuna' was perhaps a transference cure and only constituted symptomatic improvement not accompanied by resolution of underlying conflicts.

Thus between Malan's[3] enthusiasm and Aldrich Knight's[18] optimistic expectations, therapy becomes shorter but with differing results; Malan claiming structural changes, Aldrich claiming only symptomatic improvement.

SELECTION OF PATIENTS

Short term dynamic psychotherapy rests on two basic factors; selection and technique. In this chapter, I shall deal with the former.

Not all patients are suitable for short-term dynamic psychotherapy, but a substantial proportion of those who are considered suitable for longer term analytic therapy are equally suitable for the shorter term approach.

At the outset of the selection process, it is important to underline the necessity for a good history and a psychodynamic diagnosis, i.e. evaluating both the inner and outer forces that contribute to the patient's psychopathology.

Inasmuch as short-term dynamic psychotherapy involves an uncovering and searching out of unconscious intrapsychic

factors, the therapist looks for qualities in the patient that will indicate his capacity to work effectively in this way.

Marmor[14] put forward the following five factors for selection of patients for psychotherapy:

(1) Evidence of ego strength (e.g. intelligence, level of education achievement, sexual adjustment, type of work, ability to assume responsibility;

(2) At least one meaningful interpersonal relationship in the past, indicating a capacity for basic trust;

(3) The ability to interact with the therapist in the first session (i.e. the capacity to form a positive transference;

(4) The ability to think in psychological terms (i.e. the ability to accept interpretation or insight which is usually tested in the initial interview by making a tentative interpretation and evaluating the patient's response to it;

(5) The ability to experience feeling, i.e. the degree to which the patient is in touch with his own emotions.

The above five factors are essential in the selection of patients for any form of dynamic psychotherapy - long or short term.

Are there any factors specific to short-term psychotherapy in the selection of patients?

Malan's[3] review of the literature on selection of patients for short-term psychotherapy shows very contradictory ideas on the subject. He found that the most widely held hypothesis about selection criteria is that the prognosis is best in 'mild' illnesses of acute and recent onset, but also found strong dissenting statements.

Berliner[21] (1941) stated that the feasibility of short treatment

does not depend on the acuteness and duration of the illness but on the depth of the neurotic disposition.

Guthei[23], in 1945, reported that good results were obtained at the Brief Psychotherapy Congress in Chicago, presided over by Franz Alexander in "Psychopaths,delinquents, and psychotics".

Another writer was Pumpian Mindlin[22] who said in 1953 that "short term treatment is not dependent on the amount or seeming severity of the psychopathology present in the patient nor upon the severity of the earlier traumata suffered by the patient. The mere presence of severe psychopathology is no contra-indication to short term therapy. Rather it appears to depend upon other factors present in this group of patients- which we might ordinarily sum up in the term "ego strength" i.e. the patient's ability the obtain satisfaction from personal relationships, in spite of his symptoms and the ability to tolerate frustration.

Stekel[24], in 1938, recognised few limitations to his treatment which lasted one to six months - and took on patients with psychopathology generally considered to be severe.

Malan[3] noted that without an adequate follow-up on the above cases, the same objection can always be made i.e. the therapeutic results consist of "transference cures".

Thus from the confusion about the hypothesis that the prognosis is best in mild illness of acute onset, Malan[3] believed that there must be criteria which are relatively independent of the type or severity of the illness.

Ripley, Wolf and Wolff[25] (1948) regarded flexibility of person-

ality structure as important in brief psychotherapy. An important clinical way of assessing a factor connected with flexibility is made by Alexander[11] i.e. trial interpretations "The patient's reaction to initial interpretations is the best guide in evaluating the patient's capacity for insight as well as the character and strength of his resistance and future co-operation".

High motivation in the patient was mentioned by Ripley[25] et al and Knight[26] (1937) as correlated with acuteness.

Stekel[24] (1938) regarded low motivation as almost the only contra-indication to his technique. Malan[3] found that the prognosis may be related to patients who show evidence from the beginning of a willingness, and an ability to work in interpretative therapy; which can be broken down into two factors, motivation and some response to interpretation.

Malan[3] concluded from his study that if mildness of psychopathology and recent onset of symptoms do exert any favourable influence on outcome, then this influence is much less important than that of other factors. Also that the point at which severity and extensiveness of psychopathology begin to exert as appreciable unfavourable influence lies far nearer to the severe and extensive end of the scale than the current hypothesis would suggest.

Malan[3] was of the opinion that motivation offered the only hope of being of value in selection of patients.

By motivation he meant the strength of the wish to come for treatment and clearly the patient must want the treatment he is being offered. Malan was offering insight and if it is something else the patient wants he will not get it here.

As Balint[27] said "the therapist and patient's aims must be the same". Malan[3] noted that "A phenomenon universally experienced in dynamic therapy is resistance. This means that every patient's motivation for insight, and many patients' motivation to come, are ambival containing both a positive and a negative component. Moreover, marked fluctuation in motivation occur regularly in therapy especially during the first four or five sessions".

Malan[28] found from studies of his patients that the aspect of motivation that may turn out to be reliable indicators of poor prognosis is acting out over appointments. Another factor was the falling off of motivation in session 2 to 5 a low prognosis, or good prognosis if he started with high motivation.

(1) Thus a high initial motivation both to come and for insight or an increase in motivation following insight equals a good prognosis.

(2) A low motivation and decrease from an initially low motivation - equals a poor prognosis.

(3) While an early decrease from an initially high motivation may equal a good prognosis.

Under the concept of motivation, it might have been Rank[9] who first talked about the importance of mobilizing the patient's "will" in the course of therapy and claimed that by so doing the therapeutic process would be facilitated.

The word "will" might be substituted for the more modern term "motivation". In this connection it is worth noting that four of the seven criteria for motivation to change used by Sifneos[29], in selecting patients, employ the concept of willingness (willingness to actively participate in the treatment situation, willingness to understand oneself, willingness to change, willingness to make reasonable sacrifices in terms of time and fees. Malan's ideas were similar; The patient's

willingness to explore feelings and ability to work within a therapeutic relationship based on interpretation.

Freud[30] in 1913 said almost the same thing "One must distrust all prospective patients who want to make a delay before beginning their treatment --- when the time agreed upon has arrived they fail to put in an appearance ..." This is perhaps the earliest reported statement about the relationship between motivation and prognosis.

Balint's[12] criteria for selection of patients for focal therapy, overlap with Malan's ideas but are not identical:
To be able to predict a reliable therapeutic alliance between patient and therapist that will be strong enough to withstand the considerable strain that the therapy must cause:
It should appear unlikely that the patient will defend his illness as a narcissistically valuable part of his personality i.e. prefer to remain ill to changing. The patient appears capable of accepting interpretations "on approval" and doing some constructive work with them.

The report of the psychiatrist and psychologist must either confirm each other or if not they must make sense together. This factor tests the patient's ability to make meaningful relationship with two different people in two different settings.

A focus should be found not later than the third or sixth session i.e. that the patient can be understood at sufficient depth and with sufficient reliability by the therapist.

Harold Stewart[31] selected patients for his 6 month dynamic therapy who were motivated, had sufficient intelligence, had

to be working, had to "relate" to persons of both sexes, no extreme characteristics and use interpretations at the diagnostic interview.

Malan[29], in 1976, reiterated his selection criteria on slightly different lines; The current conflict and precipitating factors are defined, indicating a specific focus. The life problem is defined and the nuclear conflict can be identified. There is a clear link between the current conflict and the nuclear one. A trial interpretation is made to which the patient responds. This can be in the form of clarification, summation or identification of transference interpretation.

The patient demonstrates capacity for interaction with the therapist and motivation for insight.

The patient demonstrates the capacity to tolerate anxiety.

Thus the emphasis is on a focus, motivation and the patient's response to interpretation and insight.

Sifneos[16] clarified his selection criteria: The patient must have a circumscribed chief complaint i.e. a capacity to choose one out of a variety of problems which the patient considers to be important and to assign it top priority for resolution.

There must be a history of a meaningful relationship during the patient's early childhood, i.e. a relationship where there is give and take, exchange of ideas, sacrifices are made for the sake of someone else.

A failure to develop a meaningful relationship with another person is usually due to an early fixation, most likely caused

by one or all of the following:

narcissism

passivity

dependence

sado-masochism

Flexible interaction with the evaluater and ability to express feelings openly during the interview.

Motivation for change implies an activity on the patient's part to take responsibility for the therapeutic task and to rely on his own resources. To recognise that his difficulties are psychological in origin, honesty in reporting about himself, introspection and curiosity, lack of grandiose or magical expectations, willing to make a reasonable and tangible sacrifice. Sifneos[16] selects patients with oedipal conflicts who usually present with interpersonal difficulties and appearance of circumscribed symptoms such as phobias, anxieties, mild obsessive-compulsive complaints, and mild depression.

Paranoid delusions and hypochondrical preoccupation are more serious and not associated with oedipal problems.

Sifneos recognises his approach is anxiety provoking, therefore he chooses only those who can bear the pain without disintegrating or terminating prematurely.

H Strupp[32] did a study of two patients with brief dynamic psychotherapy and found that the results of the two young men suffering from anxiety, depression and social withdrawal showed that the outcome of psychotherapy depends "markedly on the patient's ability to form a productive working relationship with the therapist early in therapy.

Conversely deep seated characterological problems manifesting themselves particularly in negativism, hostility, and other resistences may give rise to insurmountable barriers resulting in negative therapeutic outcome".

Lastly, one of the major workers in this field is Davanloo[33] whose work seems to correlate with the previous writers.

The questions he asked in evaluating his patients, who have been successfully treated by short-term dynamic psychotherapy are:

Does the patient have a circumscribed problem?

Is there a psychotherapeutic focus on which patient and therapist agree?

Could he provide a psychodynamic formulation for patient's problem?

Object relationship?

Affect?

Evaluation of patient's motivation?

Intelligence?

Psychological mindedness?

Patient's ability to respond to transference interpretation and past-present transference link?

Davanloo[33] indicates that response to transference interpretation in the initial interview significantly correlated with the psychotherapeutic outcome and that patients who scored highly in their motivation also showed a very high correlation with therapeutic outcome. There is also a definite correlation between motivation and psychotherapeutic focus.

Thus from the preceding pages it would seem that patients

with a wide variety of personality disorders and psychoneuroses as well as those with traditional crises may be suitable for short-term dynamic psychotherapy. The critical issue is not diagnosis so much as the possession of certain personality attributes plus the existence of a focal conflict and high degree of motivation.

Having selected the patient, the next question facing a short term therapist is how to choose a particular method for a particular patient.

Burke[34] poses the question : Does the selection of the therapeutic method depend on the patiert or on the therapist? Both are important but matching the patient and the method should not be a random or intuitive process. His suggestion is that each of the short-term therapeutic schools is best suited to patients whose problems run along a developmental continuum. Patients can be grouped in accordance with conflicts that occur at different stages in adult life according to Erikson[37] and Levinson[36] whose description of developmental stages in early and mid-adult life correlates with the sequence of developmental stages in childhood.

Burke lists three principal methods of dynamic short term therapy:

(1) the interpretive, to increase and focus the interpretations

(2) the corrective, to increase the therapist's manipulations

(3) the existential, to pressure the patient by clearly limiting the amount of time and then increasing the therapists empathy.

Beginning with the third method, the existential approach of

Mann seems most useful with passive, dependent patients who have been unsuccessful in resolving Erikson's[37] adolescent's conflict of identify versus role confusion.

At this stage, the patient must consolidate an autonomous, cohesive sense of self; the task is analogous to the separation-individuation phase of childhood.

In Levinson[36] terms, this is the Early Adult Transition, in which the first task is to start moving out of the pre-adult world, to modify or terminate existing relationships, to reappraise and modify the self that has formed in it. The second task is to make a preliminary step into the adult world and to consolidate an initial adult identity.

To reach such a patient the therapist must adopt an empathic approach. By formulating the patient's pain, the therapist identifies and shares the patient's diffuse sense of suffering. This close sharing stimulates the patient's fantasies of union and merger and by allowing himself to get "close enough" in an idealized way, Mann[35] creates the basis for an internalization. This new, more positive introject can serve as the necessary prerequisite for separation by the patient. But termination is not automatic, it has to be imposed, like weaning, on a patient who is only now mastering the ordeal of separation - individuation.

The patients treated by the interpretive method of Sifneos[16] and Malan[3] have moved beyond the crisis of identity to later challenges in early childhood of intimacy versus isolation (Erikson[37]) and the creation of Levinson's[36] First Adult Life Structure - The young man must shift from the position of a child in his family to the position of novice adult, with a

new home base that is more truly his own. He must make and live with initial choices regarding occupation and love relationship.

As the patients seek to develop a mature relationship with another person, their attempts can be frustrated by a resurgence of Oedipal conflicts. These are the patients who can be expected to respond to Oedipal interpretations with the most anxiety, since the therapist aims to develop a new capacity for insight.

The dramatic affective style of these hysteric patients make them well suited to the unemotionally involved therapist whose intellectual activity provides them with a useful but unfamiliar model for dealing with psychological problems.

The therapist also serves as an engaging, instructive nonseductive figure at a time when such a person can have most impact on the patient.

Alexander's[11] corrective approach treats patients confronting the typical mid life problem of "generalivity vs stagnation" (Erikson[37]), a stage that encompasses issues of productivity, creativity and the maturity to deal with new difficulties at home and at work. For Levinson[37] this represents a stage in mid-adulthood : "It becomes important to ask: What have I done with my life? What do I really get from and give to my wife, children, friends, work? What is it I truly want for myself? The process of reappraisal activates neurotic problems. The pathology is not in the desire to improve one's life but in the inner obstacles to pursuing this aim.

These tasks correspond to the latency period, when a child

who has passed through his oedipal phase learns ways to manage and adapt to his environment.

A therapist who takes an intellectual approach to these patients might foster the patient's own typical defensive style.

Attempting an emphathic encounter can be equally frustrating either because the patient can find it too gratifying and be diverted from the task at hand or because the therapist and patient are not able to sustain such closeness. The issue in the patient's life is action, perhaps the maximum therapeutic effect comes from transference manipulations and a managerial stance by the therapist evoked in Alexander's method.

This correspondence between the schools and the developmental stages may explain how the short term methods can be successful in a brief period of time. They may help a patient master the crisis of a particular developmental stage, and thus make possible his or her further development.

Goldberg[38] has directed short term therapy to patients suffering from acute narcissistic injuries who require assistance in repairing their damaged self esteem, leaving attempts at restructuring to longer forms of therapy. In this situation the therapist's function is to serve as a narcissistic self object, to restore, maintain and hold together their self esteem.

Kohut[39] describes two kinds of narcissistic self objects. One relates to the patient's sense of grandiose self through the patient's need for responsiveness from the therapist

expressed by the therapeutic action of reflecting; the other relates to the internalized parental image, the need for a connection of the weak patient to the greatness of the therapist expressed by the therapeutic function of protecting.

Thus taking the patient's hurt feelings seriously allows the therapist to meet the patient where he is and the therapist can be accepted as part of the patient's self system, accepting and encouraging the injured self's need to re-establish its own sense of gradiosity or the perfection of its protective internalized parental image.

Functioning as a self object, reflecting or protecting, the therapist will help the patient recover from the felt injury and re-establish his organising fantasies.

Behind the vulnerable psychic constellation of the self is one or other childhood fantasy of glory, which is once again traumatized and forced into regressive retreat. Psychotherapy aims to re-establish the narcissistic equilibrium and hopefully to uncover a screen for the childhood fantasy.

Therapists often find it difficult to tolerate the primitive idealization that patients express in the transference. But that is the basic task, to meet the patient where he is, to accept the patient's admiration, so the patient can re-establish his narcissistic balance. Therapists who insist on being modest might prevent the patient from regaining equilibrium.

With what Goldberg[28] calls the "pain of being unabashedly adored day after day", there are inevitable failures of empathy, which provide an opportunity for making interpretations about

the patient's needs. In long term therapy, Goldberg[38] considers these interpretations of the empathic failures and their effect on the patient, to be the curative feature; for short term therapy however, Goldberg operates from a conservative stance, with the view that simple restoration of narcissism is a sufficient goal.

The ultimate point in psychotherapy of narcissistic injuries is ultimately to interpret the implicit role assignments in terms of the injuries and the associated fantasy. These interpretations range from clarifying the obvious fantasy which may be denied, to more deeper or repressed ones involving early infantile fantasies of greatness of power either in one's self or one's protectors.

Thus, understanding the techniques of the different schools, and their applicability to the developmental conflicts, will enable therapists to achieve a better match by selecting both the patient and the method for short term therapy.

INSIGHT AND INTERPRETATION

The question that many writers have asked themselves regarding interpretation is: "how deep to go in brief therapy". i.e.

(a) whether the therapist should make his interpretations only in terms of the current life problem, or external reality or (b) should he not be afraid where necessary to make interpretations about the roots of the patient's neurosis in childhood, his relation with his parents, or his inner world.

There is a wide divergence of views on the above question. Fuerst[40] (1934) was of the opinion that the aim is not so much to make unconscious material conscious, as to build up an ego, which can handle the conflicts of the present situation. Finesinger[41] (1948) had similar ideas. He said that brief insight therapy seldom exposes the phantasies and memories that are deeply repressed.

Pumpian-Mindlin[22] (1953) also fitted into the above mould. For him interpretations are couched in more general terms and not related to specific historical conflicts in the patient's life.

On the other hand, Stekel[24], Alexander and French[11] say that no limits can be set beforehand, that the therapist should go as deep as is necessary to help the patient and that sometimes a conflict should be traced to its roots in childhood.

Malan[3] (1963) concluded from his study on brief therapy that almost all the lengthening factors, which have played such an overwhelming part in the development of psychoanalytic technique, can in certain cases be avoided or counteracted. Thus resistance, transference, dependence, negative transference, anger over termination, and the roots of neurosis in early childhood can all simply be handled by direct interpretation.

It is generally held that interpretation is the major mutative technique in psychoanalysis.

Central to the interpretative technique is the belief that the patient needs assistance in bringing underlying conflicts into conciousness. These conflicts, which result in symptom

formation, derive from the threat that defenses are losing ground in warding off unacceptable impulses.

To quote Alexander[42]: "Interpretation which connects the actual life situation with past experiences and with the transference situation - since the latter is always the axis around which such connections can best be made - are called total interpretations ... They accelerate the assimilation of new material by the ego and mobilise further unconscious material.

Malan[3] concluded that thorough interpretation of the transference plays an important part in leading to favourable outcome.

Secondly that important subdivisions of transference interpretation are:

(1) negative transference

(2) the link between the transference and the relation to one or both parents

Thirdly that those therapies tend to be more successful in which transference interpretations become important early and/or in which interpretations of the patients grief and anger at termination are a major issue.

Malan[3] goes on further to say that in his view for brief analytic psychotherapy transference interpretation is essential. The negative transference should not be feared but welcomed. It is quite safe - sometimes even necessary - to make "deep interpretation, to use dreams, and phantasies and to make the link with childhood".

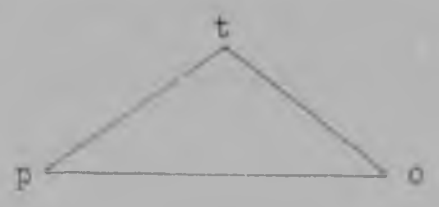
Malan[28] 1976a, in a later work on brief psychotherapy, con-

centrated of the examination of the "triangle of insight", i.e. the three types of figures (objects) toward whom the patient may experience conflict:

the parent (p)

the therapist (t)

other significant persons (o)



Malan's[28] findings, significantly linked the transference-parent interpretation to outcome i.e. (t/p link).

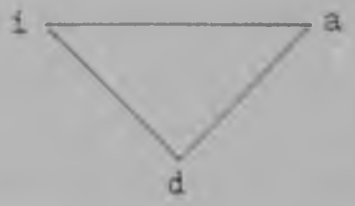
Marziali and Sullivan[43], in a study on brief psychotherapy, analysed the therapist's interpretations which identified the component parts of the two triangles and their interlinkage.



t = therapist

p = parent

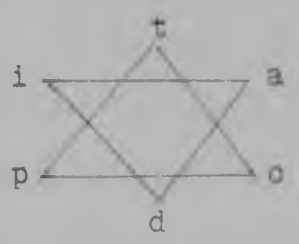
o = other



d = defence

a = anxiety

i = impulse



They asked whether in each interpretation the therapist makes reference to an impulse, a defence and/or anxiety. Does he make specific linkages amongst these factors. Furthermore, does he link these factors to current and past objects.

For impulse they used the concepts of libido and aggressions as instinctual drives, introduced by Freud, i.e. unacceptable infantile, sexual and aggressive wishes persist into adult life where they play a major part in basic motivation and promote the development of a variety of defensive reactions in order to ward off the accompanying anxiety.

The concept of dependency (Horowitz[44]) i.e. the need for safety and human contact, and the notion of envy - jealousy (Melanie Klein[45]) were included as an impulse because of the aggressive, possessive qualities contained in these concepts.

Defense was described as a warding off of anxiety, guilt and painful feelings. Interpretation in therapy is concerned primarily with bringing to consciousness the inhibiting, warding off aspects of defensive behaviour.

Anxiety - two types were described; primarily anxiety which resulted from a state of helplessness due to overwhelming instinctual tension and secondary anxiety brought about by fear of an internal or external danger situation.

Malan[28] (1976) said that in ordinary clinical terminology it is important to make clear that the same patterns of defense, anxiety and impulse occur in the transference as in current relationship and that usually, each of these is a repetition of a pattern that originally arose in the distant past.

Marziali and Sullivan[43] studied the presence or absence of the six factors in each interpretation and the linkage between factors.

They replicated Malan's[28] finding i.e. the t/p factor was positively and significantly correlated with outcome. The addition of the i,d, or a to the t/p did not reach significance when correlated with outcome.

From Freud's famous statement that dreams are "the royal road to the unconscious", various writers have studied its implications in brief psychotherapy.

Stekel[24] (1938) in his brief psychotherapy uses active interpretation, particularly of the patient's dreams. This emphasis on dreams is clearly an attempt to bypass the resistances and quickly enter the patient's unconscious world.

In contrast Finesinger[41] (1948) discourages the interpretation of dreams for the same reason as he discourages free association, because he feels it leads away from reality.

Malan[3] (1963) felt it was quite safe - sometimes even necessary - to make "deep"interpretations, and to use dreams and phantasies.

Merril and Cary[45] said that through interpretation of dream the therapist has a powerful tool in recognising the conflict and showing the patient, even in brief psychotherapy, that if such an impulse is being considered during sleep it must have remained unresolved during the day.

In brief analytic psychotherapy the therapist concentrates on the manifest content of the dream, creating participation in

the therapeutic process, thus forming the basis for active change inside and outside therapy, and alleviating symptoms and acting out of conflicts.

If a change cannot be produced in this way due to threatening dream content and further intensity of transference, the increased resistence is represented and symptoms continue.

However in brief psychotherapy, Merril and Cary[46] were of the opinion that the transference is less likely to become an intensified transference neurosis but remain free floating, while insight is actively utilized and integrated into the current life situation of the patient. Thus the focus is away from the patient-therapist relationship and outward toward other significant relationship.

The dream serves as a catalyst in establishing sharing and accepting between patient and therapist. When the patient becomes more willing to recognize his part in creating and experiencing conflict in current reality, his self-awareness and self-acceptance increase, ushering in a transitional phase of active participation in the therapeutic process leading to the patient's recognition of his active role in creating and experiencing conflict.

Merril and Cary[46] feel that magical dream interpretation should be judiciously avoided. One should not be tempted to use this method as some sort of short-cut device in brief psychotherapy.

Symbols may be meaningful for the therapist but their active elucidation by him forces the patient into a dependent and passive role.

To prevent over-dependence the therapist should suggest that the dream is something that he and the patient will work on together.

TRANSFERENCE

The early analysts did not use transference interpretations and the most important of all the lengthening factors has been the development of, and the necessity for resolving, the transference neurosis.

A complete spectrum of views exist on the question of whether transference should or can be avoided or discouraged, should be ignored if it develops, should be interpreted only when absolutely necessary, should be interpreted without fear, or should even be encouraged.

Deutch[47] (1949) used no transference interpretations at all.

Pumpian-Mindlin[22] (1953) avoided or diverted the transference: "In short term therapy there is a general tendency to avoid an intense transference and to take measures to diminish the transference phenomena which inevitably appear --- this is accomplished by means of less frequent visits and by implicitly or explicitly structuring therapy in terms of the circumscribed presenting problem only", which is deflected onto an important figure in the patient's environment rather than focusing the problem around the patient-therapist relationship.

Berliner[21] (1941) and Stekel[24] (1938) believed that it was sometimes necessary to interpret the transference, but only when it begins to distort the therapy, particularly when it

becomes used as resistance or becomes "negative".

Fenichel's[48] (1945) technique was to develop prescriptions for advice and provocations of transference based on diagnostic categories, which is similar to Alexander's[11] use of role playing to provoke a corrective emotional experience.

Ferenzi[6] (1919), opposed the analyst's passivity by such activity as assuming a definite role vis a vis the patient, a role that would somehow speed up the treatment of eliciting from their hiding places the patient's neurotic transference reaction.

He felt that the re-experiencing of infantile conflicts in the transference neurosis was enough. It was not necessary to wait for infantile memories to re-appear, thus analyses could be considerably shortened. They thought that, once the past conflicts were repeated in the transference and they were thoroughly understood, even without connecting them to the actual genetic events, the analyst could set the date for termination of the analysis.

Ferenzi's[6] experiments were widely opposed and he himself soon acknowledged their failure (1928). The failure of his experiments, along with Freud's negative reactions to them, after his initial endorsement of the direction they took, inhibited the development of brief analytic psychotherapy.

Ferenzi and Rank[8] had attempted to correct the over-intellectualized procedure of psychoanalysis. Alexander and French[11] (1946) re-emphasized the central importance of the emotional experience in analysis along with a re-emphasis of

the need for intellectual integration, i.e. working through which was relatively neglected by Ferenzi and Rank[3].

The patient in his inevitable transference reaction anticipates from the analyst the parental attitudes that shaped the adoptive defensive repertoire of his behaviour.

The fact that the analyst's responses are different from those of the parents provides the patient with an opportunity to correct his distortions. The emotional experience in the transference lends conviction to and is the necessary underpinning of insight. Having thus reached some stability, this insight elicits new more up to date and reality orientated, solutions to old conflicts.

Alexander[42] thought that the intensity of the emotional re-experiencing of the past (i.e. transference) could be regulated to reach optimal intensity by:

(1) Changes in the frequency of the interviews

(2) temporary interruption of the treatment (especially to deal with excessive dependency problems)

(3) replacing the spontaneous counter transference attitude of the analyst by assuming a deliberately planned stance, the opposite of the parental attitudes, to enhance the "corrective emotional experience"

"Re-experiencing the old unsettled conflict but with a new ending is the secret of every penetrating therapeutic result, the actual experience of a new solution in the transference situation gives the patient the conviction that a new solution is possible and induces him to give up the old neurotic pattern".

An example of Alexander's[42] approach would be for a patient

with a tyranical father to impose the old father-son pattern on the therapeutic setting, but the therapist instead of remaining passive, allowing the patient to make him the father of his childhood, would counteract this tendency of being forbidding, punitive and indifferent and would be kind and tolerant. This is transference activity, not interpretation and the role playing is intended to help the patient achieve mastery of his conflicts by action, not enlightenment.

Most of the modern analysts are of the opinion that transference interpretations, both positive and negative, are essential ingredients of Brief Psychotherapy, but avoid the transference neurosis.

Malan's[3] study made the hypothesis that interpretation of the negative transference was an essential factor in therapy, that transference interpretations do not intensify dependence, but that the more successful cases tend to be those in which dependence does develop in moderation. Prognosis seems most favourable when transference arises early and becomes a major feature of therapy. Burke[34] noted that, "Malan's approach is to remain removed from the patient, somewhat shadowy and uninvolved. Every interpretation is to be precise and controlled. He is didactic, less intense as he proffers interpretations to weave together past and present".

Davanloc and Beroit[49] stress the importance of using positive transference, avoiding the development of transference neurosis, and come to the conclusion that there is a very high significant correlation between transference interpretation and the outcome of short-term dynamic psychotherapy.

Interpretation of the negative transference is of great

importance for the maintenance of therapeutic alliance.

Sifneos[16] was of the opinion that once a transference neurosis sets in an impasse is reached and therapy is prolonged unnecessarily without a clearcut resolution.

The therapeutic work must be done quickly before the transference neurosis makes its appearance. The best way is to use the transference feeling early. Transference feeling should be encouraged to develop and must be discussed as soon as they make their appearance.

Burke's[34] feelings about Sifneos was that: "He sees himself as an unemotionally involved teacher. He uses a provocative, confronting approach, educating the patients about themselves and showing them new methods about themselves. He is like a schoolmaster seeing through the excuses and alibis of his recalcitrant pupils. Almost from the start, the patient is not only made aware of his transference feelings, but are linked with Oedipal feelings. The interpretation is made in such a forceful way that the patient has the choice of either fighting him, acknowledging that it is true or quitting treatment".

An example of Sifneos'[16] vigorous use of confrontation and interpretation with a 17 year old female college freshman with anxiety around examinations in which the following interchange takes place:

Dr : You mean to say that there is a part of you that is very feminine and likes boys.

Patient: The way you put it makes me mad. It isn't exactly like that ...

Dr : (interrupting) It is exactly like that and you know it perfectly well.

importance for the maintenance of therapeutic alliance.

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An example of Sifneos'[16] vigorous use of confrontation and interpretation with a 17 year old female college freshman with anxiety around examinations in which the following interchange takes place:

Dr : You mean to say that there is a part of you that is very feminine and likes boys.

Patient: The way you put it makes me mad. It isn't exactly like that ...

Dr : (interrupting) It is exactly like that and you know it perfectly well.

Patient : But if ...

Dr : There are no ifs and buts. We know your feelings about father and your cousins, the handsome student at the library and this also includes me.

L Bellak's[50] model of brief analytic psychotherapy is a five session course of therapy with its main feature being a very clear conceptualization of the dynamics of the patient and their relationship to his current problem.

In his first session he takes as complete a history as possible. He includes in his questions almost routinely one concerning any dream the patient might have had the night before the appointment, thus hoping to get an idea of the preformed transference expectation.

To be sure, in the broad meaning of the "transference relationship" the patient already comes programmed with certain apperceptive distortions derived from the past, which he ascribes to the as yet-unknown therapist ... Certainly, more personal transference countertransference relations form as soon as the patient and therapist meet in the waiting room.

In the course of the history taking, a significant interpersonal relationship is established, including positive or negative countertransference features - on Bellak's[50] part, it is of "rescue fantasy".

For the patient the intense interest in his history is often a form of narcissistic gratification. It conveys the genuine interest of the interviewer and thus contribute to the establishment of a positive transference.

At the end of the interview Bellak[50] reviews the salient

features of the history and the complaint or problem which brought the patient into therapy and tries to point out some common denominators that one can easily perceive between the history and the current problem and their relationship to himself as therapist as expressed by the patient.

Bellack[50] considers it important to give the patient the feeling that he understands his problem, decreases his feeling of helplessness by giving him an intellectual understanding of what the problem might be and thus contributes further to the development of an interpersonal relationship.

Rosen[51] considers it necessary to avoid the development of a transference neurosis. He feels that the effects of interpreting transference are to alter the affective climate of therapy and to increase the intimacy of the occasion.

The interpretation of transference should be considered in the following circumstances:

(a) when there is a need to alter the level of arousal

(b) when the therapist detects the presence of feeling towards him or her which impair the patient's progress in therapy

(c) when it would be helpful to illuminate patient difficulties in extra therapy situations

(d) during the discussion of termination.

A couple of writers are of the opinion that it might not be the interpretations that evoke change in the patient, but rather the positive transference that develops between patient and therapist that is the crucial factor for change.

Rechetnick[52] put the emphasis on analysing the dynamic effect of the defence mechanism of the ego, rather than interpreting

the derivatives of the unconscious and thus by interpreting defenses, we approach what is upsetting the patient, namely anxiety.

Thus transference is used by creating those conditions which favour the evocation of positive transference experience and interpreting focal areas of anxiety and defenses in the context of such transference.

This approach i.e. brief transference focused therapy, utilizes the concept of early selective intervention and the selective use of positive transference themes. In addition to nurturing the positive transference the therapist interprets the nature of the transference to the patient in the course of treatment.

Waltzer[53] in his study on brief therapy in a hospital setting, notes that the patient's favourable response to treatment may be "completely unrelated to any significant dynamic interpretation but rather to a transference phenomenon".

If negative transference develops, it is important that the therapist bring it to the patient's notice.

Waltzer[53] and Rechetnik[52] felt that a negative countertransference is as destructive to any therapeutic gain as is negative transference.

It is important that the therapist be aware of his own feelings towards the patient for the very outcome of treatment may hinge on either the unconscious or conscious expression of these feelings.

An important manifestation of continued negative transference

may at times be the continuous use by the patient of denial. The patient must be shown how he is rejecting any and all statements and suggestions the therapist makes.

Gillman[1] (1965) states that attentive neutrality itself is the basis for a positive transference. In brief interpretive therapy, the therapist brings his psychoanalytic understanding to focus on the presenting problem, but following the patient's lead, permits the patient to use his unique resources to reach new solutions. Psychoanalysts understand that much symptomatic improvement in psychotherapy is due to transference; the transference may be to a good parent figure whose protection and love can be depended on or to a threatening parental figure who motivates an increase in repressive forces.

Most of the caution over the benefit of symptomatic improvement in brief therapy is due to the psychoanalytic knowledge that unconscious conflicts have remained untouched. There are now enough cases of lasting improvement in brief therapy to suggest that the reduction of anxiety that occurs in treatment can, in certain cases, permit growth and mastery to take place so that the unresolved conflicts are decreased in relative force.

FOCUS

A specific feature of short term dynamic psychotherapy is the persistent focus throughout therapy on the core conflict and the refusal to permit defensive digressions from that central focus.

Insisting on adhering to the central focus and actively discouraging digressions maintains a high level of therapeutic tension and interaction throughout the therapy more effectively that the traditional abstinence pattern of the therapist in

classical psychoanalysis.

There have been various authors who have developed different forms of focal psychotherapy.

Malan[3] (1963) described this technique in the following way: "The therapist keeps in his mind an aim or 'focus' which should ideally be formulated in terms of an essential interpretation on which therapy is to be based". He pursues this focus single-mindedly: he guides the patient toward it by interpretation, selective attention or to quote Pumpion-Mindlin[22] 'selective neglect'. It is a deliberate attempt to overcome several of the lengthening factors; passivity, the willingness to follow where the patient leads, and over determination.

It also depends on a successful interaction between patient and therapist, where a mutual offering can be seen quite clearly in the initial interview and one or two subsequent sessions resulting in a crystallization of a focus on which most of the therapy is based.

An important selection criterion, especially advocated by Balint[11] may be that a workable focus should crystallize within the first few sessions.

Balint, Orenstein and Balint[12], says that the choice of the phrase "Crystallisation of a focus" suggests that the focus was not chosen but gradually emerged out of the joint work of patient and therapist.

In a research group Balint[55] inquired into the possibility of what he called "ten minute psychotherapy" which suggested another way of thinking about how a focus is found.

The setting created by the condition of ten minutes demanded

a very high intensity of interaction between patient and doctor. This atmosphere helped the doctor to tune in with his patient's actual mental state which is a conglomerate of hope and despair, trust and mistrust, confusion and clarity.

If he succeeds in this task then it will amount to a "flash" of understanding which usually unites patient and doctor and is felt by both. Another way of expressing this feeling is to describe it somewhat poetically as the "meeting of two minds" or a "moment of truth" or perhaps the closing of a Gestalt.

In the general practitioner's office it is not necessary to express the experience of a flash in so many words. It is sufficient that the event is felt and recognised by both partners and that this recognition is kept alive in subsequent meetings. Perhaps then the dynamic process resulting in choosing a focus had something in common with a "flash". There is however an important difference in focal therapy; this experience must be expressed by the therapist for his own use in fairly exact ideas, a process that is more or less identical with translating the flash experience into concise words. Without this precise formulation no focal plan can be devised, which means that the therapist will find it difficult to decide when and how to use selective attention or selective neglect.

The focus must be specific, sharply delineated and unambiguous.

The focus should be expressed in the form of an interpretation that could be given meaningfully to the patient towards the end of treatment.

Formulating the focus in the exact way just described demands

a high degree of sensitive observation, a good knowledge of psychoanalytic theory, freedom from compulsive ways of thinking about psychopathology and above all, resisting the attraction of well worn psychoanalytical phrases.

Thus on the process of choosing a focus there are two alternatives:

One is to rely entirely on the tuning in; the therapist must create a climate for his patient that is free from petty mistrust and thus allows the essential conflicts to emerge; permitting the therapist to make observations that really matter, to experience the "flash" and translate it into a concise sentence.

The second alternative is the idea of crystallization of a focus which is not a flash but a gradual emergence in the give and take between patient and therapist.

The focus is tested and retested in every session of the treatment necessitating in certain cases a slight or considerable modification of the chosen focus, or even a complete repudiation of it.

Anthony Ryle[56] has devised a novel way in which the focus of interpretive psychotherapy might be more adequately conceptualized than is at present the case. Using the patient's own conplaints as target problems, though acceptable to behaviourists, does not satisfy the dynamic therapist, who is concerned with underlying processes of which the patient is often not aware.

Malan[28] (1976) noted that psychoanalysts' formulations, if "deep", show low inter-rater reliability, while if superficial

have little explanatory value.

Though Malan[28] reported that "focality" was associated with successful outcome in brief therapy, it is not clear how far the focus was agreed with the patient or how far, in practice, it served to predetermine conduct of the therapy. In most of Malan's case histories the focus was given in the form of a relatively superficial psychoanalytic formulation and expressed in terms such as "exploration of oedipal issues in the transference" or "work with problems around dependency and aggression".

Anthony Ryle[56] describes a method of defining the focus of therapy by identifying, in a language the patient can share, those mental conflicts underlying the patient's symptoms and difficulties.

In the first few sessions with a patient, painful experiences, unwanted behaviours, and problems in relationships with others, for which help is sought, indicate, in the patient's terms, the goals of treatment. The therapist will also wish to modify the beliefs, assumptions, fantasies, and defensive modes underlying the patient's problems. This process leads to a reframing of the problem and the redefinition must be shared with the patient in terms acceptable to him; which like an interpretation, must not jump too far ahead of his understanding. This involves linking together in new ways what the patient has communicated, i.e. how the patient's perceptions and understandings of the world and his behaviour in it, cause or maintain his difficulties.

Ryle[56] proposes that neurotic difficulties and the patient's inability to change are related to the terms in which he

construes the world, and that these terms can be usefully conceptualized as "dilemmas, traps and snags". While the patient can only see possible action in terms of his dilemmas, while his interactions with others are maintained in terms of traps or while change has, or is felt to have, snags, the possibility of change is slight.

Thus the first task is to extend understanding of these terms to the patient, they then can become an appropriate focus for therapy.

Ryle[55] defines "dilemmas" in the form of "either/or" (false dichotomies that restrict the range of choice) or of "if/then" (false assumption of association that inhibit change).

"Traps" are usually the result of relating to others in terms based upon complementary dilemmas.

"Snags" - An important obstacle to change may be the consequence anticipated as a result of such change.

Often the consciously or unconsciously feared implications of change are largely "fantasy", as in the common oedipal fears which can limit assertion or prohibit success as if these would be damaging to, or would provoke revenge from parents.

In Ryle's[56] survey of 25 patients, six main problems were identified:

(1) Distant or in danger dilemmas; either isolated or at risk. Emotional closeness provokes fears of loss of self or damage to self.

(2) Dyadic control dilemmas, either controlled or controlling; either powerfully giving or helplessly receiving.

The above two can be seen to relate to the psychoanalytic theory of separation, individuation, basic trust, and the oral stage.

(3a) Must/won't dilemmas, obligation are responded to by resentful compliance or are blocked or sabotaged with the loss of the sense of being able to choose or want. This is often associated with

(3b) problems of access to feelings and of self control i.e. either in tight control of behaviour and feelings, or in chaos.

No. 3 can be seen to relate to autonomy versus shame and doubt (Erikson[37]) and the anal stage (Freud).

(4) Instrumental/expressive dilemmas, usually experienced in relation to sex-roles, the person feeling forced to choose between strength and sensitivity or between thought and feeling.

No. 4 can be seen to be related to the oedipal stage.

(5) Traps are usually the acting out of dilemmas with others who maintain the system by playing the complementing role in the dilemma. Traps in psychoanalytic terms represent the interpersonal manifestation of intrapsychic processes usually of splitting and projective identification.

Snags - the common pattern here is of feared consequences for, or from a parent or sexual partner. They are related to fantasy and to ego defences against both id and super ego forces.

The description of neurotic difficulty in terms of "dilemma traps and snags" does not conflict with the psychoanalytic

model. It differs in that it aims only to give an account of process and not of genesis and hence use a language that is simple and accessible to patients. In any case, to accept that the origins of these patterns are to be found in infantile modes of conceptualization does not imply that this explanation need be communicated to the patient. Such explanations are not necessarily helpful for interpretation of the origins of a problem and can represent a terminal hypothesis with no implications for change or action; patients are more helped by instrumental hypotheses indicating possible alternative paths.

When the patient's problem is described as being limited within a dilemma, caught in an interpersonal trap, or blocked by a snag the goal of treatment is clearly to achieve a change in terms through which his experience is construed.

Thus these formulations represent provisional hypotheses about some of the mental constrictions underlying the patient's difficulties and inability to change and therefore serve to focus attention on cognitive processes and to emphasize that the revision of these is a central task of therapy.

The focus of therapy is not seen as a prescription for guiding or restricting its course, but represents rather the early recognition of its themes by therapist and patient - a recognition which, if achieved, is likely to anger a successful therapeutic relationship.

LENGTH OF TREATMENT AND TERMINATION

When does brief therapy become long term therapy? Perhaps it is only an arbitrary point. The issue of how many sessions

should be involved is still unsettled among short term psychotherapists.

Mann[35] sets an arbitrary fixed limit of 12 sessions but Sifneos[57], Malan[3], Wolberg[58] and Davonloo[33] are rather more flexible, varying the number of visits from 15 to 40, depending on the severity of the patient's problem as well as his ego and adaptive capacities.

Malan, Heath[59] et al (1975) and Saul[60] (1951) have indicated how just one or two sessions can contribute significantly to a patient's welfare and insight.

Marmor[4] (1979) discusses the issue of setting a time limit and identifies three fundamental consequences derived from this technical manoeuver.

Firstly the setting of time limit places a central emphasis from the very beginning of the therapy on the issues of separation and individuation. This creates an entirely different set of expectations than in long term therapy, where the patient is told at the outset that the length of therapy is open-ended, unpredictable, or may go on for a year or two or more.

Second, not only is the issue of separation and individuation relevant, if not central, to the problem presented by most patients, but putting it in the forefront of the therapeutic technique reflects a basic respect for and encouragement of the patient's capacity to be autonomous. This counters the patient' impulse to see himself as helpless, inadequate and in need of dependent support.

Third, the very process of termination constitutes a thera-

peutic act that tends to encourage the patient's independence and self confidence. This is not to deny that the initial response of most patients to approaching termination is one of anxiety and often of regression. Nevertheless the firm and steady insistence of a termination date and the working through of separation anxieties is critical to the process of short term dynamic psychotherapy.

Previous workers did not emphasize the termination. Pumpian-Mindlin[22] stated that termination should be considered when there is a danger of drifting into long term therapy.

Alexander and French[11] state that termination should only be considered when there has been sufficient therapeutic gain and after an initial preparatory interruption. During the interruption the patient learns which of his previous difficulties he still retains and usually the analysis, after interruption, becomes much more intensive.

Malan's[3] (1963) hypothesis is that termination is an essential part of almost every therapy for the patient to pass through, and experience his negative feeling towards the therapist, since only in this way could he learn to tolerate these feelings in relation to people outside.

The situation in which the patient was most likely to experience negative feelings was over the withdrawal of therapist's care at termination. If these feelings were not brought into the open and worked through and the relation with the therapist remained idealized, there was a very real danger that the patient might spoil the therapeutic result in order to spite the therapist.

The therapist must become a bad figure accepted as such and

tolerated by the patient, otherwise only idealization can occur which brings Malan's ideas in line with Alexander and French's[11] concept of the corrective emotional experience i.e. the experience of the old problem in the relation with the therapist - but with a new ending - is an important factor in therapy.

Michael McGuire[61] has examined the concept of time and noted that almost everything that happens or is thought about in brief therapy may be related to it.

Patients respond to the knowledge of briefness both by assigning a variety of meaning to it and anticipating a number of happenings. Some patients imagine their "cure" will require only a few visits. Therapy proceeding on this basis advances well in the early phase but bogs down later since this belief invariably means the patient expects to be cured magically rather than by his own participation.

An opposite consequence is noted when patients believe "the clinic does not care". Other patients assume that "very little must be troubling me" if only a few hours of therapy are prescribed.

To most patients "long term" means that the therapist will refrain from active guiding whereas in short term work he is expected to direct, the latter having a specific task-like quality to many of the patients.

If the patient's ego is receptive and flexible the guiding may be very helpful, if however the patient feels subjected by his environment, he imagines that the therapist will manipulate him and is thus ambivalent about the suggestions the therapist makes.

Other effects of "briefness" are that those patients who eventually gain insight, most begin their own mental ordering and analysis of conflict in the period between the initial evaluation and the start of therapy. Conceptually it may be considered defensive, but it does not interfere with aims.

The ordering is usually not accurate and thus reviewing the patient's way of conceptualizing may be an excellent technical manoeuver, ascertaining how the patient's defenses and biases influence the conflict formulation. Patients who order do so because they have a definite task in mind, i.e. giving shape to causal explanations for their problems. McGuire[61] anticipates that to encourage the task concept may be detrimental to therapy, missing the emotional conflict, perpetuating neurotic expectations and illusions.

Thus part of the therapist's work in therapy is to keep it a task for the patient but to change the aims of the task when it is to avoid discussion of conflict and symptoms.

A different aspect of time are patients' fantasies concerning the relationship of their life to time. These fantasies are repetitious beliefs somewhat like compulsions which patients use as a focal point to order and explain their experiences.

The patient comprehension of briefness affects the particular form of fantasy. McGuire[61] lists 5 types of fantasy:

(1) Return of the past - i.e. they feel that previous unpleasant occurrences are imminent in the immediate future and that the past will not return, e.g. "The same thing happens again and again". Pessimism prevails, the future is

feared. They wish to forget the past because of its disappointments.

The knowledge of briefness has made these patients more pessimistic than before, e.g. "This wi`l end up like everything else. You can't help me, no one else could".

(2) "Expected moment of realization".

The immediate future holds the potential of the longed for happiness. lse optimism is common. The present is unsatisfying. The past is remembered as a series of abortive attempts at self-realization. Short term therapy heightens these fantasies:

"I thought a couple of interviews would solve the matter".

"If only I get this solved, everything will be perfect".

These patients are difficult to treat since a good part of therapy must be devoted to stressing the realities of therapeutic possibilities.

(3) The present is alone.

These patients believe that the present is isolated from both past and future. There is a feeling of being unable to move, isolated and distant. Yet their present lacks meaning.

McGuire[61] finds that these patients are the most difficult to treat since past and future can seldom be meaningfully brought into therapy and they are least affected by the idea of briefness.

(4) "The present is the door of the future".

The present is closely tied with the future determined by moves made now and therefore the consequences of any commitment becomes exceedingly great as revealed by repetitive

anxiety attacks preceding decision-making.

Short-term therapy is responded to first with the attitude that it is "the answer to all my problems" and later by indecision as to its worth and the patient's involvement.

(5) "The present is the inevitable result of the past". The world has already fallen in. Life is sensed as a continu- and patients believe that they will continue to fail and suffer. Their response to the offered brief therapy is humiliation, with rejection of therapy.

Another aspect relating to time is the timelessness of the unconscious and its relationship to short-term therapy.

That the unconscious is "timeless" helps explain the repetitive nature of ingrained conflict. If the repetitious, and therefore "timeless" nature of the conflict is so well established, how can one explain the apparent rapid conflict resolution so often observed in short-term therapy.

McGuire[61] gives the following explanation:
Those patients who are successfully treated, the emotional conflict has a long history of repression. Prior to admission to therapy, repression has lessened and the patient begins suffering.

Thus problems usually treated are those where there is a breakdown in repressive mechanism to which the patients respond with displeasure. Thus the patient seen in short term therapy are those who are dissatisfied with his immediate situation, who are voluntary and who are motivated to alter their existing emotional state. Thus therapy works to utilize both the dissatisfaction and the motivation.

The effective use of the response and the drive hinges on a particular manoeuvre, that of shifting the responsibility of getting well from the therapy situation to the patient. Interpretation are most fruitful when the patient has shifted from the expectation of joint problem-solving and the awaiting of something from the therapist, to that of using the therapist as an assistant to facilitate understanding.

There are factors in the therapist which would prevent termination and thus prolong therapy. Knight Aldrich[18] discusses some of these issues.

The pattern of private psychotherapeutic practice encourages pessimism. Anyone who takes the plunge into private practice is understandably apprehensive. After so many years of training, his financial needs are considerable and his confidence about his ability to keep his treatment hours filled may be limited. As he accumulates patients however his confidence increases and his apprehension diminishes. His patients give him security and he is predisposed to keep them with him. Long term treatment also represents security for his patients and thus there is an unspoken and unconscious collusion between therapist-patient to prolong treatment.

Ewalt[62] observed that the problem of terminating therapy is an irrational act. Patient, particularly very sick ones, live up to our expectations and that their behaviour fits very closely to what we more or less consciously expect. But we don't understand how to make use of this expectation, instead we tend to infantalize the patient to overprotect him, to overserve him and what happens, he regresses, and obligingly fulfills our own needs to be caretakers.

Therapeutic optimism is not as easy to maintain as therapeutic pessimism. The optimistic therapist is attempting to outweigh the pessimism of many others in the patient's current and past environment, and he may not succeed. Aldrich[18] noted that disappointments are inevitable and tend to disillusion the experienced therapist; perhaps it is the optimism of the inexperienced that accounts for their reported frequency of success. "Nevertheless, I would rather err on the side of optimism than of pessimism: I would rather have a few patients return following premature termination than have many other continue in treatment past the time when they are able to carry on without outside assistance".

Psychotherapy can be resumed after termination without too much damage to the patient's self-esteem if termination is properly managed and if the patient is encouraged to perceive a return to treatment as a temporary setback rather than as a failure of treatment.

The therapist may have to be firm in his recommendation for termination. Offering the patient a choice about continuing may be interpreted to mean that the therapist really expects the patient to need more help. Since psychotherapy is a secondary gain of neurosis, - the patient may want to be treated more than he wants to be cured - the patient is predisposed to find justification for continuing and so the therapist's optimistic expectation of the patient's capacity to cope may have to be made explicit.

Mann's[35] development of short term therapy, in his book: "Time limited Psychotherapy" emphasizes the fact that limited time is available for the treatment. Working in an existential

style, he pushes the patient toward greater autonomy and self esteem by helping him bear the "horror of time" in his life. To achieve this, Mann[35] sets up a time limited therapy and guides the patient to the essential task of termination.

Mann[35] postulates that a patient's personality can be traced to conflict about dependency, passivity and self esteem that arise from the period when reality confronted the child and he was faced with accepting separation from the mother.

"Old unconscious fantasies of union with the mother" are reflected in a childish sense of unlimited time: passage into adulthood with separation from mother demands acceptance of the reality principle and recognition that time is limited: "Timelessness is the fantasy in which mother and child are endlessly united".

The patient, seeking to preserve his unconscious fantasies, tries to ignore the fact that time passes and that he stands alone. Because the struggle between fantasy and reality is a fundamental one, and because the treatment will end as surely as time passes, Mann[35] takes this general issue as his major focus.

"The recurring life crises of separation - individuation is the substantive base upon which the treatment rests- In this kind of time limited psychotherapy, mastery of separation anxiety becomes the model for the mastery of other neurotic anxieties".

Mann[35] is confident that he is considering a basic pervasive human conflict. He uses psychodynamic understanding to

formulate a specific focus with each patient but with his more existential approach, Mann[35] puts the central issue in terms of a feeling state, the patient's "present and chronically endured pain- which brings the patient closer to the therapist, a feeling that he is in the presence of an empathic helper".

After stating the central issue to the patient, Mann[35] suggests a treatment agreement based on a final termination after the 12th meeting. In Mann's experience, setting termination in therapy has a profound effect on the patient. The threat of inevitable separation overwhelms the patient and comes to dominate the course of therapy.

The specific limitation of time and the framework of the treatment agreement create a clearly demarcated beginning, a middle and an unavoidable end. The beginning restores to the patient unity with mother, preseparation in endless time. The middle brings with it the disappointment that a relationship once wholly unambivalent will once more become ambivalent. And the end introduces the unavoidable harsh reality that what was lost must be given up.

Termination provides difficult therapeutic work for both patient and therapist. Patients drop out of therapy to preserve what is left of their unconscious fantasies and to protect the therapist from their negative reactions. The therapist may also be tempted to allow this denial and withdrawal to develop, remembering their own troubled responses to separation - individuation conflicts. Unless the therapist confronts termination directly, he will distance himself from the patient, instead of placing himself with the patient to share the pain of termination.

The therapist withdraws from the patient's suffering by fostering the patient's resistence, or allowing the therapy to end prematurely or not ending at all.

Unless the patient's emotional reaction to termination is fully explored, the separation will simply repeat the patient's previous experiences and his conflicts will remain unsolved.

Active and appropriate management of the termination will allow the patient to internalize the therapist as a replacement or substitute for the earlier ambivalent object. This time the internalization will be more positive, less anger laden, and less guilt-laden, thereby making separation a genuine maturational event.

ACTIVITY OF THE THERAPIST

The activity of a therapist is an essential factor of short-term therapy which has two major psychodynamic elements, as identified by Marmor[14].

First, it is a reflection of the therapist's interest in and concern for the patient, which are important therapeutic factors.

Second, insisting on adhering to the central focus and actively discouraging digressions maintains a high level of therapeutic tension and interaction throughout the therapy more effectively than the traditional abstinence patterns of the classical psychoanalysis.

It should be emphasized that such activity does not mean

that the therapist is being directive. On the contrary, the therapist follows essentially the non-directive line of psychoanalysis. The activity consists of persistent confrontations and interpretations and thus the discouragement of regression.

Active transference interpretations and the bringing out of negative and positive feelings constitute an essential part of the technique of short-term psychotherapy.

Passivity in analysis has many aspects; the use of the couch, of free association, the willingness to deal with whatever material the patient brings, the sense of timelessness. In brief dynamic therapy these factors are corrected.

Fuerst[35] (1938)and Stone[59] (1951) mention that the couch should not be used as it tends to lead the patient away from reality into fantasy. The couch encourages free association, the tendency to talk into the empty air, with the corresponding tendency in the therapist to abandon initiative. The face to face technique creates an entirely different atmosphere in which the patient talks to the therapist. Thus therapy tends to become more of a dialogue and the therapist tends to take a more active part in the relationship.

Ferenczi[6] (1919-20) had opposed the analyst's passivity by such activity as: firstly, preventing certain forms of behaviour, such as omitting rituals in obsessional patients; the use of forced fantasies to speed the exposure of hidden conflicts and assuming a definite role in relation to the patient, that would somehow speed up the treatment by eliciting from their unconscious, the patient's neurotic transference reaction.

Freud[5] in 1919, commented on Ferenczi's active technique as the possible avenue along which psychoanalysis would further develop. Freud also felt that the necessary, and desirable shortening of analysis, might use such activities to make psychoanalytic therapy available, on a large scale, in state supported outpatient clinics.

Ferenczi's[63] experiments were widely opposed and he himself soon acknowledged their failure.

Alexander and French[11] resorted to the use of a variety of activities; changes in the frequency of the interviews, temporary interruptions of treatment and forced termination of treatment, both to increase the intensity of the emotional re-experiencing of the past.

Balint, Ornstein, Balint[12] (1972) were of the opinion that Alexander's and French's activity was manipulative in the sense that it was used either instead of understanding and interpretation, or because it was felt that such understanding and its communication to the patient would not bring about the desired results. These interventions also block avenues to new observations and thus to new knowledge regarding those problem areas of therapy for which these activities were introduced originally.

In Balint's[12] focal therapy, the activity of the therapist consists of finding the appropriate focus from what the patient offers and secondly, consistently approaching the focal problem with interpretative activity alone. The therapist is aided by selective attention and selective neglect of the focus chosen. What is not directly related to this focus is left uninterpreted. The objection might be r aised

that this too is manipulative on the part of the therapist. To the extent that interpretation influence the direction of treatment, the flow of associations, the nature of what is permitted to enter into the therapeutic relationship, focal therapy is indeed manipulative. However, it should be stressed that the patient's associations following the interpretation chosen by the therapist may not confirm his diagnosis and therefore his focal aim may not be justified. Should this be the case the therapist will not force the patient to give up the direction he himself wishes to take.

Sifneos'[16] "anxiety provoking short-term psychotherapy", similar in theory to psychoanalytic or dynamic psychotherapy, emphasizes that a certain degree of anxiety is necessary during the interview, because it motivates the reluctant patient to understand the nature of his emotional conflicts, to recognise the reactions that he utilizes to deal with them, and to enable him to have a "corrective emotional experience".

Anxiety generated during the interview may be used as a tool in assisting the patient to change his maladaptive behaviour and to attain a state of improved emotional functioning.

Sifneos'[16] interviews are face to face, once a week, lasting for about 45 minutes. Sifneos encourages the establishment of rapport with his patient and tries to create a therapeutic alliance early. He utilizes the patient's positive transference feelings explicitly as the main therapeutic tool. His specific goal is to concentrate on a circumscribed area of unresolved emotional conflicts underlying the patient's symptoms. He actively bypasses character traits such as masochism, excessive passivity and dependence which give rise to therapeutic complications. Sifneos takes advantage of the

fairly lengthy time lag in the appearance of the transference neurosis, in relatively healthy patients, in order to perform his therapeutic task, and thus he avoids its development. His emphasis is on problem-solving so that such techniques learned by the patient can be utilized in the future after therapy has been terminated. The treatment ends early when the patient starts giving hints that the goals of therapy have been achieved, or warnings that he wants to prolong therapy.

BRIEF DYNAMIC PSYCHOTHERAPY vs OTHER BRIEF THERAPIES

Sloane[64] et al. compared behavioural therapy with short-term analytic psychotherapy by comparing the attitudes of the patients towards their therapy.

Both groups emphasized the same factors as being most important in their treatment, which are factors that have traditionally been thought important in analytic psychotherapy.. These include insight or providing an explanation to the patient's problem, the patient-therapist relationship, catharsis, trust and development of confidence.

He[64] noted that behavioural therapy patients place much more emphasis on the therapeutic relationship than do their therapists. Analytically orientated therapists feel that in many cases the relationship is the treatment.

Such attitudes are rarely cited in the behaviour therapy literature, and behaviour therapists may sometimes diminish or underutilize a powerful force that is nevertheless operating unacknowledged in their treatment.

V Patterson[65] contrasts behaviour therapy with brief psychoanalytic therapy. In brief behaviour therapy the therapist

helps the patient to understand the basis for his anxiety and designs a specific programme to combat it; **in vivo** desensitization, relaxation techniques, assertion training. The therapist presents himself to the patient as an ally who has expertise in dealing with anxiety and modifying maladaptive behaviour patterns. The therapist is often in the role of a teacher who conveys information to the patient/or student, then supports or guides him while he learns. With the mastery of one area of his life situation, the patient may then come to feel more in control of his life and himself.

In brief analytic psychotherapy the therapist attends to all aspects of his interaction with the patient. He may make dynamic connections between events within the interview, current life problems and past history. The therapist is an attentive non-judgemental listener and a collaborator who at appropriate times offers tentative formulations of the patient's reported experiences.

The goal of brief analytic therapy is to increase the patient's self-understanding through self-exploration and examination of the therapeutic relationship.

Similarities between brief behaviour and analytic psychotherapy is that the assessment of the patient is part of the ongoing therapeutic process. Each approach stresses current functioning; either current crisis, current symptom behaviour or current transference behaviour. While historical data or future plans are used to clarify present issues, the attention of the two brief therapies is directed towards the person's immediate situation. Each of the two therapies makes an explicit contract with the patient in the first hours. The conditions

of therapy are made explicit, the therapy will be brief, the amount of fee, the type of therapy. These therapies are alike in their devotion to maintaining and enhancing the autonomy of patients. Therapist interventions which encourage dependency are viewed as having long-term effects that can only be detrimental.

H Avnet[66] did a study on the effectiveness of brief therapy by analytically trained psychiatrists. Admitting the crudity of measurements, he reported that 81% of patients reported recovery or improvement. There is little doubt that a strong feeling existed on the parts of both patients and psychiatrists that some changes for the better occurred as a result of the few sessions made available to the patients.

Wolberg[68] felt that while symptom relief occurred and a rapid return to adaptive functioning occurred, no extensive change would be registered at termination of therapy in the personality organization itself. A cardinal principle in short-term therapy is acceptance of modest and non-perfectionistic goal

Sloane et al.[67] did a controlled evaluation of the effectiveness of behaviour therapy and short-term analytic therapy conducted by experienced therapists with patients with anxiety neuroses and personality disorders and also compared both therapies with the effect of an initial assessment interview plus the mere promise and expectation of help.

He found there was very little difference between the two active treatment groups in amount of improvement but behaviour therapy produced significantly more overall improvement at four months than short-term analytic psychotherapy. However this is a very general subjective measure and there was no significant difference between analytic psychotherapy and

behaviour therapy on any other measure at any other time.

At four months both treated groups had improved significantly more than the waiting list group on target symptoms but not on general adjustment. This is impressive in view of the great improvement shown by patients receiving the minimal treatment of placement on a waiting list.

Patterson[68] compared brief behavioural therapy with brief analytic psychotherapy with regard to how they evaluate change in themselves.

A year following termination of treatment she found no significant differences between the mean scores of patients who had had brief psychoanalytical psychotherapy and those who had had brief behaviour therapy. Both groups saw themselves at one year follow-up as improved over their status at three months follow-up. The type of therapy did not appear to make a significant difference at either 3 months or one year follow-up.

At the immediate termination of treatment, results of the study favoured behaviour therapy.

It was also noted that almost half of the patients who had no previous therapy sought treatment again after the brief therapy. Thus there is a tendency for patients to seek repeated therapeutic contacts. The proportion of patients from each type of therapy who sought subsequent therapy were roughly equal.

Patterson's[68] study agrees with Sloane's[67] et al. study. In Sloane's[67] study patients who had had behaviour therapy improved most at the end of four months of treatment on a

global measure of change but there was no significant difference among the group at one and two-year follow-up. All patients had improved over their initial status.

Despite lack of outcome differences there were some interesting observations:

A high proportion who had behaviour therapy stated that as a result of the therapy, they concluded that they were not "sick".

Patients who had analytic therapy tended to complain that their therapists did not care enough about them.

Patients were unimpressed with technique but concerned with the warmth, helpfulness and human characteristics of their therapists.

CONCLUSION

To end I shall look into two reports of one session therapy. Malan[59] did a study on patients who, when asked to come for follow-up, had not been interviewed by a psychiatrist more than twice in their whole life. Fifty-one percent were judged to be at least improved symptomatically, but 24% were judged to be improved dynamically.

He dealt with the 24% who had received one session psychotherapy. He found that the therapeutic mechanism responsible for their dynamic improvement was:

(1) insight, acquired during the first diagnostic interview
(2) the capacity for self analysis after the very minimum of therapeutic intervention

(3) working through feelings with the people involved

(4) normal maturation and growth

(5) therapeutic relationships

(6) the patient taking responsibility for his own life

(7) genuine reassurance

(8) the breaking of a vicious circle between the patient and his environment.

These eight mechanisms were facilitated in the patients by the single diagnostic interview.

An important question is whether or not patients who will improve after a single interview can be recognised in advance, but even without an answer, however, the existence of such patients has important implications in the operation of psychotherapeutic clinics. "Clearly psychiatrists who undertake consultations should not automatically assign patients to long-term or even brief psychotherapy, but should be aware of the possibility that a single dynamic interview may be all that is needed."

Saul[60], in an article (1951)"on the value of one or two interviews" treated a woman suffering from severe hypochondriacal ideas who "was tremendously relieved in one interview ... She was quick to sense that by deflecting her attention from the hypochondriacal anxiety to the emotions which underlay it, she was dealing with the main issues and had a nucleus of insight which gradually with life experience would grow." This case illustrates the value of two interviews, where the analytic interpretation is accurate and sharply focused upon the central issues.

Thus as early as 1951, Saul[60] was considering the efficacy of brief focal dynamic therapy.

To finish on the subject of one-session psychotherapy is, I think, an appropriate ending to "Brief Psychotherapy". In fact to prolong this brief report any further, would be going against the forces for which I have been preaching.

From the confusion of early analysts, and my own confusion, it now seems apparent that brief dynamic psychotherapy, apart from being active and focal, closely resembles that of psychoanalysis, and that lasting improvement can be obtained in patients with moderately severe and long standing illnesses.

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