

CHAPTER 8 TOWARD THE REFINEMENT OF TIME-LIMITED DYNAMIC PSYCHOTHERAPY

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Short-term psychotherapy—and the subform, time-limited dynamic psychotherapy, which will be the primary focus of this chapter—is a product of our time, and the developments that will occur in this area in the foreseeable future are a reflection of society's current concerns: to evolve forms of treatment for specific disorders that are efficient, cost effective, and applicable to the largest possible number of patients. In other words, the developments that are being sought are technological; they are not principally aimed at the advancement of knowledge, such as the etiology of neurotic disorders, the basic ingredients of psychotherapy, and so on. Increments in scientific knowledge may, of course, occur as a result of improvements in technology, but they are clearly seen as secondary. Instead, the emphasis is pragmatic: "does it work?" not "why does it work?"

The distinction impresses me as important, because the contemporary thrust appears to be based on the assumption that available knowledge is sufficient to support technological developments. In my view, serious questions must be entertained whether this is, in fact, the case. It can be argued, of course, that the two positions are not mutually exclusive, and the history of science is replete with instances where attempted solutions to practical problems have given rise to significant advances in scientific knowledge. My concern is with the inordinate emphasis on technology, the furor with which "horse races" between seemingly divergent forms of psychotherapy are currently being implemented, and the relatively scant attention accorded the necessarily slow and painstaking efforts aimed at achieving a better understanding of the dynamic forces con-

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fronting the psychotherapist. Modern psychotherapy, in general, has become or is threatening to become a field "in a hurry." It remains to be seen whether a more orderly, scientific development can be short-circuited or bypassed. My comments suggest that I have doubts on that score. The danger lies in the preoccupation with gimmicks rather than technologies that are based on solid knowledge and understanding.

In this chapter, I discuss a number of basic issues confronting psychotherapy. Whether or not they are explicitly recognized in technological developments, they are, nonetheless, real, and they will eventually have to be faced. In my view, it is unlikely that we shall achieve victories on the frontiers of technology without addressing ourselves to these core problems, which will remain with us. Nonetheless, time-limited dynamic psychotherapy may provide us with golden opportunities to examine in greater detail and depth why, in a given case, we succeed or fail and to open the doors to a better scientific understanding of the process of psychotherapy in general.

Let us start with the following questions: How can therapeutic outcomes be improved in the shortest possible time? There are several possible options:

1. We can select patients whose presenting difficulties and personality makeup is such that relatively minor interventions will guarantee good therapeutic results.
2. We can scale down the therapeutic goals we wish to achieve and declare that we shall be satisfied with relatively circumscribed improvements.
3. We can seek to improve the therapeutic technology, such that therapeutic change occurs more rapidly. A distinction must be made here between rapid improvement and lasting improvement. Furthermore, questions must be entertained as to whether a particular approach is humane, is in keeping with the patient's best interest (however this may be defined), is consonant with reasonable demands on the therapist (time, effort, commitment, etc.), and addresses other *practical considerations*.

If we examine the state of the art in time-limited dynamic psychotherapy (notably the work of Alexander & French, 1946; Davanloo, 1978; Malan, 1976a, 1979; Mann, 1973; and Sifneos, 1972, 1979), we find that major efforts in this area have been directed at the foregoing issues, and that solutions have been sought through a better alignment between pa-

tient selection, goals, and appropriate technology. In this chapter, I attempt to illuminate these issues in somewhat greater detail, particularly with reference to tasks to be accomplished in the future. Such an exploration may prove useful in highlighting the potentialities as well as the limits of time-limited dynamic psychotherapy and may help sharpen the thinking of the clinician and the researcher. It may lead to the implementation of much-needed empirical research, which may tell us more about who can help whom and how. Finally, it may enable us to provide legislators, policymakers, and the public at large with better and more precise information on what may be expected from psychotherapy under particular conditions. As we all know, the challenge is great.

PATIENT SELECTION

One of the notable ways in which modern proponents of time-limited dynamic psychotherapy have sought to improve therapeutic outcome: has been to select patients who are most likely to benefit from what the therapist has to offer. This approach follows the classical psychoanalytic tradition of a method in search of patients. Not surprisingly, the selection criteria formulated by contemporary workers in the time-limited area show a remarkable resemblance to those invoked by classical analysts (Bachrach & Leaff, 1978; Freud, 1905/1953, 1913/1958). It is well to remember here that Freud, in his earlier writings, viewed psychoanalysis as a last resort (1905/1953), and although his practice did not seem fully in keeping with his pronouncements on this subject, he defined the radius of psychoanalysis in rather narrow terms (the so-called transference neuroses) (1917/1958). Butcher and Koss (1978), in their admirable review of the literature, considered the following "types of patients" optimally suited for time-limited psychotherapy:

1. those in whom the behavioral problem is of acute onset
2. those whose previous adjustment has been good
3. those with a good ability to relate
4. those with high initial motivation

The foregoing variables are, of course, complex and far from independent. If one attempted to bring them under a common denominator, "strong ego resources" might be the most suitable term. This would include a relatively high level of emotional maturity, responsibility, autono-

my, success in mastering and adapting to life's challenges (including stability in interpersonal relations), and ability and commitment to work collaboratively with a therapist, whose major tool is the facilitation of understanding and insight into intrapsychic conflicts. Conversely, patients who are unsuitable for time-limited dynamic psychotherapy can be characterized as showing profound dependency, persistent acting out (impulse disorders), self-centeredness, masochism, and self-destructiveness (Butcher & Koss, 1978, p. 739). In the Vanderbilt Project (Strupp & Hadley, 1979; Gomes-Schwartz, 1978), we identified additional contraindications: pervasive characterological disturbances, profound negativism, and rigidity. Our findings also lend weight to the overriding importance of motivation as a key variable (Keithly, Samples, & Strupp, 1980).

These criteria are obviously in need of further refinement, but our research provided strong evidence that the patient's suitability can be determined fairly readily in the first three interviews—and often in the course of a single assessment interview. If these results can be replicated, we might soon have a rather powerful tool for identifying those persons who are well suited for time-limited dynamic psychotherapy. Malan's (1976a) concept of a "focal conflict," which allows the formulation of a "dynamic focus" in therapy, appears to be another important criterion for patient selection.

We have, as yet, little evidence on the degree of departure from these criteria that can be tolerated before time-limited dynamic psychotherapy is definitely contraindicated, and it is clear that few patients are ideally suited on all counts. We must also be prepared to adduce further evidence to answer the criticism that (a) time-limited dynamic psychotherapy, as currently practiced, is appropriate only for a very small percentage of the total patient population, (b) the patients selected by these criteria might be the ones who improve "spontaneously" without therapeutic help, and (c) such patients may improve with almost any kind of therapeutic help (i.e., there is nothing unique about time-limited dynamic psychotherapy that conduces to the improvement of such patients). In this connection, the finding from the Vanderbilt Project that the most suitable patients showed the greatest improvement when treated by a highly experienced professional therapist may suggest that optimal matching between patient and therapeutic method results in the greatest payoff. Conversely, neither experienced therapists nor untrained college professors were impressively successful with patients who fell short of the major selection criteria.

appears to be the most controversial and perhaps the least important. It is reminiscent of a maladaptive stress response in a previously well functioning personality. It is quite plausible that such patients may be unsuitable on other grounds. Malan (1976b) provided evidence that acute onset is not necessarily a good prognostic sign. He also showed that persons with relatively severe character pathology may profit from time-limited psychotherapy, thus refuting the widely held misconception that time-limited psychotherapy is most helpful to those who may need it the least.

At the same time, one of the best established findings, corroborated in a number of the better studies, points to severity of the disturbance as one of the key variables for predicting success in almost any kind of psychotherapy, both time-limited and long-term. This result constitutes powerful evidence against the traditional claim of psychoanalysis that long-term, intensive psychotherapy can be instrumental in producing a radical reorganization of the personality. I know of no hard evidence that such reorganization occurs with a high degree of frequency. Obviously, this is not to say that it never occurs. The selection criteria traditionally invoked by psychoanalysts, however, probably contain a highly valid core. That core again points to the presence of a constellation of strong ego resources, which despite the presence of significant psychopathology, allow the patient to become engaged in a meaningful and productive relationship with a therapist, which, in turn, leads to significant amelioration.

One might say that good prognosis depends markedly on the extent to which a patient's difficulties are intrapsychic as opposed to "behavioral." That is, the best candidates for psychotherapy of all kinds are those individuals who suffer more or less silently while at the same time being able to discharge their day-to-day adult responsibilities. An unfortunate corollary of this hypothesis is that, by superficial standards, these patients also *appear* least disturbed. Conversely, those persons whose disturbance is of the impulse-dominated, acting-out variety are far more difficult to help via psychotherapy. Thus, we may have come full circle: psychotherapy is, indeed, what it originally was intended to be, namely, a treatment for basically intrapsychic disturbances. These disturbances obviously have their manifestations in the patient's intimate relationships with significant others, but they are not typically the kind of disorders of which society, rather than the patient, complains (e.g., antisocial behavior, drug addiction, delinquency, and the like).

Another critical implication of the selection criteria for time-limited

gories set forth in such systems as DSM-III. I believe it is highly significant that the clinical experience of time-limited dynamic psychotherapists points to the importance of "person" variables rather than "pathology" variables. Previous adjustment, ability to relate, and motivation are variables that point to particular personality organizations rather than to discrete symptoms or "disorders." By the same token, it is probably no accident that practitioners of time-limited psychotherapy have not focused on the development of specific treatments for depression, phobias, and the like. Instead, time-limited therapists seem to say that they can help individuals with particular kinds of personality structures, and that those with other kinds of personality organizations are more or less unsuitable.

To be sure, we need to explore much further what is meant by "more or less," but the thrust of the evidence throughout psychotherapy research strongly supports this viewpoint. Correspondingly, the beacon for future research points toward the identification of people with particular personality organizations rather than the treatment of specific disorders. This suggests that greater effort should be invested in studying which people rather than which disorders can be treated. To be sure, there tend to be certain correlations between the two; however, the direction of investigative work will be quite different, depending on which viewpoint one adopts. The findings of time-limited psychotherapy may prove a most important guide. As we shall see, there are also important implications for technique development in terms of the extent to which it is realistic and fruitful to devise specific techniques for specific disorders.

This point impresses me as so critical that I would like to highlight it from another perspective. What contemporary time-limited psychotherapists have done is to attempt an articulation between a particular form of diagnostic assessment and therapeutic operations; that is, they have begun to make clinical determinations that have a more or less direct bearing on what needs to be done in psychotherapy. Conversely, assessments of the degree, extent, and severity of a symptom (e.g., depression, anxiety, etc.) are static; they may serve to pigeonhole a patient for "statistical" purposes, an activity that may help insurance companies in determining a patient's eligibility for benefits, but they do not point to ways in which a therapist can help a patient via psychotherapy. We may need both static and dynamic assessments, perhaps to assess the locus and function of the patient's disturbance in his current adaptation; but from the standpoint of technique development in psychotherapy, dynamic assessments will be infinitely more useful. So far, we have made only modest strides in that

direction, and much greater refinement of selection criteria, as well as studies to determine precisely where the dividing lines between suitability and unsuitability lie, are needed. There is no doubt in my mind, however, that this is the road we need to travel if psychotherapy is to become a more refined art and science.

THERAPEUTIC GOALS

Closely related to problems of patient selection is the stipulation of therapeutic goals. Again, this is an area in which clinical thinking and research are in need of much closer scrutiny by means of systematic research. In terms of selecting patients with impressive ego resources, it might be argued that the latter produce synergistic effects in the hands of a skillful therapist. In other words, the striving toward health in those patients who are judged as most suitable is so strong that impressive therapeutic results may be achieved with relatively little effort and in relatively short periods of time. Conversely, where a patient is markedly deficient in this area, either we will have to settle for much more modest achievements or the therapeutic effort will have to be intensified. With respect to the latter set of circumstances, this inevitably means longer periods of time.

The Vanderbilt Project again provides leads. We found that in the case of patients who were markedly hostile, negativistic, rigid, and resistant, none of the therapists—neither highly experienced professionals nor untrained college professors—was able to achieve impressive therapeutic results in 25 hours or less. To me, this signifies that, on the whole, therapeutic progress is severely circumscribed by the difficulties and obstacles posed by the patient's personality organization at the time of entering therapy. In much of the therapy literature, insufficient attention has been paid to the precise nature of the improvements achieved (or achievable) in a given unit of time. For example, if we are satisfied with a diminution of a patient's current depressive episode (measured by a drop in the MMP!D scale or similar measures), we have posited a very different goal than if we demand that sufficient reorganization of the personality should have occurred to lessen the likelihood of recurrences of depressive episodes. In short, symptom relief is a very different order of improvement than more pervasive personality reorganization.

The trouble is that we do not know exactly what the latter is. It could be asserted, perhaps with considerable validity, that symptom improve-

ment almost always carries with it some degree of cognitive reorganization, and that improvements of all kinds must be reflected in some form of behavioral change. Stated otherwise, it is unlikely that improvement can be diagnosed in the absence of symptomatic and behavioral change. The distinction between "symptomatic improvement" and "character change" posited by classical psychoanalysis may be artificial. Again, we are faced with the extraordinary difficulties in measuring structural (intrapsychic) change in the absence of subjective and behavioral change. The former is always an inference from the latter, and apart from projective techniques which, at present, enjoy a low degree of popularity and credibility, I know of no highly satisfactory techniques which would allow us to reliably assess changes in personality organization.

We must also disabuse ourselves and our consumers of the notion that psychotherapy achieves cures "once and for all." All practicing clinicians have the experience of dealing with patients who, following a formal course of therapy, return at subsequent times in their lives to deal with difficulties that crop up as a result of new stresses. There are, in all of us, vulnerabilities and *loci minoris resistentiae* that may lead to the recrudescence of neurotic disturbances; in other words, a predisposition to neurotic disturbances may forever remain. This idea has already been enunciated by Freud (1937/1964) in "Analysis Terminable and Interminable," but I believe it has not been taken sufficiently seriously. I would strongly resist the allegation that patients of this kind are "failures."

We have not yet succeeded, however, in developing good indices that would allow us to assess that significant progress has been made, even though the patient may return at a later point for further therapeutic help. Somehow, we must develop better measures of adaptive functioning, which is not synonymous with the total absence of symptoms and invariably must differ from individual to individual. Nonetheless, I believe that the task is not insuperable. There are some reasonable practical indicators that might be adapted for this purpose. At the same time, I believe that we should not rest content with some minor improvements in functioning. The point is how to make these differentiations. When is an improvement a "real" improvement, and when is it an insignificant or transient change? These are real and important issues for time-limited psychotherapy as well as for any other form. To reiterate, our thinking on this point has been far from clear, with the result that outcome statistics may convey a misleading picture.

THERAPEUTIC TECHNOLOGY

The major objective of time-limited dynamic psychotherapists has been to adapt the therapeutic technology to the achievement of appropriate objectives. This has meant refining and sharpening the technology, a goal which, of course, also has broad implications for psychotherapy in general. It may be said that time-limited psychotherapy provides a unique proving ground for testing the efficacy and utility of techniques, something that is difficult to accomplish in open-ended approaches. Thus, it is no accident that innovations and experimentation with techniques have occurred chiefly in time-limited approaches. The research potential of time-limited psychotherapy, in this regard, is a fairly recent realization, and contemporary research on therapeutic techniques has found time-limited approaches particularly congenial and germane to systematic testing. To carry out the necessary tasks, close attention must be paid to the therapeutic process and the variables affecting it. As elsewhere in psychotherapy research, progress has been severely hampered by the crudeness of available tools to assess pertinent process variables. Nonetheless, advances have occurred, and we may look forward with considerable confidence to future developments.

In this connection, it is important to note that process research must be linked to outcome and cannot meaningfully be conducted in the absence of suitable outcome measures. To this end, we must, as a minimum, have complete process records as well as outcome measures. The latter provide important anchors for exploring whether particular process variables are meaningfully related to outcome. This strategy has been followed in several recent outcome studies, including the Temple study (Sloane, Staples, Cristol, Yorkston, & Whipple, 1975) and the Vanderbilt Psychotherapy Project (Strupp & Hadley, 1979).

As we have seen, even without tampering with the therapeutic technology, it is possible to improve therapy outcomes by selecting appropriate patients and delimiting therapeutic goals. In some sense, these stipulations may be seen as artificial, because, in themselves, they do not address the question of whether refinements in therapeutic technique produce better results. On the other hand, they can be viewed as genuine advances, because they are realistic attempts to determine the potentialities and limits of psychotherapy. In this respect, they are no different from exploring systematically under what conditions a particular drug or a surgical

procedure is appropriate and effective. On the whole, such developments have been too slow in coming in psychotherapy, although they are precisely the direction in which the field must move.

Another logical move for improving therapeutic outcomes is to examine the technology itself for the purpose of achieving possible refinements. Major areas of possible technological advances seem to fall under the following rubrics, all of which are, of course, closely related to the therapist's attitude, stance, and activity: (1) management of the patient-therapist relationship, which subsumes issues of transference and countertransference, and (2) technical interventions, which include primarily interpretive activities (addressed often to a "dynamic focus"). I shall omit from consideration the setting of time limits, a maneuver which, in a number of studies, has been shown to accelerate therapeutic progress in itself.

MANAGEMENT OF THE PATIENT-THERAPIST RELATIONSHIP

The importance of focusing on the therapeutic relationship has been stressed since Freud's (1911-1915/1958) writings on technique. Indeed, Freud (1917/1958) stated forcefully that therapeutic progress occurs solely and uniquely through the patient's relationship to the therapist. Nonetheless, the bulk of the literature has been concerned with the technical management of the transference, that is, the patient's relationship to the therapist, rather than the interactional system. The fact that countertransference has been recognized as a weighty problem since 1910 does not mitigate this fact.

Only in relatively recent years has there been a resurgence of interest in the "therapeutic alliance" or "working alliance," particularly in the writings of Greenson (1967), who set the stage for the newer emphasis on what might be called a systems approach. Thus, it is characteristic of the literature on time-limited dynamic psychotherapy that major emphasis has been accorded the technical management of the transference and the nature of the therapist's interpretive activity. This emphasis on technical management is also manifest in the behaviorally oriented literature (e.g., Beck's, 1976, cognitive therapy). By its very nature, it tends to deemphasize the therapist's attitudes and stance at the expense of technical considerations.

In the following discussion, I propose to follow an approach that stresses the interactive aspects of the patient-therapist relationship. Within that context, particularly the quality of the relationship, technical

features may exert a facilitative, perhaps even a synergistic, effect. As I have maintained for a number of years, however, technique, in and of itself, remains inert. I base my adoption of this position on accumulating research evidence—for example, the Temple Study (Sloane *et al.*, 1975), the Menninger Project (Kernberg, Burstein, Coyne, Appelbaum, Horwitz, & Voth, 1972), the Tavistock Studies (Malan, 1976a, 1976b), and the Vanderbilt Psychotherapy Project (Strupp & Hadley, 1979)—which has shown that the quality of patient-therapist interaction represents the fulcrum upon which therapeutic progress turns. The second source of evidence derives from the finding that, with very few exceptions, no specific techniques have been shown to be singularly effective (Bergin & Lambert, 1978; Frank, 1979).

The quality of the therapeutic relationship, as we were able to show, depends heavily on (a) the patient's character makeup, motivation, and readiness to enter and participate in a therapeutic relationship of a particular type (i.e., the kind offered by a particular therapist), and (b) the therapist's ability to capitalize on the patient's qualities just enumerated. In practice, the latter means a certain flexibility of approach, empathy, and skill in contributing to the formation of a productive therapeutic alliance; most importantly, it means the therapist's ability to control and effectively channel his or her countertransference reactions. In addition to this ability to neutralize the patient's negative transference (hostility, negativism, resistance, and other obstacles which are part and parcel of the patient's problems), the therapist must also be able to resist his or her own ambition, which may be manifested by a furor sanandi, a tendency to mount frontal attacks on the patient's defenses, and impatience with what the therapist may experience as slow progress.

THE ROLE OF INTERPRETATION

Interpretive activity has been one of the major emphases of time-limited dynamic therapists. Sifneos (1972) stressed interpretations of Oedipal conflicts; Malan (1976a, 1976b) gave great weight to interpretations linking the conflicts which come alive in the patient-therapist relationship to the patient's parent figures; Mann (1973) placed interpretations dealing with separation in the forefront of his scheme; and Davanloo (1978) advocated frontal attacks on obsessional defenses. To a greater or lesser extent, all these activities presuppose the identification of a "dynamic focus" or a "core conflictual theme" (Luborsky, 1977). In other words, it

seems clear that any interpretive activity can become effective only to the extent that a conflict becomes "alive" in the transference, that is, sufficient affect has been mobilized, and the patient is actively struggling with a painful conflict in the here and now.

This requirement cannot be overemphasized, because it relates crucially to what every therapist knows—the *timing* of an interpretation. Unless the timing is right, interpretations have no more effect upon producing a dynamic reorganization of a cognitive-affective structure than reading a menu satisfies a starved person. I place so much emphasis on these facts because they appear to have weighty implications for what might be done to accelerate progress in time-limited therapy (or any other form) and the obstacles impeding progress. I perceive the following issues:

Context versus Content

Although the proponents of different approaches to time-limited dynamic psychotherapy have made claims for the unique effectiveness of particular kinds of interpretations, there is, as yet, no convincing evidence that such specific classes of interpretations (or, for that matter, any other technical maneuver) produce *unique* therapeutic results. These findings might be coupled with a previously cited result from the Vanderbilt Project, that professional therapists appeared to be particularly effective (more effective than untrained counselors) with patients possessing the highest levels of ego resources, including motivation. On the other hand, none of the therapists (either experienced professionals or lay counselors) was notably effective with patients showing marked resistance, negativism, rigidity, and hostility. This suggests that the effectiveness of dynamically oriented time-limited psychotherapy does not depend upon particular *kinds* of interpretations offered by the therapist, but rather upon the *quality* of the therapeutic relationship existing between the two participants.

The latter is a reasonably well documented finding also obtained by other investigators. It may be possible, however, to specify its significance more sharply: Interpretive activity of a particular kind may be notably effective, provided there exists a good therapeutic alliance, which, in turn, is determined by particular qualities preexisting in the patient and coming to fruition in the therapeutic process. Stated somewhat differently, interpretations of a particular kind may be highly effective, provided they happen to be the kind of interventions that appeal and make sense to the patient and to which he or she can positively resonate.

In this connection, it is important to mention that in the Vanderbilt

Project, therapists tended to be relatively invariant in their use of techniques (Strupp, 1980). Again, this means that if the patient was able to "use" the therapist's particular interpretive approach, therapeutic movement occurred. If, on the other hand, the therapist's approach remained alien to the patient, if resistances and other impediments in his psychological makeup prevented him from taking advantage of what the therapist had to offer, the effect of interpretations or similar activities was essentially nil.

To reiterate, I continue to be skeptical that particular kinds of interpretations per se exert a mutative effect; instead, they are effective if, like a piece in a jigsaw puzzle, they happen to constitute an important missing piece. This is not to say that one interpretation is as good as another (e.g., whether it deals with current interpersonal relationships or a classic childhood conflict), but it does say that, first and foremost, it must be personally meaningful to the patient in the context of the cognitive and affective constellation of the particular moment in therapy.

Technical Flexibility

Proponents of time-limited psychotherapy have traditionally stressed the need for flexibility on the therapist's part. In the Vanderbilt Project, we found little evidence that such flexibility existed in our therapists; on the contrary, their approach tended to be rather rigid. We can only speculate whether therapists in general possess the kind of "flexibility" apparently demanded by short-term approaches. It is more likely that some degree of flexibility exists in most therapists, but it may not be nearly as great as one might like to believe. The term "flexibility," of course, is in need of better definition.

One of the questions raised is the extent to which individual therapists can adopt a "special" therapeutic stance (even if it were clearly indicated on technical grounds) without sacrificing their authenticity, ceasing to be spontaneous, and becoming "gimmicky," none of which may remain hidden from sensitive patients. I believe that there is a distinct affinity between therapist and technique, and it is no accident that particular therapeutic approaches are uniquely congenial to particular therapists. If this is so, one might ask if it is possible for a therapist, who, for example, has gravitated toward a therapeutic model in which the gradual emergence of latent themes is stressed, to comfortably adopt the role of, say, a "relentless therapist" who mounts frontal attacks upon a patient's characterological defenses. Can the same therapist make "homework assignments,"

require patients to keep diaries of behavioral events, and so on? I do not pretend to know the answer, but I wonder whether therapists are not at their therapeutic best if they follow a technical approach that is maximally congenial to their own personality style. I do not wish to be misunderstood as advocating that the therapist should, without training or extensive clinical knowledge, do "what comes naturally," but it does seem that there should be a harmonious marriage between the therapist's personality makeup and the techniques he or she uses. Furthermore, interpretations must be anchored in, and emerge from, the therapist as a total human being rather than a therapeutic machine.

Person-Technique Blend

The foregoing considerations have important implications for the practice of time-limited dynamic psychotherapy. In light of the preceding exposition, I wish to advance the hypothesis that the time-limited therapists whose writing are currently in vogue are largely and perhaps predominantly successful not so much because of the particular kinds of interpretations they use (and consider uniquely effective), but rather because their particular personalities and the technique they have evolved constitute a special blend which works because these therapists are the kinds of people they are. Add to this the finding that the therapist's enthusiasm (plus, undoubtedly, his or her commitment) conduces to better results, and one arrives at the conclusion that the effects of therapy are a function not of the techniques per se, but rather of the unique constellation consisting of the therapist-as-a-person-in-conjunction-with-certain-techniques.

If this is so, we are faced with the thorny question concerning the extent to which particular techniques are teachable to others whose philosophy and personality makeup may be different from that of the originator of the system. The answer seems to be that just as certain patients benefit peculiarly from certain techniques, if the latter happen to coincide with what they need and find congenial, so particular therapists tend to gravitate toward certain therapeutic approaches for much the same reasons. Thus, there are distinct limitations with respect to the kinds and numbers of therapists who can be trained in a particular approach.

Having said this, I believe it is important to counteract the possible impression that technical developments in time-limited psychotherapy are foredoomed. This has been the problem of classical analysis. Because of the unfounded belief that the "classical model" was immutable, very little experimentation with technical alternatives occurred for many years, and

Alexander's (Alexander & French, 1946) attempts in this direction were greeted with a fair degree of hostility. Although there appear to be clear limits to what interpretations (and other techniques) may accomplish, it does not follow that *no* technical developments should occur, nor does it follow that therapists should allow themselves the luxury—society no longer does!—of waiting for the "right" patient to come along, that is, one who fits a rigid technical model.

Progress in technique development has also been retarded because many therapists have adopted a totally open-ended stance, which seemed to say that sooner or later, something of therapeutic value may transpire without the therapist doing much to hasten its occurrence. It is in this area that time-limited therapists have made significant contributions that merit further development. Such efforts will produce a sharper delineation of which patients can be helped by particular therapists who have been trained along particular lines. In the concluding section, therefore, I attempt to spell out, as clearly as possible, the directions in which the field must move for progress to occur.

FUTURE DIRECTIONS

In order to clarify my points, I would like to introduce a schematic presentation which, needless to say, should not be taken literally. Figure 1, parts A and B, summarizes major results of the research literature presented in the preceding section:

A1: Patient's Ego Resources Strong—Resistances Relatively Weak. Provided the patient possesses strong ego resources (including successful adaptation to life, high motivation for therapy, ability to become engaged in a collaborative relationship with a psychodynamically oriented therapist) and character resistances and distortions that are not too severe, the therapeutic outcome will generally be good. The diagram is designed to suggest that in this case, the therapist's human qualities (empathy, commitment, warmth, etc.), as well as specific technical skills, play a relatively minor role, as long as certain minimal requirements are met and the therapist is generally constructive and not psychotoxic. One qualification may be noted: therapists functioning at a high level, that is, those who are able to bring to bear an optimal combination of human qualities and therapeutic skills, achieve particularly impressive results with such patients. In this case, the therapist's skills seem to exert a synergistic effect. This is the

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CHAPTER 9 CHOOSING A METHOD OF SHORT-TERM THERAPY: A DEVELOPMENTAL APPROACH

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INTRODUCTION

In recent years, a number of methods of short-term, individual dynamic psychotherapy have been introduced. These methods differ significantly in their techniques and in the types of problems or conflicts which are used as the foci of the therapy. They include the interpretive method, based on vigorous interpretation of Oedipal conflicts, the empathic method, based on a brief, empathic encounter with the patient around the experience of loss, and the corrective method, based on the therapist's use of suggestion and transference management.

Because of the important technical differences among the methods, we suggest there may be types of patients for whom a particular method would be especially useful. Such a schema for matching method and patient would permit a therapist to take full advantage of the technical distinctions.

Furthermore, we suggest that a schema based on adult developmental stages integrates these schools of short-term work and provides a way of testing and determining their areas of application. We have chosen a developmental schema (rather than, for example, a diagnostic one), because

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