

# 02 - 28.2 Brief Psychodynamic Psychotherapy

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28.2 Brief Psychodynamic Psychotherapy The growth of psychotherapy in general and of dynamic psychotherapies derived from the psychoanalytic framework in particular represents a landmark achievement in the history of psychiatry. Brief psychodynamic psychotherapy has gained widespread popularity, partly because of the great pressure on health care professionals to contain treatment costs. It is also easier to evaluate treatment efficacy by comparing groups of persons who have had short-term therapy for mental illness with control groups than it is to measure the results of long-term psychotherapy. Thus, short-term therapies have been the subject of much research, especially on outcome measures, which have found them to be effective. Other short-term methods include interpersonal therapy (discussed in Section 28.10) and cognitive-behavioral therapy (discussed in Section 28.7). Brief psychodynamic psychotherapy is a time-limited treatment (10 to 12 sessions) that is based on psychoanalysis and psychodynamic theory. It is used to help persons with depression, anxiety, and posttraumatic stress disorder, among others. There are several methods, each having its own treatment technique and specific criteria for selecting patients; however, they are more similar than different. In 1946, Franz Alexander and Thomas French identified the basic characteristics of brief psychodynamic psychotherapy. They described a therapeutic experience designed to put patients

at ease, to manipulate the transference, and to use trial interpretations flexibly. Alexander and French conceived psychotherapy as a corrective emotional experience capable of repairing traumatic events of the past and convincing patients that new ways of thinking, feeling, and behaving are possible. At about the same time, Eric Lindemann established a consultation service at Massachusetts General Hospital in Boston for persons experiencing a crisis. He developed new treatment methods to deal with these situations and eventually applied these techniques to persons who were not in crisis, but who were experiencing various kinds of emotional distress. Since then, the field has been influenced by many workers such as David Malan in England, Peter Sifneos in the United States, and Habib Davanloo in Canada.

**TYPES Brief Focal Psychotherapy (Tavistock-Malan)** Brief focal psychotherapy was originally developed in the 1950s by the Balint team at the Tavistock Clinic in London. Malan, a member of the team, reported the results of the therapy. Malan's selection criteria for treatment included eliminating absolute

contraindications, rejecting patients for whom certain dangers seemed inevitable, clearly assessing patients' psychopathology, and determining patients' capacities to consider problems in emotional terms, face disturbing material, respond to interpretations, and endure the stress of the treatment. Malan found that high motivation invariably correlated with a successful outcome.

Contraindications to treatment were serious suicide attempts, substance dependence, chronic alcohol abuse, incapacitating chronic obsessional symptoms, incapacitating chronic phobic symptoms, and gross destructive or self-destructive acting out.

**Requirements and Techniques.** In Malan's routine, therapists should identify the transference early and interpret it and the negative transference. They should then link the transferences to patients' relationships with their parents. Both patients and therapists should be willing to become deeply involved and to bear the ensuing tension. Therapists should formulate a circumscribed focus and set a termination date in advance, and patients should work through grief and anger about termination. An experienced therapist should allow about 20 sessions as an average length for the therapy; a trainee should allow about 30 sessions. Malan himself did not exceed 40 interviews with his patients.

**Time-Limited Psychotherapy (Boston University-Mann)** A psychotherapeutic model of exactly 12 interviews focusing on a specified central issue was developed at Boston University by James Mann and his colleagues in the early 1970s. In contrast with Malan's emphasis on clear-cut selection and rejection criteria, Mann has not been as explicit about the appropriate candidates for time-limited psychotherapy. Mann considered the major emphases of his theory to be determining a patient's central conflict reasonably correctly and exploring young persons' maturational crises with many psychological and somatic complaints. Mann's exceptions, similar to his rejection criteria, include persons with major depressive disorder that interferes with the treatment agreement, those with acute psychotic states, and desperate patients who need, but cannot tolerate, object relations.

**Requirements and Techniques.** Mann's technical requirements included strict limitation to 12 sessions, positive transference predominating early, specification and strict adherence to a central issue involving transference, positive identification, making separation a maturational event for patients, absolute prospect of termination to avoid development of dependence, clarification of present and past experiences and resistances, active therapists who support and encourage patients, and education of patients through direct information, reeducation, and manipulation. The conflicts likely to be encountered included independence versus dependence, activity versus passivity, unresolved or delayed grief, and adequate versus inadequate self-esteem.

**Short-Term Dynamic Psychotherapy (McGill University-Davanloo)**

As conducted by Davanloo at McGill University, short-term dynamic psychotherapy encompasses nearly all varieties of brief psychotherapy and crisis intervention. Patients treated in Davanloo's series are classified as those whose psychological conflicts are predominantly oedipal, those whose conflicts are not oedipal, and those whose conflicts have more than one focus. Davanloo also devised a specific psychotherapeutic technique for patients with severe, long-standing neurotic problems, specifically those with incapacitating obsessive-compulsive disorders and phobias. Davanloo's selection criteria emphasize evaluating those ego functions of primary importance to psychotherapeutic work: the establishment of a psychotherapeutic focus; the psychodynamic formulation of the patient's psychological problems; the ability to interact emotionally with evaluators; a history of give-and-take relationships with a significant person in the patient's life; the patient's ability to experience and tolerate anxiety, guilt, and depression; the patient's motivations for change, psychological mindedness, and an ability to respond to interpretation and to link evaluators with persons in the present and past. Both Malan and Davanloo emphasized a patient's responses to interpretation as an important selection and prognostic criterion. Requirements and Techniques. The highlights of Davanloo's psychotherapeutic approach are flexibility (therapists should adapt the technique to the patient's needs), control, the patient's regressive tendencies, active intervention to avoid having the patient develop overdependence on a therapist, and the patient's intellectual insight and emotional experiences in the transference. These emotional experiences become corrective as a result of the interpretation. Ana, a divorced 60-year-old woman, sought psychiatric help following a severe depressive episode lasting several months. This episode, which was one of many in her life, was especially severe in terms of loss of energy, interest, and motivation, as well as in terms of the intensity of her sadness and her wish to die. Only her profound religious convictions protected her from acting on these wishes. Ana had lost a lot of weight, had trouble sleeping, experienced many nightmares, and had difficulty with concentration. She was plagued by pervasive feelings of hatred for her mother, who was very old, ill, and dependent on Ana, who was unable to forgive her for abandoning her in an orphanage when she was 5 or 6 years of age. After an extensive assessment, the dynamic formulation of Ana's problem was represented as follows:

1. Life problems: Recurrent depressive episodes plagued by feelings of guilt and selfreproach; problems with men involving choosing partners who are commonly cold, distant, or otherwise unavailable; involuntary and painful emotional distance from her children, friends, and other close relationships; and unproductive and unrewarding work life, despite considerable intellectual gifts.
2. Dynamics: Ambivalent relationship with her mother, whom she blames for most of the tragedies of her life; guilt and need for punishment in relation to her unrelenting

hatred for her mother; and pathological grief reaction for the loss of an idealized and more optimal relationship with her mother, the one she remembers she had prior to her orphanage placement. From this focus there flows a melancholic conviction of the inevitable failure of human relationships. 3. Pathogenic foci: Grief and inability to mourn the loss of her mother after she was placed in the orphanage, with attendant rage and guilt; pathological grief for the loss of her father, who, because of severe alcoholism, abandoned the family first, a move that caused the mother to place her children in an orphanage in order to be able to work and ultimately recover their care. Unconsciously, she blamed her mother for the family catastrophe, thus "protecting" an idealized view of her father, to whom she was profoundly attached. For Ana, the initial phase of treatment

focused on the clarification and the experience of her destructive impulses toward her mother, which, as they were worked through, made possible the appearance of a modicum of empathy with her mother's painful life situation around the time she placed Ana and her sisters in the orphanage. Next, the therapy focused on Ana's father. Deep feelings of idealization, disappointment, anger, and grief were experienced with increasing clarity and intensity, frequently via displaced feelings in the transference and after overcoming considerable resistance. The last phase of treatment permitted the development of realistic feelings of empathy and appreciation for her mother, now without anger or emotional distancing, and the reawakening within Ana of feelings of joy and hope, as well as professional ambition. (Courtesy of M. Trujillo, M.D.) Short-Term Anxiety-Provoking Psychotherapy (Harvard University- Sifneos) Sifneos developed short-term anxiety-provoking psychotherapy at the Massachusetts General Hospital in Boston during the 1950s. He used the following criteria for selection: a circumscribed chief complaint (implying a patient's ability to select one of a variety of problems to be given top priority and the patient's desire to resolve the problem in treatment), one meaningful or give-and-take relationship during early childhood, the ability to interact flexibly with an evaluator and to express feelings appropriately, above-average psychological sophistication (implying not only aboveaverage intelligence but also an ability to respond to interpretations), a specific psychodynamic formulation (usually a set of psychological conflicts underlying a patient's difficulties and centering on an oedipal focus), a contract between therapist and patient to work on the specified focus and the formulation of minimal expectations of outcome, and good to excellent motivation for change, not just for symptom relief. Chris, a 31-year-old single man, sought help for a moderate depressive episode precipitated by the loss of his relationship with his girlfriend, Joanna. She had broken

off the relationship after approximately 1 year, tired of Chris's erratic work ethic and emotional instability and discouraged by his fear of commitment to the future of their relationship. This cycle of infatuation, increasing fear of commitment, and relationship loss had become a pattern in Chris's interpersonal life. His work life was plagued with similar problems. Jobs were frequently lost because of serious conflict and threatening confrontations with his superiors. As conflicts arose at both work and home, Chris typically suffered increasing anxiety and episodic panic attacks. After the loss of each relationship, Chris usually confronted moderate depressive feelings, at times accompanied by suicidal ideation. After an assessment, the dynamic hologram for Chris was represented as follows:

1. Life problems: Recurrent episodes of anxiety and depression; work problems; unstable interpersonal relationships; conflict with authority figures; antagonism toward, and emotional distance from, his father, brother, and male friends; and fears of heterosexual intimacy and of commitment.
2. Dynamic forces: Ongoing hostility and envy toward males, authority figures, and successful people, and compulsive and possessive seeking of female love objects with a serious inability to consider, fulfill, or tolerate their independent needs.
3. Genetic pathogenic foci: Unconscious loss of maternal objects precipitated by birth of a brother when Chris was age 2 years; uncontrolled grief for that loss with a compulsive drive to experience child-like possession of love objects; and compulsive hostility toward others perceived as rivals. The therapist's active inquiry yielded additional confirmation of the persistence of repressed sexual feelings toward his mother and the presence of hostile feelings toward all rivals for his mother's affection. A memory suffused with very

visceral feelings emerged in this phase as a result of the therapist's active inquiry. In this memory, Chris saw himself in his mother's arms in a dark room. He remembered vividly the intense pleasure of the contact with the warm skin of his mother, the texture of her clothes, and the smell of her perfume. While narrating this memory to the therapist, Chris was so absorbed in the experience that he blushed intensely. He also described the painful termination of this moment of pleasure by his father's sudden and disruptive opening of the door and the flood of light that disturbed his pleasurable absorption. This sequence gave way to the experience of grief at the loss of the intense and exclusive bond with his mother after his brother's birth and to a reexperiencing of a sense of anger, impotence, and loneliness. These feelings were all too familiar in his present life when his romantic attachments would be threatened or lost. The affective link between this childhood experience and his intimacy problems in the present became very obvious to Chris, and the acceptance of this link enhanced his capacity to work through this essential component of his pathology. A parallel conflict appeared in the transference as the patient resented the "intrusion" of the inquiring therapist into the zealously guarded privacy of this primal fantasy of material possession. (Courtesy of M. Trujillo, M.D.)

Requirements and Techniques. Treatment can be divided into four major phases: patient-therapist encounter, early therapy, height of treatment, and evidence of change and termination. Therapists use the following techniques during the four phases. **PATIENT-THERAPIST ENCOUNTER.** A therapist establishes a working alliance by using the patient's quick rapport with, and positive feelings for, the therapist that appear in this phase. Judicious use of open-ended and forced-choice questions enables the therapist to outline and concentrate on a therapeutic focus. The therapist specifies the minimal expectations of outcome to be achieved by the therapy. **EARLY THERAPY.** In transference, feelings for the therapist are clarified as soon as they appear, a technique that leads to the establishment of a true therapeutic alliance. **HEIGHT OF THE TREATMENT.** Height of treatment emphasizes active concentration on the oedipal conflicts that have been chosen as the therapeutic focus; repeated use of anxietyprovoking questions and confrontations; avoidance of pregenital characterological issues, which the patient uses defensively to avoid dealing with the therapist's anxietyprovoking techniques; avoidance at all costs of a transference neurosis; repetitive demonstration of the patient's neurotic ways or maladaptive patterns of behavior; concentration on the anxiety-laden material, even before the defense mechanisms have been clarified; repeated demonstrations of parent-transference links by the use of properly timed interpretations based on material given by the patient; establishment of a corrective emotional experience; encouragement and support of the patient, who becomes anxious while struggling to understand the conflicts; new learning and problem-solving patterns; and repeated presentations and recapitulations of the patient's psychodynamics until the defense mechanisms used in dealing with oedipal conflicts are understood. **EVIDENCE OF CHANGE AND TERMINATION OF PSYCHOTHERAPY.** The final phase of therapy emphasizes the tangible demonstration of change in the patient's behavior outside therapy, evidence that adaptive patterns of behavior are being used, and initiation of talk about terminating the treatment. **OVERVIEW AND RESULTS** The shared techniques of all the brief psychotherapies described above outdistance their differences. They share the therapeutic alliance or dynamic interaction between therapist and patient, the use of transference, the active interpretation of a therapeutic focus or central issue, the repetitive links between parental and transference issues, and the early termination of therapy. The outcomes of these brief treatments have been investigated extensively. Contrary to prevailing ideas that the therapeutic factors in

psychotherapy are nonspecific, controlled studies and other assessment methods (e.g., interviews with unbiased evaluators, patients' self-evaluations) point to the importance of the specific techniques used. The capacity for genuine recovery in certain patients is far greater than was thought. A certain type of patient receiving brief psychotherapy can benefit greatly from a practical working through of his or her nuclear conflict in the transference. Such patients can be recognized in advance through a process of dynamic interaction, because they are responsive, motivated, and able to face disturbing feelings and because a circumscribed focus can be formulated for them. The more radical the technique in terms of transference, depth of interpretation, and the link to childhood, the more radical the therapeutic effects will be. For some disturbed patients, a carefully chosen partial focus can be therapeutically effective.

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