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# IN THE BEGINNING: THE HISTORY OF SHORT-TERM THERAPY IN THE DEVELOPMENT OF PSYCHOANALYSIS

Freud was the original brief therapist. If symptoms, as originally suggested, were caused by traumatic memories which were repressed – or forgotten – 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 since 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, symptom-focused, and relied heavily on the active intervention of the therapist. In this they are 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 since Freud stressed the resistance which would surface once the patient becomes 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 the patient 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).

Freud believed that psychoanalysis was not applicable to the 'most serious' cases and could only be used for the milder ones. Ironically today the reverse is claimed by the proponents of psychoanalysis and the more lengthy open-ended therapies: more intensive therapy is applicable for more serious pathology, less so for minor developmental problems. This debate, as we shall see, is one which is current 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 the correct interpretations and the client accept them for symptoms to abate. If the client resisted, the therapist would make every effort to convince the client of the correctness of the interpretation. Early analysis, including Freud's self-analysis, was very brief. Gustav Mahler's treatment consisted of one 4-hour session while an initially sceptical Bruno Walter was successfully treated in five to 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 consultation 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 these episodes occurred 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; 'she 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 client 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 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 goes 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 break-up of the '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* [this raises the interesting issue of the use of intuition in therapy which will be discussed in Chapter 6], 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 contemporary short-term therapists) and appears to place reliance on what he terms 'guesswork', he is perhaps unnecessarily defensive about this since his interventions are based on both his clinical experience and 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 1920's 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 longer 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 take longer. Therapists became less active, challenging or supportive, and interpretations, both in relation to the therapist (i.e. transference) and in relation to the patient's early history (i.e. 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 clients spent in the consulting room? 'Rigour' and 'depth' still remain contentious issues in contemporary debates about 'long-term or 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 and it is this – and the increasing evidence base for short-term treatments – which in part fuel the development of briefer treatments among contemporary psychodynamic practitioners.

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 explaining why psychoanalytic clinicians have become so suspicious, uncomfortable and uneasy with the idea of time-limited therapy (TLP), 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. Malan (1992) views the choice that Freud made in reacting to increased resistance on behalf of the client with increased passivity on the part of the therapist as disastrous for the development of the psychodynamic therapies.

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/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 intra-psychic, 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, a 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). 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 therapists' '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 short-term therapy. Rank advocated:

- an 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 finish. 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 maternal separation. 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 best be addressed through

acknowledging and working with limited time. His 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 the increasing therapeutic passivity, intellectualisation (a fear that psychoanalysis was becoming an academic and pedagogic discipline) and the increasing lack of any affective contact between patient and therapist which was being sacrificed to the increasing 'scientific approach' of Freud's developing practice. 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 was becoming 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', an accusation 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 (i.e. the therapeutic relationship), rather than intellectual understanding, in therapy, as he comments 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)

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 traumatised by the hypocrisy of adults, the mentally ill person traumatised 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)

Ferenczi believed that patients suffered from childhood deprivations and believed that rigid therapies were likely to revive and repeat the childhood traumas which they were attempting to cure. Inflexible therapies, and by implication therapists, could damage your health by subjecting you to a further trauma. This then becomes 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. The treatment needed to fit the patient, rather than the other way round.

At the time, these were radical ideas. They can be seen to predate modern concepts of the multi-disciplinary team – or triage – where clients 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)

This raised the interesting issue of the therapist's self-disclosure – still a contentious topic – which will be discussed in Chapter 6. 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 enable both therapist and patient to 'place themselves in relation to the other with greater assurance'. 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 to the development of time-limited therapies. Taking up the issue of power in relationships, Adler saw this sense of powerlessness as rooted in the child's earliest reality. He proposed that the child has a primary wish to achieve mastery and 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. This has a particularly contemporary relevance. 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 hypothesis 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. Due to this they were in time condemned to 'the psychoanalytic Gulag; the world of not psychoanalysis' (Mitchell 1997).

## 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 both 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)

Intensive treatment thus has the opposite outcome from what was intended. 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 client 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 client 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, i.e. a therapist who could be both accepting and nurturing. This is 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 client 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. (Alexander, in Barton, 1971, p. 67)

What was required was the '*principle of flexibility*'. Alexander believed that therapists had tended to select their clients to fit their technique or theoretical base and that few had attempted 'to adapt the procedure to the diversity of cases they had encountered'. Consequently, he advocated the principle of clinical flexibility to ensure that the therapist – or therapy – can adapt the technique to the needs of the client rather than the other way round.

He was aware of the danger of dependency and advocated that treatment be interrupted for periods so that clients could actively work on their real-life problems without the therapist. Alexander made the point that many analyses had been revitalised 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. Believing that 'the analytic process is not confined to the analytic interview', what clients did between sessions was as important as what happened in them. Sessions were then arranged 'flexibly' which aided the independence of the client and acknowledged real-life events outside the consulting room.

Clients 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 [client] 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 wander 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 aetiology of his condition, but for help in solving his actual life problems. (Alexander, in Barton 1971)

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, while in his later years it had led to his difficulty in inducing them to finish. The notion of the 'impassé', and the need to

focus actively on it, are 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' (Alexander, in Barton 1971).

Regression, seen in psychoanalysis as the means by which early conflicts became accessible, was thought by Alexander less as evidence of the depth of an analysis, than '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 stressed that it was more important to work on '*transference patterns of behaviour*' rather than allowing/encouraging a regressive transference neurosis to develop.

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 accusations that the concept of flexibility was artificial, Alexander countered that it was less a manipulation than 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 transference relationship, by timely directives and encouragement) is one of the most effective means of shortening treatment' (Alexander, in Barton 1971).

It is perhaps ironic that these issues have become contentious again in contemporary psychoanalysis not least in relation to Lacan who found 5-minute sessions more effective than the standard 50-minute analytic hour.

The work of Alexander, together with 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 length of psychoanalytic treatments were actually providing new 'obstacles to cure'.

The work of Balint and his colleagues (Balint et al. 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. 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 client. 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 (i.e. *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 interview.

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 and only those aspects of the client's material that enhance the work of the chosen focus are interpreted.

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 client'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. In a letter to Balint, Mr Baker says 'You, Dr. Balint, started something very important and I was able to finish it' (Balint et al. 1972, p. 121). This is very similar to what has been termed the 'ripple effect' in modern short-term therapies. In addition, for psychoanalytic practitioners, the notion that therapies may be incomplete and yet beneficial was radical and new.

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 client 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 client 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 unconscious and pre-conscious 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. Balint applied these new techniques when offering a consultancy service to family doctors.

We now move on to look at how concepts highlighted by the early brief therapists have developed over time, who, by placing emphasis on interpretation, insight and the transference relationship can be seen to continue in the mainstream of analytic tradition.

Generalisations are problematic since contemporary short-term therapies differ not only from long-term therapies but also among themselves particularly in relation to therapeutic activity, focus, what constitutes brevity and the selection criteria. There are, however, increasingly areas of similarity and overlap. We shall begin with Sifneos, Davanloo and Malan.

### Peter Sifneos: anxiety-suppressive and anxiety-provoking therapies

Peter Sifneos (Sifneos 1972, 1979) distinguished between anxiety-suppressive and anxiety-provoking short-term treatments. His anxiety-provoking technique is based upon careful selection criteria, early and active use of transference interpretations, and confrontation. Relatively little attention is paid to termination.

Sifneos places a high emphasis on the first meeting with a new client, seeing it as a microcosm of therapy. Active himself as a therapist, he expects the same response from his clients. Anxiety-provoking therapy is applicable to clients with well-circumscribed neurotic symptoms and aims at limited dynamic change, emphasising problem solving and crisis intervention. Anxiety-suppressive therapy is aimed at more disturbed clients and is more supportive in nature.

In *anxiety-provoking therapy*, Sifneos only included clients who could be seen to have problems at an Oedipal level of functioning. Clinical assessment required some evidence that the client's difficulties originated from the Oedipal stage of development which were seen to be a legacy of three-person relationships. Clients who were thought to evidence pre-Oedipal problems, a result of faulty or disturbed dyadic relationships, were thought to be unsuitable for anxiety-provoking therapy since they would have difficulties establishing the basic trust fundamental to the forging of a working therapeutic alliance and terminating treatment. This continues to be an important distinguishing criterion used by some contemporary time-limited therapists.

Treatment is seen as 'anxiety-provoking' since it directly confronts the client's defences rather than attempting to 'interpret the meaning or function of the defences' (Flegenheimer 1982). Transference is interpreted rigorously as is any form of resistance. This bears similarities to contemporary emotionally expressive short-term therapies (see ISTDT and AET below).

Sifneos does not use the framework of a definite termination date. No time limit is set but the client is informed from the outset that the treatment will only last 'several months', and is encouraged to share responsibility for the decision of when to terminate. Termination is, in part, the client's responsibility which decreases the client's dependence and passivity. What assists termination is 'the diligent avoidance of all pregenital issues throughout the treatment process' (Flegenheimer 1982). What this means is that issues around separation anxiety, and the development of an unhelpful transference neurosis, are kept to a minimum. Sifneos suggests that these problems can be avoided by stringent selection, the client sharing responsibility for the treatment, and the 'selective neglect' of all pre-Oedipal material. Sifneos' anxiety-provoking therapy has a maximum of 20 sessions with most lasting between 12 and 16 sessions.

His selection criteria are carefully drawn up and include:

- ability of the client to present with a circumscribed complaint;
- evidence of a 'meaningful' relationship during childhood;
- capacity to relate to therapist in the first meeting and to be open in expressing feelings;
- psychological sophistication and intelligence;
- motivation for change over and above symptom relief;
- ability to see symptoms as having a psychological dimension;
- 'emotional honesty' and capacity for introspection;
- ability to 'participate actively' in treatment;
- curiosity;
- a realistic view of what can be achieved in therapy and a willingness to make the 'necessary sacrifices'.

The focus of this therapy is extremely narrow: 'the failure to grieve a death, inability to finish a project because of success, fear, triangular futile love relationships – the standard grist of the analytic mill – these high level neurotic conflicts are the province of anxiety-provoking therapy' (in Groves 1996).

One of the objections that Sifneos himself acknowledged was that the selection criteria mainly included clients who 'were so healthy that they do not require any treatment at all'.

Sifneos contrasts anxiety-provoking therapy with *anxiety-suppressive therapy*. This is aimed at less healthy clients who might be discomforted by the more confrontational stance of anxiety provoking therapy. It is aimed at more disturbed, by implication, pre-Oedipal, clients and is more supportive in nature and includes environmental manipulation, reassurance and, if necessary, medication. Crisis support could last up to two months, brief therapy could last from two months to one year while, for clients with long-standing psychological difficulties and a history of poor interpersonal relationships, longer-term therapy may be indicated. However, similar selection criteria to the anxiety-provoking therapies applied. Clients receiving anxiety-provoking therapy were seen weekly over a period of time, anxiety-suppressive clients frequently were seen more intensively, often a number of times a week, but sometimes only for a few minutes. This reflects the more crisis-oriented and supportive direction of the therapy.

These two types of therapy are offered to different clinical populations and recognise that treatment needs to be tailored to the client's presenting problem and psychopathology. However, insight and interpretation are still seen as central to progress and

cure and the 'one-person psychology' of the drive/structural model predominates.

### David Malan and the triangle of insight

David Malan had worked with Michael Balint in the Focal Workshop at the Tavistock Clinic. Having initially thought that they would attempt to apply analytic techniques to relatively healthy clients who presented with acute problems they 'found none ... [so] we were then forced to take on any patient who came for treatment' (Malan 1979). Believing at first that they would need to use 'superficial techniques', they were surprised to find that clients responded well to 'deeper interpretations'. Attempting to avoid transference interpretations, they found that as psychoanalysts they were 'conditioned' to respond to transference material with transference interpretations. As a result, they 'stumbled' on a surprising and unexpected finding: even clients with long-standing difficulties appeared to achieve both symptomatic and dynamic relief in a brief time scale using a 'deep' technique (transference interpretations). Particularly therapeutic appeared to be interpretations linking the current interaction with the therapist with significant figures from the client's past.

In the initial interview, a *focus* was sought and a *trial interpretation* attempted. This gauged the client's initial suitability for brief work and became the cornerstone of their assessment process. The focus tended to be relatively narrow and defined by the therapist. Trial interpretations were seen as important not only in estimating the client's suitability to work with interpretations in the therapy, but also enabling a therapeutic alliance to be formed. If the interpretation was helpful in the first session, then therapeutic work could start. Care would be taken before making one since the therapist has to have some confidence that the client will be able to make constructive use of it rather than experience it as persecutory. The interpretation should be linked to the area of the focus and serves to find - or reformulate - a tentative focus. If the focus is correct, the client is likely to become more intensely engaged, more committed to the treatment and produce more material. The therapist's formulation of the focus is done on the basis of the triangle of insight. Assurance is sought that the focus is acceptable to the client. This is done by gauging the response to trial interpretations, the ease with which the client talks about feelings and problems, and the extent to which

he displays positive motivation to engage in the treatment and consider change.

Brief intensive psychotherapy is then indicated, providing the following factors are not in evidence:

- prediction (on the therapist's part) that issues are too involved, complex or deep-seated;
- severe dependence and 'other unfavourable' transference manifestations;
- depressive or psychotic decompensation;
- the threat of suicide;
- uncontrollable acting out.

The client needed to be able to make substantive contact with the therapist, and to be motivated for change. Recognising that difficulties in termination were likely to pose problems in briefer work, clients who appeared to have 'complex or deep-seated issues' in this area were deemed inappropriate since 'there [seemed] little hope of working [these] through in a short time' (Malan 1976). Inevitably these selection criteria included some clients who presented with pre-Oedipal problems but Malan increasingly came to believe that this was not necessarily a contraindication for brief intensive therapy. Of more importance was the *capacity to have formed previous meaningful relationships*. This was highly correlated with good outcomes and a positive indicator as to how the client would respond to the therapist.

Central to the technique was clarification and interpretation of the *triangle of insight or persons*. This is the three-way link between the here and now relationship with the therapist, similar feelings which have been directed toward significant people in the client's past, and the problem as it manifests itself in the client's current relationships. The *current* conflict is frequently associated with the precipitating factor which brought the client into treatment and is observable in the therapeutic relationship. The *historical* – or *nuclear* – conflict can be a result of 'early traumatic experiences ... family constellations or *repetitive patterns*'. The closer the current and nuclear conflicts, the better the prognosis. In Malan's example of 'The Man with the Headaches', who presented with anxiety symptoms and chest pains precipitated by the cardiac illness of his father, the current and nuclear conflict were virtually the same, which ensured that 'the therapy will sort of roll out in front of you automatically'. The client will always be talking about his core conflict and the therapist will merely have to make focal interpretations.

The triangle of insight links with another psychoanalytic triangle: that of *impulse*, the resultant *defence* and consequent *anxiety*. This was in keeping with the Freudian belief that it is censored desire which causes symptoms. In therapy, it is the clarification of this in relation to the triangle of insight which is helpful.

Initially no time limit was set at the beginning of treatment. Clients were told that they would be seen for a matter of months and if further treatment was indicated, they would be referred for longer-term therapy. However, as confidence in the new technique grew, a time limit was set from the start. Malan eventually set a time limit of between 20 to 30 sessions from the outset of treatment and went on to recommend 'twenty sessions for an ordinary (straight-forward) patient with an experienced therapist' and 30 sessions for 'an ordinary patient with an inexperienced therapist' (Malan 1992). According to Malan:

[Time limits] give therapy a definite beginning, middle, and end – like the opening, middle and end game in chess – and help to concentrate both the patient's material and the therapist's work, and to prevent therapy becoming diffuse and aimless and drifting into long-term involvement. It enables the prospect of termination to be brought in quite naturally as the time for this approaches; and often this enables a therapy that had been in danger of becoming diffuse of becoming clear and focal again. To adapt Dr. Johnson, being under sentence of termination doth most marvellously concentrate the material.

Malan went on to believe the setting of a termination date, as opposed to a specific number of sessions, was preferable, since it dealt with the 'chore' of keeping track of missed sessions and the possible ambiguity as to whether they counted towards the total. Despite the time limit, the client is given to understand that he can see the therapist on an ad hoc basis after the therapy is finished. In contrast to other approaches, Malan does not believe that this compromises the emotional impact of termination.

Malan believed that the need for therapeutic activity stemmed from the need to keep the therapy in focus given the wealth of material that can be produced. Activity includes '*selective interpretation, selective attention, and selective neglect*' (Malan 1976). Material is selected according to its proximity to the focus.

Malan acknowledges that termination may need specific attention in short-term therapy, particularly with clients where separation

factors are paramount. In clients where the focus is more on Oedipal issues, termination may not be central but in extending briefer therapies into his work with pre-Oedipal clients, he recognised that endings are crucial and must be incorporated into the treatment.

Malan, however, used the standard techniques of psychoanalysis; interpretation of the transference, of defences and of the 'nuclear' or 'core' conflict. At pains to stress the technical similarities between psychoanalysis and brief intensive psychotherapy, Malan believed '[I]nterpretations used differ in no way in any form of psychoanalytic therapy ... interpretations of resistance, fantasies, and above all, forms of transference' (in Davanloo 1978).

Using techniques which are not dissimilar to open-ended analytic treatments, Malan's outcomes suggested that the beneficial effects went well beyond mere symptom relief. Rather than being superficial, Malan's brief intensive psychotherapy included an understanding of the underlying dynamic conflicts and their origin.

### Unlocking the unconscious: Habib Davanloo

Habib Davanloo's Intensive Short-Term Dynamic Psychotherapy (ISTDP) includes many of the clinical techniques of Sifneos and Malan, including the use of trial interpretations to test the client's motivation and the capacity or willingness to work briefly in an intensively analytic way. Davanloo suggests that the client's response to a period of 'trial therapy' is the best indicator of a client's suitability for the treatment. Other criteria considered important include:

- some evidence of reciprocity ('give and take') in relationships, particularly in relation to the therapist;
- access to specific feelings or affects and whether they can be tolerated (e.g. anger);
- affective, rather than intellectual, response to interpretation;
- flexible defences;
- transference and counter-transference reactions.

Davanloo initially believed motivation, especially if increased after interpretations, to be an important criteria, but more recently has viewed the need for client motivation to be 'a criterion created by therapists who cannot treat highly resistant, complex patients' (in Groves 1996).

Contraindications include those clients who show 'intense reliance on projection, massive denial, major reliance on acting out in

dealing with conflicts, acting out combined with projections, or a few rigid persistently used ego defence mechanisms' (Davanloo 1978).

Davanloo (1990) has described the trial therapy as serving to 'unlock the unconscious'. The most important aspect of this period of trial therapy is to acknowledge and confront the client's resistance (often evidenced by passivity, withdrawal and vagueness), especially in relation to its manifestations in the transference. This frequently mobilises anger which is then defended against but produces more material in relation to the client's central conflict. A similar triangular link is then made between the client's material in relation to the therapist (T), significant figures in the client's current life (C) and significant people in the past, e.g. a parent who 'may have taught such (relational) patterns in the first place' (P). Davanloo terms this the *triangle of persons* (TCP). As with Malan, this is seen in relation to a further therapeutic triangle, *the triangle of conflict*. The triangle of conflict is similar to Malan's impulse, defence, anxiety triangle. Davanloo terms this the *DAI triangle* - defence, affect and impulse. The closer the congruity between these two triangles, the more effective the treatment is likely to be. The earlier that interpretations in the triangle of persons can be made, the shorter the likely treatment. It follows that feelings (which may be denied or defended against by passivity or vagueness) towards the therapist or treatment, need to be addressed from the beginning of the trial therapy. We shall return to these triangles in Chapter 3. Davanloo also makes use of what he calls '*subtly loaded words*' in order to speak to some fundamental, often unconscious, trait in the client, a theme we shall return to when discussing technique. The therapist formulates the presenting problem in relation to the therapeutic triangles which enables the client and the therapist to agree on the focus for treatment at the end of the period of trial therapy

Davanloo's technique is aimed not only at Oedipal or neurotic problems but is also described as benefiting clients who may evidence personality problems of long duration. What is most apparent in Davanloo's work is the direct, and some would say, relentless, attack on the client's passivity, withdrawal or vagueness. These are seen as defensive *choices* on the part of the client. The 'gentle but relentless' confrontations are particularly designed to elicit feelings of anger or resistance. The client's powerful emotions, particularly towards the therapist, are defended against, but the therapist's constant interpretation of these leads to their expression in the therapy. The acceptance of these uncomfortable feelings, without any negative consequences in the therapy, further

strengthens the therapeutic alliance and increases client motivation. The client shares responsibility for the treatment and warded off feelings and behaviour in the therapy are actively pointed out to the client.

While no definite time limits are set, treatments appear to last between two to forty sessions depending on the client's psychopathology and the complexity of the focus. Davanloo (1978; 1994) sees short-term therapies on a continuum depending on the 'central structure of the patient's conflict'. Oedipal problems are treated in 'two to fifteen' sessions while 'deeper problems produce excellent results in twenty-five to thirty-five, or an upper limit of forty, sessions'. Treatment is ended when there is evidence of improvement – or change – in one or more areas of the triangles described above.

The assault on defences and the concentration on the client's anger and resistance make this a potentially problematic technique. Davanloo's method demands the utmost therapeutic neutrality and control on behalf of the therapist and an ability to pick up and focus on the early, and frequently slight, manifestations of resistance. However, neutrality does not mean a passive therapist. For Davanloo, activity does not mean having to be directive; one can be extremely active yet non-directive. There is no place for a passive therapist in this treatment since 'we cannot wait for the material to bubble up'. Resistance is dealt with by relentless questioning:

Interpretation of the negative transference is highly essential. I would also emphasize the importance of early and repeated interpretation of resistance and ambivalence ... which are of great importance in maintaining the therapeutic alliance. (1994, p. 344)

Termination is not viewed as a major issue and with less disturbed clients can be dealt with in one session while in treatments with multiple foci or with more disturbed clients, termination is addressed in the last two to six sessions.

What can be seen as potentially disquieting is the frequent repetition of an interpretation until the client is ground into submission and agrees with the therapist. Paradoxically, these 'bulldozer' techniques make Davanloo's therapy potentially helpful to obsessive and phobic clients, who had been thought to be unresponsive to briefer treatments, by addressing the split between their feelings and intellect (Flegenheimer 1982).

Sifneos, Malan and Davanloo closely follow in the psychoanalytic tradition by placing great emphasis on interpretation, transference

and the importance of insight. The drive/structural model of the mind of id, ego, superego and impulse, defence, and anxiety is central to their frameworks. Allowing for modifications of psychoanalytic technique, change is based on those factors found in psychoanalysis: deep interpretations, aimed at the unconscious, which make distinctive emotional contact and lead to insight. They assume that any assessment for short-term therapy would essentially be along these modified psychoanalytic lines and that the establishment of a focus is achieved within this context. If a focus cannot be determined within the first few interviews, brief intensive therapy is not indicated. Central to Malan's approach is selective listening and selective interpreting in the context of the focus. Davanloo concentrates on repeated confrontation of the client's defences in order to expose the hidden feelings and conflicts while Sifneos confronts the client's 'impulses as well as teaching patients about their psychodynamic' (Messer and Warren 1995, p. 92).

What we can see here are the attempts to place brief therapies within the context of psychoanalysis. Unlike Alexander and Ferenczi, who were viewed, perhaps somewhat erroneously, as proposing a heretical and threatening model of analysis, these writers, by using basic psychoanalytic techniques, were not seen as a challenge to psychoanalysis. Thus they were able to present themselves as following in the mainstream psychoanalytic tradition and, if somewhat uneasily, to be incorporated within the psychoanalytic fold. However, this did not mean the acceptance of brief therapies but led to a renewed debate on their efficacy and whether they constituted a treatment that could be called analytic. These debates led to the notion that brief dynamic therapies might be 'different' from psychoanalysis while still making use of fundamental analytic ideas in clinical practice. What we also begin to see, in the importance placed on the client's interaction with the therapist, is a move towards the 'object relational' model of therapy where the client's use of the therapist as a microcosm of relationships in the real world, gradually replaces the emphasis placed on the drive-instinct, observer-observed, model of early psychoanalysis. The idea of a two-person psychology is introduced which liberates the therapist from the stance of passive observer. Therapist and client can potentially be part of a dyad that constantly interacts and it is this recognition that enabled focal therapies to further develop with the therapeutic relationship increasingly being the agent of change.

## Experiential short-term therapy

This is most apparent in the more recent developments in focal therapies where the work of Malan and Davanloo have increasingly coalesced in a range of expressive/experiential short-term treatments (Fosha, 2000; Della Selva, 2004; Malan and Della Selva, 2006). Fosha's Accelerated Empathic Dynamic Psychotherapy (AEDP) is closely linked to the Intensive Experiential/Expressive Short-term Dynamic Therapies (IESTDP). What these approaches (Davanloo's Intensive Short-term Dynamic Psychotherapy, Accelerated Empathic Psychotherapy (AET) (Foote 1992; Alpert 1992), Accelerated Experiential Dynamic Psychotherapy (Fosha 2000]) share and stress is the primacy of the experiential component of therapies. It is the experience of the previously defended against affect in *the here and now of the client-therapist relationship* which is the central agent of change. These therapies feature a high level of therapeutic activity, selective focusing, an active therapist and client engaging in a collaborative endeavour, focus on the here and now of client-therapist interaction, attention to minute somatic/bodily fluctuations during sessions and a belief in the experiential element of therapies to facilitate change. In their development, they are also less manifestly adversarial/confrontational than the original ISTDP, viewing the treatment as 'radical empathy and emotional engagement through attunement, resonance, affect sharing, affirmation and self disclosure' (Fosha 2000, p. 3).

These treatments view themselves as within the psychoanalytic tradition (symptoms arise from feelings which have become unconscious because they are too painful) but place central importance on asking the client what he feels rather than interpreting what he feels (which can be used defensively by both client and therapist) so that the affect, often experienced somatically, can be experienced directly in the session. Following from Frieda Fromm-Reichman's (1950) comment that the patient is in 'need of an experience not an explanation', the initial phase of treatment – where clients are asked what they feel rather than told via interpretations – leads to what is termed the *central dynamic sequence* between therapist and client which would include the client's 'tactical defences' to avoid painful affect. These are not interpreted but the client is encouraged to experience the painful affect which they are blocking via their defences, and to verbalise or visualise (we see here how even contemporary psychodynamic brief therapists tend to use a variety of interventions drawn from many therapeutic traditions)

previously hidden impulses in the session. This is facilitated by the increasing emotional engagement with the therapist. What is of interest is that these therapies are making much use of attachment theory, reflective self-function and affect regulation which we shall discuss in Chapter 5. It is a reflection of their confidence in the efficacy of their treatment, and the psychodynamic foundation of their interventions, that they have been able to move beyond the holy grail of interpretation as the agent of therapeutic change.

Termination (and the time frame) tend not to be major issues since the treatment ends when the client has 'got what he came for' although it is noted that characterological problems take longer than developmental ones and that clients in crisis are particularly open to shorter treatment times. Extensive use is made of follow-up sessions.

### Summary

Early psychoanalysis was symptom-focused and active. As we have seen, resistance and the transference neurosis led to therapy becoming longer, unfocused and passive. It is possible that the embarrassment felt by the analytic profession towards hypnosis and the cathartic method of the early Freud have contributed to the vehement response with which short-term therapies have been subjected by the analytic community. For psychoanalysis, focal time-limited therapy is nothing less than the return of the repressed. The interest now shown by the analytic community in shorter therapies is a recognition that analysis is going back to its origins. However, as we have seen in this chapter, this has not been achieved without considerable ambivalence and resistance which has led to the unease which is felt towards short-term dynamic therapy within the psychoanalytic tradition. This historical legacy continues to exert considerable influence on the development of dynamic time-limited therapies. This chapter has traced the development of psychoanalytically informed short-term therapies from the early Freud to contemporary experiential treatments based on analytically informed practice. We now consider how contemporary time-limited therapies are widely influenced by psychodynamic theory and practice before articulating a model of short-term dynamic interventions.

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