

# Brief dynamic psychotherapy

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## Definition

The notion of brief dynamic psychotherapy (BDP) may seem at first sight to be a contradiction in terms. 'Dynamic' is a Freudian psychoanalytic term implying conflictual psychological forces – an opposition between the conscious and unconscious mind, and the use of defence mechanisms to arrive at a compromise between them. The rigidity of the obsessional person whose self-expression is traded for security, the self-reproaches of the depressive reflecting inhibited aggression, the clinging of the phobic individual who lacks an inner sense of a secure base – these would be examples of the relationship between dynamic conflict and psychiatric symptoms. But the image of psychoanalysis conjures up a picture of prolonged and intensive couch-based therapy. How can this be brief?

There are several answers to this. First, Freud's original conception of psychoanalysis was, by modern psychoanalytic standards, extremely brief – a therapy lasting six months would have been considered long, and occasionally consisted of no more than a brisk walk with the master round the Vienna woods.

Second, as analyses became more and more prolonged, some early analysts, notably Ferenczi and Rank, saw the need for more circumscribed, time-limited treatments, and began to discuss techniques to make these effective, such as reducing therapist passivity and focusing on the here-and-now rather than on the reconstruction of past trauma.

Third, Freud himself addressed the problem of the 'interminability' of some analyses (Freud, 1937) and experimented with setting a definite date for ending.

Fourth, research suggests a negative logarithmic 'dose-effect' curve in psychotherapy (Howard *et al*, 1986), such that more than two-thirds of total therapeutic benefit is achieved within the first 25 sessions.

Fifth, there is evidence that quality rather than quantity of good attachment experience in childhood is linked with security and self-confidence

### Box 1. Pioneers of BDP

Rank and Ferenczi – active therapist  
 Freud – setting a date for termination  
 Alexander and French – corrective emotional experience  
 Michael and Enid Balint – focal therapy  
 Malan – brief dynamic psychotherapy  
 Sifneos and Davanloo – short-term anxiety-provoking therapy  
 Luborsky – core conflictual relationship theme  
 Mann – time-limited psychotherapy  
 Ryle – cognitive analytic therapy

and, by analogy, the same may be true in psychotherapy (Holmes, 1993).

Finally, it has been found that psychotherapy based in community mental health centres in the USA has a median length of treatment of 13 sessions (Howard *et al*, 1989): BDP can be conceptualised as an organised form of what otherwise would be a premature closure of therapy.

BDP can be defined as a time-limited form of psychoanalytically based therapy, usually lasting between 6 and 40 sessions, characterised by high levels of therapist activity, and the attempt to work with a psychodynamic 'focus' which links presenting problem, past conflict or trauma, and the relationship with the therapist. Although there are distinct schools of BDP, this article synthesises the main clinical features common to all of them, and highlights important differences where relevant.

## Assessment: indications and contraindications

Most authors emphasise the need for careful assessment before embarking upon BDP, but there is little systematic research on the specific indi-

cations for it, as opposed to dynamic therapy generally. An exception was Horowitz *et al* (1984), who found in brief therapy following bereavement that the more disturbed patients did better with behavioural supportive therapy, while those with greater ego strength improved more with BDP. This is consistent with the usually cited indications for BDP, which include high motivation for change, a circumscribed problem, evidence of at least one good relationship in the past, and the capacity for self-reflection or 'psychological mindedness'.

Malan (1963, 1976*a,b*, 1979) indicates contra-indications such as:

- (1) chronic addiction
- (2) serious suicide attempts
- (3) chronically incapacitating phobic or obsessional symptoms
- (4) evidence of gross destructive or self-destructive 'acting out' behaviours.

However, there is clinical evidence (Malan, 1979; Ryle, 1990) that quite disturbed patients with long-standing difficulties can, if sufficiently motivated, be helped with BDP. Since Malan's list contains qualifying terms such as 'gross' and 'serious', which are matters of judgement, in the end the 'feel' of the assessment interview remains a critical determinant of whether BDP is likely to be helpful. This is consistent with research indicating that a positive therapeutic alliance and the capacity to show affect in the early sessions of therapy are the best predictors of good outcomes in therapy generally (Orlinsky & Howard, 1986). This finding can be linked with Malan's notion of therapeutic 'leap-frogging' in BDP, in which the therapist responds to the patient's material with a brief comment or interpretation, leading to deepening of rapport, and further elaboration by the patient, perhaps with an affective response – usually sadness or anger – followed by another intervention by the therapist, and so on.

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## Therapeutic contract

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If the decision is to proceed with BDP, the patient should be informed at the outset what the terms of the therapeutic contract are:

- (1) how many sessions are being offered
- (2) how long they will last, what the arrangements are in case of missed sessions
- (3) where 'homework' is part of the therapy, as in cognitive analytic therapy (Ryle, 1990), what is expected.

Most BDP includes a follow-up session after treatment has ended, and this too should be mentioned at the outset. Some BDP is defined by time rather than number of sessions (e.g. six months, or 'from now until Easter'). This may seem less draconian than defining a number of sessions, and leaves room for transference reactions as to whether six months, say, is a 'long' or 'short' time, but has the disadvantage of promising rather more than is often delivered because of holidays and breaks due to illness.

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## Finding a focus

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The Balints (1961) introduced the notion of a 'focus' in dynamic therapy, and indeed 'focal therapy' is often used interchangeably with BDP, although the phrase could equally be applied to cognitive therapies. A focus brings together

- (1) the patient's presenting problem
- (2) past difficulty – usually a hidden impulse or affect related to loss or trauma
- (3) the current transference relationship with the therapist.

The focus thus is a crystallisation of the patient's core or nuclear problem, based in the past, but permeating present difficulties and conflicts. The idea of focus operates at several levels in the course of dynamic therapy. It provides an overall conceptualisation of the problem; ensures that patient and therapist do not become distracted by interesting but irrelevant side issues; and acts as a guide to the therapist's interventions.

## *The man who beat his wife*

John was a 30-year-old panel beater, whose marriage was in tatters when he presented for help with his intense jealousy, bordering on morbid, of his wife. She responded to his jealous outbursts with provocative flirtation, and so a vicious circle built up. Both had been married before, but they had two children together and were desperate for the marriage to succeed. John was clearly depressed, with a score of 28 on the Beck Depression Inventory. The final straw had come when, rather than just shouting at his wife, he had physically assaulted her.

Although not particularly psychologically minded, and with no educational qualifications, he was strongly motivated for change, made a good rapport with the therapist, and was taken into a project specifically offering BDP to men with problems of violence.

He came from a family of four; when he was seven his sister developed cancer and eventually died; at the

same time he and his brother were sent to a children's home about 150 km from his home town for a year. Their parents visited once a fortnight.

The therapist made a focal link between his feelings of abandonment as a child and the emotions which were aroused in him when he imagined his wife was fancying other men. John, 'leapfrogging', then recalled his feelings of fury and incomprehension when his parents left after visiting the home, and how he would invariably get into a fight with one of the other boys at that moment, for which he would be severely punished (just as he now was by his wife's withdrawal from him, and, sometimes, by the law), further fuelling his feelings of rage and injustice. In the sessions he was generally friendly, punctual, and positive, and relations with his wife seemed to improve. The therapist often felt rather overwhelmed and importuned by John's rapid-fire delivery, which made it hard for him to get a word in, and it was a relief when the session came to an end. This countertransferential reaction provided a view into how stifled John's wife might feel, perhaps based on John's feeling that any space or distance in a relationship was equivalent to abandonment. This was highlighted when the therapist mentioned he would be unavoidably away in two sessions' time. John became despondent, and referred at the next session to the therapist "going away on your holidays". The therapist pointed out that he had not said he would be on holiday, but simply "away" (in fact his absence was work-related). John conceded that this was true, and revealed that he thought the therapist had had enough of him, needed a break, and was "flying off for a bit of sun". Once more he felt abandoned, and this led to discussion of how he imagined his parents having a good time away from him as a child, when in fact they were struggling with his sister's death, which was never openly discussed in the family. When he returned from the home she was simply not there. This in turn led onto his misery at the thought of losing his children if the marriage broke up. He missed the next session after the break, but returned for the following one, saying that things had been very bad with his wife, confirming Malan's view that the patient's worst problem will manifest itself at some point during therapy. This was once more taken up around the focal notion of abandonment and his furious reaction to it. Thereafter he continued to improve. At follow-up there had been no more serious outbreaks of violence, and he was still using his 'mood diary' when he felt bad, a device which had been suggested in the course of therapy.

The capacity to find and work with a focus is central to BDP, and several authors have developed conceptual tools to help therapists think focally. Malan (1979) extended Menninger's idea of a psychodynamic 'triangle of insight' into his 'triangle of person' and 'triangle of defence' (see Fig. 1). The

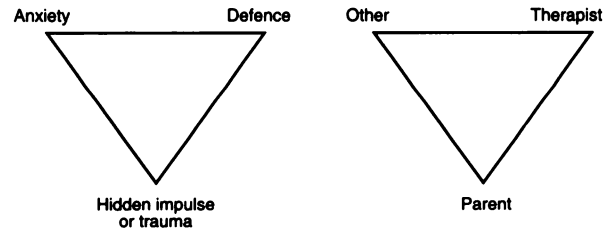


Fig. 1. Malan's triangles

former links the relationship with the 'significant other' (in John's case his wife), the therapist, and the parent; the latter connects a hidden impulse or forbidden feeling, a defence, and a resulting anxiety. John's hidden feeling was abandonment; his defence was to attack and fight and so punish in the hope of preventing his 'object' from leaving him; and his anxiety manifested itself in his jealousy.

Molnos (1984) has combined these into her four triangles in which the triangle of defence is experienced at different times in relation to other, therapist, and parent.

Ryle (1990) similarly uses pictorial means to crystallise a focus, in his 'sequential diagrammatic reformulation' (SDR) (see Fig. 2), which emphasises the self-perpetuating nature of neurotic difficulty – John's violent 'defence' against abandonment producing the very result it aimed to prevent.

Like Ryle, Luborsky (1984) uses for research purposes a set of standard foci, or 'core conflictual relationship themes' (CCRT). These comprise

- (1) a wish
- (2) an imagined response by the other
- (3) the reaction of the self to that response

For John this would be the wish not to be abandoned, the abandonment, and his consequent violent retaliation, manifest in his symptoms, his behaviour as a child, and his reaction to the therapist's absence.

## The corrective emotional experience

Alexander & French, who pioneered BDP in the USA in the 1940s, popularised Strachey's idea that cure in dynamic therapy comes about not, as Freud originally suggested, through intellectual insight alone, but by a reworking of relationship patterns with the therapist in a way that disconfirms

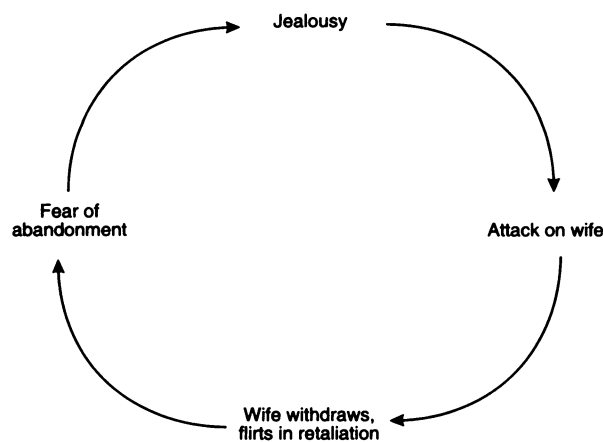
**Exits**Count to ten (*behavioural*)Awareness of fear of abandonment from childhood (*dynamic*)Perhaps wife is just friendly, not unfaithful (*cognitive*)

Fig. 2. Sequential diagrammatic reformulation

previous neurotic expectations – the ‘corrective emotional experience’. John’s riposte to the therapist’s missed session was to fail to turn up next time himself, but the therapist reacted to this with understanding, not punishment, a response which John was perhaps able to internalise and use when he next felt let down by his wife.

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## Managing resistance

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Entering therapy is risky – patients are invited to abandon defences which may have served them reasonably well for many years. BDP offers two contradictory strategies for overcoming resistance – the cautious and the confrontative. Malan originally counselled caution, arguing that it is best to proceed from interpretations directed against anxiety and defence before going to the underlying feeling that is being defended. In John’s case the therapist suggested that his jealousy was not some inherently evil part of his character, but could be understood dynamically to arise from his fear of abandonment. The sequence was from his fear of splitting up with his wife (anxiety) to his jealousy (defence). Only later were the underlying feelings of rage and murderousness towards those who threatened to leave him (parents, wife, therapist) tackled.

Later, Malan became strongly influenced by the work of Davanloo (1980), a pupil of Sifneos (1979) who developed the method of ‘short-term, anxiety-provoking psychotherapy’ (STAPP). Davanloo, a powerful and charismatic figure, goes further than Sifneos and advocates the relentless confrontation of resistance, in which patients are held in the here-and-now by a therapist who will not let them go until they have faced their negative feelings and destructiveness. A depressed patient will be confronted with her anger for example, and if she denies it, the therapist will interpret the denial until the patient actually becomes angry in the session with the therapist. Expressing such ‘healing anger’ is a great relief to the patient, who at this point usually begins to let go of other feelings, especially sadness and tears (Ashurst, 1991).

This cathartic approach can, in the right hands, be highly potent, but is not a necessary part of routine BDP practice. Ryle, for example, in his cognitive analytic therapy, which combines the techniques of BDP and cognitive therapy much more gently, urges the patient to consider possible ‘exits’ from his self-perpetuating vicious circles of neurosis. John used a variety of these, including the folk-wisdom of ‘counting to ten’ when he felt enraged, identifying the fear of abandonment that underlay his violence, and discussing with himself the possibility that his wife was simply being civil when talking to other men, rather than planning to go to bed with them.

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## Active therapist

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Implicit in the above is the requirement of an active therapist, intervening frequently, holding the patient to the focus, attending to the here-and-now interactions. This is very different to the caricature of the passive analytic or Rogerian therapist who says little and suggests not at all. Whether such therapists exist in reality, even in full psychoanalysis, is debatable, but BDP undoubtedly implies active collaboration between therapist and patient, a relationship based as much on learning as holding and interpreting.

Malan studied the types of interventions made by therapists and claimed that good outcomes were particularly associated with high frequency of transference interpretations (T-P links) – for those committed to psychoanalysis a particularly satisfying result. However, this finding has not been replicated, and may well be an artefact (Marziali, 1984), quality rather than quantity of interpretation

being the more likely candidate for therapeutic efficacy. This view is supported by Piper *et al's* (1991) study showing that high frequencies of transference interpretations were related to poor outcomes, although whether this was a causal relationship, or merely a desperate attempt by therapists to salvage an already rocky therapeutic alliance, was unclear.

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## Termination

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Perhaps the defining feature of BDP is its time-limitedness, attempting to turn to advantage what, from a traditional psychoanalytic viewpoint, might seem a major drawback (Rosen, 1986). The limit to the contract, it is claimed, as well as being cost-effective, concentrates the mind of both patient and therapist, intensifies feelings, and enables a working through of themes of loss which are so central to many neurotic difficulties.

Mann's (1973) time-limited psychotherapy (TLP) particularly stresses termination, and the patient is informed at each session how many are left. This aspect of brief therapy can be stressful for therapists when first embarking on BDP, especially if from a psychoanalytic background. It is often clear towards the end of therapy that much psychic work has been left undone, but this is balanced by an affirmation of the patient's autonomy and capacity to cope, and for the therapist of a feeling of a job begun and completed. Ryle's cognitive analytic therapy includes a 'goodbye' letter, given to the patient at the penultimate session, and, as mentioned, most BDP schemata include a three-month follow-up. While most patients are satisfied with BDP, there will be some who require either a further course of BDP or a move into another mode of therapy, perhaps marital therapy or a long-term analytic group therapy.

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## Outcome

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The evaluation of controlled studies of psychotherapy remains controversial. Two meta-analyses of outcome in BDP compared with waiting-list controls (Crits-Cristoph, 1992; Svartberg & Styles, 1992) confirmed impressive effect sizes (0.8–1.1) in target symptoms, general psychiatric symptoms and social adjustment, with treated patients better off than 90% of those awaiting treatment. However, the improvements were less impressive when compared with non-specific treatments such as 'clinical management' and self-help groups, although on

### Box 2. Factors predicting good outcomes in BDP

**Circumscribed problem**  
**Strong motivation**  
**Able to express feeling at assessment**  
**Psychological-mindedness**  
**At least one good relationship**  
**Evidence of achievement**  
**Not actively suicidal**  
**Not chronically obsessional or phobic**  
**Not grossly destructive or self-destructive**  
**Not actively abusing illicit drugs**

target symptoms BDP patients were still better off than 60% of controls.

Crits-Cristoph (1992) found the effect size for 11 studies when compared with alternative treatments was on average only 0.32. But in two studies from highly reputable centres the effect sizes were much higher: Luborsky's group (Woody *et al*, 1990) compared BDP with routine drug counselling (effect size 0.74), and Weissman's group (DiMascio *et al*, 1979) contrasted interpersonal therapy (IPT) with 'low contact therapy' (effect size 0.67). Winston *et al* (1994) compared two different BDP models, 'brief adaptive therapy' and 'short-term dynamic psychotherapy' in the treatment of personality disorders. As in most psychotherapy outcome studies, no consistently significant differences emerged between the different BDP models, although both were superior to waiting-list controls on all measures.

In general, depression, especially as measured with the BDI, seems to respond well to psychological treatments such as BDP, and, in the follow-up studies performed, such interventions can be as effective as antidepressant medication in preventing relapse (US DHHS, 1993).

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## Conclusions

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BDP is a successful, logical, cost-effective, teachable and appropriate form of therapy for a wide range of patients with neurotic disorders and moderately severe personality disorders (Winston *et al*, 1994; Stevenson & Meares, 1992). It is relevant to the work of NHS psychiatric departments, and should be part of the repertoire of most psychiatrists.

Interesting convergences are beginning to emerge between BDP and cognitive therapy, as the former

**Box 3. Requirements for successful practice of BPD**

Appropriate setting – regular time, quiet place  
 Commitment  
 Focal thinking  
 Positive therapeutic alliance  
 Sticking to a particular model  
 Good supervision  
 Experience of personal therapy (desirable but not essential)

acknowledges the cognitive component of much analytic work, while the latter recognises the importance of resistance and transference (Teasdale, 1993). To be effective, therapists should learn and stick within a particular model of therapy: Frank *et al* (1991) have shown that for interpersonal therapy (IPT) good outcomes can be linked to the extent to which therapists remain faithful to the method they purport to practise.

Training manuals are available for a number of forms of BDP (e.g. Luborsky *et al*, 1984; Ryle, 1990), and most psychotherapy departments provide relevant training and supervision. An essential prerequisite of practising BDP, as indeed with all forms of psychotherapy, is regular supervision, which, in the current political climate, can be characterised as continuing professional development or quality control.

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## Multiple choice questions

- 1 The following names are particularly associated with BDP:
  - a Malan
  - b Jung
  - c Freud
  - d Kohut
  - e Balint
  
- 2 In assessing for BDP the following are contra-indications:
  - a actively suicidal
  - b severe psychopathology
  - c poor motivation
  - d age over 40
  - e chronic obsessional neurosis
  
- 3 In the triangle of defence:
  - a anxiety should be interpreted before hidden impulse
  - b the patient uses obsessional mechanisms
  - c Malan was using Menninger's ideas
  - d issues of transference are likely to be involved
  - e the triangle is based on compensation neurosis
  
- 4 Termination in BDP:
  - a should not be mentioned until the last few sessions
  - b brings up feelings from previous losses
  - c is a form of abortion counselling
  - d may be associated with anger
  - e may make the therapist feel guilty

- 5 BDP:
  - a is never a first choice of psychotherapy
  - b is usually practised only by experienced analysts
  - c requires continuing supervision
  - d should never be offered more than once to the same patient
  - e is no more effective than being on a waiting-list

### MCQ answers

- |          |          |          |          |
|----------|----------|----------|----------|
| <b>1</b> |          | <b>3</b> |          |
| <b>a</b> | <b>T</b> | <b>a</b> | <b>T</b> |
| <b>b</b> | <b>F</b> | <b>b</b> | <b>F</b> |
| <b>c</b> | <b>T</b> | <b>c</b> | <b>T</b> |
| <b>d</b> | <b>F</b> | <b>d</b> | <b>T</b> |
| <b>e</b> | <b>T</b> | <b>e</b> | <b>F</b> |
|          |          | <b>4</b> |          |
| <b>2</b> |          | <b>a</b> | <b>F</b> |
| <b>a</b> | <b>T</b> | <b>b</b> | <b>T</b> |
| <b>b</b> | <b>F</b> | <b>c</b> | <b>F</b> |
| <b>c</b> | <b>T</b> | <b>d</b> | <b>T</b> |
| <b>d</b> | <b>F</b> | <b>e</b> | <b>T</b> |
| <b>e</b> | <b>T</b> |          |          |
|          |          | <b>5</b> |          |
|          |          | <b>a</b> | <b>F</b> |
|          |          | <b>b</b> | <b>F</b> |
|          |          | <b>c</b> | <b>T</b> |
|          |          | <b>d</b> | <b>F</b> |
|          |          | <b>e</b> | <b>F</b> |