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# 1

# The History of Short-Term Therapy in the Development of Psychoanalysis

> In analysis one asks: How much can one be allowed to do? . . . in my clinic the motto is: how little need be done?
>
> – D.W. Winnicott (1990)

Freud was the original brief therapist. If symptoms, as originally suggested, were caused by traumatic memories which were repressed – or forgotten – then it followed that if these memories could be recalled, and the feelings associated with them experienced, the symptoms would abate. Hypnosis was the preferred mode of treatment, beginning with Breuer's treatment of Anna O. (Freud 1955). This was thought to be efficacious because recovery depended on the patient remembering something which was excluded from conscious thought or experience. Freud, noticing that not all patients could be hypnotised, developed the 'cathartic' method where the patient would lie on the couch and, often with the aid of gentle pressure on the forehead and the therapist's active urging, 'forgotten' memories and feelings were recalled. These techniques were to become the forerunners of psychoanalysis. However, these early and experimental treatments were brief and symptom-focused, and relied heavily on the active intervention of the therapist. In this they were very similar to modern focal therapies where brevity, therapeutic activity and a central organising focus are central themes.

## The legacy of Freud

Freud suggested that the patients who would benefit from psychoanalysis included those who were highly motivated, reasonably intelligent and showed a 'positive attitude' towards therapy and the therapist. Motivation was important, Freud stressed, because of the resistance which would surface once the patient became aware of 'the direction in which the treatment is going'. The therapist had to be firm in encouraging and insisting on the patient's ability to remember while at the same time allowing himself to be appropriately supportive and educative both in terms of talking about the process of treatment and in 'making the unconscious conscious'. This would enlist the patient as a collaborator rather than condemn them to being a passive and dependent receptacle of the therapist's wisdom. Transference only became the central feature of the treatment much later, although even at this time Breuer and Freud recognised that 'material may be considered *either in the transference or in the memories of the past*' (Flegenheimer 1982, p. 22, my italics.).

Freud believed that psychoanalysis was not applicable to the 'most serious' cases and could be used only for the milder ones. Ironically, today the reverse is claimed by the proponents of psychoanalysis: psychoanalysis is applicable for more serious pathology, less so for minor developmental problems. It is interesting to note a similar debate among contemporary time-limited therapists.

Freud's early treatments only lasted a few weeks or months. Given the nature of his theories at the time – that a combination of interpretation and insight would lead to recovery – the therapist need only make a correct interpretation and the patient need only accept it for the symptom to abate. If the patient resisted the therapist would make every effort to convince the patient of the correctness of the interpretation. Early analyses, including Freud's self-analysis, were very brief. Gustav Mahler's treatment consisted of one four-hour session, while an initially sceptical Bruno Walter was successfully treated in five or six interviews spread over a period of time (Walter 1947). Lucy R. was seen regularly over a nine-week period, a therapeutic frame which would be seen as standard by many modern time-limited therapists, while Katharina (Freud 1955) was seen once. Katharina's con-

sultation is of particular interest since it resembles many of the theoretical and clinical applications of contemporary short-term therapies.

Freud was walking in the Hohe Tauern mountain range 'so that for a while I may forget medicine and more particularly the neurosis', when he was approached by Katharina enquiring whether he was a doctor. Freud, surprised and interested to 'find that neurosis could flourish in this way at a height of over 6,000 feet', entered into what he called a '*conversation*' (rather than a consultation) with her. Katharina complained of periods of being 'out of breath' and, after enquiring about the context in which they occured and their associations, Freud was able to *reframe the symptom* within a psychological framework. Freud was sure that the episodes of breathlessness were anxiety attacks; '[S]he was choosing shortness of breath out of the complex of sensations arising out of anxiety.' By questioning her on the exact nature of the symptom (*start where the patient is* and do not be afraid to be active in asking questions and taking control) he was able to explore possible formulations for Katharina's difficulties. Freud's (1955, pp. 125–34) account of his meeting with Katharina is worth quoting in some detail. (Italics highlight the similarities between early Freud and modern time-limited therapies, particularly in the areas of brevity, focus and therapist activity.)

> Was I to make an attempt at analysis? I could not venture to transplant hypnosis to this altitude but perhaps I might succeed with *simple talk*. I should have to try *a lucky guess*. I had found often enough that in girls anxiety was a consequence of the horror by which a virginal mind is overcome when it is faced for the first time with the world of sexuality. So I said '*If you don't know I'll tell you how I think you got your attacks*.' [This can be seen as a tentative and humble reconstructive formulation similar to modern focal approaches.] At that time, two years ago [the time of the initial attack], you must have seen or heard something that very much embarrassed you, and that you had rather not have seen.

Katharina went on to relate seeing her 'uncle' (discretion led to Freud only subsequently revealing that 'Uncle' was actually Katharina's father) in a sexually compromising position with her

cousin which led to the breakup of 'Uncle's' marriage. Katharina blamed herself for this and goes on to recall 'Uncle's' attempts to seduce her. Freud ends by saying:

> If someone were to assert that the present case history is not so much an analysed case of hysteria as a case solved by *guessing*, I should have nothing to say against him . . . I hope this girl, whose sexual sensibility had been injured at such an early age, derived some benefit from our conversation. I have not seen her since.

While Freud can be accused of 'leading the witness' as a result of his activity, questioning and focus (which as we shall see is a common criticism of brief therapists), and appears to have placed reliance on what he termed 'guesswork', he is perhaps unnecessarily defensive about this, since his interventions are based on both his clinical experience and his theory of neurosis. Freud was left not knowing the outcome of his conversation with Katharina, leaving us, and possibly him too, curious – an outcome common to many contemporary focal therapists. As Groves (1996, p. 447) points out, Katharina:

> shows [Freud's] willingness to adapt the therapeutic frame to the temporal situation of the 'patient' . . . it is equally remarkable for the artistic tension and narrative force that survive translation and partly explain Freud's being nominated in the late 1920s for the Nobel Prize – not in medicine but in literature.

Freud eventually replaced the cathartic method with free association, which required therapeutic passivity and increased the likelihood that patients would regress and become more dependent on the process of therapy. They were also more likely to form a transference neurosis (a specific illusion of the therapeutic relationship) which would take more time to analyse and treat. Trauma theory was supplanted by the Oedipus complex. Issues of resistance, character analysis, working through, and difficulties over termination can all be seen to be a consequence of the new analytic technique of free association, and ensured that therapies were destined to become longer. Therapists became less active, challenging or supportive, and interpretations, both in relation to the therapist (that is, trans-

ference) and in relation to the patient's early history (that is, reconstruction), became central to the treatment and to therapeutic change.

Therapeutic grandiosity, in the belief (and hope) that all aspects of mental life could and should be analysed, led to therapies developing a sense of timelessness which therapists, in thrall to the new 'science', did nothing to dissuade. With the loss of any sense of finite time there was consequently no need for a focus and a reduced urgency for symptom relief or symptomatic attention. If therapies were becoming longer they had almost by definition to become more rigorous; what other rationale could there be for the increasing length of time patients spent in the consulting room? Rigour and depth still remain contentious issues in contemporary debates about long-term versus short-term treatments. In psychoanalysis and psychoanalytic psychotherapy, increasing knowledge has led to the inevitable belief that treatments need to be longer; we could however infer that knowing more about them should make them shorter.

The fact that many of the early cases treated by the cathartic method improved while others treated by free association showed less progress did nothing to dampen psychoanalytic zeal. Therapies became longer and longer and, as in many fundamentalist sects, anything that deviated from the true faith was rejected and ostracised. This may go some way to explain why psychoanalytic clinicians have become so suspicious, uncomfortable and uneasy with the idea of TLT, and are tempted to regard it as somehow an inferior and diluted version of the 'real thing' (Coren 1996).

However, therapeutic passivity was not the only option for Freud at the time. Some believe he took the wrong turn:

> It needs to be stated categorically that in the early part of the century, Freud unwittingly took a wrong turn which led to disastrous consequences for the future of psychotherapy. This was to react to increasing resistance with increased passivity. (Malan 1992)

There is a long and honourable tradition of brief psychoanalytic psychotherapy and it is to its original proponents that we now turn.

## Otto Rank and birth trauma

Freud had proposed a theory which was increasingly dominated by the ideas and philosophy of medicine. The 'drive–structural theory', as it was called, relied heavily on the belief that there were instincts or drives which were seeking release and which were confronted by an 'ego' or sense of self, which mediated between the individual and his environment. Essentially an intrapsychic, one-person, theory, it paid relatively little attention to the involvement of other people. As a consequence, its clinical applications viewed the therapist as a detached observer or, if intervention was required, guide. Many of Freud's contemporaries became uncomfortable with these ideas and began to posit clinical approaches which were more based on relational, that is two-person, concepts. Among the earliest dissenters were Otto Rank and Sandor Ferenczi.

Rank, emphasising the trauma of biological birth, drew attention to this event as a metaphor for separation, individuation and development for all individuals. Rather than view anxiety as a consequence of the individual's struggle to contain impulses, more especially sexual and aggressive drives, Rank saw it as a response to a 'primal fear, which manifests itself now as a fear of life, another time as a fear of death' (Rank 1929, p. 123). Implicit in his view is the belief that therapy, like life, would need one day to end, and that in every therapeutic hour issues of separation and individuation would be in evidence. Rank saw the patient as being in a relationship with the therapist which must end one day, and the acceptance of this became the core ingredient of any successful therapy. The patient was encouraged to *individuate and separate* from the therapeutic process, and, since this involves similar issues to those experienced in the original birth trauma and its metaphoric equivalents, it is this element of therapy which is curative. Rank thought patients needed to be actively empowered to express their will, and thought the danger of Freudian therapy was that the patient would passively capitulate to the therapist's new explanation for their behaviour or feelings. Along with this, he was the first to express concern that long-term, open-ended therapies, while enabling the therapist to learn more about psychological and psychic functioning, were unlikely to cure, or help, the patient as quickly as possible. Rank was among the first to

espouse a *developmental model for psychoanalysis* rather than one circumscribed by ideas of medical cure. These ideas continue to inform some of the contemporary 'lifetime models' of brief therapy. Rank advocated:

- Emphasis on present experiences and relationships.
- Emphasis on transference, especially in relation to the primary attachment to the mother, rather than any sexual or aggressive manifestations of 'drives or instincts'.
- Setting a termination date for therapy.
- Open exploration of feelings and thoughts – and their clinical resistances – in relation to the therapeutic dyad.

Termination dates were set according to when Rank thought the patient was 'struggling with the will to individuate' (Messer and Warren 1995). For Rank the patient is always aware that the treatment must one day be finished. Not surprisingly, given Rank's belief in the trauma of birth and intrauterine life, he believed most patients would choose a period between seven and nine months in treatment, repeating the original period of gestation. Issues of dependency, separation and relatedness were central to any therapy, and needed to be incorporated into the therapeutic frame. Individuation, the fundamental goal of therapy, could be addressed best through acknowledging and working with limited time. Rank's views on this are similar to those held today by James Mann; setting a time limit assists the patient in accepting the reality of finite time. The theory of the birth trauma and time limits led to treatments often only a few months long and heralded the ending of Rank's relationship with Freud in 1926.

## Sandor Ferenczi, mutuality and the theory of trauma

Ferenczi, like his early collaborator Rank (Ferenczi and Rank 1925), was concerned about increasing therapeutic passivity, intellectualisation (fear that psychoanalysis was becoming an academic and pedagogic discipline) and the increasing lack of any affective contact between patient and therapist. Believing that

by placing paramount importance on the *emotional experience* of therapy shorter therapies would result, Ferenczi experimented in increasing the emotional content of sessions, challenging the belief that the therapist should be a blank screen, and raised issues, alive today, about therapeutic neutrality which had become a cornerstone of psychoanalysis. Uneasy with the increasing academic preoccupation of psychoanalysis in its desire to become a profession allied to science and medicine, Ferenczi believed that psychoanalysis had become confused as to whether it was an academic, intellectual discipline or a clinical treatment aimed at curing distressed people. Believing that Freud had lost interest in the therapeutic aspects of psychoanalysis (that is, in essence, a relationship between two people centred around curing the patient's 'pain'), Ferenczi advocated *active* involvement with patients during the therapy. While therapeutic passivity and inactivity were justified by those claiming scientific objectivity and neutrality for psychoanalysis, Ferenczi believed that vulnerable patients needed interpretations and scientific integrity less than support, encouragement and therapeutic 'nourishment' (Stanton 1990).

Together with Rank, Ferenczi held that childhood deprivation and conflict led to neurosis. As a consequence, he believed that deeply distressed or disturbed patients needed sometimes to be held and physically comforted and that to withhold this would be cruel if not sadistic. Ferenczi suggested that therapeutic activity could redress the earlier parental failures that the patient had experienced and had brought them into therapy. Freud dismissed this by calling it 'the kissing technique', something from which Ferenczi's reputation in mainstream psychoanalysis never fully recovered, but in retrospect we can see how Ferenczi was attempting to stress the *importance of process* (that is, the therapeutic relationship), rather than understanding, in therapy; he stresses this in a letter to Freud dated 17 January 1930: 'I do not share . . . your view that the therapeutic process is negligible or unimportant, and that simply because it appears less interesting to us we should ignore it' (quoted in Dupont 1995, p. xiii).

Rejecting the 'rigidity of analysis', Ferenczi advocated active and flexible interventions. Believing that Freud was becoming a pedagogue, teaching his patients what their symptoms meant and

represented, Ferenczi wanted to establish a new *cooperative therapeutic relationship* and thereby empower his patients. Uncomfortable with what he viewed as the hypocrisy and conceit of certain analytic stances, he linked 'the trauma of the powerless child' in the face of the adult world with the trauma of the patient faced with an overbearing analyst:

> Ferenczi draws parallels among the child traumatized by the hypocrisy of adults, the mentally ill person traumatized by the hypocrisy of society and the patient, whose trauma is revived and exacerbated by the professional hypocrisy and technical rigidity of the analyst. (Dupont 1995, p. xviii)

Ferenczi believed that patients suffered from childhood deprivations and also that rigid therapies were likely to revive and repeat the childhood traumas they were attempting to cure. Inflexible therapies, and by implication therapists, could damage your health by subjecting you to a further trauma. This then became merely a repetition (as opposed to repairing or healing) of previous traumas. Uneasy with a theory which was increasingly becoming transformed into a rigid dogma, he was concerned that patients who were excluded from the increasingly rigid criteria of analysability were being effectively denied any therapeutic help. This was in itself traumatising. Ferenczi believed that all patients who asked for help should receive it, and it was up to the therapist to decide and devise the most appropriate therapeutic response. As a consequence Ferenczi had the most difficult patients referred to him by his colleagues.

At the time these were radical ideas. They can be seen to predate modern concepts of the multidisciplinary team where patients are allocated to the treatment which most suits their needs rather than having to adapt to a single, possibly inappropriately rigid, therapy. This issue is also of central significance when assessing for time-limited therapies.

Ferenczi's view about trauma included a belief that therapists were often defensive about their own feelings and experiences in a manner which was unhelpful, and often harmful, to their patients. His response to this was the idea of 'mutual analysis'. When the therapist found himself struggling to help or provide support, he was encouraged to acquaint the patient

> as sincerely, as he can, with his own weaknesses and feelings. The analyst thus allows his patients to know better where they stand with him; even if in that way the patients must confront and assimilate some painful realities, they will cope better with these than with feigned friendliness. (Dupont 1995, p. xx)

Ferenczi undertook these early experiments in the use of what we now call 'counter-transference' by having double sessions, or alternating sessions – one for the therapist and one for the patient. This clearly became extremely problematic, not least in respect of boundaries and confidentiality, but was designed to address the power imbalance in therapy as well as to enable both therapist and patient to 'place themselves in relation to the other with greater assurance' (Dupont 1995, p. xxi). Ferenczi's experiments in mutual analysis failed, not least since they led to the roles of patient and therapist becoming blurred. Ferenczi eventually recognised the difficulties in this method, but mutual analysis can be seen as an early way of understanding and using counter-transference interpretations, especially in relation to the therapist's blind spots. This has particular relevance to short-term therapy.

## Alfred Adler

Mention should be made in this section of Alfred Adler, with particular reference to his contribution in the development of time-limited therapies. Taking up the issue of power in relationships, Adler saw the sense of powerlessness as rooted in the child's earliest reality. He proposed that the child has a primary wish to achieve mastery, and that this was rooted in social reality. Believing Freud was wrong to pay so little attention to reality factors in the child's (and by definition the adult's) development, Adler's thinking extended into social and educational areas. Adler believed that psychopathology arose because of

> a mistake in the whole style of life, in the way in which the mind has *interpreted its experiences*, in the meaning it has given to life, and in the actions with which it has answered the impressions received from the body and its environment . . . these *mistaken impressions* are acquired in early childhood. (Adler 1958; my italics)

In striving for unattainable personal goals and the pursuit of personal superiority, the individual was in danger of losing sight of his relatedness to others. While Adler was one of the first analysts to place the individual in a social and relational context, it is his therapeutic techniques which are of interest to us. Adler helped the patient to understand and recognise '*faulty beliefs*', which were not necessarily in the realm of consciousness. The patient had the 'courage' to do so as a result of his relationship with the therapist. Adler's approach took the form of '*discussions*' around the patient's misconceptions and how they related to his life. His therapeutic technique, while empathic and intuitive, also included '*guessings*', which were tentative suggestions and hypotheses which could be confirmed, negated or changed by subsequent material. He was also attentive to physical appearance, manner, posture and the symptom in giving clues to the faulty maladaptive beliefs which caused the patient difficulties. As we shall see, these are themes that recur in contemporary short-term therapies.

Ferenczi Rank and Adler had become concerned at the increasing amount of time that analyses were appearing to take and the clinical application of theories that they thought were becoming increasingly impersonal. They emphasise how the patient's early deprivation or conflicts are repeated in the therapeutic relationship, advocate a more active therapeutic stance rather than the purely interpretative, and, in their belief in focusing on the symptom and its relationship to earlier deprivations or traumas, can be seen to be advocating a form of treatment which mainstream psychoanalysis found difficult to incorporate. Because of this they were in time condemned to 'the psychoanalytic Gulag; the world of not psychoanalysis' (Mitchell 1997, p. 15).

## Alexander and French

Alexander and French (1946) considered their work an extension of the more relational models of Ferenczi and Rank. They shared Ferenczi and Rank's belief that problems were related to previous deficiencies in environmental provision and parenting, and their treatments reflected this in having an explicitly reparative aim.

Alexander and French challenged the importance of facilitating the expression of repressed memories, historical reconstruction and interpretations. What was mutative in therapy, they believed, was the patient's emotional experience, rather than the correct interpretation. Therapy needed to be an emotionally intense and short experience. Like Ferenczi and Rank, Alexander believed that long therapies often drifted into intellectualisation and consequently became less emotionally involving:

> An extreme generosity with interviews is not only uneconomical but, in many cases, makes the analysis less penetrating. Daily interviews often tend to reduce the patient's emotional participation in the therapy; they become routine, and prevent the development of strong emotions. (Alexander in Barton 1971, pp. 28–41)

In this context, it is of interest to note that the belief that it is only long-term therapies that can be emotionally intense is a relatively recent development.

The 'corrective emotional experience', as it became known, was based on the *new experience of an old conflict*. Moreover, the repetition of previous experiences in the therapeutic relationship (although anticipated in that the patient would seek, consciously or unconsciously, to repeat previous patterns) needed to be met by a new and different therapeutic response. It was these differences which were seen to be therapeutic. An example would be of a patient who, subject to hostile and rejecting parenting, would expect the same, or a similar, response from the therapist only to be met with the opposite: that is, a therapist who could be both accepting and nurturing. This was what was held to be curative:

> Because the therapist's attitude is different from that of the authoritative person of the past, he gives the patient an opportunity to face again and again, under more favourable circumstances, those emotional situations which were formerly unbearable and to deal with them in a manner differently from the old. (1971, p. 67)

What was required was the '*principle of flexibility*'. Alexander believed that therapists had tended to select their patients to fit their technique or theoretical base and that few had attempted 'to

adapt the procedure to the diversity of cases they had encountered' (Barton 1971, pp. 28–41). Consequently he advocated the principle of clinical flexibility to ensure that the therapist – or therapy – can adapt the technique to the needs of the patient rather than the other way round.

Alexander was aware of the danger of dependency, and advocated that treatment be interrupted for periods so that patients could actively work on their real-life problems without the therapist. Alexander made the point that many analyses had been vitalised by an unexpected absence or change on the part of the analyst, which he believed could precipitate more 'relevant' material than the weekly or daily routine. On the grounds that 'the analytic process is not confined to the analytic interview', he believed that what patients did *between sessions was as important as what happened in them*. Sessions were then arranged flexibly, which aided the independence of the patient and acknowledged real-life events outside the consulting room.

Patients were encouraged to focus on current life problems rather than the past, which was only seen as relevant if it was in any way related to the current problem:

> The nearer the analyst can keep the patient to his actual life problems, the more intensive and effective the therapeutic process is. From the point of view of . . . research it might be advisable to encourage the patient to wonder back into . . . his early youth. Therapeutically however such a retreat is valuable only insofar as it sheds light on the present. Memory material must always be correlated with the present life situation, and the patient must never be allowed to forget that he came to the physician not for an academic understanding of the etiology of his condition, but for help in solving his actual life problems. (as quoted in Groves 1996, p. 36)

Alexander also cautioned against what he termed 'transference gratification'. Alexander was aware that Freud had struggled with the possibility that the gratifications that the transference relationship may offer might outweigh, or replace, the desire to be cured. Freud had remarked that transference impasses had, in the early years of his practice, led to difficulty in persuading the patient to continue with therapy, while in his later years they had led to his difficulty in inducing them to give it up. The notion of the impasse, and the need to focus actively on it, is important in

short-term therapies. For Alexander the transference relationship ran in parallel with real-life experience; it was less a repetition than a rehearsal, and in essence must be orientated towards the present and future. Therapy must be in the service of life, not the other way around. Transference can also provoke compliance. Having discovered the analyst's 'predilections', the patient may 'bring interesting material and give the impression of deepening insight and steady progress', and while 'the analyst may believe they are engaged in a thorough "working through", in reality the procedure has become a farce . . . procrastination on behalf of the patient' (Groves 1996, p. 38).

Regression, seen in psychoanalysis as the means by which early conflicts became accessible, was thought of by Alexander less as evidence of the depth of an analysis than as 'a neurotic withdrawal from a difficult life situation back to childhood longings for dependence gratifiable only in fantasy'. Thus regression can be a defence which needed to be interpreted. The principle of flexibility ensured that regressions, where untherapeutic, were avoided.

Alexander's concept of the 'corrective emotional experience' was criticised as a 'manipulation' of the transference, not least by attempting to provide a therapeutic response diametrically opposite to the one the patient would expect. In response to this, and to accusations that the concept of flexibility was artificial, Alexander countered that it was less a manipulation than was analytic neutrality and the emotional non-participation of the traditional analytic approach.

Commenting that Freud himself had come to the conclusion that the time comes when the analyst must encourage the patient to 'engage in those activities he avoided in the past', Alexander believed that

> curbing the patient's tendency to procrastinate and to substitute analytic experience for reality (by careful manipulation of the tranference relationship, by timely directives and encouragement) is one of the most effective means of shortening treatment. (Groves 1996, p. 42)

It is perhaps ironic that these issues have become contentious again in contemporary psychoanalysis specifically in relation to

Lacan, who found five-minute sessions more effective than the standard fifty-minute analytic 'hour'.

The work of Alexander together with that of Ferenczi and Rank not only offered a coherent blueprint for how psychoanalytic concepts could be used in shorter therapies but also presaged a shift from the one-person drive-structural, instincts, defence model to modern object relations theory, which recognised a therapeutic relationship in which both parties were constantly relating and influencing each other. The therapeutic relationship was now becoming the central feature of therapeutic improvement or change, no longer merely a blank screen for the projection of the patient's fantasies. However, in their time, brief treatments and their exponents were severely attacked by the psychoanalytic establishment and suffered a period of often malign neglect. Psychoanalysis believed – and some would say continues to believe – that notions of brevity and relationship are incompatible. It was the work of Michael Balint and his colleagues which led to time-limited therapies being rediscovered.

## Michael Balint

Balint had been analysed by Ferenczi and shared with him the belief that patients attempt to obtain the unconditional love in therapy which had been denied them in childhood. This he came to term 'the search for the primary love object'. Like Ferenczi he recognised that the increasing lengths of psychoanalytic treatments were actually providing new 'obstacles to cure'. The work of Balint and his colleagues (1972) implicitly recognised that previous attempts at describing briefer therapies had foundered on issues of therapeutic 'activity' and 'manipulation'. They had been rejected by the psychoanalytic establishment because of their apparent disregard of the value of transference interpretations. Since psychoanalysis had not been able to incorporate these new techniques, Balint attempted, through stressing the importance of interpretation, to place focal therapy back onto a continuum with psychoanalysis. Balint's initial attempts at focal therapy foundered, perhaps not surprisingly, because of familiar

concerns among his colleagues over whether the new techniques and methods might challenge and endanger pure psychoanalysis. Balint however persevered and a focal therapy workshop was set up at the Tavistock Clinic from which Balint and colleagues (Ornstein and Enid Balint) wrote up a single case-study – a Mr Baker, who presented with episodic paranoid jealousy. He was seen by Balint for 27 sessions over a 15-month period and followed up for a further four and a half years. Mr Baker had initially only asked for five or six sessions. The case-study makes interesting reading for modern brief therapists for the light it throws on Balint's attempts to apply psychoanalytic concepts to focal therapy while still placing importance on central psychoanalytic tenets such as interpretation and instinct theory. Balint's focal therapy can be seen to develop themes outlined by both Ferenczi and Alexander. Primacy was placed on the *developing relationship between the patient and the therapist*. The psychopathology of Mr Baker – which most analysts would have considered severe, and at times during the treatment led to the possibility of hospitalisation – was of less importance than the developing therapeutic relationship and interaction between Balint and his patient. Primacy was placed on viewing treatment as a *process* between two people.

In the account of Mr Baker's treatment the workshop pioneered the use of an assessment form, which placed emphasis on the specific quality of the doctor–patient relationship, salient features (that is, *important moments*) of the initial interview, and the importance of having *focal aims*. Mr Baker's treatment roughly followed the two focal aims which were set in the initial interviews.

Having a well-defined focal aim brought up the issue of *selective attention and selective neglect* specifically in relation to interpretations. The focal therapist could not pay equal attention to all material; 'of all that the patient offers only those aspects are interpreted that facilitate and enhance the work on the chosen focus (in Balint *et al.* 1972, p. 134).' This is not to say that whatever appears unrelated to the focus is ignored, but that the therapist has to choose what to 'name and respond to'. In this way the therapist chooses what to interpret and influences the direction and process of the therapy. This was a very new concept of interpretation.

Balint believed attention had to be paid to material within the orbit of the focal aim. He acknowledged that interpretations can be manipulative but are tentatively offered and confirmed or rejected by the patient's ensuing material. They assist in defining the focus and are amenable to change and development.

Therapeutic flexibility included seeing Mr Baker with his wife – and occasionally only seeing his wife – as well as on occasion seeing Mr Baker's friends, which Balint termed 'milieu therapy'. Recognition is paid to the work that goes on outside the therapy and that this might be as important as the work done in sessions. The notion that therapies may be incomplete and yet beneficial was radical and new. In a letter to Balint, Mr Baker says 'You, Dr Balint, started something very important and I was able to finish it . . .' (in Balint *et al*. 1972, p. 121).

The 'focal workshop' led to early attempts to delineate criteria for those who may benefit from shorter therapies. These included:

- a willingness/ability to explore feelings;
- a willingness to work within a therapeutic relationship based upon interpretation;
- the therapist's ability to understand the patient in dynamic terms;
- the therapist's ability to formulate some kind of circumscribed treatment plan. (Malan 1963)

Balint viewed therapeutic change as a three-stage process. The therapist had to 'accept' what the patient offered, 'understand' it and then 'interpret' it at the appropriate moment. Consequently, focal therapy could be seen as being a form of applied psychoanalysis; the interpretation of un- and preconscious material was still seen as being central and mutative. In this way Balint hoped to bridge the gap between the early brief therapists who were seen as challenging, and being a threat to, psychoanalysis and the psychoanalytic profession. Central to this was a clear therapeutic aim, a focus which enabled the aim to be achieved and the necessity not to be sidetracked by the wealth of analytic material.

In the next chapter we look at how concepts highlighted by the early brief therapists have developed over time.

## Summary

In this chapter we have:

- Traced the development of shorter-term psychoanalytic ideas in the work of Freud, Rank, Ferenczi, Adler and Balint.
- Seen how, and discussed the reasons for, psychoanalytic therapy becoming longer and open-ended.
- Highlighted the concern expressed by a number of psychoanalysts at the increasing length of treatments.
- Suggested that the work of Alexander and French can be seen to be a link between early psychodynamic treatments and modern time-limited approaches. Particularly important are:
  - The concept of therapeutic *flexibility*.
  - The need for an assessment and the setting of *therapeutic goals*.
  - The importance of focal goals involving some *benign neglect* of other therapeutic material.
  - The 'manipulation' of intervals between sessions, which predates the importance modern brief therapists give to the 'therapeutic frame'.
  - The early acceptance by Alexander and French among others that the *meaning of the time frame* had to be recognised and brought into the treatment process.
  - Viewing the transference as non-neurotic and the importance of the *real-present-therapeutic relationship*. This served to decrease the 'irrational' elements of the transference and stressed the reality orientation of the treatment.
  - The need for therapeutic eclecticism depending on the needs of the patient.
  - The use of the present as a link with, rather than a consequence of, the past.
  - The importance placed on *influence, activity and direction*.
  - The suggestion that the therapist could be transformed from a passive listener to an *active participant and/or observer*.

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