CHAPTER 5
THE COMPLEX SECRET OF BRIEF PSYCHOTHERAPY IN THE WORKS OF MALAN AND BALINT

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FROM INTUITIVE TO CONCEPTUAL MASTERY

"Why is it that the secret of brief psychotherapy keeps getting lost?" Malan (1963) asked at the start of *A Study of Brief Psychotherapy.* Freud (Breuer & Freud, 1895/1955; Freud, 1905/1953, 1909/1953), Ferenczi and Rank (1925), Alexander and French (1946), all had a period of dramatic short cases, only for this therapeutic secret to disappear as mysteriously as it had come. I suspect that this history is repeated in a minor way by most of us who practice psychotherapy. It is one thing to have some successful brief treatments, and quite another to have a systematic method of brief therapy that is consistently reliable. Because the practice has so many necessary elements in complex relation to one another, we are unlikely to hold them together for long. As we identify one critical element in our technique and take delight in learning more about it, such as interpreting the transference, we lose elements which we practiced intuitively, such as staying close enough to the patient to help him bear his pain. Thus, intuitive mastery is essential to early success, while integration of the relevant concepts of brief therapy is essential to retaining this mastery.

Balint provided the intuitive brilliance for this school of brief psychotherapy at the Tavistock Clinic in London, as Freud, Ferenczi and Rank, and Alexander and French did before him in other centers. The necessary elements are shown in his book *The Doctor, His Patient and the Illness* (Balint, 1957), where we shall begin. Malan then provided the passion and capability for scientific clarity by pinning down some of these necessary

elements. In a series of books, he has defined early, middle, and current acquisitions of "focal psychotherapy," as this body of work has come to be known.[1] At each stage, we will identify these conceptual gains, which have been essential to retaining the complex art of this method over the past 25 years of their clinical research.[2]

This school of brief psychotherapy is vital not only for its intuitive clinical capability and integration of concepts. It has continually posed the most fundamental questions about psychotherapy itself and has proposed bold hypotheses in reply. What repertoire of relationships offered by the doctor bring about the intense contact necessary to the start of brief therapy (Balint, 1957)? Is it inevitable that psychoanalysis has changed from being a brief psychotherapy to a long-term method; or can this be reversed (Malan, 1963)? Can psychotherapy be planned for each patient in advance, as a thought experiment (Malan, 1976a)? Is it possible to show the continuum from a simpler "psychotherapy of everyday life" to more complex psychotherapy (Malan, 1979)? Is interpretation a sufficient method for bringing about change (Balint, Ornstein, & Balint, 1972)? When a new theory makes predictions opposite to the current theory of psychotherapy practice, we have a scientific clash. These situations are of the greatest interest when the clash is over fundamental questions in psychotherapy, since evidence may be introduced to decide which theory makes the reliable predictions, and we may choose between the rival theories.

Yet every kind of scientific project, in its delimiting and defining aspects of reality, has to ignore some aspects and take others for granted. Something is aways lost; some fixed assumptions are made, which facilitate the research, even though they may later be shown to be rough approximations. At every stage of this project, Malan chose to hold onto the classical psychoanalytic theory of technique of Glover (1955), Strachey (1934), and Karl Menninger (1958), despite an immediate loss of many of the interpersonal and existential elements in the technique of Balint, and despite a continuing series of complex cases which Malan describes beautifully but which do not fit his classical model. Thus, the intuitive elements remain together in the case descriptions, although they are excluded from the theory of technique.[3]

I shall propose alternative models to account for these complex case descriptions. To anticipate this argument in one sentence, I may say that the actual technique that has been successful in their hands is more difficult than Malan's theory of technique contends. Often, is is a technique in

three steps that is described by a two-step theory. Furthermore, this technique, as it is practiced, cannot be reduced to verbal interpretations, as argued by Michael Balint and demonstrated by him in the only full-length description of brief psychotherapy we have from this school, the book *Focal Psychotherapy* (Balint *et al.*, 1972), which I will fully present. Finally, I shall close with a review of the remarkable contributions we have received from Balint and Malan, both intuitive and conceptual.

THE COUNTEROFFER: *THE DOCTOR, HIS PATIENT AND THE ILLNESS* (BALINT, 1957)

We are not surprised by Freud's startling offer to his patients, because we have heard it over and over: say whatever comes to mind. We have been assured already that he will not be the forbidding and didactic man that we fear. Hence, we can scarcely imagine what it must have meant to be invited to lie down in a room of classical wealth and wander as freely in one's associations as possible—a romantic contrast to Victorian parents, which is lost on us.[4] As Alexander and French (1946) would later argue, this difference between the transference expectations and the actual doctor brings on the intense contact that is essential to brief therapy. We can get a little feeling for this in our own terms when we consider how psychotherapy has come to mean seeing the accepting doctor and talking endlessly. What a contrast when James Mann (1973) tells his patient that 12 sessions will be all that he will need! This is the kind of surprise that Balint was interested in.

While Freud never organized his account of his activities in interpersonal terms, Balint decidedly did. Prior to the first focal therapy workshop, Balint experimented with brief therapy in the general practitioner (GP) workshops. All the elements necessary for brief therapy by the analysts of the focal therapy workshops were present in the earlier work with GPs, who were relatively untrained in psychological matters.

Balint and his colleagues offered a new kind of relationship to medical patients, as Freud had. Unlike Freud, the account in *The Doctor, His Patient and the Illness* (Balint, 1957) is directly interpersonal. Even the "illness" is conceived of as an interpersonal construct. It is the result of offers by the patient (e.g., symptoms, complaints) being met by counteroffers by the doctor. Together they "organize" an illness. Balint argued that the usual way for an illness to become organized is for the patient to offer bodily symptoms, whereupon the counteroffer of the doctor is to

work them up, to some extent, by clinical investigation. Gradually, perhaps even irrevocably, a state of bodily distress, often occasioned by painful life events, is organized into a physical illness.

Balint now proposed that the initial offers of patients, although in the form of physical sensations, could be met by deeper counteroffers by the doctor, often in the form of a "long talk." Balint's colleagues would later offer intense but brief contact through very spontaneous emotional reactions on the part of the doctor—the so-called "flash" method (Balint & Norell, 1973).[5] Either a long and deep talk or a sudden, deep connection would provide a dramatic contrast to patient and doctor slowly working up a physical illness together. If the patient met this new counteroffer with a deeper response of his or her own, they might together "organize" an illness which offered a better hope of treatment than would a chronic, physical illness.

Not only was the viewpoint more directly interpersonal than that of Freud—Balint spoke of two-body psychology being more relevant than one-body psychology—but the doctor was given much more flexibility, more room to be active. The doctor, especially if untrained, could be none other than himself, with his "apostolic" notions of how his patients should behave when ill. The aim would be not to stop this, but to make it less automatic and bring it to conscious awareness, so the dose of "the drug doctor" could be controlled. Freud's counteroffer had been to remove himself and allow the patient to organize a new illness within him- or herself, namely, an intrapsychic conflict, that had a better chance of being cured. This, of course, put great restriction on the doctor's movements. Balint's doctors might also make the specific counteroffer Freud made—to listen deeply—but they, from the start, might make many offers other than that of being the psychoanalytic doctor. The kind of offer often depended on the practitioner's own personal bent, which was given great latitude to emerge.

One counteroffer, then, might be psychoanalytic. The doctor might listen deeply and comment on the conflict, hovering evenly between the impulses and the prohibitions (see especially Case 19 in Balint, 1957).

Another counteroffer might be for the doctor to simply listen deeply while putting him- or herself "with" the patient as much as possible, "being" and "staying" with the patient through thick and thin. Havens (1976) argued that this is the essence of the existential therapeutic relationship. Balint emphasized this alternative a great deal as having specific

potential for the GP (see especially Case 16 in Balint, 1957), who could always be at hand. He referred to this never-ending partnership as the "mutual investment company," putting an existential idea in terms a doctor could appreciate.

Another counteroffer might be more in the tradition of interpersonal psychiatry (Havens, 1976), inasmuch as it would involve removing from the doctor the projections that interfered with care. This might require great skill, as the doctor would have to be taught to accept some projections (e.g., that giving tonics is a sign of a caring doctor) while gradually approximating to more emotional topics.

Finally, Balint did not shrink from explicitly behavioral conceptualizations or treatment relationships. If the patients of England had been "trained" to expect pills and physical diagnoses, they could be "untrained." The doctors would often simply reinforce the different kind of working relationship that they wanted, whether it was about when night calls would be made or when pills might be gotten. Balint was also shrewd enough to couch *his* offer to GPs in behavioral terms or, more exactly, in the objective-descriptive terms of medicine (Havens, 1976). His opening paragraphs considered that the most important drug in the pharmacopoeia—the "drug doctor"—has no pharmacology. Balint shows here the kind of bold offer of relationship that takes into account the specific relationship needed by the client.

It is amazing to consider that Balint intuitively offered at least the four kinds of relationships prominent in modern psychiatry and psychotherapy (Havens, 1973): the psychoanalytic, the existential, the interpersonal, and the objective-descriptive. He also knew how to offer the right kind of relationship to the right client. In the case of GPs, he knew well enough that they respected an objective-descriptive endeavor like pharmacology, so he offered them, first, an opportunity to take on the most critical drug of all, with careful attention to specifying the action, the dose, and the follow-up results. He knew they felt lowly and disrespected and bossed by specialists, so he offered them the chance to be themselves and make "independent discoveries." (See Balint, 1954, for the strategy of his seminar method.) One would have to look to the cases of Alexander and French (1946) for an equally deft assessment of the kind of relationship that would be different enough from the old, painful relationship to allow intense, new contact and to provide new endings to old experiences. ... for an appreciation of the full range of relationships available to

modern psychiatry. These are the necessary tools for a complete technique of brief psychotherapy, which Balint carried over from his enormously varied and deep clinical experience, especially the recent experience with the GP workshops.

Perhaps Balint decided that his psychoanalyst colleagues in the first focal therapy workshop had to be themselves, that is, to be strictly psychoanalytic in their offers to patients and in their thinking. In any case, with the first book on focal therapy itself (Malan, 1963), the interpersonal and existential elements brought out by Balint disappeared into the background, only reappearing 12 years later in the complicated case reports of later books on focal therapy. The reader of the first series of cases in *A Study of Brief Psychotherapy* (Malan, 1963) will be struck by how every case is met with a counteroffer of Oedipal interpretations, sometimes augmented by Kleinian interpretations (of the bad feelings spoiling the good breast). Certainly, these doctors were offering deep relationships.

Indeed, Malan argued that they "discovered" that deep transference interpretations were often the only way to keep open a contact that was bogged down immediately by transference. It is difficult to say, from the outside, how much of the narrowing down of the therapeutic offers and thinking to the psychoanalytic and the objective-descriptive comes from the other therapists in the workshop and how much from Malan who took over the clinical research leadership. I suspect, from Balint's ironic conclusion to his chapter on the "history of the focal therapy workshop" (Balint *et al.*, 1972), that it is Malan as well as many of the others. Regarding the second workshop (1956–1961), Balint wrote:

> Although the reasons for its termination were many and complicated, one that is perhaps worth mentioning was that most of its members, being fairly new qualified analysts, were perhaps too absorbed with traditional analytic thinking to be able to proceed with the tasks that lay ahead. It was very difficult indeed to realize that the new techniques and way of thinking did not endanger psychoanalytic theory and practice: that they were supplementary and not antagonistic to each other. (Balint *et al.*, 1972, p. 13)

Although this is said in criticism of Malan, that he narrows down considerably from Balint's wide range of therapeutic relationships, it must be equally stressed that he increased the power and precision of the psychoanalytic and objective-descriptive frames of reference for brief therapy. Indeed, in his later books, he makes it entirely clear that he finds himself in a historic battle to vindicate Freud's discoveries, which have been denied their proper recognition by historical forces. He brings a passion for both a radical, "penetrating" psychoanalysis and a scientific rigor and objec-

tivity that corrects many of Freud's failings (e.g., not sorting observations carefully from theories). He even writes with some of the style of Freud, with a novelist's power of description and storytelling combined with both elegant and trenchant thinking. He does not simply draw from a single case at a time, but from an entire ensemble of cases with memorable names. The Neurasthenic's Husband, the Pesticide Chemist, the Gibson Girl, the Indian Scientist, the Stationery Manufacturer, and the Falling Social Worker return again and again in different combinations.

He also draws upon the whole maternal side of English analysis that has been so fertile in clinical and conceptual achievements—from Anna Freud on the defenses, from Melanie Klein in the conception of depressive and paranoid positions, from Winnicott on "good enough" mothering and the need for ruthlessness. Malan's capacity to integrate opposites is very impressive. Qualities which, for others, are merely dichotomies become, for him, possible in the same man and the same breath, very much like Freud again: boldness and cautionary tales, ruthlessness and sympathy, high drama and science, Holmesian shrewdness and wonder.

While all of this, I think, is his due, I must conclude that the change from Balint's leadership to that of Malan results both in narrowing and in very high powered development in the focused areas. The model of technique becomes heavily and classically interpretive. The model of selection is a very powerful combination of psychoanalytic and objective-descriptive psychiatry. The Balint emphasis on interpersonal flexibility and existential staying-with-the-patient recedes into the background. This is especially true of Balint's understanding of nonverbal and preverbal archaic relationships, "basic faults" that cannot be healed by words but must be handled by ways of relating. Interpretation becomes the central device. We shall see, however, that these Balint elements do remain in the cases, although they are less prominent in Malan's models to account for the cases.

Perhaps this is inevitable with complex secrets like brief therapy. A man has only so much attention, so that concentration of interest on one side cannot but lead to neglect of other matters. Perhaps we should simply be grateful to Malan for the increase in power that he has given in his selective interest. Having sketched the main line of our story of 25 years of brief therapy at the Tavistock Clinic, we now turn specifically to the early, middle, and recent stages of this remarkable development, in order to see what has been the context at each stage, what has been attempted, and what has been grasped scientifically so that the complex secret might be retained.

BREAKING THE TRADITIONAL BONDS OF PSYCHOANALYSIS: *A STUDY OF BRIEF PSYCHOTHERAPY* (MALAN, 1963)

CONTEXT

Why had psychoanalysis become a longer and longer method of treatment, so that few could have its benefits? How had it continued to stay disconnected from science, so that its discoveries remained unaccepted? In most quarters, this context has been not altered from 17 years ago, since few understand how Malan and his colleagues boldly set themselves against the two major problems of psychoanalysis and, I think, solved them both. I can only recommend to the reader who finds himself blocked by these questions to turn at once to Chapters 2 and 3 of *A Study of Brief Psychotherapy*, only the bare outline of which I can provide here.

WHAT WAS ATTEMPTED

What have been the "lengthening factors," Malan asks, which changed psychoanalysis from a brief therapy to a long-term therapy? Psychoanalysis seemed to "discover" more and more inevitable, lengthening factors in the patient: "1. Resistance, 2. Overdetermination, 3. Necessity for working through, 4. Roots of neurosis in early childhood, 5. Transference, 6. Dependence, 7. Negative transference, connected with termination; 8. The transference neurosis." Some lengthening factors could directly be located in the change in analysts, however: "9. A tendency towards passivity and the willingness to follow where the patient leads, 10. The 'sense of timelessness' conveyed to the patient, 11. Therapeutic perfectionism, 12. The increasing preoccupation with ever deeper and earlier experiences" (Malan, 1963, pp. 8–9). If these were the lengthening factors, were they inevitable? Or could the focal therapy workshop deliberately set itself against *all* these lengthening factors, either by interpretation or setting limits? This was the therapeutic project.

What were the antiscientific factors separating psychoanalysis from the main body of scientific inquiry? "1. The failure to publish sufficient details of individual cases, with the result that an independent observer is rarely able to draw his own conclusions; 2. The tendency to select only the most successful cases for publication, so that no lessons are learnt from failure; 3. The utter neglect of the vital necessity for developing psychodynamic methods, based on published evidence, for assessing therapeutic results; 4. The partial neglect of the equal necessity for long follow-up" (Malan, 1963, pp. 35–36). The scientific project was to correct all these failures at once, with detailed case reports, psychodynamic outcome criteria with published evidence (including the failures as well as the successes), and strict and long follow-up.

This was a pilot study of 21 patients, with 7 therapists who were supervised by their colleagues in the workshop (including Balint), all of whom either were analysts or had had several years of training in psychoanalytic psychotherapy. Between January 1955 and Easter 1956, patients were seen from 4 to 40 times; all but 3 received less than 20 sessions. Follow-up for assessment of psychodynamic change continued for 3 months to 5 years beyond treatment. The criteria for success were defined as follows: 0 meaning no change, 1 meaning only symptomatic change but no new methods for handling the stressful conflict, 2 meaning symptomatic change *and* evidence of facing comparable stress without new symptoms and with new coping strategies, 3 meaning ability to handle these stressful conflicts in both major spheres of life (both at work and at home), with both men and women. The interest was in whether or not brief psychotherapy could produce clinical results that would compare favorably with long-term psychoanalysis, that is, scores of 2 or better, indicating stable psychodynamic change, rather than a change that was symptomatic or temporary or obtained by withdrawing or avoiding the central conflicts. The critical test (scores below 2 or above 2) bears repeating, because it is central to the claim that brief therapy can compare favorably with long-term analysis. The idea is that a central conflict in a patient can be considered improved only when the patient shows evidence of tolerating the full force of the conflict, with appropriate coping strategies and without symptoms. For example, if the patient has a central conflict about rivalry with other men, which causes anxiety, lengthy obsessive preparations, and withdrawal from competition, he can be considered "psychodynamically improved" only when he faces new situations of rivalry with men without these symptoms and with full capacity to do his best. This concept is essential to the scientific status of psychoanalysis, for it makes possible objective measurement of what psychoanalysis seeks to change at the heart of the neurosis.

The intended clinical experiment was based on the conservative anticipations of the therapists in the workshop. They believed that only mild cases of recent onset would do well, and that the interference should be avoided, deflected, or ignored because of fear of the

sis," that is, that the clock should be turned back to the primitive psychoanalytic technique, before transference was made central to the technique.

The actual clinical experiment, as Malan noted, brought together two populations which would do what was most natural to them: the analysts, who would use their interest and skill in transference interpretation, and the Tavistock patients, who would demonstrate their long-standing and severe character disorder problems. As Malan suggested, it was an experiment in nature, an "ecological" event.

OUTCOME

From the methodologic point of view, the clarity about dynamic criteria for change is superb, but the histories of "all known disturbances in the patient's life" are very weak (e.g., strictly oriented to Oedipal phenomena, the ignoring of separation–individuation events), as are the accounts of the therapies (e.g., listing therapist interpretations but very little about the responses of the patients).

Despite Malan's heralding, the clinical results read as a succession of failures, with an occasional dramatic success. Only 6 of the 21 patients scored either 2 or 3 on outcome, 3 scored 1, and 10 scored 0 (2 were unscored). On the three- to four-year follow-up, however, 3 of the 6 star cases had scores which improved from 3 to 4.* Certainly, this powerful and stable psychodynamic change in brief therapy is not consistent with the conservative psychoanalytic position.

THE EARLY MODEL OF SELECTION

The conservative Hypothesis A in the literature had suggested that only mild neurotic problems of recent onset would be suitable for brief therapy. Hypothesis A was refuted, to the surprise of the workshop members themselves. In fact, mild problems of recent onset were not among the successes at all. Instead, all but one of the cases in which dynamic change (score of 2 or better) occurred were chronic character disorders with disabling anxieties, phobias, hysterical symptoms, and deficient interpersonal capacities of at least several years duration. The only exception was the Lighterman, with severe panic attacks two to three months prior to treatment. The most severe disturbances, of paranoid and psychopathic characters, indeed failed as predicted. Hypothesis B was confirmed: "The prognosis

is best in those patients who show evidence from the beginning of a willingness and an ability to *work in interpretive therapy*" (Malan, 1963, p. 178).

THE EARLY MODEL OF TECHNIQUE

The conservative hypothesis of technique was that the transference had to be avoided. Malan argues that this Series 1 showed that *(a)* radical interpretation of the transference did not bring on the feared effects, *(b)* it often was "inevitable" to resolve an early deadlock of communication, and *(c)* the more radical the technique, the better the results. Radical or complete transference interpretation included the parent-transference link, early genetic material, negative transference, and termination experiences. With the thinly reported cases, it is very difficult for this reader to judge whether propositions *(a)*, *(b)*, and *(c)* hold up as consistently as claimed by Malan. I will return to these claims again, where the evidence is more complete in the replication of Series 2. In any case, the early model of technique offered nearly complete freedom from the constricting belief that interpreting the transference should be avoided. It was *either* not harmful, inevitable for continuing, or essential to success, depending on how one judges the evidence.

THE FIRST OVERALL CONCEPTION OF BRIEF THERAPY

Malan (1963) summarizes as follows:

> Prognosis seems to be most favorable when the following conditions apply: The patient has a high motivation; the therapist has a high enthusiasm; transference arises early and becomes a major feature of therapy; and grief and anger at termination are important issues. (p. 274)

The most important result of this pilot study was that the two major obstacles to brief therapy from classical analysis had been effectively challenged—the inevitability of the lengthening factors, and the inevitability of subjective judgments. Even if the star cases were a small minority, Malan and his colleagues had demonstrated that powerful and stable psychodynamic change could be brought about in brief therapy, and that the subjective events of psychoanalysis could be handled objectively. The deadening assumptions had been broken, and the second study could be planned.

THE POTENTIAL FOR PLANNING BRIEF PSYCHOTHERAPY IN ADVANCE OF TREATMENT: *THE FRONTIER OF BRIEF PSYCHOTHERAPY* (MALAN, 1976a), *TOWARD THE VALIDATION OF DYNAMIC PSYCHOTHERAPY* (MALAN, 1976b)

CONTEXT

Despite the radical evidence from *A Study of Brief Psychotherapy* (Malan, 1963) and from Sifneos (1972) and Mann (1973), the same spectrum of opinion about brief therapy continued as before, and psychoanalysis and science continued their separate ways. Apparently, the argument for the clinical paradigm of focal psychotherapy and the scientific argument for the validity of the evidence would have to be strengthened. Malan elected to write *The Frontier of Brief Psychotherapy* (1976a) for clinicians, and *Toward the Validation of Dynamic Psychotherapy* (1976b) for psychotherapy researchers, dividing what had been the double labor of *A Study of Brief Psychotherapy* (1963), in recognition of the reality that these audiences remained quite separate.

WHAT WAS ATTEMPTED

Series 1 had been a pilot study. Series 2 would be a replication, with the clinical acumen gained from the first series and stricter scientific standards. The second focal therapy workshop (1956–1961), consisting of 10 therapists, treated 39 patients and followed up 30 of them successfully, with a median follow-up of five to six years after treatment. Of the 30 cases, 22 were actually brief therapy cases of less than 30 sessions; the other 8 went on to long-term therapy.

The selection criteria were much stricter than in Series 1. At the referral stage, before the patient was seen, those with grave pathology were excluded, following Hildebrand's exclusion criteria: serious suicidal attempts, drug addiction, convinced homosexuality, long-term hospitalization, more than one course of electroconvulsive therapy (ECT), chronic alcoholism, incapacitating chronic obsessional symptoms, incapacitating chronic phobic symptoms, gross destructive or self-destructive acting out. At the second stage, that of interview and psychological testing, a prima facie case for brief therapy would be necessary. The patient had responded to interpretation, a focus was conceivable, and the dangers were not inevitable; that is, the patient was not likely to break down into serious depression or psychosis along the way or be unable to terminate. (See Malan, 1976a, p. 69, Table 3, for an excellent summary.)'

OUTCOME

The median outcome score rose dramatically, from 1 in the first series to 2.11 in the second. The reader will recall that the 2 score represents symptomatic relief plus evidence of having managed the stressful conflict in appropriate new ways. Taking a score of 2 or higher as a favorable outcome, and less than 2 as unfavorable, the 30 patients divided into several distinct groups. There were 9 short favorable cases (9 SF), of which 7 had moderately severe neurotic problems and 2 were drastic cases, to which we shall return. There were 6 long favorable cases (6 LF), making a total of 15 out of 30 clear successes, in which psychotherapy brought about significant dynamic change. There were 9 short unfavorable cases (9 SU), 4 false-positive cases (4 F) which were short in duration and brought about by spontaneous remission long after a negative result from therapy, and 2 long unfavorable cases (2 LU).'

In regard to predicting outcome from content analysis of the technique (therapist notes), the higher percentage of parent-transference links made by the therapist gave the only successful correlation with higher outcome. In addition, the patients who ranked highest in receiving parent-transference interpretations had the best outcome. Malan argues that this is the first validation of a psychoanalytic principle with empirical evidence.

THE EMERGENT MODEL OF SELECTION

The trouble with the emphasis on motivation as the central indicator for selection (Malan, 1963) is that motivation varies a great deal, depending on what difficulties have to be faced. What we want to know is whether motivation will remain high as patient and therapist go through each stage of brief therapy and as they link separate areas of the patient's experience. How can one anticipate the effect of these difficulties?

The reply is that the therapist can conduct the therapy in advance as a thought experiment. This is possible because Malan has clearly defined the typical dynamic events of brief therapy and the kinds of experiences in the patient's life which will help or hinder these events in brief therapy.

What, then, is the logic of the interaction in brief therapy? It is very

straightforward. The patient must be capable of beginning effective therapeutic work within the first four sessions. This will not happen if the therapist cannot make emotional contact with the patient, or if he must work for a long while either to generate motivation or to penetrate the defenses. The patient must be capable of terminating therapeutic work after the focal issue has been worked through. This will not happen if the issues are too complex, or if the dependency aroused cannot be given up. Finally, the patient must be capable of carrying on his life without breakdown as the focal conflict is being faced. This will not happen if the depressive or psychotic potential is considerable, and if there is little or no support in the patient's outside life. (See Malan, 1976a, p. 69, Table 3.)

In effect, brief therapy has a beginning, a middle, and an end, for which the patient must be capable. Malan defines six different arenas where we may test this hypothesis in advance of therapy:

1. the psychiatric history
2. the psychodynamic history
3. the history of interpersonal relations
4. the present outside relationships
5. the relationship made with the interviewing therapist, especially in response to trial interpretations
6. the projective tests

The material in all six sectors should integrate into a recurrent, unsolved conflict (what Mann, 1973, would describe in existential terms as "the present and chronically recurring pain"). If the same focal conflict keeps reappearing in all six sectors of the inquiry, there is likelihood that these areas may be linked by the therapist in the course of the brief therapy itself. It is foolhardy, Malan suggests, to miss any one of these sectors of inquiry by imagining one has a plausible case from one or two. This was learned by some very painful errors, which comprise the "Cautionary Tales" in the closing of *The Frontier of Brief Psychotherapy* (Malan, 1976a).

In the ideal assessment, the therapist predicts in advance, from his survey of the six sectors described, the current conflict, the nuclear conflict and its relation to the current one; the patient responds to initial interpretation of this conflict, with a rise in motivation; this conflict is about to emerge in the transference; and the termination version of the conflict can be imagined clearly. For example, the patient is conflicted about becoming a painter against her parent's wishes. She has always felt that her

parents were easily injured by her independence, and she experiences a surge of determination when the therapist tells her that it is not easy to feel your strength is so overpowering. It is evident that the patient will become concerned about hurting the therapist's feelings with her intensity (the transference), especially in the termination, when she is likely to direct the ending on her own terms. (See Malan, 1976a, pp. 92–100, for a case such as this, i.e., the Almoner.)

The stages in the selection can be clearly demarcated:

1. The therapist eliminates the absolute contraindications (Hildebrand's exclusion criteria) at the point of referral.
2. The therapist declines brief therapy in the first interview, if the dangers of beginning, surviving, and ending the therapy are inevitable for the patient.
3. The therapist attempts to define the focus from the interview and the projective test, which will integrate the dynamic eventsin all six areas of the inquiry.
4. The therapist offers the focus to the patient.
5. If the patient responds to this offer with deeper material and increased motivation, the therapist will set up an agreement to see the patient for brief therapy, ending on a definite date—after 20 sessions if the therapist is experienced, or 30 if the therapist is a trainee or the therapy has some other special complication. For example, a long-standing, outside, dyadic relationship in difficulty may take longer. The patient is told that if and when he needs to talk further, he may return after the termination on an ad hoc basis.

THE EMERGENT MODEL OF TECHNIQUE

Havens (1973) wrote of Freud:

> He possessed to the highest degree what Napoleon called the supreme desiderata of generalship: complete patience and utter decisiveness. We can consider whether he had the same emotional flexibility but we need to understand at the start this striking power: both to act and not to act. (p. 94)

Malan's general scheme of technique for brief therapy appeals to the military general in us all. The plan for battle is to stick completely to interpretation, the one and only necessary weapon. The "strategic aim" is that of psychoanalysis itself: to bring into consciousness the emotional conflicts. The only difference from classical psychoanalysis is that the brief therapist

usually limits him- or herself to analysis of a single conflict. This "focal conflict" is often the very same "nuclear conflict" which would be at the center of a lengthy analysis. In exceptional cases, the "focal conflict" chosen would be more superficial than the nuclear problem. In any case, the "strategic aim" is the same as that of psychoanalysis itself, except that it takes a single conflict as its object rather than a series of different conflicts that are handled in a full-scale analysis. The "tactical aims" are taken in two steps:

1. Analysis of the defense and anxiety allows analysis of the repressed impulse in one sector of the patient's life, ordinarily his present outside (O) situation being taken first.
2. This battle having been won, it is linked to the other two major sectors, the transference (T) and the genetic past situation with the parents (P)—in Malan's favorite schematic terms, the O/T and O/P links and, most essentially, the T/P link.

The theory of therapy, always assumed but rarely discussed by Malan, is that unconscious conflicts from childhood govern adult life, unless they are made conscious (Glover, 1955). Interpretation mobilizes this material into contact with the adult ego, which assimilates what has been repressed and arranges more appropriate solutions.[9]

THE EMERGENT UNIFIED CONCEPTION OF BRIEF THERAPY

I hope it is apparent to the reader by now that Malan plans the attack in brief therapy with a schematic clarity and thoroughness of preparation that is not likely to be surpassed. The optimal result is what he calls "dynamic interaction," which may be thought of and even measured as a summation of motivation, focus, and the percentage of parent-transference interpretations. A graph (Malan, 1976b, p. 265) of motivation + T/P% plotted against outcome shows that all but a few cases, which are "exceptional" on clinical grounds, fall along the slope showing that outcome is proportional to the degree of "dynamic interaction" measured in this way.[10] The scheme for focal therapy has become highly organized.

UNEXPLAINED COMPLEXITY

I do not believe, however, that it actually works this way. There are three different sets of clinical observations provided by Malan himself. Correctas

he has been to give the independent observer a chance to come to his own conclusions on the strength of the published evidence, these observations are not explained by his model of technique.

1. The model does not explain the difference in outcome between the short favorable (SF) and the short unfavorable (SU) cases.
2. The very cases that are described at length show much more complicated mechanisms of improvement than the theory can allow for.
3. The model does not explain anything about the other mechanisms of improvement (besides interpretation) that Malan (1976b) admits in the conclusion of *Toward the Validation of Dynamic Psychotherapy* are significant.

Let us take these three sets of clinical observations one at a time. A minimum requirement for a theory of brief therapy is that it explain the difference between successful and failed cases. Now, if we compare the seven short favorable neurotic cases with the seven unfavorable neurotic cases," what kind of explanation for the difference can Malan's theory provide us?

On the basis of initial motivation, three of the seven SF cases are negative, while only two of the seven SU cases are negative. Motivation itself is no explanation. The reply must be that the therapist's selection of the correct focus and his vigorous interpretation of the parent-transference connections explain the favorable outcome as opposed to the unfavorable.

But if we inspect the case reports of the unfavorable cases, we find no lack of vigorous interpretation. Rather, we find that the four "false" cases were put in touch with powerful affective experiences that they could not control, leading to flights from therapy. The three other SU cases are obviously patients with very uncertain identities, which will remind readers of Kohut's (1971) "disorders of the self." It is not surprising to such readers that these patients would be put in touch with powerful Oedipal feelings without being able to manage them. All seven of these patients were engaged in "dynamic interaction" but could not contain it. It is no wonder they broke off from "dynamic interaction" and consequently scored low on focus and T/P%. Of course, Malan surely might give counterexplanations for these failures to the ones I have offered. The point is not that I am correct in my interpretation, when indeed I am much farther from the realities of these cases than he was. Rather, I argue that "dynamic interaction" is no explanation at all for the difference between successful and failed neurotic brief cases. As Malan himself admits

(1963, p. 36), an adequate model of brief therapy must face the failures and explain them.

The second set of unexplained clinical observations are the cases of successful brief therapy cited at length in *The Frontier of Brief Psychotherapy* (Malan, 1976a). They are admirable pieces of clinical work, vividly described. It is even possible for Malan to link together all the associations of the patient with his minimum set of concepts: defense, anxiety, and impulse, and current outside, transference, and parental problems. But the decisive interventions of the therapist are not explained within this scheme.

Consider the frustrated young man, the Zoologist. The current problem is that he has given up his love for biology, in deference to his father's ideas about a career, but then has angrily spoiled his success in college. He is very intense about his love and his anger but has to defend against both. Already Malan is obliged to construct (correctly, I think) two triangles of defense, anxiety, and impulse, for the love and for the anger. But the therapist's first decision is what to take up with the patient, given these two possibilities. The frustration is so prominent that he is tempted to go after the anger, interpreting the defense, anxiety, and impulse, but the patient does not respond. Then he simply tells the patient there is a "choked" quality in his voice when he speaks of what matters to him, that "he seemed to have a lot of intense feelings that couldn't come out." The patient suddenly opens up, telling of how a young girl had once put her hand in his and said, "I like you," one of the proudest moments of his life.

The Zoologist tempts the therapist to see only his frustration and hate. When the therapist, like the little girl, appreciates his loving side, he opens up. Several interviews later, the therapist must pass the same test, this time over why the patient feels like "wandering off" from therapy. The therapist is tempted to emphasize the anger, true as it may be, but instead tells the patient that the latter wishes the therapist would "actively show him that I loved him." In summary, the patient has to have his love appreciated before he is willing to engage about his hatred. I could argue that this is a *necessary sequence* for this patient. When the therapist shows that he appreciates the loving side of the patient, the patient is reassured he can show his hatefulness without losing love. If the therapist persisted in pushing for the anger, however sophisticated he might be about taking the defense and anxiety ahead of the impulse and choosing the current outside sector or past relationship ahead of the transference, little could be expected.

In fact, this therapist intuitively follows the first plan, understanding

the patient's initial need for love, then vigorously facing his hatefulness, alternating back to the need for love when reassurance was needed. He handles being tempted to the wrong issue by not being tempted—the critical *test*—and he keeps to the right order or *sequence* of issues. The two critical decisions described cannot, however, be directed by the theory of concepts Malan has available. The best he can do is acknowledge that there are *two* defense–anxiety–impulse triangles, and that the therapist shows great intuitive "skill."

All the other cases described at length in *The Frontier of Brief Psychotherapy* (Malan, 1976a) have a similar set of tests, in which the therapist must do more than "interpret" the defense–anxiety–impulse relations and the connections between current outside, past, and transference problems. In all of them, he is tempted to be like the transference expectations and, as Alexander and French (1946) have argued, must show that he is different. By tempting the therapist to repeat the traumatic activities of the parents, the patient tests him to be sure he is different, to be sure it is safe to bring out the deeper feelings (Sampson, 1976; Weiss, 1978; Weiss, Sampson, Caston, Silberschatz, & Gassner, 1977). The Magistrate's Daughter has literally been seduced by her brother and continually flirted with by her father. She arranges an increasingly steep set of tests for this therapist, to be doubly sure he will not repeat the trauma. She gives him a fascinating set of sexual details, tempting him to go deeply and fast. She becomes indecisive and confused about where she wants to go, inviting him to take over. She tempts him to keep her in therapy "even though she might run out of things to say." Miss Persistence is another remarkable case, in which the therapist puts a stop to all the "great expectations" held out to this patient through years in the clinic and years with her parents and boyfriend. This patient is now able to be angry, knowing her therapist is strong enough to resist and calm her.

In the case of the Falling Social Worker, Malan admits a complex set of themes, that the "use of complex foci requires a great deal of further exploration." But what he calls the exception to his classical model of technique is shown by his own full examples to be the rule. By my reanalysis of all nine short favorable (SF) cases in Series 2, all but the Indian Scientist show this same evidence of either a complex *sequence* of issues or a series of difficult *tests* in which the therapist must show him- or herself to be different from the transference expectations, or usually both.[12] The intuitive mastery of this method shows through, despite the conceptual model of pure interpretation.

The third set of unexplained clinical observations

the research book that most clinicians will not read, *Toward the Validation of Dynamic Psychotherapy* (Malan, 1976b). There they are least apt to contradict the classical paradigm of technique which Malan wants to emphasize. There he acknowledges that maturing, finding a satisfactory marital partner, taking responsibility for one's life, and gaining insight from situations which involve little dependence or transference interpretation can bring about lasting dynamic change. This is evident from the follow-up study conducted by Malan on patients seen for one interview at the Tavistock (Malan, Heath, Bacal, & Balfour, 1975) and from the "spontaneous remissions" of the false cases in Series 2 of the focal therapy workshop. What does Malan do with these contradictions to his clinical paradigm? He admits that both "nonspecific" mechanisms and "specific" interpretive mechanisms can bring about dynamic change, as if interpretation were the only way to give the patient assistance that is specific to his psychodynamics! Alexander and French (1946), Balint *et al.* (1972), and Kohut (1971) surely would not agree. The therapist can be quite specific about what kind of interaction a particular patient needs to solve his or her problems or what specific emotional experience must be shared by another. The interpersonal and existential methods can be quite as specific as the interpretations of psychoanalysis without telling the patient about it.

In summary, *The Frontier of Brief Psychotherapy* (Malan, 1976a) and *Toward the Validation of Dynamic Psychotherapy* (Malan 1976b) demonstrate a powerful new capacity for organizing brief therapy, both in the logic of selection (conducting the therapy as a thought experiment) and in tight battle plans for the therapy itself. The unifying conception of "dynamic interaction" also allows the outcomes to be roughly encompassed.

THE CURRENT METHODS OF SELECTION AND TECHNIQUE: *INDIVIDUAL PSYCHOTHERAPY AND THE SCIENCE OF PSYCHODYNAMICS* (MALAN, 1979)

CONTEXT

Malan's double project remains the same: to bring psychoanalysis to its rightful honors, and to bring out its abstract core of scientific truth. Now he brings these aims back together in a new form, a textbook on psychotherapy. Traditional psychoanalysis is held to be an immutable set of

truths, but its order is reversed. No longer is long-term therapy the central paradigm of psychoanalysis, with brief therapy a special variation. Now brief psychotherapy is the central paradigm, because it shows the basic principles of psychodynamic knowledge clearly and succinctly, and long-term analysis is a special variation for patients with more complex issues and deeper deprivation. At once, Malan upholds the principles of orthodox psychoanalysis, while reversing the relative priority of long-term and short-term treatment! It is a very quiet and clever revolution. The scientific failures of psychoanalysis are attacked more directly and simply. Psychoanalysis has kept apart from science and biology, maintained an esoteric language, and turned to ideology.

THE ATTEMPT

The generative idea of this book is to separate the reliable clinical observations of psychoanalysis from its ideology. Malan starts with the most elementary and familiar and proceeds in language as plain as possible toward the strange and more difficult problems, keeping a continual eye on man's biological past and future. As he moves toward the more strange and difficult problems in patients, Malan emphasizes the uncontrolled problem of aggression in man himself. He ends with five powerful chapters on assessment for psychotherapy, which emphasize that we must be sympathetic but ruthlessly honest about what we can do about all this. This is not a textbook in any conventional way, but rather an extended position-paper on where we stand with our psychodynamic knowledge.

THE CURRENT MODEL OF SELECTION

The planning methods of *The Frontier of Brief Psychotherapy* (Malan, 1976a) remain as stated there, but Malan is able to render them even more concisely by facing two strategic problems:

1. How can one have the benefits of deep contact with the patient—to see the patient's ability to work with interpretation, his motivation, and the suitability of the therapist's focus—without the risks of arousing hopes, disturbance, and attachment that may be dashed?
2. How does one balance psychodynamic contact with traditional

psychiatric inquiry? the essential subjective events with the history of objective events?

The "fundamental law of psychotherapeutic forecasting" says that the extremes of psychopathology discovered by psychiatric history are likely to return in an intense period of psychotherapy but are apt to tell little of how the patient may take advantage of psychotherapy. In plain English, the essence of the two questions may be stated as follows: How does one care for the patient and ruthlessly face facts? By dealing with these potential contradictions, Malan reaches a new integration of psychoanalysis and objective-descriptive psychiatry.

At the risk of becoming overly schematic myself, I will outline the logic of Malan's proposal (1979, Chapter 17) for the steps in selection:

1. If there are known disturbing facts, or if the patient hints at severe deprivation or psychotic experiences, the interviewer proceeds directly to the psychiatric inquiry before making much contact. For example, a social worker sought a "training brief therapy" in order to "come to life in my work." Rather than follow this emotional lead, the interview shifted directly to asking about when she had ever "come to life" and discovered her coming to life in the last therapy had been way out of control, with her smearing carbolic acid on her face. Better to find this out, certainly, before setting contact in motion again (1979, p. 213)!
2. If psychotherapy openings are not available, one also restrains contact for the same reason.
3. One may risk interpretive comments to make some contact, but no more than necessary.
4. If the disturbance seems containable, therapy is available, and contact has been made, the interviewer should proceed vigorously with trial interpretations.
5. The interviewer should gently halt when he or she has sufficient information.
6. The interviewer must be prepared to take responsibility for situations created by the interview.

In summary, Malan solves the two strategic problems of selection interviews: (1) the interviewer controls for the dangers of contact prior to making it; and (2) the interviewer uses psychiatric history to face the worst, and psychodynamic contact and history to find out what the patient can do to change.

THE MODEL OF TECHNIQUE IN BRIEF THERAPY, FROM ELEMENTARY TO COMPLEX

The technique of psychotherapy will no longer be vague when we can describe what the psychotherapist actually does. Malan's reply is that he lends to the patient definite capabilities that the patient lacks. In "the psychotherapy of everyday life," other people provide what the patient lacks, but if these talents are not available, the psychotherapist can supply them.

In Chapters 1 and 2, he tells us simply that the complexities of psychopathology arise from "unexpressed painful feeling." The Economics Student, enjoying herself with a young man in Spain, becomes jealous when her girlfriend joins them and takes over the interest, but she cannot express this painful jealousy because of shame and fear of losing control of her anger. She hints to them of her distress, and they read between the lines to her pain. Were her friends unable to read this, she might turn to a psychotherapist to appreciate the source of her pain. This is the simplest version of what we therapists do. We take a history, reading back to where the pain began. We face the unbearable feelings that the person cannot tolerate alone, so that he or she can find a more direct way of relieving them. In Chapter 3, Malan adds the ability to translate unconscious communications, and in Chapter 4, the ability to face conflict fearlessly and even-handedly, both of which patients may not be able to do for themselves. In Chapter 5, Malan reminds us that taking an accurate history may be all that is necessary. The patient may have the remaining talents to face the situation and take a new course, making one interview psychotherapy quite common! (See Malan, 1979, Chapter 4, the Geologist.)

Now he takes the reader beyond "the psychotherapy of everyday life" to consider, in Chapters 7, 8, and 9, the "sexual problems in women," the "problems of masculinity in men," and "transference." Here it is also possible to be economical with theory, paring down psychoanalytic theory on Oedipal issues to its recurrent clinical observation that adult conflicts become intelligible when linked to the sexual dilemmas of children. He demonstrates the variations on the theme when this light is cast.

Finally, in Chapter 10, Malan explains the overall strategy in which the described actions of the therapist are employed: "The aim of every moment of every session is to put the patient in touch with as much of his true feelings as he can bear" (1979, p. 74). The therapist can decide if he or she is proceeding in this true direction by judging whether rapport is increasing or decreasing, this being the "universal indicator."

In Chapter 11, Malan demonstrates that the most successful area for applying this strategy is in the problems of assertion. He believes these are workable in two basic steps: (1) identify the defense against aggression and the anxiety about losing control, which will allow the patient to experience his true angry feelings in one sector (transference, outside, or past), and (2) link this experience to the other areas, where the patient will repeat his advance.

BEYOND THE BASIC MODEL OF TECHNIQUE: THE CORRECTIVE EMOTIONAL EXPERIENCE AND TERMINATION

I was startled to discover a break from this orthodoxy hidden away in Malan's Chapter 13 on "regression and long-term therapy." Here, in three pages (140–142), is a clear exposition of what Alexander and French (1946) had argued, and how it had been misconstrued on the way to throwing it out. The "corrective emotional experience" is not the attempt to provide the nurturance missed from the depriving parents. Indeed, one cannot make up this failure. But one can help the patient to experience the longings, giving up those that are impossible and seeking what satisfactions life can offer. The good therapist fails to nurture the patient as much as the latter would like to be nurtured. The therapist is "corrective" in that, unlike the parents, he or she is willing to face this failure and help the patient bear it. This is the "new ending" that Alexander and French said was possible.

But how should the therapist *behave* in order to bring about the "new ending," if, indeed, he or she is not going to make up the failure? Malan here stops short of explaining Alexander and French. Perhaps that would be going too far from the classical model. But he shows a perfect working understanding of their principles in Chapter 16 (regarding termination) without ever making them explicit.

What "the new ending" means, specifically, is that every termination is somewhat different. This is by far the most flexible model of termination current in brief therapy. In the Geologist, the therapist accepts the gratitude of the patient without trying to hold him beyond the single interview. Yet, in the Factory Inspector and the Neurasthenic's Husband, the therapist opposes the flight of the patient. In the Factory Inspector, he compromises, suggesting the patient try out his new-found potency for three weeks and then come back to discuss it. Why the differences? How would one know which way to go, when one would certainly be tempted to either let go or confront in nearly every case? The governing principle, which Malan illustrates beautifully but never states, is that the therapist *behaves differently* from the patient's parents, specifically avoiding the kind of trauma they would inflict about ending. Hence, a "new ending" becomes possible. That is, the Geologist was trying to free himself from a possessive mother, which required the therapist not hold on to the patient at the end,[13] whereas the Neurasthenic's Husband had a weak father, who could not handle the strength of his child, which required his therapist to be boldly confronting, so that the patient would know the therapist was ready and capable of tolerating his anger at the end. In the case of the Factory Inspector, it is even more subtle, since the therapist ends up showing that he is glad for the patient's new-found potency, yet does not need him to leave. Confronting him could have been an attack on his new, marvelous claim, while letting him go could have signaled unwillingness to get closer. The final two termination cases, the Swiss Receptionist and the Man with the School Phobia, are powerful and extremely bold versions of the principle of being different from the parents. In the first, the therapist bears with a woman who lost her mother at 14 years of age, not relenting from the time limit, while in the second, the therapist bears with an extreme problem of rage, using a series of emergency adjustments.

REINTERPRETATION OF THE INTUITIVE MASTERY IN MALAN'S CASE EXAMPLES

AN ALTERNATIVE HYPOTHESIS OF TECHNIQUE FOR THE COMPLEX NEUROSES

In the background of my exposition on *The Frontier of Brief Psychotherapy* (Malan, 1976a) and *Individual Psychotherapy and the Science of Psychodynamics* (Malan, 1979), I have been sketching the lines of an alternative explanation of Malan's technique, which I will now bring out as clearly and directly as I can. Let us take, as a starting point, the case that Malan (1979) has made up to exemplify his conception of technique, the Imaginary Case (pp. 81–89).

Here we have a young man who, when he was a teenager, lost his mother from a terrible cancer. This was so shocking to the boy's father that he withdrew, and both father and son retreated into numb silence and work. This loss was worsened for the boy by his having had a quarrelsome relationship with his mother for years before her death. Now, as a young

man, he comes for psychotherapy because of his relationships with young women, where he loses feeling for them after a promising start, and finds they become angry and disappointed in him.

The classical theory, of course, finds no difficulty in linking the past and the present outside problem to predict the two problems in the transference. The patient will have difficulty getting close to the therapist, and he will have difficulty with anger at the therapist, as he had with his mother and girlfriends. Malan has his imaginary therapist-in-training make two major mistakes in this Imaginary Case, one with each of the transference problems. After initial closeness, the patient backs away, as he has with young women he starts to care about. The therapist is tempted to confront the patient about this defense against his true feelings, pointing out the defense and the anxiety. This confrontation leads to a breakdown in communication. In the termination phase, as the patient is getting angry about being left by the therapist and is worried about letting go with the anger, the therapist again is tempted to confront the patient about these true feelings, his defense against them, and the anxiety about loss of control. Again, the communication is disrupted.

In both instances, Malan (1979) has the imaginary, experienced supervisor caution the therapist-in-training against confronting the transference resistance too deeply and too fast (pp. 83, 89). These are two instances of his precept that the "skill" of the therapist is in knowing "how deeply to interpret, at any given moment, with any particular patient" (Malan, 1976a, p. 262). Yet, both errors are consistent with the model of technique: to interpret the defense, anxiety, and impulse or true feeling, and to connect the present, outside version with the past and with the transference. Malan has to go outside the theory for practical help to an ill-defined something called "skill."

An alternative psychoanalytic theory of technique, whereby we may predict the temptations and errors of the therapist, takes us beyond these limitations of the original theory of the defenses, which Malan adopted from Anna Freud, Glover, and Strachey. This new "control–mastery" theory of Weiss and colleagues (Sampson, 1976; Weiss, 1978; Weiss *et al.*, 1977) builds upon the early ego psychology of the defenses, as well as more recent advances. Sandler and Joffe (1969) suggested that defenses are not lifted until the patient is reassured that it is safe to do so and is sure he will not be traumatized again ("the conditions of safety"). Patients then have to protect themselves against the repeat of the old trauma by being defensive.

Weiss (1978; Weiss *et al.*, 1977) and Sampson (1976) take this further.

They argue that the patient unconsciously tempts the therapist to repeat the earlier trauma, to test whether the therapist is actually different from the traumatic parents—whether, in the terms of Alexander and French (1946), the therapist is capable of providing or allowing a "new ending" to the "old problem." In Malan's (1979) Imaginary Case, control-mastery theory predicts that the therapist will be provoked by the patient (1) to either reject him or withdraw from him, as his mother did by dying and his father by becoming suddenly unavailable, and (2) to get into fights with him, which would make him feel very guilty. If the therapist does not fall to these specific temptations, the patient will be reassured that he can become close, without the danger of being left suddenly again, and get mad, without fear of protracted quarrels.

The fascination of Malan's Imaginary Case is that Malan intuitively shows his appreciation that therapists-in-training will fall to these very temptations which the classical theory cannot define for the trainee in advance, but which are predicted specifically by control–mastery theory as the critical tests of the therapist. As we have seen, Malan frequently refers to the idea of Alexander and French (1946) that the new ending comes about because the therapist is different from the transference expectations. Malan, the workshop therapists, and the therapists of his brief therapy unit continually show that they intuitively appreciate this critical idea, but when pressed to provide a conceptual model, they revert to the orthodox concept.

Of course, Malan is right that monitoring of "rapport" is essential and will help the therapist correct a divergence away from what is useful to the patient. He also has two methods for slowing down the confrontation with what is most difficult for the patient to bear: (1) by facing the defense and anxiety ahead of the impulse, and (2) by choosing the sector in which to face it, that is, transference, outside present relationship or past relationship. Why, then, do therapies get into trouble, even when the therapist is most tactful about showing the defense and anxiety first and in the most tolerable sector?

There are two reasons. First, even if interpretation makes the patient aware of the defense and anxiety, he or she may not be able to control the impulse when it is reexperienced. Hence, several kinds of preliminary steps are often necessary before interpretation. Second, interpretation of the transference may help to distinguish therapist from parent, or it may not. If the therapist makes a demanding interpretation, for example, he or she may become the essential, demanding parent.

Patients acquire the necessary "control and mastery" of the defenses

either by finding a new control in themselves or by borrowing control temporarily from the therapist. Of the first type, patients may be stubborn because they are afraid of passivity that will endanger them. As they practice being stubborn with the therapist (and the therapist accepts their willfulness), they become reassured that they can always revert to being stubborn, should they lift their defense and be passive. The defense comes under conscious control, allowing it to be used selectively and reliably. Of the second type, patients may invite the therapist to do what is traumatic, to be sure in advance that the therapist is capable of withstanding the temptation and providing the control that is protective. Given the same problem of stubbornness and fearful passivity, patients might tempt the therapist to take over and run a session by forceful interpretation that is frightening. When the therapist does not take over, patients are reassured that they may show the passive longings, because the therapist will not assault them. Thus, the same danger may be controlled in advance of its full appearance either by a new capability of control in the patient (especially by more skillful use of the defense) or by proof of capable control in the therapist (Weiss, 1971). When these steps are omitted by the therapist who moves directly to pure interpretation, retreat by the patient is predictable.

When the dynamics are very similar according to the classical theory (e.g., in problems of assertion), the routes of control may be opposite, as may the tests of the therapist. For example, the Interior Decorator (Malan, 1979, pp. 75–79) fears his temper because of being able to threaten his weak father. After a bold start, he becomes tentative and submissive, tempting the therapist to explore the latter topic. But the therapist does not fall to this temptation, which the patient's father would have preferred, and challenges the patient about the contrast between his start and his backing off. The patient now is reassured that the therapist can handle his forcefulness and brings out his propensity for finding fault in bigger men and bringing them down. He relies on the therapist to control these attacks without being hurt by them.

The Pesticide Chemist (Malan, 1979, pp. 101–107) has a similar problem with rage, but the route of control is opposite. The patient's approach is to learn to reduce the demands on him by others, so that his rage will not be so stimulated and too terrific to contain. He refuses to accept the therapist's challenges to go deeper, getting the therapist to stop being so demanding! Now it is possible to bring out the anger, knowing in advance that he can handle it by not letting others push him around.

The patient relies on his own new capacity of control. In the Interior Decorator case, the therapist's challenging of the patient proves the therapist different from the weak father and capable of providing the control, whereas in the Pesticide Chemist, the therapist's backing off from challenging the patient allows the patient to control the amount of anger induced in himself.[14] Thus, similar dynamics may require opposite responses before interpretation.[15]

Hence, most neurotic problems cannot be reduced to Malan's two-step model of pure interpretation, that is, to interpret the defense, anxiety, and impulse and to interpret the link to other sectors. Only the Indian Scientist appears to work this way. All the other short favorable (SF) cases in Series 1 and 2 and all the extended case reports in *The Frontier of Brief Psychotherapy* (Malan, 1976a) and *Individual Psychotherapy and the Science of Psychodynamics* (Malan, 1979) are three-step cases:

1. The patient acquires the capacity to control the danger of the impulse, either by testing to be sure the therapist is different from the parent and is able to supply the control or by the therapist permitting the patient to practice a new control of his or her own.
2. The patient then exposes the dangerous impulse, and practices and masters it in one sector of his or her life.
3. The patient finally links this to the other sectors (transference, present outside relationship, past relationship), where the mastery is completed.

CROSS-VALIDATION OF THE CLASSICAL THEORY

Popper (1962) emphasized that a scientific hypothesis is no better than the tests to which it has been subjected. Correlations are always made to back up new theories and will continue to hold up, even if statistical calculations show they are significantly far from random distribution, as long as no serious attempts are made to disrupt the correlations with challenging experiments. After all, one could show that good health correlates with drinking milk in a dairy state (e.g., Wisconsin), because the healthy would tend to drink the favorite drink of the state, while the unhealthy would turn to other tonics. As long as one stayed in the dairy state, one would have powerful correlations to back up the theory, since no serious attempt would have been made to get outside the state, where the correlations could be disrupted.

Therefore the importance of interpretive linking to dynamic change

cannot be considered corroborated until experiments are done in which therapists try to avoid making interpretations. If the experiments fail, then we may be more sure that parent-transference links are as necessary as Malan would have us believe. In fact, in the two therapies in his series in which the therapists designed the therapy in advance to avoid interpretation, namely, Mrs. Morley and the Stationery Manufacturer, the outcomes were outstanding. Thus, a minor experiment by Malan's colleagues suggests the correlation is easily disrupted.

Indeed, this kind of testing of one psychodynamic hypothesis against another is exactly what is needed to judge to what extent interpretive measures are necessary. One current set of such experiments are those by Weiss, Sampson, and colleagues (Weiss *et al.*, 1977). They use a tape-recorded analysis of a patient by an analyst in another city, who is unfamiliar with their theory of change. Independent judges predict the course of the therapy from the first ten sessions, one team using the classical theory, another team the control–mastery theory. The relative adequacy of the theories can be tested over the predictions which are opposite.

Not until more of these experiments are conducted can we judge the validity of one theory against another. Even on the basis of the clinical evidence Malan provides, I hope I have shown that the interpretive two-step model does not explain the clinical events. I am not claiming that my counteranalysis is more correct (a preposterous idea, since I am much farther from the actual case histories than Malan), but rather that an alternative explanation is, at least, plausible. Brief therapy could provide the evidence in manageable complexity to decide between these rival theories. Not until these decisive experiments are carried out can Malan consider his theory of technique to be corroborated.

THE NEGLECTED STUDY OF TECHNIQUE: *FOCAL PSYCHOTHERAPY* (BALINT *ET AL.*, 1972)

CONTEXT

Balint (Balint *et al.*, 1972) realized that the scientific project led by Malan was strongest in specifying the dynamic criteria for outcome and following up the cases and was weakest in the study of the technique used by the members of the workshop (p. 5). He believed that the close study of an outstanding case might begin to remedy this weakness. He did not say that

many of the intuitive elements in his technique were being lost because of Malan's narrower construction of psychoanalysis. Rather than lecture against this trend, he gave a remarkable clinical demonstration to show his technique at work, bringing back all the necessary elements we began with in *The Doctor, His Patient and the Illness* (Balint, 1957).

Nowhere are they missed more than in the brief psychotherapy of more disturbed depressive and paranoid patients. A moment's reflection will show why. A successful brief psychotherapy must arouse the very disturbance it seeks to remedy, but it must do so within the limits of control that the patient and therapist can muster. In more deprived patients, the impulses are huge, and the fears of renewed trauma are terrifying. Yet, Malan proposes only to interpret in the Kleinian tradition. These patients are told about their primitive defenses, fears, and impulses, and the parallels between present outside, past, and transference are clarified. Should we be surprised that the impulse, although well described, still feels wildly out of control to the patient? or that the therapist, interpreted as different from the parent, still seems very much like that parent? No wonder that the preliminary steps of control necessary to neurotic patients are even more essential here. The desires, rage, and retaliatory fears are enormous. Without preliminary phases of control, the dosage of intensity is usually neither tolerable nor safe. The treatments are erratic and often stopped by the patient without warning.[16]

But the problem is not only quantitative. When the child has been failed by his parents long before words were available to him, interpretations are not likely to come close enough to the disturbance.[17] The nonverbal climate or atmosphere matters more. Actions speak louder than words, how the patient and doctor fit together, "hit it off." These are the very elements left out by Malan's emphasis on interpretation but brought back into the center of treatment in *Focal Psychotherapy* (Balint *et al.*, 1972).[18] We shall see that these qualities allow the therapist to contain and control the primitive experience, which has to be aroused in the course of the treatment.

THE CASE

The patient, Mr. Baker, was apparently a very able and successful man. At the age of 43, he was a joint director of a stationery manufacturing firm, deeply in love with a loving and admirable wife, and the father of three children. His chief complaint, however, ran very deep. He had become in-

creasingly preoccupied with his wife having had another suitor before they were married. On psychological testing, it was apparent that he was overwhelmed by fear of a powerful, phallic woman and was desperately defending himself by ruthless, jealous attacks. In other words, here was an extreme, jealousy paranoia in a man with considerable strengths. He was treated by Michael Balint from November 1960 to February 1962 in 27 sessions. The long follow-up was in two interviews, the latter in November 1966, and in letters until Balint's death in 1970.

THE NEW METHOD FOR OUTLINING CLINICAL EVENTS

Balint and his two coauthors, Enid Balint and Paul Ornstein (Balint *et al.*, 1972), attempt to make intelligible the interaction between this patient and this doctor, as reconstructed from Balint's notes after each session. Two-thirds of the text consists of the session reports (with commentary), in a very interesting form, which draws upon Balint's concepts of the doctor-patient interaction:

A. initial expectations
B. atmosphere in interview, with changes, if any
   1. patient's contribution
   2. therapist's contribution
C. and D. main trends and therapeutic interventions given
E. therapeutic interventions thought of but not given
F. therapist's focal aims in interview
G. outcome of the interview
H. afterthoughts

Perhaps at first glance, this session report form is not remarkable. In using it in experiments with my own psychotherapy cases, however, I have found that it redirects my attention very effectively away from interpretation and toward the nonverbal and interactive events. You begin with your own feelings and hopes in advance (A), which set the stage for the atmosphere (B) (e.g., where the contact is strained or boisterous or alters over the course of the interview). The main trends and interventions given are itemized (C and D) as a set of offers by the patient and counteroffers by yourself. In the next category (E), you write down all the interpretations you were tempted to make but refrained from making, aiding your self-restraint in the session itself. You can locate your brilliance afterwards on

the form, rather than having to dazzle the patient. Your intelligence goes into bringing about a certain kind of interaction, specified by the focal aims (F), rather than into explaining matters to the patient. In other words, "focal therapy" need not mean "interpretation of focal conflict" but, rather, "focal aims" for a specific kind of interaction.

THE GENERAL OUTLINE OF THE TREATMENT

Balint discovered in the first two sessions that two breakdowns had occurred previously, one in the mid-1950s when the patient had moved himself and his wife into a new house and his father-in-law had died, the other in the spring of 1960, a half year prior to seeing Balint, when the patient became a director of the firm, replacing his father. Oversimplified, his formulation was that the patient could not tolerate these Oedipal victories, because they threw him back upon relations with women that were extremely primitive. His calm was destroyed when he succeeded, because the fathers (men) were no longer available to protect him.

Balint does not propose to explain this to the patient. He does not formulate a "focal conflict," which would construe the situation in verbal, intrapsychic terms, for a man in danger of falling into the black depths of his early deprivation, which is the "basic fault." Instead, Balint sets up "focal aims" to bring about a specific kind of interaction which will protect him. They are, first, to help him accept his triumph over his male rivals and, if that is too ambitious, to help him share his wife (symbolically) with the therapist (another man).

In general, the treatment divides into two distinct phases. In the first 13 sessions, Balint and the patient become very close, with great relief to the patient, but the attempt to "tail off" treatment brings back the disturbance. In the last 14 sessions, the patient pushes Balint to the limit with his jealous rage, finally calming himself down and making most of the interpretations himself. The result on follow-up is spectacular. What could easily have become a chronic paranoid psychosis, like the Schreber case, instead showed complete symptomatic relief and an ability to weather the kinds of stress that had brought about previous decompensations (i.e., the retirement of his father, competitive athletics with his son, the factory badly damaged by fire, and his son wishing to become independent of him and to take over the business). This outcome was scored 3.75 (the mean of four independent judges) at the follow-up of three years and four months.

MALAN'S ACCOUNT OF THE TREATMENT

In *The Frontier of Brief Psychotherapy* (1976a), Malan gives a lengthy account of this treatment in an attempt to fit it into his classical psychoanalytic conception. According to Malan, the first half is about all the interpretations given and not given, requiring many pages to explain but defying summary. This view is completely at odds with that taken by Balint and his coauthors. They believe that nonverbal or noninterpretive moves by the therapist are, in fact, equivalent to verbal ones and should be scored as such. When the total number of these interventions were divided into those based on previous psychoanalytic knowledge (PPsaK), those made strictly from current observations with the patient (CO), those which were mixed (M), and those that were independent discoveries of the patient (ID), only 2 out of 120 interventions were rated (PPsaK). According to Malan, the second half of the therapy has only two interpretations, consisting of "working through" and confronting the patient with reality. Balint and his coauthors emphasize that the final six sessions contained an equal number of interventions by the therapist and independent discoveries (IDs) by the patient, namely, 13 of each.

Malan ends up with an account of the first half, which is so dense with interpretive content that it cannot be followed, and an account of the second half, which is virtually empty. He writes, in summary, "Balint stuck to very limited interpretation and confrontation with reality," leaving us with what analysts like to call "supportive psychotherapy," which is completely lacking in specificity. We meet again the usual dichotomy present in Malan's thought between specific interpretive treatment (truly psychoanalytic) and nonspecific treatment (not very psychoanalytic). This misses the whole point of Balint's attempted treatment and attempt to explain what he did: that is, that it is possible to be very specific about one's interaction with the patient without interpreting all of this to the patient. But this takes one out of the classical psychoanalytic model and toward interpersonal and existential methods, which Malan continually eschews.

THE NEGLECTED POWER AND INTELLIGIBILITY OF BALINT'S TECHNIQUE

Because this treatment is simply intelligible in interpersonal terms, as Balint claimed, because the neglected power of this point of view has been obscured in Malan's hands, and because this was such a brilliant therapy, I have decided to present it here.

Session No. 1. After Balint listened to "this dreary and very painful story" in the minutest detail about the patient's wife, the other man, the various alternative suspicions, and so on, Balint "brushed it aside," "not brusquely but in a friendly manner," telling the patient that the details were not important but that his feelings were, and that he needed someone to act as a "sounding board." The patient returned to this idea several times, very moved and grateful.

Session No. 2. In this session, Balint made a different counteroffer to "look into things more deeply that had gone wrong," and the patient broke off treatment for 15 weeks.

Session No. 3. Here Balint had learned from his success in the first session and his failure in the second. He brushed aside everything but the fact that the patient was subjecting his wife to cruel harassment, but the truth was that he had won, he was the powerful man, and why couldn't he accept that! This brilliant maneuver set up the success of the treatment. It reassured the patient that *he* was the powerful man, respected rather than overrun by Balint. It actively countered the projection, so easily aroused in Session No. 2, that Balint would "look into him" as the intruding parent. At the same time (with the other hand, as it were), he was confronted with the malignant activity that he must stop. This is the kind of balancing maneuver practiced by Sullivan and recently described by Havens (1976).

Sessions No. 4–8. The patient now brought out spontaneously that his feeling of inferiority must have come out of childhood, when he was frightened by his father. His need for love made him accept homosexual advances at the expense of his self-respect. Malan goes into enormous detail about this. The essential point, however, is that Balint displaced away from himself any idea the patient had that Balint would ridicule or assault him for this need and for what he had allowed.

Session No. 9. After yet another counterprojective move by Balint, to the effect that "no wonder you were so vulnerable to homosexual advances," the patient revealed he had had a dream of a big snake curled up with him, and he entered a period of marvelous symptomatic improvement.

Very specific to his "focal aim," Balint made being close to the powerful father (i.e., the big snake) safe by differentiating himself from the assaulting father. Although he was continually tempted by the patient to ridicule, criticize, or make pronouncements that would belittle the patient, Balint refused to be tempted, passing the tests which differentiated him from the father, displacing these negative projections away from himself.

Session No. 10. Now the patient could use Balint to help him cope with women. He literally brought his wife to this session to share her with Balint. The patient calmly enjoyed his victory, having the powerful father close to him to ward off any dangers from the primitive mother.

Sessions No. 11–13. The attempt to "tail off" the treatment did not work, since the patient could not manage separation from Balint without losing the power Balint had loaned him.

Sessions No. 14–17. There was now an enormous build-up of rage directed against Balint.

Sessions No. 17–24. The patient began to treat Balint as if Balint were the child assaulted by the father, as if the patient had become the father. This route is not an uncommon one in psychotherapy, according to Weiss *et al.* (1977), when the therapist will permit the patient to use it. It is a reversal of the transference, what they call turning "passive into active." The patient subjects the analyst to what the child received from the parents in order to learn from the analyst how to handle it. Balint was now called upon to use all his resources.

Session No. 17. Baint took a firm stand against the patient's attempt to "mangle" his wife and "trip them (his wife and Balint) up" in complications; yet, in the same sweep, he showed the patient he was "tormenting himself" as well. Here Balint was placing himself over against the father-like assaults on others or himself, with that part of the patient which was helpless to do much about this. This is what Havens (1980) has called counterintrojection, namely, helping the patient to not be overrun by his powerful introjects.

Session No. 18. Here Balint empathized with the patient's requirement of a completely harmonious, archaic relation (Balint, 1959, 1968). No wonder the patient was so ruthless!

Session No. 19. Balint carefully avoided getting ahead of the patient, not offering interpretations which would carry the danger of making Balint the phallic mother or father. Instead, he let the patient make the independent discovery that he had been conditioned by his parents to see himself as inferior.

Sessions 20–23. Balint finally just had to stay with the patient, wondering if this assault would go on forever. In brief, Balint was subjected to a severe series of tests, tests of whether he could stay with the patient and still show him how to ward off these assaults.

Session No. 22. Just as Balint had begun to despair, the patient re-[illegible] because he felt completely understood by Balint.

Sessions No. 23–27. The patient now emerged spontaneously with a

series of "independent discoveries," starting with fear of abandonment, how he came to feel inferior, empathy for the position in which he had put his wife, and so forth. He now was carrying away Balint with him, inside.

Reviewing this interaction in very broad strokes, I would emphasize the following points. In the first half, Balint had to make it possible for the patient to take him close for protection; he did this by separating himself from previous assaults by "fathers" (counterprojection). In the second half, Balint had to weather all the assaults of the introjects with the patient, staying with him by understanding his archaic needs, standing with him against the introjects (counterintrojection), and letting the patient make independent discoveries.

I have been suggesting all along that the clinical capability of this school of brief therapy is greater than its concepts would allow, and I have used various alternative concepts at different points. This technique of Balint in the case of Mr. Baker shows all of them together. The overall idea is this: The patient is invited to run a major risk in the course of a few months, namely, to lift a defense (ruthless attacking) that is giving a lot of trouble. How does the patient decide to run this risk? The general answer is that the patient will go ahead if it is safe enough to do so, if he believes the big dangers will be avoided en route. The specific technique for the specific patient, however, must be in the hands of the therapist. The specific concepts of technique are demonstrated by Balint's handling.

First, Balint recovers from an early mistake, in which he suggests he "will look into" the patient's problems with him. He backs off a purely interpretive attitude, which is too terrifying to the patient, grasping that a "prior step of control" (Weiss *et al.*, 1977) is necessary before much can be said to him. Most of the therapy deals with securing this control rather than clarifying it for the patient with interpretation. Indeed, the patient does the interpretation for himself.

Second, Balint has to take the issues in the right order or sequence (Weiss *et al.*, 1977). The patient cannot borrow Balint's friendly power until Balint is distinguished clearly from seductive, powerful people who have assaulted him. Balint takes this first.

Third, as Alexander and French (1946) argued, it is necessary for Balint's *role* to be sufficiently different from that of the frightening parent. Since the father was bossy and demeaning, Balint had to be the opposite, giving the patient all the credit as a man and letting him make all the discoveries independently (very similar to the role taken by Alexander in [illegible]

revert to the father's traumatizing behavior, thus passing tests that he is indeed different and the new situation safe (Sampson, 1976; Weiss *et al.*, 1977).

Fifth, neither the neutral analytic attitude nor the role taking suggested by Alexander and French is enough to reassure some patients, such as this, about the difference between the dangerous past and the new present ending.

Balint not only had to be different in his behavior from the feared projections, but he also had to actively counter the role forced upon him, displacing it into others who had assaulted the patient, where the danger could be clearly focused (Havens, 1976). Certain people did seduce the patient; no wonder he must be careful about getting close. In other words, in order for a patient to feel adequately protected in the risk to be run, he or she may need methods and relationships specific to schools of psychiatry *other than psychoanalysis* (Havens, 1973), such as this use of counterprojection. This is the full technique of Balint, which we have previously seen, in part, through the many complex, successful cases described by Malan.

THE REMARKABLE CONTRIBUTIONS REVIEWED

We have followed the development of 25 years of experimentation with brief therapy at the Tavistock Clinic, led by Balint and Malan.

- They have attempted to retain the complex secret of the art by defining a science of brief therapy. At each stage, we have kept track of the intuitive clinical capabilities and the progress in conceptual clarity.
- Balint provided the generative idea that patients could be offered new kinds of relationships, allowing doctor and patient to organize new forms of brief treatment relationships corresponding to the four modern schools of psychiatry. Thus, in *The Doctor, His Patient and the Illness* (1957), he supplied the necessary equipment with a minimum of theory to secure this intuitive knowledge.
- In *A Study of Brief Psychotherapy* (1963), Malan broke the long-standing bonds of traditional psychoanalysis, which held that the lengthening factors were inevitable, and that subjective judgments inevitably separated psychoanalysis from the objective traditions of science.

- In *The Frontier of Brief Psychotherapy* (1976a) and *Toward the Validation of Dynamic Psychotherapy* (1976b), Malan became so clear about the dynamic events of brief psychotherapy that he could demonstrate how to plan the selection and technique in advance. At the same time, he introduced the complex clinical observations distorted by this conception.
- Malan's current thinking in *Individual Psychotherapy and the Science of Psychodynamics* (1979) allows him to provide a clear line of procedure through the complexities of selection and termination and through definition of the specific clinical capabilities of psychoanalysis, from the elementary skills to the complex.
- This clarity about the tools of psychoanalysis succeeds until Malan reaches the complex neuroses, where the conduct of the actual cases cannot be explained by his ideas of pure interpretation. An alternative hypothesis is offered by this author.
- The neglected power of Balint's technique, lost in Malan's narrowing conception of brief therapy as the essence of psychoanalysis, is represented by Balint, Ornstein, and Balint in *Focal Psychotherapy* (1972). The "focal aims" need not be to "interpret focal conflict," but rather may be to bring about a specific kind of interaction that the patient needs.

This tradition gives us, then, the complex secret of brief psychotherapy both in intuitive clinical brilliance and in increasingly sharpened concepts. The clinical acumen in Balint's *The Doctor, His Patient and the Illness* (1957) and *Focal Psychotherapy* (1972) and in the complex cases of Malan's *The Frontier of Brief Psychotherapy* (1976a) and *Individual Psychotherapy and the Science of Psychodynamics* (1979) is exemplary. The specific conceptual tools could not be clearer:

1. the methods for providing complex clinical observations in short form to allow independent assessment
2. the objective criteria of dynamic change
3. the powerful model of selection that integrates psychoanalysis and objective-descriptive psychiatry
4. the capacity for planning technique in advance of brief therapy
5. the most flexible of termination strategies, based on the logic of the "new ending"
6. clarification of the specific capabilities that an analytic psychotherapist loans to his patient

Balint provided the intuitive mastery of relationships that made possible the beginning of this tradition, while Malan provided the militant, integrative, organizing power of psychoanalysis and science to retain it. True to objective science, Malan has kept before us both his hypotheses and the clinical observations in all their complexity in order to allow continued building of the complete science of brief psychotherapy.

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NOTES

[1]For those readers who prefer early definition, I may add that the idea of "focal psychotherapy" has been used by this school of brief therapy in several ways. Malan chiefly uses it to mean a brief psychotherapy in which the therapist limits himself to interpretation of a single "focal conflict." Balint, however, uses "focal psychotherapy" to refer to a therapy which has "focal aims." A focal aim may be to interpret a focal conflict, but it may also be to bring about a *specific* kind of interpersonal interaction with the therapist, which will represent a new kind of mastery for the patient. A focal aim may also be to help the patient bear certain feelings which have been unbearable to the patient alone, such as grief (cf. Malan, 1979, "The Nurse in Mourning"). In other words, the focal aim of a focal psychotherapy may be psychoanalytic, interpersonal, or existential. Whatever the focal aim, the brief therapist has to accept the reality that he cannot make up to the patient the ways in which the environment has failed him. This "basic fault" is a given. He must consider whether a small but well-chosen additional supply to the patient's life will have a multiplier effect that will produce a big difference. What will do this? In general, if the patient can safely lift one of his major defenses, there can be major ramifications. The focal aim is then to supply the right kind of relationship in which the patient can lift a single but major defense, with full control of the consequences (control against the recurrent trauma and control of the unrepressed capability that is allowed to emerge). For the most fully described and analyzed case from this entire school of brief therapy, see Balint *et al.* (1972) and the section of this chapter entitled "The Neglected Study of Technique": The patient, Mr. Baker, achieves control and mastery of the defense of ruthless persecution.

[2]In other words, the aim of this chapter is to be helpful to the clinician. Research findings have been discussed where they directly influence clinical method. I have made no systematic attempt to present or evaluate the research methodology or content of these works. That would be another large project.

[3]A recent article reviewing the different schools of brief psychotherapy (Burke, White, & Havens, 1979) gives a distorted account of the work of Malan and Balint, primarily because it takes the model of technique offered by Malan at face value. From this, the authors argue that the entire school uses heavy interpretation, didactically weaving together present and past. They have not read the successful cases carefully. Balint is said to have offered a heavily interpretive technique in *Focal Psychotherapy* (1972), when, in fact, his whole aim was to avoid interpretation. The errors continue: Malan is said to have emphasized exclusion criteria, when, in fact, the ability to work in interpretive therapy (Hypothesis B) has been of equal or greater importance all along. Patients with deep-seated characterological problems are said to have been handled through the use of a more superficial focus, when, in fact, most of the star cases have had deep-seated characterological difficulties and have had their central problems taken on. Termination is said to have been downplayed by Malan, when, in fact, it was considered to be very important. A flexible strategy of termination does not deny its importance. The summary table used by these authors for comparison then collects these errors in one place (p. 184). Of course, it is not easy to carry out sweeping comparisons because of the sheer amount of study required. Minor errors should be forgiven when broad strokes are intended. These distortions, however, are large. The present chapter may allow more accurate comparisons to be made in the future between this and other schools of brief therapy.

[4]For a vivid introduction to the Victorian world, see the novel of Fowles (1969). Given this context, it is easier to appreciate the surprise of Freud's approach. This is also captured by the recent film, *The Seven Per Cent Solution*, in which Alan Arkin plays Freud in a manner which contrasts with our sober expectations. Malan (1979) has also written a similar paragraph about Freud (pp. 141–142).

[5]Strictly speaking, this school of brief psychotherapy divides into two main streams: brief psychotherapy by GPs, and brief psychotherapy by specialists (analytic psychotherapists). I will be considering only the latter, but we should not forget the continuing development of the GP line of work. For further reading, compare Balint and Balint (1961) and Balint and Norell (1973).

[6]Between the first scoring for *A Study of Brief Psychotherapy* (Malan, 1963) and the second scoring of Series 1 (Malan, 1976b), Malan and his colleagues added the possible score of 4 to the scale. The score of 3 now meant "substantial resolution" but with "some important reservations," whereas the score of 4 meant hardly any reservations (Malan, 1976a, p. 61).

[7]The ideal research arrangement, Malan suggested, would be to have two separate judges for judging the patient factors in the selection phase, two for analyzing the content of the technique, and two to judge the outcome, all making totally independent judgments, in order to correlate factors in the patient (selection criteria) and in the therapy (technique), on the one hand, with outcome on the other. Because Malan and Eric Rayner were contaminated by the knowledge of selection and the conduct of the therapies due to being two of the workshop therapists themselves and participating in the discussion of the cases of their colleagues, Malan decided to separate himself and Rayner, as the contaminated judges of outcome, from two other, totally uncontaminated judges of outcome. Since reliable assessment of psychodynamic outcome was the most important objective, this would provide two teams (of two judges each) for outcome, one team contaminated, one not, thereby allowing measures of interrater reliability between the two teams. After outcome judgments were made, Malan and Rayner went back to content analysis (from therapist notes) and finally back to evidence on patient factors in the selection phase. Two new uncontaminated judges of selection factors were added later. In general, interrater reliability was superb.

[8]In regard to predicting outcome in the selection phase, recent onset and mild pathology (Hypothesis A) again did not predict good outcome. Motivation for insight gave the best correlation but was not statistically significant. What was powerful and interesting was that high motivation in the patient and a consistent therapeutic focus from the therapist between the fifth and eighth sessions were reliable predictors of outcome. In other words, therapies "going well" ended up with the high outcome scores, whereas therapies "going badly" after the introductory phase ended up with low outcome. Either the patient and therapist "hit it off"