From: Levenson, H., Butler, S.F., Powers, T.A., & Beitman, B.D. (2002). ***Brief Dynamic and Interpersonal Therapy*****, Washington, DC: American Psychiatric Publishing, Inc. pp. 11-14**

CHAPTER ONE

INTRODUCTION

THE FOCUS OF THE BOOK

Psychodynamic Orientation

In writing this book on individual dynamic brief therapy we have taken the position that the clinician who is trying to institute time-limited or time-efficient approaches needs to operate from a systematic, theoretically-based model. As Kurt Lewin, a social psychologist, is credited with stating, "There is nothing so practical as a good theory" (1, p. viii). We have chosen to focus on psychodynamically-based or dynamically-informed models, not because psychodynamic theory is the be-all and end-all of all approaches. In fact, there is now ample empirical evidence that most "schools" of therapy achieve approximately the same magnitude of outcomes and all do better than no treatment or various types of control groups (2).

> We have instead selected to present various psychodynamic treatment models because "dynamic psychiatry simply provides a coherent conceptual framework within which all treatments are prescribed. Regardless of whether the treatment is dynamic psychotherapy or pharmacotherapy, it is *dynamically informed*" (3, p.4). This viewpoint is supported by the conclusion of the joint task force of the Association for Academic Psychiatry and the American Association of Directors of Psychiatry Residency Training (4) which held that psychodynamic psychotherapy is critical in general psychiatry education. In short, a deep, usable understanding and ability to apply clinically the concepts of a dynamic unconscious, transference/countertransference, and mental defense mechanisms is central to being an effective pharmacotherapist, behavior therapist, inpatient psychiatrist, consultation psychiatrist, and, perhaps, even a laboratory research psychiatrist (p. 9).

As Perry and colleagues (5) writing on the topic of psychodynamic formulation stated, "Therapeutic effectiveness or failure often hinges on how well or poorly the therapist understands the patient's dynamics, predicts what resistances

the patient will present, and designs an approach that will circumvent, undermine, or surmount these obstacles" (p. 543).

A recent national random survey of 4,000 mental health professionals (6) found that half of the psychiatrists, and a quarter of the psychologists and social workers identified themselves as having a purely psychodynamic orientation. An additional forty percent overall held an eclectic/integrative stance. Thus the psychodynamic perspective has been and remains quite robust and fundamental to the day-to-day practice of clinicians.

Throughout this book we define psychodynamically-informed therapies as those that consider, to a greater or lesser degree, the importance of early development, unconscious determinants of behavior, conflict, the therapeutic relationship between therapist and patient (including transference and countertransference), patients' resistance to the work, and repetitive behavior. We will not, however, present psychodynamic models that use complex, highly inferential constructs (e.g, oral, anal, phallic stages of development) and require adoption of an elaborate, metapsychological framework with unclear behavioral referents (e.g., id, ego, superego) . Rather, we have selected dynamic approaches that stick close to the observable data, because they have been shown to be quite clinically useful and didactically teachable.

Brief Psychotherapy

To the novice reader it may seem that brief psychotherapy is a recent phenomenon brought on by the advent of managed care and third-party payers due to the shrinking mental health dollar. However, for years patients themselves have been electing to be treated "briefly" by choosing to stay in therapy an average of six to eight sessions regardless of the type of outpatient treatment they are receiving (7, 8). These findings hold even for treatments that are intended to be long-term (9). It has been estimated that 90% of all patients leave treatment by the tenth session. While we do not know precisely the reasons for these "drop-outs," improvement data indicate that approximately 50% of patients report considerable benefit by the eighth session (10). Most patients who come for therapy are in emotional pain. They want to have their pain alleviated as soon as possible. Most of them are not fascinated by their psyches, nor are they pursuing mental health perfection.

These consumer-defined brief therapies, or what have been called, "naturally occurring brief therapies," are quite different from therapies that are planned from the start to make the most of limited time. Brief therapies *by*

default, which has been the norm, is in contrast to the therapies presented here that are brief therapies *by design*.

Outcome data for *planned* short-term therapies indicate that the average brief therapy patient does better than 80% of untreated control subjects (11). In fact, empirical studies have failed to demonstrate that long-term approaches achieve better measurable outcomes than short-term therapies. "Since brief therapy requires less time (for both therapist and patient) and therefore less social cost, it has been suggested that brief methods are equally effective and more cost efficient than long-term psychotherapy" (11, p. 692).

Today there is an increasing demand for mental health professionals to use briefer therapeutic approaches due to limited mental health resources, emphasis on accountability, third-party payers, and consumer need. In the Davidovitz and Levenson national practitioner survey (6), 84% of all clinicians said they are doing some form of planned brief therapy for a portion of their practices.

Brief Dynamic Approaches

Traditionally, 25 sessions has been defined as marking the upper limit of brief dynamic therapies (11), but in practice, the range may be a few as 1 (12) or as many as 40 (13). Although many health maintenance organizations (HMOs) have a stated limit of 20 sessions per year usually for crisis intervention or medical necessity, their average comes closer to six. Other settings impose various time limits--but most fall between six and twenty visits.

Recently, however, there has been a movement away from considering brief therapy just in terms of the number of sessions. Instead researchers, theoreticians, and clinicians are talking about time-attentive models that try to make every session count regardless of the length of treatment. Here the emphasis is on the therapist's and patient's *time-limited attitude*, and terms such as *time-effective, time-sensitive*, and *cost-effective* seem more relevant.

As expected in the nationwide practitioner survey (6), psychodynamically-oriented therapists reported they did fewer brief therapy hours than their colleagues with other theoretical orientations. However, because the dynamic therapists comprised such a large proportion of the sample, they were responsible for one-fourth of all the brief therapy being conducted in the United States! Unfortunately the survey data also indicate that the psychodynamic practitioners who were doing brief therapy had received significantly less training in it, felt less skilled to do it, and judged it less effective than their colleagues trained in other orientations.

These findings are alarming from a consumer perspective. It is now widely accepted that brief therapy is not dehydrated long-term therapy (14) nor just less of the same (15), but rather requires specialized training in its own methodology (16, 17). Therapists who are trained in brief therapy and follow specified methods have better outcomes than those who do not (18-20); and trained clinicians feel that they are better skilled in brief therapy than their untrained counterparts (21). Yet it seems apparent that a major discrepancy exists between the demand and the supply of professionals who are prepared effectively to use time-efficient methods. This Concise Guide on individual, brief dynamic therapies is a step in the direction of helping to educate beginning and experienced clinicians in the strategies and techniques of brief dynamic therapeutic models.

QUALITIES THAT DEFINE BRIEF DYNAMIC THERAPY

In a content analysis of books and articles addressing essential features that distinguish brief dynamic from long-term dynamic therapy, Levenson (17) found a number of fundamental qualities pertinent to brief therapy repeatedly mentioned. Table 1 contains a list of these qualities rank ordered in terms of the frequency with which they are mentioned in the literature. This list provides a consensual, operational definition of short-term dynamic psychotherapy. All of the therapies presented in this book manifest these characteristics to some extent.

Table 1: Qualities that Define Brief Dynamic Psychotherapy

Limited focus and limited goals
Time limits and time management
Specific selection criteria
Therapist activity
Need to develop a therapeutic alliance quickly
Rapid assessment
Termination
Optimism on the part of the therapist
Treatment contract

Adapted from Levenson H, Butler SF: Brief dynamic individual psychotherapy, in The American Psychiatric Press Textbook of Psychiatry, 2nd Edition. Edited by Hales RE, Yudofsky SC, Talbott JA. Washington DC, American Psychiatric Press, 1994, p 1012

VALUES AND ATTITUDES

Unfortunately, it is not just for lack of didactic information that there are not more psychodynamically-oriented therapists who feel more skilled in applying brief interventions. Because many dynamic clinicians operate from an orientation that has valued long term, depth-oriented work, they have resistances toward learning short-term methods despite clinical advances and outcome data that demonstrate their effectiveness. Such clinicians may hold a number of myths or erroneous beliefs that make them reluctant to learn briefer interventions. The reader might want to peruse the items in Table 2 to assess his or her "resistances" to briefer therapies.

Table 2: Sources of Resistance Against Short-term Dynamic Psychotherapy

1. The belief that "more is better"
2. Therapeutic "perfectionism"
3. Confusion of patient's interests with the therapist's interests
4. Demands greater activity and intense alertness
5. May be less profitable and dependable
6. Therapists' conflicts around separation and loss
7. Therapists' conflicts around attachment with new patients
8. Therapists' negative reaction to being told what to do
9. The need to be needed
10. Insecurities regarding one's own skill
11. Anxiety over the loss of one's professional role
12. Overconcern for the "successful" termination

Adapted from Bauer GP, Kobos JC: Brief Therapy: Short-term Psychodynamic Intervention. Northvale NJ, Jason Aronson, 1987; Hoyt MF: Therapist resistances to short-term dynamic psychotherapy. J Am Acad Psychoanal 13:93-112, 1985; Martin ES, Schurtman R: Termination anxiety as it affects the therapist. Psychotherapy 22:92-96,1985

Budman and Gurman (22) proposed that the value system of the long-term therapist is significantly different from that of the short-term therapist. They suggested that one of the critical criteria for defining the nature of brief therapy is "*a state of mind of the therapist and of the patient*" (p. 278), rather than the number of sessions or length of treatment. These authors postulated eight dominant values pertaining to the ideal manner in which long-term therapy is practiced. They then contrasted these with the corresponding ideal values pertinent to the practice of

short-term therapy. Table 3 lists the comparative dominant values of the long-term and the short-term therapist.

Table 3: Comparative Dominant Values of the Long-term and the Short-term Therapist

Long-term Therapist	Short-term Therapist
1. Change in basic character.	Least radical intervention, does not believe in the notion of "cure."
2. Significant psychological change is unlikely in everyday life.	Adult developmental perspective; psychological change is inevitable.
3. Presenting problems reflect more basic pathology.	Presenting problems are taken seriously (although not always at face value).
4. "Be there" as patient makes significant changes.	Many changes will occur "after therapy"
5. Therapy has a "timeless" quality; therapist is patient.	Therapy is finite; therapist is active
6. Fiscal convenience of maintaining long-term patients.	Fiscal issues muted by an organizational structure.
7. Psychotherapy as almost always benign and useful.	Psychotherapy is sometimes useful, sometimes harmful.
8. Therapy as the most important part of patient's life.	Being in the world is more important than being in therapy.

Reprinted with permission from Budman SH Gurman AS: Theory and Practice of Brief Psychotherapy. New York, Guilford, 1988, p 11

In an empirical study, Bolter, Levenson and Alvarez (23) found that for two of the eight dominant values responses were different between therapists who prefer doing long-term therapy and those who prefer short-term approaches. Specifically, short-term therapists believe more strongly that psychological change occurs after therapy (Value # 4), and that setting time limits intensifies the therapeutic work (Value # 5). However, results also indicate that clinicians with a psychodynamic orientation (in contrast to those trained in cognitive-behavioral models) were more likely to believe that therapy is necessary for change (Value # 2), that therapy should be open-ended (Value # 5), and that ambitious goals are desirable (Value # 1). Thus findings suggest that while one's preferred approach (short versus long-term) is related to therapeutic values, the therapist's theoretical orientation (psychodynamic versus cognitive/behavioral) also plays a significant role.

In the national practitioner survey (6), 90 % of psychodynamic therapists said they preferred doing long-

term and moderately long-term therapy! Thus we can expect there are a sizeable number of therapists who are in conflict--doing brief work they do not believe in, feel skilled in, or prefer to do, but who, out of economic or administrative constraints feel pressured to do so. Without the proper training *and* positive attitudes, we can expect poorer therapeutic outcomes done by professionals who feel burned out and demoralized.

We, therefore, hope that this Concise Guide will not only help educate clinicians that brief psychodynamic approaches have much to offer in the meaningful treatment of people coming for help, but also that it will foster more positive and optimistic attitudes toward using brief therapy.

SPECIFIC MODELS PRESENTED

Eight psychodynamic brief individual therapy models are presented:

Supportive Therapy

Time-Limited Therapy

Interpersonal Therapy

Time-Limited Dynamic Psychotherapy

Short-Term Dynamic Therapy for Post-traumatic Stress Disorder

Brief Dynamic Therapy of Substance Abuse Disorders

Brief Psychodynamic Psychotherapy with Children

Pharmacotherapy and Psychotherapy Integration

These eight were chosen because they represent well-established short-term approaches to clinical issues that therapists commonly encounter in their clinical practices. In addition, most of them have clearly defined intervention techniques and formulation strategies that should help the novice as well as the experienced clinician who wishes to use brief interventions in a more informed manner. We also tried to select models that could be used within the ten to twenty session time-frame of most managed care settings. Nonetheless, many of these approaches are equally applicable regardless of the length of the treatment. (One notable exception is that of James Mann, Chapter 3.) The above list is not meant to be exhaustive or representative. We do think, however, that the psychodynamically-informed practitioner who is knowledgeable about these eight models has an enormous armamentarium of clinical interventions to help patients in a time-efficient and effective manner.

In each chapter a different model is discussed in terms of its overall framework, selection criteria, goals,

therapeutic tasks and strategies, empirical support and relevance for managed care. Clinical cases are used to illustrate the application of each model. In addition, a chapter on the use of psychopharmacotherapy is provided from the standpoint of the dynamically-informed use of medications.

In addition, we have listed at the beginning of each chapter the various presenting problems we think are most suited to be treated by that particular approach. While psychodynamic models have often been used generically to treat all comers for every problem, we are impressed with how each model seems more applicable to certain types of problems and/or particular patients. By highlighting these relevant problems, we hope the practitioner will be guided to consider using a particular approach for reasons other than previous indoctrination, bias, or lack of knowledge.

However, some problems are so prominent or overwhelming that the clinician should first consider using a treatment specifically designed to treat them. For example, for significant substance abuse, one should use models designed to treat that problem before considering treatment for other (presumably less pressing) problems. The sophisticated and experienced clinician will be able to combine aspects from various approaches to treat more precisely any combination of presenting problems. Because all of these approaches are basically psychodynamic in orientation, they can still maintain an overall coherence if several are blended. The eight treatment models can be characterized by the degree to which they use supportive versus expressive techniques; focus on acute versus chronic problems; target changes in symptoms versus personality; and highlight intrapsychic versus interpersonal dynamics.

Since this a *concise* guide, the reader will be given just a brief overview to each approach. We hope that the clinical and empirical relevance of these models will whet the reader's appetite to delve further in learning more about them. In each chapter we have identified the major references for additional reading. Of course, no one can learn therapy, brief, dynamic, or otherwise, solely from books. We therefore encourage readers also to obtain clinical supervision in the particular approaches in order to practice them with sophistication and satisfaction.

REFERENCES

1. Marrow AJ: The Practical Theorist. New York, Basic Books, 1969

2. Smith ML, Glass GV, Miller TI: The Benefits of Psychotherapy. Baltimore, MD, Johns Hopkins University Press, 1980

3. Gabbard GO: Psychodynamic Psychiatry in Clinical Practice. Washington, DC, American Psychiatric Press, 1990

4. Mohl PC, Lomax J, Tasman A, et al: Psychotherapy training for the psychiatrist of the future. Am J Psychiatry 147:7-13, 1990

5. Perry S, Cooper AM, Michels R: The Psychodynamic formulation: Its purpose, structure, and clinical application. Am J. Psychiatry 144:543-551, 1987

6. Davidovitz D, Levenson H: National survey on practice and training in brief therapy: Comparison of psychologists, psychiatrists and social workers. Paper presented at the annual meeting of the American Psychological Association, New York, August, 1995

7. Garfield SL: Research on client variables in psychotherapy, in Handbook of Psychotherapy and Behavior Change, 3rd Edition. Edited by Garfield SL, Bergin AE. New York, Wiley, 1986, pp 213-256

8. Phillips LE: The ubiquitous decay curve: Delivery similarities in psychotherapy, medicine and addiction. Professional Psychology: Research and Practice 18:650-652, 1987

9. Pekarik G, Wierzbicki M: The relationship between clients' expected and actual treatment duration. Psychotherapy 23:532-534, 1986

10. Howard KI, Kopta SM, Krause MS et al: The dose-effect relationship in psychotherapy. Am Psychol 41:159-164, 1986

11. Koss MP, Shiang J: Research on brief psychotherapy, in Handbook of Psychotherapy and Behavior Change, 4th Edition. Edited by Bergin AE, Garfield SL. New York, Wiley, 1993

12. Bloom BL: Planned Short-Term Psychotherapy. Boston, Allyn and Bacon, 1992

13. Sifneos PE: Short-Term Dynamic Psychotherapy: Evaluation and Technique, 2nd Edition. New York, Plenum, 1987

14. Cummings NA: The dismantling of our health system: Strategies for the survival of psychological practice. Am

Psychol 41:426-431, 1986

15. Peake TH, Bordin CM, Archer RP: Brief Psychotherapies: Changing Frames of Mind. Beverly Hills, CA, Sage, 1988

16. Bauer GP, Kobos JC: Brief Therapy: Short-Term Psychodynamic Intervention. Northdale, NJ, Jason Aronson, 1987

17. Levenson H, Butler SF: Brief dynamic individual psychotherapy, in The American Psychiatric Press Textbook of Psychiatry, 2nd Edition.. Edited by Hales RE, Yudofsky SC, Talbott JA. Washington DC, American Psychiatric Press, 1994, pp.1009-1033

18. Burlingame GM, Fuhriman A, Paul S, et al: Implementing a time-limited therapy program: Differential effects of training and experience. Psychotherapy: Theory, Research and Practice 26:303-312, 1989

19. O'Malley SS, Foley SH, Watkins SD, et al: Therapist competence and patient outcome in interpersonal psychotherapy of depression. J Consult Clin Psychol 56:469-501, 1988

20. Rounsaville BJ, O'Malley S, Folwy S, et al: Role of manual-guided training in the conduct and efficacy of interpersonal pscyhotherapy for depression. J Consult Clin Psychol 56:681-688, 1988

21. Levenson H, Speed J, Budman SH: Therapist's experience, training, and skill in brief therapy: A bicoastal survey. Am J Psychotherapy 49:95-117, 1995

22. Budman SH, Gurman AS: Theory and Practice of Brief Psychotherapy. New York, Guilford, 1988

23. Bolter K, Levenson H, Alvarez W: Differences in values between short-term and long-term therapists. Professional Psychology: Research and Practice 4:285-290, 1990