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The Challenge of Short-term Psychotherapy

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An Ideal Therapy

IN 1980, DAVID MALAN wrote about *a wish fulfillment fantasy* of brief psychotherapy based entirely on psychodynamic principles. He stated:

1. It would be applicable to a high proportion of the psychotherapeutic population.
2. Therapeutic effects would begin to appear within the first few sessions.
3. At termination no traces of the original disturbances would remain, and this position would be maintained at follow-up.
4. Adverse phenomena that complicate ordinary therapy—sexualized or dependent transference, acting out, and difficulties over termination—would not appear.

The purpose of this book is to describe the work of six short-term clinicians who aspire to these lofty outcome goals. The authors of this book have dedicated their careers to the goal of delivering to their patients the promised results of dynamic psychotherapy in as effective a way as humanly possible.

A Definition of Short-term Dynamic Psychotherapy

Short-term dynamic psychotherapy (STDP) has its theoretical origins in psychoanalysis but at the same time has a mutually ambivalent relationship with

psychoanalysis. The major conflict between the two treatment modalities revolves around the issue of time and efficacy. STDP ambitiously purports to treat the same disorders as psychoanalysis but in a shorter period of time. STDP uses the scientific method to evaluate outcome whereas psychoanalysis rarely does. Naturally, many psychoanalytic practitioners feel threatened by the emergence of STDP—a treatment that can comprehensively treat neurotic patients in less than 40 hours of therapy compared to between 250 and 600 hours for a "complete" psychoanalysis. Traditionally, psychoanalysis has ignored the findings of the short-term group, hiding from the implications of the research behind the superficiality hypothesis.

Technically, psychoanalysis requires the establishment of a transference neurosis between the patient and the analyst. This means that the analyst *becomes* the parent to the patient and the patient *develops symptoms* in order to deal with unconscious feelings toward the analyst. The analyst uses resistance interpretation and dream symbol analysis to uncover the patient's repressed feelings and impulses. Eventually, the unconscious transfer ends, and the patient ideally terminates analysis with a reconstructed personality. Outcome research by Malan and others questions whether, in fact, this really occurs.

Short-term dynamic therapy also uses the transference to a great extent. However, the development of a transference neurosis is discouraged by the intense focus on the affective relationship between patient and therapist in the session, and all emotions are identified and acknowledged before the patient leaves the session. The therapist is more a catalyst or guide to help the patient face unacceptable feelings, rather than a figure to attach to in order to slowly emerge from the suffering of symptoms. Transference is seen as a ubiquitous phenomenon that occurs in all intimate relationships. It is explored on an affective level in the first session and all subsequent sessions until the neurosis is resolved by discovery of genuine feelings, affect desensitization, corrective emotional experience, and insight into one's unconscious process. The specific techniques of short-term dynamic psychotherapy have been developed to accelerate the working through process in order to restructure psychic balance between id, ego, and superego (dynamic) forces in an attempt to (1) reduce symptoms, (2) change character, and (3) improve the relational capacity.

Now, within this camp there are emerging schools represented by each of the authors, as well as active debate among the practitioners of each subgroup. Those in the Davanloo group, represented by Neborsky, Patricia Della Selva, Allan Kaplain, Allen Abbass, and others, work along the lines in which they were trained and largely adhere to the central dynamic sequence as the key to their approach. For this reason, they place heavy emphasis on bringing self-punishment trends into consciousness in the initial moments of the

first therapeutic contact. McCullough and her followers organize their treatment around a flexible approach, which includes psychoeducation about defenses, mild pressure to feeling, persistent pressure not to self-punish, and encouragement to feel emotion in the session. McCullough believes that the experience of affect is essential to character transformation, but she goes one step further and adds what she calls "self-other restructuring," wherein she explores the transference-countertransference distortions that occur in treatment of patients with low self-esteem and negative self-images. She actively encourages "self-directed compassion" when patients are self-critical. Michael Alpert, Isabel Sklar, and Diana Fosha (2000) represent a school of short-term dynamic psychotherapy centered in the New York area that emphasizes the healing aspects of affect and empathy. They work exclusively in the area of self and other by focusing in minute detail on what the patient experiences in the moment between the patient and therapist. This approach evolved when Alpert noticed the affect of one of Davanloo's patients deepen when Davanloo commented on the patient's courage. In the process of the relational work, remarkable associations to the patient's past spontaneously appear and past traumas are worked through in a short time.

In summary, short-term dynamic psychotherapy takes place in three to forty hours of therapy. The initial contact is two to three hours. The length of the therapy within the range is defined by the degree of psychopathology that the patient demonstrates: low resistant neurotics with one focal conflict (e.g., Oedipal focus) can be treated in three hours; patients with diffuse pathology and multiple foci may need closer to forty hours.

Confusion About Short-term Dynamic Psychotherapy

There is considerable confusion about "short-term" in the term short-term dynamic psychotherapy. The term originated because psychoanalysis and long-term, open-ended therapy was the gold standard of treatment from the post World War II years until the 1960s. This was the form of therapy that was taught in academic centers throughout the country. In fact, most chairmen of academic departments of psychiatry from 1946 to 1960 were psychoanalysts. Thus, the curriculum presented their biases to generations of psychiatrists and psychotherapists. So the term "short-term" was an attempt by Malan, Sifneos, Davanloo, and others to distinguish their efforts from the traditional therapies of the time. Ironically, in our age of managed care, and with the authorized treatment of complex problems with the "three-session limit," short-term therapy of up to forty sessions seems like a luxury!

In addition to the time distinction there is also confusion about the term "dynamic." Dynamic has both general and specific meanings. The term dynamic has its roots in the Victorian concept of the mind as a closed system in which psychic energy flows were generated by human libido. The new science of psychoanalysis hoped to influence these energy flows away from pathogenic foci that created anxiety, depression, conversion disorders, etc. The force of libido was, of course, infantile sexual drive, which was influenced by early childhood events, which were later repressed into the unconscious. Distinct from this formulation is the structural theory of the mind, that is, the tripartite organization of the psyche into id, ego, and superego. In this context "dynamic" refers to the interplay of these three sections of experience, part of which may be unconscious. So, dynamic has multiple meanings from history and metapsychology. It is also used in one other important way. In the late 1950s and early 1960s there was considerable controversy between the schools of analytic treatment and the behavioral therapists. The behaviorists were entering territory that was the exclusive domain of psychoanalysis: phobias, compulsions, anxiety disorders, and ultimately depression. They were getting documented results and challenging the stranglehold analytic therapy had on the academic and professional training centers. Plus the treatments were scientifically conducted and results—outcomes—were measured and published in refereed journals. So the term *dynamic* became a modifier that distinguished treatment from the behavioral approach. Finally, a new and important meaning has become attached to the term *dynamic psychotherapy*: it refers to the deeply therapeutic process of accessing repressed feelings. This is a newer usage of the phrase, but it has become synonymous with STDP. Let's now explore the development of this specific approach from a historical perspective.

The Evolution of Dynamic Short-term Psychotherapy

Early History

Psychoanalysis began with Breuer's "talking cure" of Anna O (Freud, 1893). Soon thereafter, Freud struggled with the hysterical symptoms of Emmy Von M, Lucy R, Katharina, Elisabeth von R, and lastly Dora (1900). As Breuer's young associate, he was given cases of hysterical psychopathology to treat. Intrigued, Freud began to investigate the psychological causes of these women's symptoms. To do so he had to invent a technique. He first gravitated to hypnosis but became disenchanted with its results. Later, he discovered

free association as a technique, and this led to the discovery of transference and then resistance. Each of these cases was treated in months, not years. Soon Freud became enamored with dream analysis. This change in interest naturally caused the process to lengthen. Freud's initial concept of psychopathology was that of direct or actual molestation trauma as the origin of hysterical pathology. He later revised this idea concurrently with his interest in dreams. This led to his discovery of the Oedipus complex. Simply stated, he concluded that neurosis was a result of the castration complex in men and of penis envy in women. Consequently, the process of psychoanalytic treatment lengthened as theories of pathogenesis became more complex.

It is known that Freud orchestrated a number of short-term therapies. In his autobiography, the conductor Bruno Walter (1940) describes a successful six-session therapy with Freud in 1906. Ernest Jones (1957) reports that Freud successfully treated Gustav Mahler's psychogenic impotence in a single four-hour session! However, as psychoanalysis developed a more complex theoretical superstructure, treatments grew to such a length that they became interminable. Freud wrote *Analysis, Terminable and Interminable* to express these concerns in 1937.

The Pioneers

Around 1918, Sandor Ferenczi began to systematically experiment with new techniques. He called his work "active therapy." He used techniques to overcome stalemates, introduced desensitization for phobias, and tried some of the restrictive techniques that are used today to treat compulsive symptoms. He also experimented with reparative efforts of hugging, kissing, and nonerotic fondling. So he can be considered the father of both active therapeutic approaches and boundary violations in dynamic psychotherapy. Freud wrote Ferenczi a not so friendly letter putting Ferenczi's treatment technique down with humor and irony. Predicting further, more severe boundary violations by followers, Freud (Jones 1957, Vol. 3, pp. 163–164) predicts that someday Ferenczi will lament to himself, "Maybe after all I should have halted in my technique of motherly affection *before* the kiss."

Interestingly, Otto Rank collaborated with Ferenczi. Reading their work, *The Development of Psychoanalysis,* is like reading a contemporary discussion of the issues surrounding short-term/long-term therapy. They also anticipated later concepts like Alexander's "corrective emotional experience" and Davanloo's heavy emphasis on affective experience in the here and now. They asserted that psychoanalytic treatment should not remain tied to the free associative technique out of which it evolved. They criticized the preoccupation with

investigating the past and stressed the essential importance of focusing on the transference in the present treatment situation. In discussing the factors of effective therapy, they stated, like Davanloo, that the analyst should "substitute by means of the technique, affective factors of experience for intellectual processes" (1925, p. 62).

Rank (1924), known as a proponent of birth trauma, actually began to play that down later in his career and recognized that separation and individuation were core processes for the work of psychotherapy. He was the first analytic therapist to set a time limit on therapy to accentuate the separation and individuation aspects during termination phase. Rank (1947) also predated Davanloo in his focus on the concept of the patient's "will." Like Davanloo, he emphasized the importance of mobilizing the patient's "will" during the course of the therapy to facilitate the process. We now have evidence from Davanloo's and others' recorded cases that he was on the right track.

Twenty years (1946) after Rank and Ferenczi's publication, Alexander and French, at the Chicago Institute of Psychoanalysis, wrote in *Psychoanalytic Therapy* about the "baffling discrepancy" between length and intensity of psychoanalytic treatment and the degree of therapeutic success. This finding was to be confirmed in later studies by David Malan at the Tavistock Clinic and eventually by the Menninger Foundation Study in Topeka. So, nearly 70 years after the discovery of psychoanalysis, in the first systematic study of its results, the validity of the technique as a therapy was disproved. However, the theory behind the technique seemed to be shown valid. Alexander stressed three important variables in the treatment process that predicted successful outcome: (1) understanding of the patient's psychodynamics, (2) understanding the genetic development of the patient's difficulties, and (3) once 1 and 2 were established, structuring the therapist's reactions to the patient in such a way as to create a "corrective emotional experience." Alexander's work was a watershed in the history of psychotherapy. Suddenly the process of psychoanalytic psychotherapy had the potential of being helpful to large populations of people suffering from neurotic and characterologic difficulties.

The 1960s saw an upsurge in research into the process of short-term dynamic therapy, fueled in part by the Federal government's funding of mental health. Malan, Wolberg, Bellak and Small, Sifneos, Balint, Mann, and Davanloo worked on this problem and interacted scientifically with each other. Somewhat separate but extremely important is the work of Aaron Beck (1970, 1976) in the cognitive behavioral realm, where the therapist attempts to correct the patient's cognitive distortions and acts as a "coach." Under rigorous scrutiny in its application to depression, this therapy has demonstrated comparable if not superior efficacy to drug therapies for depression.

Malan (1963), a continent away, scientifically confirmed Alexander and French's counterintuitive finding that long-term therapy (psychoanalysis) shows no greater—and perhaps less—change than short-term approaches. Malan standardized the Triangle of Conflict* as well as the Triangle of People† and invented a short-term therapy for patients whose concerns were oedipal and who could work with interpretation. Malan's approach has been compared with that of Sifneos (1972), which also applied to a narrow spectrum of patients. Mann (1973) focused on patients whose difficulties centered on loss, separation, and differentiation and so was similarly limited. Bellak and Small (1965) kept their horizon narrowly focused on symptom alleviation. They went so far as to declare that character change was not a goal of short-term therapy.

Michael Balint and his wife Enid Balint, along with Paul Ornstein (1972), began to get impressive results with their *focal psychotherapy*, in which the therapist insisted that the patient focus on a central core conflictual disturbance. They studied 39 patients and struggled to create outcome measurements for dynamic therapies. In 1975, Malan summarized what he thought the Tavistock Clinic Study by Balint and his colleagues established as a standard for psychotherapy evaluation:

1. Clear-cut results, based on statistical methods, the essence of which has been cross-validated.
2. Strong evidence about specific factors in technique that are therapeutically effective.
3. Some degree of validation of scientific principles.
4. Some evidence on the validity of psychotherapy.

The Revolution

In March 1975, Davanloo set up the first of three International Symposia on Short-term Dynamic Psychotherapy. Around 1976 Malan began collaborating with Davanloo, which resulted in the publication of his "wish-fulfillment" chapter in 1980. By that time Davanloo had turned from full-time research to disseminating his findings and teaching his technique around the world. Eventually, in the 1980s, Malan and Davanloo parted ways. Interestingly, in recent years Davanloo has spent much of his time modifying his intensive short-term dynamic psychotherapy technique, which he calls "analysis." This

*This concept has its origin in Ezriel (1952).

†This concept has its origin in Menninger's Triangle of Insight (1958).

technique is designed to induce rapid and dramatic character change in appropriate patients. Malan (in Davanloo, 1980) writes:

> He was a true researcher in the field of psychotherapy who had become profoundly guilty and dissatisfied at the way in which, under the classical psychoanalytic technique, his patients went on year after year without substantial improvement. In consequence he began a twenty-year series of experiments, working single-handed . . . during this time, like Freud in the 1890s, he was secure in the knowledge that what he was doing was so original that there was not the slightest possibility that anybody else in the world might anticipate him.
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> He began to videotape every session, playing the tapes over and over in the evenings in order to see which ingredients of his technique seemed to lead to progress and which to failure. When he thought he identified an important factor, he would systematically employ it in his next half dozen cases.

Davanloo *for the first time in the history of psychotherapy* applied the scientific method to the development of specific techniques. Out of his courageous and painstaking efforts he developed a cascade of interventions, which he called the *central dynamic sequence.* Davanloo did not want short-term dynamic psychotherapy to be limited in its scope to a narrow population of patients, like the therapies of Mann, Malan, Sifneos, and Bellak and Small. He wanted this treatment model to have as broad applicability to patients as psychoanalysis. In fact, he viewed it as an alternative to psychoanalysis. Hence the therapy included a heavy emphasis on character and character change.

Davanloo also did something else unique in the history of short-term therapy. He went about systematically training therapists in his technique. With the zeal of a missionary he traveled about the world demonstrating his method. As a direct result of these efforts, short-term dynamic psychotherapy has an international presence. Now, it is perceived as a discipline of its own with devoted practitioners. At the present time Davanloo has functioning teaching centers in Montreal, Toronto, New York, Los Angeles, Amsterdam, Paris, Florence, and Nuremberg.

Modern History

Davanloo had a profound influence on current practitioners of short-term therapy. Among the authors, Alpert, McCullough, and Neborsky have studied under Davanloo, and McCullough actually studied with Malan before Davanloo. What is important here is that most of the authors of this book