

B R I E F D Y N A M I C P S Y C H O T H E R A P Y

AN EXPLORATION OF ATTITUDES AND PRACTICE AMONG A GROUP OF LOCAL CLINICIANS
- SOME IMPLICATIONS FOR TRAINING

by

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ABSTRACT

This study explores brief dynamic psychotherapy as a model of intervention with the individual adult client. The rationale for examining this area emanated from a few aspects. Firstly, increasing numbers of research studies indicated that the median length of psychotherapy, whether in private practice, or in community mental health centres, was actually of brief duration, whether planned or not; secondly, emerging studies indicated the proven effectiveness of brief intervention; and thirdly, the current emphasis on practice accountability with a more conscious use of time and outcome, were motivating factors to explore this model in practice. In addition, the study aimed to explore elements from the broader psychoanalytic tradition, which could be shaped and offered within a brief dynamic model of therapy.

A literature survey was undertaken in order to discern the relevant aspects incorporating use of the brief dynamic model. The technical and assumptive differences between long-term and brief dynamic therapy were delineated. Areas which played an important role in brief dynamic therapy were identified, including core therapeutic factors. These included use of focus, therapeutic use of time, therapeutic activity, and limited goals to effect client change.

The exploration of the literature formed the framework for the construction of a closed and open-ended questionnaire in order to tap both usage, as well as attitudes and perceptions towards this model of intervention in practice. With the questionnaire as a basis, an exploratory survey of 29 purposely sampled psychotherapists: psychiatrists, psychologists, medical doctors and social workers, was conducted.

Findings indicated that while the vast majority of clinicians had both brief and long-term patients in their patient load, a minority practised brief dynamic therapy, using time as a variable. A small minority were trained in this method and a small minority perceived themselves as skilled in brief dynamic therapy. Nearly two thirds of respondents used a dynamic frame of reference and only a small minority used a systems, or an eclectic approach in practice. Other findings indicated that setting played a part in choice of model, with clinicians in private practice using mainly long-term intervention. Years of practice played a role in perception of skill, but not in actual usage of this model. There were no apparent differences between use of and attitudes towards this model of intervention among clinicians from differing professions, thus cross-professional commonalities were present. The study confirmed that client factors could be limiting factors in relation to suitability and unsuitability for this model. Most clinicians agreed that the model was of value, and should be offered as a modality in training schools.

From both the theoretical as well as from the empirical study findings, it has appeared that specific clinical training would be required in order to promote more frequent usage. This would be applicable to all professional groups practising psychotherapy, and would help to meet contemporary practice needs. A recommendation has been made that the post-graduate internship or practicum offered an ideal period for training in this method, due to trainee potential to learn, the client expectations, as well as availability of supervision, both peer-group and individual. Resistances towards use of this model have been discussed with supervision bearing a special responsibility to meet these. Some topics for further research have been identified.

P

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SECTION ONE

CHAPTER ONE

INTRODUCTION

1.1. INTRODUCTION

This study will explore brief dynamic psychotherapy as a model of intervention. The advantages as well as the limitations of this method will be examined, and implications for training will be discussed, particularly relevant to the clinical social worker.

While brief therapy incorporates many different approaches, for example, the task-centred approach, crisis-intervention, behaviour therapy, brief family therapy, the focus in this study will be on the dynamic model of brief individual psychotherapy with the adult client. An analysis is offered incorporating elements from the broader psychoanalytic tradition, which in a distilled form, can be shaped and practised with a larger number of clients than the long-term method of dynamic psychotherapy promises.

The study will be approached from two aspects, firstly, from a theoretical base, whereby an exploration will be made of the theoretical stances, and the various technical considerations, including selection of patients, and typical techniques utilized in this method. Secondly, a questionnaire, extrapolated from the theoretical base, will form the second part of the study, an empirical one. Local clinicians, involved in therapeutic work will be surveyed, in relation to the brief dynamic model of therapy. In this manner, some findings will be obtained regarding how this therapy approach is used in practice. Finally, guidelines for training and practice will be elucidated, being informed both from the theoretical as well as from the empirical study.

1.2. RATIONALE FOR THE STUDY

The rationale for focusing on the brief method of dynamic therapy emanates from a number of different aspects. Firstly, the pragmatic one: Budman and Gurman make a salient point when they indicate that: "for the most part psychotherapy research seems to indicate that psychological treatment have their major impact in the first six to eight visits" (1986 :288). Langsley's study reveals that across all diagnoses, psychiatrists in private practice saw patients for an average of 12.8 sessions, while the average for the community mental health practitioner was 10.3 sessions (1978: in Budman and Stone, 1983: 939). Koss (1979) in a research study examining length of treatment in a private clinic, found the median duration of therapy to be eight visits, with nearly 80% of clients discontinuing therapy prior to the twentieth visit. The writer asserts, that with this and other increasing evidence concurring with the above, it is essential that clinicians utilize the time that they actually spend with clients in the most productive way.

Secondly, in this "age of accountability" (Karasu, 1986: 338), cost-effectiveness is the pivot of the public policy in mental health care. Marmor (1979) refers to the major therapeutic revolution we are living in, as new therapies of all kinds have emerged in astounding numbers. However, at the same time, with the development of third-party payers, there is increased pressure placed on clinicians to find shorter and more efficient techniques of therapy.

Thirdly, increasing numbers of research outcome studies indicate that brief and long-term treatments are equally effective, according to Smith and Glass (1980, in Karasu, 1986) who conducted a major research study doing a meta-analysis of different therapies. Rogawski (1982) asserts that the issue seems to be client-selection based therapy, as the so-called "good"

clients do equally well with either brief or long-term therapy. Wolberg (1965) has suggested that :

"the best strategy in my opinion, is to assume that every patient, irrespective of diagnosis, will respond to short-term treatment, unless he proves himself refractory to it."
(Wolberg 1965: 140).

Despite the above, which is derivative of much of the thinking on brief dynamic therapy by the brief therapists themselves, the writer is aware of a general ambivalence with which the brief model of dynamic therapy is regarded. It is regarded as a dehydrated version of long-term therapy, rather than a method which has its own concepts, parameters and techniques. The writer will argue in this dissertation that for therapy to be meaningful or "deep" does not mean that inevitably it has to be long, or that therapy is incomplete unless it is open-ended.

1.3. AUTHOR'S PERSONAL INTEREST IN THE STUDY

The writer is a clinical social worker who has had many years of experience, primarily in the field of mental health as well as in child welfare. Her interest and curiosity in the brief model of dynamic therapy was further stimulated through a recent two-semester internship experience at a psychiatric outpatient department of a large general hospital. It appeared to the writer, that, while the brief model of intervention seemed to be more comfortably accommodated in other models, such as systemic family therapy, or conjoint couple therapy, or in the task-centred approach, or in behavioural-cognitive therapy, the brief dynamic model of individual therapy was regarded with uncertainty. While it was practised, it was often seen as a bridge to long-term therapy, or regarded as a temporary approach, or was used by default, when clients voluntarily stopped coming for therapy. There seemed too little evidence of planned brief dynamic individual therapy. Also it appeared that this ambiguity

seeped into other attitudes: it seemed that "real" work could only come from lengthy work with clients, and budding therapists were advised to have long-term cases which would be a final test of their ability to work therapeutically. In addition, pragmatic considerations, in relation to numbers of clients and availability of professional help, at agencies and at clinics, created a further impetus to investigate how there could be an even spread of professional help without losing out on dynamic insights.

As a result of her observations, as well as her own experience with brief dynamic therapy, within the short term placement time of the internship, the writer wished to explore the brief dynamic model of therapy, both theoretically, through the literature, and empirically, through a study.

1.4. OVERVIEW OF PURPOSE OF THE STUDY

a) The study will explore dimensions related to the brief dynamic model of individual therapy. Its parameters, concepts, technical considerations, its advantages and its limitations will be examined.

b) The current practice of this method among a group of clinicians in Cape Town, will be examined, in order to discern trends in the use of this method in practice.

c) An attempt will be made to extrapolate from these two areas of study, in order to draw some conclusions pertaining to training and practice.

1.5. GENERAL DEFINITION OF TERMS

a) Brief or time-limited therapy refers to therapy "in which the time allotted to treatment is rationed" (Budman and Gurman, 1983: 277). This rationing of time is an integral part of treatment. In addition, the time

limit gives unique characteristics to the treatment and distinguishes it from long-term treatment (Ursana and Hales, 1986).

b) Brief DYNAMIC therapy refers to brief therapy, in which consideration is given to the intrapsychic processes and psychogenetic aspects of the client's condition. It also includes working in such a way so as to promote insight into conflict and disturbed functioning. It incorporates various techniques, including interpretation, in order to promote client change.

c) Clinician or therapist, refers to a social worker engaged in clinical practice, or a therapist from another professional group, such as psychology or psychiatry. The terms clinician or therapist will be used interchangeably.

d) The terms client or patient will be used interchangeably.

e) The terms psychotherapy, or therapy will be used interchangeably.

f) Clinical social work is defined as therapeutic, direct contact with clients, in order to provide diagnostic, preventive and treatment services

g) For the sake of convenience, the use of the pronoun "he" will be used to refer to the clinician and to the client, unless otherwise stated.

h) Any other terms used which will need definition, will be defined in the text.

CHAPTER TWO

HISTORICAL OVERVIEW

AND SOCIAL WORK APPROACH TO BRIEF THERAPY

2.1 INTRODUCTION

This chapter will trace brief dynamic therapy within a historical frame. It will also explore the social work stance towards brief intervention.

2.2 HISTORICAL ORIGINS OF BRIEF DYNAMIC PSYCHOTHERAPY

In retracing the steps of brief dynamic therapy, there is clear evidence of the ambiguity with which this method had been regarded, both in the mainstream psychoanalytic thinking, as well as in social work.

Malan asks "Why is it that the secret of brief psychotherapy keeps getting lost?" (1963, in Gustafson, 1984: 83). In attempting to find the solution, it is necessary to examine some of the early forerunners of brief therapy. Various theoreticians refer to some of the brief analytic work that Freud conducted (Marmor, 1979; Koss, Butcher and Strupp 1986; Malan 1976). He treated Bruno Walter, the famous conductor, who had developed partial paralysis of his right arm, in six sessions. Gustav Mahler was treated in a brief analytic treatment for a potency problem in 1895, and the case of Little Hans was also of brief duration. However, as the goals of analytic treatment became increasingly focused on the re-organization of the client's personality, the course of treatment became more and more prolonged. The superstructure of analytic therapy increased, with the time length, until it became of "interminable" length (Freud, in Marmor 1979).

In 1918, Freud, recognizing the need for more brief therapeutic work, stated:

"It is very probable too, that the large scale application of our therapy will compel us to alloy the pure gold of analysis freely with the copper of direct suggestion. But whatever form this psychotherapy for the people may take, whatever the element of which it is compounded, its most effective and most important ingredients will assuredly remain those borrowed from strict and untendentious psychoanalysis."

(Freud, quoted in Doctor, 1982: 4).

2.2.1 ACCEPTED THERAPEUTIC DOGMAS QUESTIONED

In the face of ever-increasing length of psychoanalysis and ambitious goals of treatment, a small group of analysts attempted some modification. In the 20's, Ferenczi started exploring the efficacy of what he called "active therapy" (Rogawski, 1982). He questioned the then accepted role of the therapist, which included passive listening and infrequent interpretations, which he felt led to a "stagnation of the analysis" (Rogawski, 1982: 336). In addition, he believed that indirect contact was insufficient for certain deprived patients and his reparative techniques included physical contact, such as non-erotic hugging and kissing. While this was disapproved of by Freud and thus discontinued, it did, however, lead to the first intensive study of the doctor-patient relationship (Bauer and Kobos, 1984).

Other analytic thinkers, who tried to shorten the process of therapy at that time, were Rank, Deutsch and Murphy (Winokur, Messer and Schacht, 1981). A major forerunner was Otto Rank (Marmor, 1979). He introduced the concept of the "birth trauma", which he saw as a cardinal source of neurosis. While this was a rejected notion then, now, in retrospect, he was instrumental in laying the foundation for the subsequent recognition of the pre-oedipal years in personality development. He placed strong emphasis on the setting of time limits in therapy to promote therapeutic focus on problems of separation. He also emphasized the importance of

mobilizing the "will" of the patient (Marmor, 1979). This concept was a fore-runner of the later importance of motivation for a positive therapy experience.

From the mid-1940's and 1950's onward, the increased experimentation was a reflection of social environmental issues: returning soldiers from World War Two and the "war neurosis" was a spur to the development of shorter modes of therapy. This led to the re-evaluation of the framework on which therapy is based. Alexander and French began investigations which questioned the validity of established therapeutic dogmas (Wolberg, 1965). They questioned whether the depth of therapy was proportionate to the length, whether shorter treatments were necessarily superficial and temporary in effect, or whether prolonged analysis produced necessarily better results. This research resulted in a major work in 1946 which challenged these dogmas. Among their recommendations, which had an impact on subsequent therapy, were that the frequency of sessions could be manipulated as a way to control transference and to limit dependency and regression. They emphasized the emotional experience of the patient in relation to the therapist, in what they called the "corrective emotional experience" and they suggested that the therapist should take a stance maximally different from that of the parents, thus helping with the "corrective" experience (Bauer and Kobos, 1984: 155). They also recommended focusing on the current life events while understanding the past. The "blank screen" role of the analyst was questioned and the idea of the "flexibility" of the therapist and the need to adapt techniques to the needs of the patient was promoted. They also believed that the therapist must know a great deal in order to work rapidly and must obtain an early understanding of the patient's dynamics. While the initial reaction to the ideas were harsh and they were accused of "abandoning the analytic ship" (Bauer and Kobos, 1984: 197), most of the principles

identified as a way to modify therapy, have become part of the tools of the contemporary therapist. It transformed the therapist from a passive listener into an active participant observer, and it presented for the first time, a well considered psychoanalytically oriented framework for short-term dynamic psychotherapies. What is of extreme importance, is that Alexander and French demonstrated that it is possible to achieve not only symptomatic change, but even "characterological" change, by less intensive, short-term techniques, at least with selected patients. In addition, the recognition of the transactional process of therapy, a process taking place between patient and therapist, rather than one imposed by the therapist, had far-reaching implications (Marmor, 1979).

2.3 BRIEF THERAPY ENDEAVOURS

In the 1950's, came the first publications indicating the usefulness of the brief therapeutic interventions. David Malan (1973) a pioneer in the systematic study of the nature of therapy, was influenced by Michael Balint (Balint, Ornstein and Balint, 1972), with whom he worked at the Tavistock Clinic in London. Their approach was called Focal Therapy, and later Intensive Brief Psychotherapy. Their major concepts and techniques were derived from analytic theory and practice, and with these procedures, Malan moulded a therapeutic technique (Bauer and Kobos, 1984). Malan (1973) felt a need to vindicate Freud's discoveries, which he thought had been denied their proper recognition by historical forces. In what appears to be a paradoxical master stroke, he manages to both uphold the principles of analysis in his orientation, and yet at the same time, to break the traditional bonds. In his work, as pointed out by Gustafson, Malan reversed the relative priority of long and short-term therapy, indicating that long-term therapy was a special variant for patients with more complex and deeper deprivation, and that short-term dynamic therapy could become

the "central paradigm" (Gustafson, 1981: 103). Among other concepts, Malan concerned himself with finding a focus, which implied making a thorough dynamic diagnosis of the patient's problem, technique refinement, which included using interpretations, and on outcome studies (1973; 1976). Further aspects of Malan's extensive contributions to the field of brief dynamic therapy will be referred to throughout.

At the same time that David Malan was undertaking research at the Tavistock, Peter Sifneos (1978; 1981) was studying brief psychotherapy in Boston. Though unaware of each other's work until 1964, many of their publications reached similar conclusions. Sifneos emphasized the importance of patient selection, because of the anxiety-provoking techniques he used, in a therapy which he called Short-Term Anxiety Provoking Therapy or STAPP. He also emphasized the importance of having a central focus of therapy, and he used techniques based on analytic principles. He also conducted systematic studies with experimental and control patients in order to investigate therapeutic outcome. Sifneos will be referred to later in this thesis to highlight certain permeating principles of assessment and treatment. Another prominent theorist and therapist James Mann (1973) focused on the specific limitation of time in brief dynamic psychotherapy. He saw the variable of time as a specific operative factor in psychotherapy, and his work offered insights regarding time limits, psychotherapy and separation-individuation issues. Another major contributor is Habib Davanloo (1978) who has been involved in brief dynamic psychotherapy since the early 1960's. His technique is also grounded in analytic principles, but also included specific active and confrontational techniques. Davanloo also emphasized the importance of selection of patients, and the establishment of a therapeutic focus. He was aware of the research of Sifneos and Malan and he was instrumental in organizing the first international symposia in 1975, 1976 and 1977,

bringing together professionals interested in brief dynamic therapy. The writer has found that Malan, Sifneos, Mann and Davanloo, the major current contributors to brief dynamic therapy have many commonalities and overlapping goals, selection criteria, and techniques. These will be elucidated later.

At this stage, in the consideration of brief dynamic therapy, the writer thinks it feasible to reflect on the social work approach to brief therapy.

2.4. SOCIAL WORK AND BRIEF THERAPY

Social work, too, grappled with the problems of brief service (Parad, 1971). Mary Richmond, in her classic definition of casework, excluded from the definition "all aimless dosings of social ills by inexperienced practitioners and all short-term services" (Parad, 1971: 120). She looked for examples of long continued service which she believed had a surer measure of success and failure. In the 1920's, cases were either "intensive" or "slight service" cases, with a constant struggle between quantity and quality, which was clearly antithetical.

However, changes in the larger social matrix, eg. the war years, and the returning soldiers, was an impetus to social work to modify its stance towards length of involvement. Jessie Taft, with early insight, observed that short contact cases "somehow contains the whole problem of therapy, if only it can be mastered" (Parad, 1971: 125). She saw time as a tool in casework.

In the 1960's and the 1970's, there was general interest in time-limited modalities, such as crisis intervention and short-term treatment. This was related to various factors (Mackey, 1985):

- disenchantment with the viability of open-ended long treatment
- empirical evidence that time-limited approaches produced positive and lasting effects
- economic pressures to make therapy more cost-effective and measurable, especially from third party payers of service.

The task-centred model of practice, a model with a strong behavioural slant, (Reid and Epstein, 1972) was one attempt to respond to those trends. It was also an effort to meet the reality needs of the poor clients in agencies. Kanter describes how this model took hold and gave some direction to a profession "struggling to maintain its collective identity" (1983: 230). He evaluates this model critically in relation to its limitations, and suggests that clinicians can benefit from the modern psychoanalytic developmental theory, to sensitize them to the client's capacities, and to the helping relationship. Lemon and Goldstein's approach (1978) was another attempt to respond to a time-limited approach, particularly in working with dependent clients.

Hollis points out how in practice caseworkers will make use of short contact and also sometimes of time limits where "they believe this to be diagnostically indicated" (1981: 439). She maintains however, that

"we do not yet have adequate or firm knowledge of diagnostic indicators as to when time-limited treatment is preferable and when longer help is needed.....when clients aspire to extensive understanding of themselves and their relationship with others, in order to bring about changes in their ways of living and in their feelings about themselves, treatment may take a long time".

(Hollis, 1981: 440).

2.4.1 SOCIAL WORK AND CLINICAL SOCIAL WORK

Social work had since the 1950's become increasingly identified with its clinical aspects, although at the time, the distinctions between casework and psychotherapy remained unresolved. Although there was some blurring of therapeutic functions, it seemed that the social worker tended to bring more of a psychosocial perspective into the work, which included an awareness of not only the inner forces but also the social contexts and its influence (Mackey, 1985).

Towards the end of the 1950's, Perlman conceptualized casework as a problem-solving process - she based her concept of practice on ego psychology and the recently emerged social role theory (1957). Thus, a client was typically a person who was having problems in a critical life role because his ego was unable to cope with the stresses of mediating internal needs with the expectations of the environment (Mackey, 1985). With the increasing emphasis in the 1960's on the family therapy movement, in particular Nathan Ackerman's contributions, an impetus was created for the integration of broader dimensions into psychosocial casework, and of seeing the family as part of the environment within which problems began or were perpetuated. Through the 1960's and the 1970's, the concern with social dimensions increased, with a questioning of larger issues and social change. This was a turbulent time during which many of the assumptions underlying casework and direct service practice were questioned. This challenge to its credibility led to various contributions by theorists. For example, Hollis attempted to accommodate to the changing focus of social work, by offering the concept of the "person-in-situation" gestalt, referring to the interacting balance of forces between the needs of the person and the influence of the environment (1964). Among other

contributors were Rubin and Gertrude Blanck (1974) and Reid and Epstein (1972). These latter two models appeared on each end of a continuum, one of which was occupied by the Blancks' model of therapy which applied psychoanalytical developmental psychology and their reformulation of theory about the inner world of the person. On the other end of the scale was Reid and Epstein's task-centred model, an approach which aimed to alleviate problems through a constructive problem-solving experience, with action-oriented techniques to engage clients in efforts towards mastery of tasks. This model was a time-limited one, and as was mentioned earlier, it was an attempt by social work to respond to the trend in time-limited modalities. By the late 1970's, according to Mackey, the term "clinical social work" was used generally to refer to social practice of a therapeutic nature with individuals, groups and families (1985: 12). More recently, the National Association of Social Workers (N.A.S.W. 1983) defined a clinical social worker as one who is

"by education and experience, professionally qualified at the autonomous practice level to provide direct, diagnostic, preventative and treatment-oriented services to individuals, families and groups where functioning is threatened or affected by social and psychological stress or health impairment".
(N.A.S.W. 1983: 13)

2.4.2 SOCIAL WORK AND PSYCHOTHERAPY

In this dissertation, the assumption is made that when the clinical social worker works with the inner mechanisms of the client, or patient, he is engaged in psychotherapy. The writer is in agreement with Saari, who asserts that "times have changed, and to-day there is a tendency to believe that psychotherapy is essentially the same process, no matter which of the helping disciplines may be practising it" (1986: 39). Berger stresses the common basis of all forms of psychotherapy, and concludes that the commonalities among the various approaches and professions are greater than the differences, and that it is a "professional defensiveness" to cling to

the idea that social work helping is unique (1986: 53). Thus, the terms, clinical social work, and psychotherapy, will be used interchangeably and refers to the same process of intervention.

2.5 CLINICAL SOCIAL WORK AND PRACTICE OF BRIEF DYNAMIC THERAPY

Clinical social work has always looked to other disciplines for its theoretical base, and in so doing, has used that base as an axis from which to develop practice skills. Mackey (1986) points out that instead of being a prescriptive structure, theory has served as a conceptual framework. For example, in current dynamic thinking, ego psychological theory is useful for understanding the structural assets and liabilities of a patient and for identifying areas of developmental vulnerability. This perspective also helps in understanding the nature of the process of therapy itself.

There is still a question of whether the theoretical orientation and model is influential on practice, and further, whether brief dynamic therapy is prevalent in use among DYNAMICALLY oriented social workers in practice.

A recent study by Mackey, Burek, Charkoudian (1987), investigated the nation-wide practice of clinical social work by senior social workers in the United States, with the aim of exploring the relationship between theory and practice. They found that there was a statistically significant relationship between specific human behaviour theories and models of social work. For example, they found that while the vast majority of respondents reported that their primary theoretical model was psychoanalytical ego psychology, 93% of that group identified the psychosocial model as most descriptive of their orientation.

In addition, and of great interest for this dissertation, was their finding that for these dynamically oriented practitioners, on-going treatment without specific time-limits was their most common mode of intervention.

The use of time-limited intervention was more commonly practised by respondents engaged in problem-solving or family therapy orientations. Thus the use of time was related to theoretical orientation and practice, with the ego-oriented, psychosocial practitioner least likely to be involved in planned short-term intervention.

The writer finds these recent nation-wide findings to be important. Two factors emerge from this which need to be considered. Firstly, it points to an underusage of time-limits in a dynamic framework and may indicate that the influences from the wider body of psychodynamic thought in relation to brief models have not seeped through into the social work repertory. Secondly, in relation to median length of treatment, Koss and Butcher (1978) have indicated from their widespread research studies that, right across the board, from private practice to agency based practice, patients stayed in treatment on average between 8 to 10 sessions, with the vast majority (80%) dropping out of treatment before the 20th session. This thus holds out implications for the issue of accountability.

The writer will hope to address this gap. She will argue that the use of a dynamic approach does not necessarily mean that intervention has to be open-ended or long-term, or that in using a brief therapeutic approach, treatment has to necessarily be task-centred or behavioural. The writer will indicate how insights and perspectives from the brief dynamic field from other disciplines can be utilized, and be incorporated into the repertoire of the clinical social worker.

2.6 CONCLUSION

This chapter has provided a short historical overview of brief dynamic psychotherapy. It has also elucidated on the social work approach to shorter forms of therapy. It has drawn attention to the need for a brief dynamic therapy model for the clinical social worker, which the writer believes has not received adequate attention in social work literature.

CHAPTER THREE

INDIVIDUAL PSYCHOTHERAPY AND THE WIDER SYSTEM: A RATIONALE FOR AN ESSENTIAL COMPATIBILITY

3.1 INTRODUCTION

This dissertation explores brief dynamic individual psychotherapy with the adult client. The writer argues that it is necessary to address two on the face of it different, but related, aspects in relation to the practice of individual psychotherapy. The first concerns the focus of help and the clinical versus community aspect, and the second concerns the conceptual base regarding the individual versus the systems approach.

3.2 CLINICAL VERSUS COMMUNITY

The focus of help and the clinical versus community aspect is a one which is of particular concern to a developing country. This argument has been addressed succinctly by Orten (1987) who identified specific functions of the clinical worker which may be of direct relevance to the wider system. These include: a humanizing function for the whole system, where in focusing on the individual, legitimization is given to the needs of the individual. It also includes serving as a monitor of ills in society, as well as using its knowledge of individual pathology, towards preventative work. Another important function is that of boundary maintenance, in which the values inherent in a society are maintained. In this respect Ann Weick (1987) notes how there are permeating social work values and collective social work wisdom, which is carried through from one generation to another. Berger (1987) comments that despite the importance of values, social work cannot hide behind a generalized value system, but needs to also develop refinement of application of methods. The writer is in agreement with the stance that any society will always need to have

clinicians who offer direct service to clients, and treat those already affected, as well as offering preventive service on an individual level. This stance has to be compatible with fundamental assumptions about help and what counts as help as given by the individual practitioner.

3.3 INDIVIDUAL VERSUS SYSTEMS APPROACH

The second aspect in relation to individual psychotherapy concerns the conceptual base as orientation to the method of practice. The writer is aware that using any single approach can cause the practitioner to ignore data and areas of concern highlighted by other approaches. In the assessment of the patient's problem, the therapist needs to consider whether the problem will be best handled from the individual, conjoint, or systems framework, i.e. in the latter instance, also whether to bring the "other" members which comprise the patient's world, into the therapy room. The focus in this thesis is on individual therapy, which after the assessment, is considered to be the method of choice. In this regard, the research from Mackey, Burek and Charkoudian (1987) referred to earlier, found that despite the influence of the family systems models, individual therapy was still the most prevalent method of intervention.

The writer wishes to make two points to substantiate her thinking and orientation. Firstly, she maintains that there is a common link between the paradigms of the individual approach and the systems approach. Both approaches, in a different orientation, provide "different" interactions in terms of the experience of the patient. This, occurring in an emotionally significant relationship, creates a change in the existing self and object representations. This can result in changes in certain distortions which exist in the patient. The feasibility of change occurring from either direction, i.e. from the direction of insight, or from the behavioural interactional side, finds support for example, in contributions from

Wallace (1982), who states that these two aspects of change co-exist phenomenologically. While the ego-oriented model of clinical social work does not purport to pay much attention to the social aspects by direct intervention into the social systems (Mackey, 1987), it does recognize the importance of that dimension in practice. It sees the individual as a whole person, and in promoting his adaptive capacities, it emphasizes psychologically oriented intervention to enhance his adaptation to the environment.

3.4 COMPATIBILITY OF THE TWO METHODS: INDIVIDUAL AND SYSTEM

The approach in this dissertation is on the individual and his intrapsychic functioning in terms of therapy and the brief dynamic model. The person-in-situation, or the systemic view of man, and the insights of Bateson (1979, in Hoffman 1981), with the systemic circularity of causation is, however, as explained above, not entirely incompatible with the individual approach, if seen from the viewpoint and in utilization of the object relations model of development. This latter viewpoint encompasses both the internal development of self, as well as to take cognizance of the relational world and its inner representations. However, it is in the area of causation that the conceptual difference really exists, as the systems view will see causation as existing in the horizontal processes, and intervention will thus purport to change those observable patterns of interaction. Various techniques may be used but all aim to change the patterns of interaction (Minuchin, 1974; Haley, 1977; Hoffman, 1981). Causality from the individual perspective arises from an intrapsychic and more vertical orientation, with, however, a horizontal overlay as well. This overlay is seen in relation to how stuck repetitive individual behaviours and conflicts re-emerge in a most predictable constancy in terms of the patient's current functioning. The past and the present come

together in a most cogent and urgent relevancy in relation to how the individual experiences come to light. The writer thinks that in any event, it is important for clinicians not to lose sight of the individual and his humanity and needs, within the broadening focus currently on the system and systemic issues. Thus, the individual focus is both a relevant and important one for the clinical social worker.

3.5 CONCLUSION

This chapter has discussed the two approaches, the individual and the systems, and considered that, despite the overt differences in relation to conceptual approach and techniques, a covert compatibility is also present, in terms of change processes. Individual change can also cause systemic change through the influence of interpersonal contact.

SECTION TWO

CHAPTER FOUR

FEATURES OF BRIEF AND LONG-TERM THERAPY

4.1 INTRODUCTION

This chapter will discuss features of brief and long term therapies. It will delineate the commonalities that exist among the brief therapies. It will elucidate differences between brief therapy and crisis intervention. Principles and values that are influential in the practice of long-term psychotherapy will also be discussed.

4.2 COMMON FEATURES OF BRIEF THERAPY

The field of brief therapy has many different models of therapy, however there are some distinct but overriding principles and common features evident. In examining the parameters of brief dynamic therapy, it is necessary to identify and to reflect upon these commonalities so as to isolate the components, prior to a later refinement and exploration of them.

Unifying features have been identified in terms of the technical aspects of brief therapies (Butcher and Koss, 1978; Marmor, 1979). They comprise the following:

- a) Utilization of time, with an awareness of time and use of this in practice. There is a limited, planned, rather than an open-ended approach to therapy. The duration of therapy can range from one to forty sessions.
- b) Limited goals, where specific problems or conflicts become the focus; this to be distinguished from "character change" as a goal in therapy.

- c) Focused interviewing and present-centredness, where there is an attempt to keep the patient dealing in a focal way with the problem at hand, rather than in an open-ended manner, or free association.
- d) Activity and directiveness in therapy, where the therapist talks more and interprets more, with an active exploration of areas, and active formulation of plans.
- e) There is rapid and early assessment, with treatment and assessment beginning simultaneously.
- f) Therapeutic flexibility is common, with the therapist using a variety of techniques to promote change.
- g) Selection of patients is considered an essential part of brief therapy. However, as will be shown later, the field has ambiguity and different opinions as to suitability of patients for brief dynamic treatment, with varying selection criteria ranging from the more conservative view to the more radical.

Brief DYNAMIC therapy adheres to the principles as above but also includes dynamic principles of diagnosis and treatment. These will receive full attention in later chapters. However the overriding common elements of brief therapy are maintained and become the hallmark of brief versus long-term dynamic therapy.

4.2.1 ATTITUDES AND VALUES OF THE BRIEF THERAPIST

Other than these technical characteristics, there are also other more implicit dimensions related to brief therapy and these are concerned with the attitudinal aspects of the therapist. These will also determine whether brief therapy will be seen as a "stopgap" by the therapist, or as an identifiable treatment modality.

Budman and Gurman (1983) make explicit some of the implicit values underpinning brief therapy. Even though most therapists will practise both brief and long-term therapy, a therapist often has an "ideal" manner with which he will approach therapy. It is necessary for clinicians to be conscious of their own ideals and values as to a preferred method of work and which can influence their approach.

a) The brief therapist will have a health rather than an illness orientation. In this respect, the patient is encouraged to build on his existing strengths and skills. This could contrast with some long-term therapy's emphasis on deficits and weaknesses. This does not mean that conflicts or stresses are overlooked, or that some regression does not occur. However the concept of competence is an overriding one and adaptive functioning is encouraged and promoted.

b) Brief therapy also recognizes parsimony of intervention, with the belief that change in one area of functioning spins into others, with an "open system" functioning approach. It takes the presenting problem and uses that as an indication of a more central repetitive problem.

c) The evolving nature of the patient's personality is important to the brief therapist. In this regard, Bennett (1984) has delineated a model which views the patient as growing and evolving throughout life, with the conflicts and problems specific to particular life stages. However, the writer wishes to emphasize that, despite the evolving nature of the patient's life, there are some conflicts that may remain fixed and repetitive and which may appear in different guises or difficulties throughout life, superimposing the developmental conflicts. This approach is borne out by Malan (1973; 1976), Mann (1973) and Sifneos (1981). In the section on selection of patients and assessment, the writer will deal with the diagnostic process, which will take cognizance of these aspects.

d) The brief therapist sees the human condition as one in which there will always be some anxieties, conflicts, and changes, and that he cannot expect the patient to be someone who is always positive, giving, kind, or responsible, according to some "ideal" person. Furthermore, he sees the patient's "being in the world" as far more important than being in therapy (Budman and Gurman, 1983). There is an emphasis on the ongoing present situation and current relationship. This can contrast sharply with the long-term therapist's rule of "abstinence", where the therapy is considered the most important event in the patient's life.

4.2.2 SETTING AND ENVIRONMENTAL INFLUENCE

The setting in which the clinician works, and its approach towards brief therapy is of importance, as these can be influential on how therapy is conducted. The literature stresses that unless strong institutional supports exist for brief therapy as a major modality in a clinic or an agency, therapy will be either unplanned and brief, because patients drop out or terminate unilaterally, or for a small number, long-term and open-ended. In a setting such as a hospital outpatient clinic, the clinician may be influenced by waiting lists or emergency admissions and engage in brief interventions eg. crisis intervention, but not necessarily brief dynamic therapy. In the private sector, practical difficulties and financial concerns and the need to fill appointments for long periods ahead, may deter therapists from using planned brief therapy. Or, as stressed by Budman and Gurman (1983), one of the major factors operating against planned brief therapy is that it is easier neither to plan nor to ration therapy by the individual therapist or the institution.

4.3 IS INDIVIDUAL BRIEF DYNAMIC THERAPY A MYTH?

In looking at the concept of brevity, psychotherapy is usually thought to be brief if it is of significantly shorter duration than the "ideal" practice of individual psychoanalytic psychotherapy. This criterion of brevity exists in the collective minds of therapists (Budman, 1981). In the minds of consumers, however, a different state of affairs exists. For example, it has been established that most people seeking therapy in outpatient clinics, expect their treatment to last less than three months: Koss and Butcher (1978) have determined that a high percentage of individual patients terminate in less than 12 sessions. This characterizes the general practice of psychotherapy, and is not only limited to patients of lower socio-economic status. The results of a study by Koss (1979) suggest the necessity of considering the socially advantaged client as well as the disadvantaged a potential candidate for brief therapy approaches. Empirically, it seems that unplanned brief treatment is in fact, therefore, very common. What is new is the notion of planned brief therapy, or brief therapy by design not default (Budman, 1982).

4.4 BRIEF THERAPY AND CRISIS INTERVENTION

There are differences between brief therapy and crisis intervention, in relation to goals as well as focus of therapy. The presenting problem and its implications for treatment has a different implication in relation to time, as well.

The goal of crisis intervention is the resolution of an immediate crisis, and the problem presented is of recent origin. Caplan (1964) has emphasized that crisis is characteristically self-limiting and lasts from four to six weeks. This is seen as a transitional period, representing both increased psychological vulnerability as well as opportunity for

personal growth. This has implications for the ready availability of professional help and outcome of intervention. The crisis is usually precipitated by an observable event, and there is a sudden loss of ability to cope with a life situation. The goals of crisis intervention are to restore the client's equilibrium, or to his previous level of functioning. X

In brief therapy, in contrast, there does not have to be a recent onset, and there may be no observable event or precipitant. Further, the goals are removal of specific symptoms, as well as promoting change in a focused area of functioning. Because the client may not necessarily be motivated to receive help, or his problems may not be focused in one area, the therapist's role and functioning may be different. The discerning of a focus, and of client motivation and commitment to the therapy, become important aspects to consider in respect of the client's use of treatment. The therapist will also be working with the present as well as past experiences as it relates to the present, as well as transference material as it emerges, in order to promote insight and change. Thus there are specific differences between these two therapeutic interventions.

4.5 LONG-TERM THERAPY: ELEMENTAL ASPECTS

As discussed earlier, there are certain principles of treatment as well as assumptions which influence the length of therapy. These are factors which can be seen as apart from the patient or his condition, as they seem to reside within a conceptual approach and stance of the therapist and his conduct of therapy.

Malan (1973) set out to identify elements which prevail in the prolongation of treatment. He and Wolberg (1965) maintained that long-term therapy can be seen as a more specialized form of intervention for specific and selected patients. However, Malan (1973) asserted that anyone trying to

develop a technique of brief psychotherapy is trying to reverse an evolutionary process impelled by powerful forces, and that it was necessary to identify specifically these forces in order to oppose them.

4.5.1 LENGTHENING FACTORS OF THERAPY

Certain lengthening factors (Malan, 1973) were identified in both the therapist and the patient and the relationship between them which contribute to longer treatment. While some of these elements may be open to question by therapists who work mainly in the long term method, or be seen as generalizations, or be seen as having specific therapeutic functions which advance the curative forces of long-term therapy, they seem to be implicitly present even though not always acted upon each time by the long term therapist.

a) Passivity, a characteristic identified by Alexander (1946) originally (in Wolberg, 1965) and again by Malan (1973), was one element. This was described as a tendency to follow the patient where he leads. More recently, Binder, Henry and Strupp promote the concept of a short-term "attitude" and place a premium on what they call the "alertness" of the therapist and a need to attend to focal themes (1987: 161). In this manner, they hope to reduce the number of "lost" sessions, with which every therapist is familiar, i.e. hours in which, for whatever reason, little seems to happen. In open-ended work with no time pressures, the therapist as well as the patient could be in danger of becoming a victim of passivity. It is thus necessary to maintain a state of "tension", reflecting the motivation of both participants to remain actively involved in the work. If not, there is the danger of the patient becoming dependent both on the therapist and the "ritualistic aspects of therapy", a term actually first coined by Alexander and French (in Binder, Henry and Strupp, 1987: 162).

b) Timelessness is a lengthening factor, and is conveyed to the patient in the open-ended attitude. This attitude can be conveyed to the patient as "I will be there for as long as you need me" (Budman and Gurman, 1983: 280). This can according to Binder, Henry and Strupp (1987), create a lulling, which can also hide a resistance to dealing with painful issues, or present an accustomed pattern, with which hidden feelings are concealed. The long-term therapist may however, argue that this very availability and lack of time structure is a necessary prerequisite for trust and the development of a relationship.

c) Therapeutic perfectionism is another element identified by Malan (1973), and one also elaborated on by others, e.g. Budman and Gurman (1983). It describes the long-term therapist who seeks more character change which he may see as synonymous with cure. "Much of this quest derives from Freud's dictum, "where Id was there Ego shall be"..... The long term therapist is not looking for mere home improvements - he or she is striving to rebuild the house from the ground up" (Budman and Gurman, 1983: 279).^x

d) The therapist's preoccupation with ever longer and deeper issues is^x another lengthening factor. In this instance the problem that is presented as a reason for seeking help is only seen as a representation of more deeply entrenched and embedded pathology. There is also a sense that symptomatic improvements are not genuine or important in and of themselves (Malan, 1973).

e) In addition to the above, there are also values inherent which also play a role in the approach of the therapist (Budman and Gurman, 1983):

(i) The implicit value that only in the relationship with a therapist can the individual patient change, and that he should "be" in therapy: this may have all the existential implication of total commitment of self to the process and to the therapeutic relationship. Furthermore, there could be a belief that therapy is always beneficial and helpful and that should there be minimal change only, or even deterioration, that it can be laid only at the patient's door. Thus they do not adhere to the view that therapy, if unselective, can produce addiction, or even negative effects (Crown, 1986).

(ii) Another value that could play a subtle part is an unstated wish in the therapist that his patient responds to his therapy, thus adding to his personal satisfaction.

(iii) Another is the present, but unexpressed wish to keep a given "slot" of paid time filled on a continual basis. Business and clinical issues can interact, even for those therapists who have good insight or even those who have been psychoanalyzed, a view that is maintained by Budman and Gurman (1983).

While there will always be some patients who will need an ongoing long-term therapeutic contact, it seems essential, in view of the increasing number of studies reflecting the high dropout rates and median length of therapy, for a therapist to have such an awareness of these lengthening factors, so as to have an objective approach to therapy based on factors other than personal preference or value assumptions, but based on patient need. In addition, the therapist's repertoire should include an approach which comprises brief planned treatment.

4.6 CONCLUSION

This section has identified some of the common elements that comprise brief therapy and long-term therapy, both on a technical as well as on an assumptive level. The differences between the two approaches were elucidated: these also indicate the differing assumptions regarding human behaviour and change between the two approaches to therapy. The differences between crisis intervention and brief therapy were also discussed. A table, succinctly delineating the differences between psychoanalysis, brief psychotherapy and crisis methodology, as given by Aguilera and Messick, is found in Appendix 1 (1973: 26). A table, presenting the comparative dominant value assumptions between long-term and brief therapy, as presented by Budman is found in Appendix 2 (1983: 270).

CHAPTER FIVE

SELECTION OF PATIENTS FOR BRIEF DYNAMIC PSYCHOTHERAPY

5.1 INTRODUCTION

This chapter will explore selection of patients for brief dynamic therapy. The assessment process will be discussed, and exclusion and inclusion of patients will be examined.

5.2 REASONS FOR SELECTION OF PATIENTS FOR BRIEF DYNAMIC THERAPY

As pointed out by Koss and Butcher (1978), brief and crisis oriented therapies serve a wide range of patients, including those who present with anxiety, depression, suicidal behaviour, excitement, panic, delirium, psychosis, assaultive behaviour, or antisocial behaviour. While there are still major disagreements in the field over who can be aided with brief dynamic therapy, several factors pose a challenge to refine selection as well as techniques in order to meet the treatment demands being placed on the mental health system. These are the social trends as discussed earlier, the greater patient flow through clinics, and some proven effectiveness through clinical experimentation.

While selection criteria are common to all kinds of dynamic therapy, additional selection criteria are required in brief therapy due to the short duration of treatment. Marmor states that brief dynamic therapy rests on two basic substructures: (a) selection and (b) technique; and that each of these is of equal importance (1979: 152). On the other hand, Wolberg (1965) has a more encompassing view and believes that many therapists over-emphasize the need for long-term therapy in many cases, where a brief period of treatment may be all that is required to set into

motion a process of growth. Even though there are some patients who require a prolonged period of treatment, Wolberg asserts:

"If the therapist approaches each patient with the idea of doing as much as he can for him, within the span of say up to twenty treatment sessions, he will give the patient an opportunity to take advantage of short-term treatment to the limit of his potential. If this expediency fails, he can always then resort to prolonged therapy."

(Wolberg, 1965: 140).

Despite the above, there are defined criteria by other brief therapists, which to a large extent dovetail with the method and technique they use. This selectivity seems to be related to two aspects: firstly, because of the possible "risks" involved in brief dynamic therapy: for example, there is less time to correct any errors in diagnosis, to deal with resistance, or to deal more extensively with issues of termination. Secondly, along with the careful attention to assessment is an assumption that the therapist can, to a large extent predict the direction and the course of therapy, a goal sought after by many therapists i.e. specific treatments for specific patients and problems (Binder, Henry and Strupp, 1987; Beutler, 1979).

5.2.1 SELECTION AND OUTCOME OF THERAPY

While the relationship between diagnosis and treatment outcome has always been regarded as important, there are other factors which could also be influential on the outcome of therapy. The literature regards therapeutic change as multi-factorial and related to other factors in addition to client variables, eg. therapist factors, such as training and professional experience, as well as therapeutic alliance factors (Wolberg, 1965; Gurman and Razin, 1977). These other aspects will receive attention later.

The writer has found that despite the emphasis on assessment and selection criteria, some doubt appears in the literature about being able to predict

the patient's ability to benefit from therapy. Binder, Henry and Strupp question the "abstract" personality variables used in the classical psychoanalytic literature, eg. "quality of object relations", or "ego strength", maintaining that it is easier to agree on the importance of such characteristics, than to specify its manifestations. It is also easier to require one "meaningful relationship" as a selection criterion, than to obtain clear, concrete evidence that such a relationship exists (Binder, Henry and Strupp, 1987: 156). They cite the Menninger Psychotherapy Project (1972) in which 45% of the patients selected for psychoanalysis eventually had to be considered unsuitable for that form of treatment. As Bacharach maintains, "no controlled empirical study of psychoanalysis or psychotherapy has ever appeared in which outcomes were more than marginally predicted from initial patient characteristics" (1980, in Binder, Henry and Strupp, 1987: 156). As a result, predictions of outcome largely lack precision.

Thus, selection criteria are important in view of the possible "risks" related to brief dynamic therapy. There is some ambiguity however, in relation to the definitiveness of selection, in relation to: a) criteria which describe personality characteristics such as "ego strength" and the accuracy of these concepts, and b) selection and its relationship with successful outcome in therapy. Other factors which could be influential on the progress and outcome of therapy, such as therapist characteristics and the therapeutic alliance were also mentioned.

At this point, it is necessary to examine some guidelines for assessment, as the clinician will assess patients, prior to or concurrent with, selecting them for brief dynamic therapy.

5.3 ASSESSMENT FOR BRIEF DYNAMIC PSYCHOTHERAPY

The assessment of a patient for therapy, as pointed out by Malan, is a complex, subtle and skilled procedure. It is not the same as a psychiatric history, nor a social history, nor a psychotherapeutic session - it contains elements of all three, however, it is more than the three put together (Malan, 1979: 210).

The assessment process occurs over a period of one to three interviews and becomes the means for determining the nature of the problems and an assessment of what treatment procedure to recommend. The therapist must be able to forecast the kinds of events that are likely to occur as the patient interacts with the therapist and starts to face his disturbing feelings. While there is a strong influence of the traditional analytic assessment method, as found in longer term therapies, there are also some changes. This is in relation to the strong emphasis on performance based criteria i.e. how the patient responds during the assessment interviews. The need for both technical competence, as well as flexibility in the therapist has been recommended and commented on by various contributors, such as Binder, Henry and Strupp (1987); Malan, (1976; 1979), Sifneos (1984) and Davanloo (1978).

Principles which are used in ASSESSMENT and in HISTORY TAKING are as follows:

a) Malan (1979) in his summary of the assessment process for dynamic therapy, recommends that the therapist think PSYCHIATRICALY as a first step. Davanloo (1978) and Malan (1979) suggest that the present diagnostic classification (DSM III) lacks guidelines to treatment as: (i) patients who belong to a similar clinical diagnosis may vary from the point of their individual psychodynamics, character structure and suitability for

treatment, and (ii) it is often purely descriptive, labelling the patient's most prominent symptom. On the other hand, they maintain that it does imply a prognosis, which is of crucial relevance for planning. Crown (1984) discusses the contraindications and dangers of psychotherapy, and concludes that the negative effects of therapy as a possibility should be anticipated during the assessment of the patient. In keeping with one of his "laws" of psychotherapeutic forecasting, which he calls the "law of increased disturbance", Malan warns that in intensive psychotherapy, a therapist always runs the risk of making a patient as disturbed as she or he has ever been in the past, or more (Malan, 1979: 220). While this does not apply to every patient, it needs always to be borne in mind.

The necessity of the therapist to know whom it is safe to allow a deep engagement in brief therapy and when to leave well enough alone, is an important principle of selection, according to Gustafson. He argues that there are many patients whose "rigidity" is best let be, especially those where the "underlying faults are too wide" (Gustafson, 1984: 941). In an attempt to extract some overriding principles of selection, he suggests that the therapist must ask himself: Has the patient been able to navigate safely through the "worst" period of disturbance in his life. The clinician needs to have an accurate picture of these periods in the patient's life, as he should expect, in intensive psychotherapy, to "revisit" them. If these states of mind brought about dangerous actions by the patient in the past or if they required more support than the patient's present environment can provide, then their reactivation is too much of a risk and the patient cannot be offered brief dynamic psychotherapy.

However, as will be discussed below, some of the recent outcome studies (Horowitz, 1986; Leibovich, 1981; 1983) indicate that brief dynamic

psychotherapy has been used with borderline patients with good outcome results.

b) The ability to think DYNAMICALLY is the second important aspect, and according to Malan (1979) the therapist must try to identify the forces in conflict both within the patient and his environment, currently and in the past, and which then become the themes of therapy that may be undertaken. The object relations, previous and current adaptive functioning needs to be assessed through the history-taking.

A crucial aspect of dynamic thinking consists of identifying recent precipitating factors, and then seeing how these repeat events or situations from the past. This often leads to the identification of a theme that runs through much of the history, which can be called the life problem (Malan, 1979: 211). Binder and Smokler (1980) describe this as a determination of a conflict, or a cluster of conflicts that is causing most of the patient's current trouble. While it can be viewed in terms of feelings, fantasies, impulses, and defences against them, this dynamic understanding will also imply how the object relations of the patient are distorted. They see the present circumscribed conflict in relation to the "nuclear" childhood experiences.

Within the dynamic assessment, Binder and Smokler recommend, as part of history taking, that the clinician obtain a few early memories. They refer to the work of Mayman who suggests that interpersonal themes prominent in the early memories are assumed to reflect conflicts bringing the patient to treatment now (1968, in Binder and Smokler, 1980). Tobin maintains that a patient selects those early memories to share which best reflect his experience of present needs and stresses (in Binder and Smokler, 1980). These early memories also have an advantage in providing a meaningful experience for the patient and they help to place the present painful

feelings within a historical context. The role the patient gives to himself vis-a-vis others, and the sense of "me-ness" that is invested with them, make them an important part of the conscious self.

The writer's own experience in relation to brief work indicates the usefulness of this approach. For example, in treating an adult patient who had presented with a psychosomatic condition, an early memory shared in the evaluation interviews, revealed how she as a young child had suffered bodily symptoms instead of expressing feelings. The sense of fear, the tension, the lack of trust in adult figures, emerged in one early memory. The sharing of this particular memory indicated the potential transference trust issues, and a difficulty with the giving over of her problems, as well as an indication of how her current context was problematic and exacerbating her ready potential to translate anxiety and depression into bodily symptoms.

c) The therapist must be able to think PSYCHOTHERAPEUTICALLY i.e. he must constantly use his experience to forecast not only the themes but also the probable course of events if this particular patient is taken into psychotherapy (Malan, 1979: 210). The knowledge obtained from the psychiatric and psychodynamic evidence will guide this psychotherapeutic "forecasting" and be assessed in terms of its implications for therapy. In this assessment stage, any possible dangers to brief psychotherapy must be considered, eg. a profoundly depressed patient, who would be uncertain as to whether he has a future, and would be unmotivated due to his condition, would be considered unsuitable for brief psychotherapy, with its limited time period of work. It is in this area of assessment for psychotherapy, that the clinician will tie together the previous information in relation to ego strength or deficit and recommend which therapy, short or long-term, medication, behaviour therapy, in-patient or out-patient, would be

best for the patient. The practical implications in relation to availability of therapist time, or clinic or hospital, is of importance as appropriate for the patient, after having made the assessments as above

d) The clinician must also take care of the interview itself, and must create enough rapport to enable him to get the evidence that is needed in order to make a correct decision (Malan, 1979). The use of trial interpretation is widely used in the assessment in order to assess the patient's capacity to use interpretative therapy, to see whether he can see his problem in emotional terms (Davanloo, 1978; Sifneos, 1978; Malan, 1979). Malan uses the term "thought experiment" (1979) to describe the clinician's dual assessment and interaction with the patient. The performance of the patient during the early interviews has great relevance as a predictive measure.

While most of the major contributors towards the brief dynamic literature make use of these performance based criteria, some criticism about the validity of these have come from Binder, Henry and Strupp (1987) who, from their Vanderbilt Study (in Strupp, 1980a), found that the collective ability of judges to assess patients on performance is actually limited and does not yield definitive results about potential to benefit from therapy. For example, a patient can appear bright, articulate and seemingly insightful in the assessment session, but be difficult to work with in brief therapy, as the "insights" could tend to be superficial intellectual formulations. However, the writer believes that this performance based assessment, as combined with the more traditional history taking and review of ego strengths, could provide a more complete picture of potential for brief dynamic therapy.

e) This clinical assessment will also make the therapist aware of the amount of support that the patient will need, as well as the amount that

his environment can provide. This will, in turn, influence the setting in which therapy will be carried out, eg. in-patient, out-patient. Finally, the clinician must assess the environment as a whole, in relation to whether others in his life need to be seen, and any other contextual work which needs to be done.

5.4 TREATMENT DECISIONS

Clinicians constantly have to make treatment decisions, often in the absence of knowledge of what works best for which problem in which patient. Even though Wolberg (1965) as discussed earlier, as well as Budman and Gurman (1983) would recommend this model for all patients, there are other therapists who have definite criteria regarding suitability, and more importantly, specific exclusion criteria.

The writer will draw from various contributors in order to make some overall conclusions, firstly in relation to exclusion criteria, and secondly to inclusion criteria for brief dynamic therapy. The sources consulted include Davanloo (1978), Malan (1973; 1976; 1979), Sifneos (1981; 1984), Mann (1973; 1981), Horowitz (1986). Krupnick and Horowitz (1985), Leibovich (1981; 1983), Binder, Henry and Strupp (1987), Reich and Neenan (1986), Budman and Gurman (1983), Rogawski (1982), Koss and Butcher (1978), (Chernus 1983), Ursana and Hales (1986), Budman and Stone (1983), Donovan (1987), Gustafson (1984) and Clarkin and Frances (1982).

5.4.1 EXCLUSION CRITERIA FOR BRIEF DYNAMIC THERAPY

The necessity to assess which patient to exclude from dynamic therapy is stressed by Gustafson (1981) who adds that it should be done at the point of referral.

According to Clarkin and Francis (1982), patients with chronic or pervasive problems would be unsuitable for brief dynamic treatment. These would include schizophrenia or other psychosis, severe anxiety and somatoform conditions, persistent and uncontrolled acting out or self-destructiveness and severe personality disorders. Patients whose problems are too numerous or unfocused to be addressed in brief treatment, would also be excluded. The patient who lacks sufficient "motivation" to utilize brief therapy would be excluded. Patients who would not be able to tolerate an early separation from the treatment because of severe separation anxiety or dependency would also be regarded as unsuitable. Other contraindications which apply to dynamic work, would include those referred to in Hildebrand's criteria : e.g. patients who have had long-term hospitalization, patients with drug addiction, serious suicide attempts and chronic alcoholism (in Malan, 1979: 225).

5.4.1.1 Exclusion Criteria - Objections and Alternatives offered.

However, in the literature some objections have been raised against the limitations imposed on brief dynamic work (Pierloot, 1981; Budman and Stone, 1983; Krupnick and Horowitz, 1985). More modified forms of dynamic therapy, for example, an integrative model, as proposed by Leibovich (1981), seems to broaden the scope of brief dynamic therapy and to include working with borderlines and more disturbed patients as well. Leibovich, in fact, regards this brief dynamic integrated treatment model as the treatment of choice for many borderline patients.

Sifneos (1984) agrees that, while the best results are obtained through careful selection, efforts should be made to investigate what "sicker" patients might respond favourably to this form of therapy. Lazarus (1982) discusses brief dynamic work with narcissistically disturbed patients and how he has carefully modified treatment goals and techniques within a

dynamic framework. Strupp and Binder (in Budman and Stone, 1984) have developed a carefully defined dynamic therapy approach for the "more difficult" patients, that is, individuals whose problems are intertwined with characterological trends and who may not become so readily involved in a working relationship with the therapist. These findings while yet inconclusive, appear to suggest that brief dynamic therapy may be useful for the more disturbed patient.

Thus, the literature seems to be divided in respect of exclusion factors, although it appears to lean on the side of careful assessment and selection in relation to offering brief dynamic therapy to patients who have lesser ego strengths. This seems to tie in with traditional trends as discussed earlier. However, what seems evident from the more recent contributions and research studies, is an attempt to modify models, techniques and goals so as to include the more vulnerable patient as well.

5.5 INDICATIONS FOR BRIEF THERAPY

Clarkin and Frances (1982) offer some fairly clear indicators for selection for ANY kind of brief therapy, not only dynamic:

- a) A clearly defined focus or event for intervention must be apparent;
- b) The patient's overall motivation must be "sufficient" to cooperate in treatment;
- c) His "usual" level of functioning would be adequate and he would be able to cope with termination;
- d) Further, they recommend that it is indicated in situations where long-term treatment could increase the secondary gain of illness, or result in negative therapeutic reaction.

This approach seems to stand in contrast with Budman and Gurman, who maintain that: "many patients who would, on the surface, seem to be poor brief therapy candidates, may with an appropriate patient-therapist match or with the correct brief modality do extremely well in short-term treatment" (1983: 288).

It appears, however, that in the area of non-psychodynamic therapies, where a problem-centred approach has been prevalent, selection criteria have, in general been less stringent than for dynamic therapies. For example, Budman and Stone point out how, in the treatment of depression, Beck's cognitive therapy, or Klerman's interpersonal therapy, or McLean's behavioural skills program, all brief models, the patients excluded are only the most severely disturbed (1983: 941). Snyman refers to the clients who require more "practical assistance" each time they call, due to their lack of coping skills; or certain "immature" clients as identified by Irving, who require both practical signs of goodwill as well as the clinician's firm guidance, as a "decisive parental figure" (in Snyman, 1987:5). Snyman recommends that intermittent brief intervention is probably more appropriate in these cases (Snyman, 1987: 5).

5.6 INDICATIONS FOR BRIEF DYNAMIC THERAPY

The patient indicators which could direct the clinician into thinking brief **DYNAMIC** treatment would be as follows:

A. A CLEARLY DEFINED FOCUS, as Manifestation of Intrapsychic Conflict.

The patient presents with a clearly defined focus, precipitating event or target and where the patient problem is best understood as a manifestation of a focal intrapsychic conflict. Different major contributors would classify the focal conflicts they work with differently. For example:

(i) Mann (1973) whose approach has been described as existential, would evaluate conflicts as centering around separation-individuation situations. His approach would incorporate a pre-oedipal focus, with issues around self and object representation. Mann views pregenital issues of separation-individuation as not only preceding the Oedipus complex, but, in essence, also incorporating and transcending it and having a pervasive effect on development. Mann maintains further that the central issue to be worked with is linked with a "time sense" and always includes "time, affects and the image of the self" and that this is an image obscured usually by symptoms, complaints, character traits and behavioural styles (1981: 35). He will thus extract out of the historical data, and the evaluation interview and the patient's complaints, what is understood to be the patient's "present and chronically endured pain" (Mann, 1981: 33). He sees this as a chronic feeling about the self that is usually preconscious and usually suppressed, denied and warded from full awareness. Young adults or persons in transitional phases, where separation issues are an issue, could be seen as particularly suited to his approach.

(ii) Sifneos (1984) focuses primarily on Oedipal issues, and would select patients who would have conflicts related to unsatisfactory relationships,

eg. in terms of sexual relationships, or rivalrous problems in relation to same sex persons, with concurrent guilt and its various manifestations. The writer wishes to point out that these "Oedipal" problems can be influencing many other symptoms, eg. depressive symptomatology, lack of assertiveness, problems in relation to achievement, or other presenting problems. Sifneos would delineate the presented problems and trace it to problems in relation to the triangular situation, and its manifestations. He regards the ability to develop a circumscribed complaint, and the capacity to choose one out of a variety of problems and to assign it priority for resolution, as an indication of ego strength. This denotes an ability to tolerate a certain amount of anxiety and potential to withstand stress (Bauer and Kobos, 1984). Sifneos' model has been criticized by Donovan (1987) as being exclusive and to reject too many patients who would not fulfil the requirements of having an Oedipal conflict.

(iii) Malan (1973; 1976) is willing to treat a broader range of disorders, but requiring also that a focal conflict be identified at assessment. Malan points out how the therapist can, from his evaluation of the precipitating factors, early traumatic experiences, repetitive patterns and the patient's response to interpretation, point to the area of internal conflict present since childhood and to the focus for treatment, which could be Oedipal or pre-Oedipal. He classifies therapies in terms of "depth" of focus and the extent to which the focus can be taken as the nuclear conflict itself, or only parts or derivatives of it. In this respect, Malan believes that most therapists view the focus as something more superficial than the nuclear conflict. Malan, with his slightly longer period of treatment (he uses a 20 session limit, with an upper limit of 40 sessions in his intensive brief therapy), would accept patients with more "serious" psychopathology. To a large extent, he refuted the widely

held misconception that time-limited therapy is most helpful to those who may need it the least.

(iv) Davanloo (1978) also maintains that one of the functions of the evaluation is establishing the focus, and the exploration of the patient's emotional difficulties and the repetitive patterns which underlie the current problems. He includes patients with an oedipal focus, a loss focus and multiple focuses. He is particularly interested in patients suffering from longstanding obsessional and phobic neuroses. His research data indicate that 30% to 35% of the psychiatric outpatient population can benefit from his broad-focus brief dynamic therapy.

Thus, the identification of a central focus or conflict situation, is essential for brief dynamic work and needs to be agreed on by both therapist and patient. It usually comprises dynamic aspects of the patients current situation and past relationships, and thus is seen as an underlying dimension influential on behaviour.

B. MOTIVATION

The patient must be sufficiently motivated to change, and not only wanting symptom relief. The area of motivation of the patient is an important one: Davanloo (1978) regards it as a major "ego function" of primary importance in psychotherapeutic work. Malan (1979) regards the balance between motivation and therapeutic focus important determinants in therapy, and maintained that the patient had to accept that these change in adaptational patterns may be necessary. Sifneos (1985) is one of the few authors who clarifies fully the assessment of motivation. He defines it as including the patient's ability to recognize symptoms as psychological, a tendency to be introspective and honest about emotional difficulties, and a willingness to participate in the treatment situation. In addition, motivation

includes curiosity, a willingness to change, a willingness to make reasonable sacrifices, and a realistic expectation of the results of psychotherapy.

C. EGO CAPACITY

The therapist will look for qualities in the patient which would indicate his ability to participate and to work effectively in dynamic therapy.

Marmor (1979) noted some major criteria:

- (i) evidence of ego strength: this would include intelligence, level of educational achievement, sexual adjustment, ability to assume responsibility and some flexibility in ego defence structure ;
- (ii) at least one meaningful interpersonal relationship in the past, indicating a capacity for basic trust, which is essential in the psychotherapeutic process; Davanloo (1978) and Malan (1979) regard this criterion as very important, and indicate that it refers to the presence of an altruistic, give-and-take relationship. At the same time, the clinician must be aware to what extent the stresses currently on the patient, have led to some regressive changes and brought about impairment of the capacity for object relationships;
- (iii) the ability to interact with the therapist in the first session, i.e. the capacity to form a positive transference;
- (iv) the ability to think in psychological terms, i.e. the ability to accept interpretation, or the capacity for insight;
- (v) the ability to experience feelings, i.e. the degree to which the patient seems to be in touch with his own emotions. The affective functioning of the ego as noted by Davanloo (1978) is an important area to assess and refers to how the patient tolerates affect eg. guilt and

depression and anxiety, which are seen as important prognostic indicators for dynamic therapy.

5.7 DEVELOPMENTAL ISSUES AND SELECTION PROCESS

In recent years, various researchers have focused attention on the systematic developmental changes occurring in adult men and women (Budman and Stone, 1983). The particular developmental stage that the patient is in may have a clear relevance to the problem he presents with in therapy. Or it can, at the same time re-evoke inadequately dealt with previous phases. The writer believes that this continuity on a longitudinal basis needs always to be kept in mind. Bennett stresses the developmental framework of the individual, and the nodal points of stress developmentally, with particular tasks which have to be met. He sees the individual presenting for treatment, as linked to the point in his life in which that presentation occurs and considers the brief psychotherapy encounter as "shooting at a moving target" (Bennett, 1984: 174).

White, Burke and Havens (1981) take this developmental consideration further and suggest that for particular adult developmental stages, certain models or methods of brief therapy may be more appropriate. For example, in adolescence, the issues of separation-individuation surface again and again, and they suggest that the approach as advocated by Mann (1973) would be useful for these conflicts. Or to take a further example, in early adulthood, conflicts around intimacy and commitment become central themes. In this stage too, conflicts about occupational success or competitive striving could interfere with work achievements. In this way, conflicts from earlier phases, eg. Oedipal attachment, triangular issues, or unresolved conflict about succeeding, could become highlighted and could block the assumption of adult roles. The approach as advocated by Malan (1976; 1979) or Sifneos (1979) could fit well into this stage, as they

advocate interpretation of Oedipal conflicts. Similarly, at mid-life, or in old-age, where specific conflicts as specific to those stages, surface, certain models, or variation of the models, can be utilized, to deal with stresses or with re-evoked conflicts.

Thus, the utilization of the developmental stage paradigm is a useful one, which can add a relevant dimension to the selection of patients, in conjunction with the personality variables previously discussed.

5.8 CONCLUSION

In concluding this section, it must be noted that one of the ways in which the proponents of brief therapy have sought to improve outcomes, has been to select patients who are most likely to benefit from what the therapist has to offer. The majority of studies point to specific characteristics needing to be present. These characteristics can be "strong ego resources", which would include a good level of emotional maturity, autonomy, and ability to relate in therapy. Conversely, patients who on the whole, are unsuitable for brief dynamic therapy, may be those with profound dependency, persistent acting out, and self-destructiveness. Other negative characteristics identified were rigidity, and profound negativism. While more data appears to be necessary in respect of the more disturbed patient, it appears that there are some provocative findings in relation to outcome studies of brief dynamic therapy with this patient. The patient's suitability can be determined fairly readily in the first three interviews, and often in the course of a single assessment interview.

Strupp states that, on the whole, the importance of "person variables" rather than "pathology variables" is significant in selection for brief dynamic therapy (1981: 224). Ability to relate and motivation, are variables that point to particular personality organizations, rather than

to discrete symptoms or "disorders". While there is a correlation between "people" and "disorders", brief therapy places less emphasis on the severity of symptoms, regarded as a "static" assessment, and instead points to a dynamic assessment, which is more useful for therapy purposes. Thus, while psychiatric assessments are important for prognosis, as discussed earlier, dynamic assessment have become the indicators for the brief therapists.

In this chapter, the area of assessment and selection of patients for brief dynamic therapy has been discussed. It necessitates that the therapist possess the necessary knowledge and skill in making assessments. It also implies that the therapist possess a range of alternative skills which can be utilized with those patients who would not meet the criteria, but would be able to benefit from nondynamic therapy.

While characteristics of the patient are important in relation to outcome, however, it is important to recall what Binder, Henry and Strupp (1987) wrote about the significance of the quality of the patient-therapist relationship on the outcome of therapy. The following chapter will explore technical aspects of brief dynamic therapy and will consider among other aspects, relationship factors in brief dynamic therapy.

CHAPTER SIX

TECHNICAL ASPECTS OF BRIEF DYNAMIC PSYCHOTHERAPY

6.1 INTRODUCTION

There are a number of technical dimensions which need exploration in order to define more clearly the characteristics of the brief model. The dimensions which the writer would like to examine are: firstly, relationship factors in brief dynamic psychotherapy, which includes transference and countertransference; secondly, the importance of the time dimension and its implications for therapy, and thirdly, activity of the therapist which includes examination of specific techniques in brief dynamic therapy.

6.2 RELATIONSHIP FACTORS IN BRIEF DYNAMIC THERAPY

Research has shown that of all variables studied to date, a positive therapeutic relationship is related most consistently to a positive therapeutic outcome. It is regarded as the key variable within which all other factors operate to produce positive or negative outcome (Horn-George and Anchor, 1982). Various studies on process have looked increasingly at the therapy relationship (Strupp, 1980a; 1980b). Strupp found that "the therapeutic relationship becomes established and fixed very early in treatment (before the end of the third session) and that it is fateful for its course and outcome" (1980b: 716). In addition, given relatively constant therapist and technique variables, that the outcome of therapy depends most on the client's ability to use the relationship as provided by the therapist (Strupp, 1980a). Psychodynamic therapy makes special emphasis of the relationship between patient and therapist as the medium through which change is accomplished. While the value of the relationship is also recognized by other models, eg. behaviourist model, it is the

psychodynamic and psychoanalytic approaches that appear to make the relationship itself an object of scrutiny. Gurman and Razin (1977) point out how while Freud was concerned with the counterproductive attitudes of the therapist, he actually did not pay much attention to the curative aspects of the good human relationship, which took second place in his attention after technical factors. In this respect, there is still a continuing debate about the comparative value of the specific, i.e. technical, opposed to the non-specific aspects of therapy, and the questions about which is more influential in the change process continue. This aspect will receive further attention below.

The question can also be asked whether the relationship as found in brief dynamic therapy would have the impact that a long-term relationship would have. Or, whether lasting change can occur in the patient, given this relatively short exposure to a healing type of relationship. It is therefore necessary to address some features of the therapeutic relationship and to evaluate it in terms of brief dynamic therapy.

6.2.1 A CREATED INTERPERSONAL CONTEXT

The treatment relationship is a human relationship and is inevitably mutual and interactive. Saari points out how each therapy relationship is a unique construction created together by a particular patient and a particular therapist. It can also be seen as a "created context" in which a particular "culture" prevails (1986: 49). This culture is comprised of a sample of reality which both patient and therapist have, though from different perspectives. It is in their sharing and contemplation of these perceptions, about the nature of the reality of the treatment situation and of the patient's problem, that constitutes the therapeutic culture that is unique in the treatment of each patient.

The distinctively interpersonal aspect implicit in the patient coming for therapy was recognized by Balint (1973, in Gustafson, 1984). Even the patient's condition or illness he saw an interpersonal construct: of the patient offering symptoms or problems, and of the therapist making a "counteroffer", thus together a symptom or problem was "organized" (Gustafson, 1984: 85). Donovan (1987) in similar vein, addresses the controversy of the neutral therapist, and the question of whether he promotes or inhibits change. He notes how Winnicott and the introduction of the "holding environment" represented a radical re-evaluation of therapeutic neutrality, with an emphasis on its interpersonal aspects (in Donovan, 1987: 181). This is an essential characteristic of brief therapy: that the therapist is actively involved in the interpersonal aspects of therapy.

6.2.2 A SECURE BASE

The "fluidity" of the two-person interaction, as compared with the "rigidity" of the one-person intrapsychic structure of the patient, with its solutions to his problems, is described by Gustafson (1984). For the patient to cross over from this rigid realm to the realm of the fluid two-person interaction is usually fearful, and no patient will do this, unless he feels the therapist is completely with him. The safety that the patient experiences in interacting with the therapist is essential. Bowlby maintains that the clinician must provide for the patient "a secure base from which to explore and express his thoughts and feelings" (1987: 140). According to Gustafson, all the technical skill in the world will not do this, unless the therapist possesses a quality of empathy. This can be said to be a measure of whether or not one is able to put oneself with the patient and stay there. An exacting test of empathy is described as

whether or not one can finish the patient's sentences (Havens, in Gustafson, 1984). Gustafson explains that the patient has come with some kind of pain on his mind and coming to see the therapist has all the trappings of a "special occasion" that has a "sacred" quality to it. Either this sacred moment is used, or it is wasted. If it is wasted, a belief in being understood is lost (1984: 937). The brief therapist needs to activate all the security and safety features within the relationship and to engage rapidly in order to maximize the brief encounter.

6.2.3 RESEMBLANCE TO CHILD-REARING

The therapeutic relationship and its resemblance to child-rearing has been suggested. In this respect, Chescheir in discussing some of Winnicott's concepts, and its implication for clinical practice, suggests that the therapeutic process is to some degree a metaphor for the original holding environment provided by the "good-enough" mother (Chescheir, 1985). Burton believes that the patient: "..... searches out to find that healing personality who can stand in locum tenens for them for childhood and adult experiences never completed - their unfinished business, which they must now finish" (Burton, 1976: 324). In this respect, the writer finds that of the brief dynamic therapists in the literature, the work of Mann comes closest to this in the manner in which he uses himself: he is described as employing subtle techniques that serve to intertwine the patient and therapist in a "symbiotic orbit" (Rasmussen and Messer, 1986: 175). This also fits in with his aim of utilizing the separation-individuation focus in his therapeutic style, and his confirming, soothing, mirroring techniques.

According to Burton (1976), many personal relationships derive their inherent gratification at least in part, from commonalities with the parent-child relationship, and it is thus possible to use this relationship

to produce "corrections". In this respect, Strupp (1976) states cogently that psychotherapy is potentially useful when the patient has remained responsive to parental-type influences and it is essentially less productive where such receptivity has either never existed, or has been severely frustrated. This ready potential in the client is seen as an important indicator for brief dynamic therapy.

6.2.4 CONTAINMENT FUNCTION OF THE RELATIONSHIP

Caseament maintains that the patient coming to the therapist looks also for a personal form of containment, and how crucial it is for the patient to be "held" in this way in order to recover. The ability and strength as also the "survival" of the therapist to be able to bear the difficult feelings of the patient, provides a most important healing effect, and in itself is containing. At the same time he states that "the best containment is a good interpretation" (1985: 153) : this means being able to make sense of what a patient is saying and feeling and able to convey this to the patient. Both these aspects, containment as well as interpretation are necessary forms of technique especially relevant to brief dynamic therapy.

6.2.5 POWER BASE

The therapeutic situation as a "power base" for psychological influence is maintained by Strupp (1976). He suggests that the patient's readiness and "felt need" for a parent-type relationship (transference readiness), even though the need may be denied, coupled with the supplies the therapist can provide, constitutes the pivot upon which the therapeutic relationship turns. It constitutes a powerful base for influencing the patient's feelings, beliefs and behaviour. Thus, within a relationship, the full range of "common influencing techniques", such as suggestion, persuasion, or manipulation of rewards, are brought to bear, and that constitutes one

of the defining characteristics of psychotherapy (Strupp, 1976: 105). However, as a paradox, while there is a controlling aspect present through the influencing process, when properly handled, it also provides a vehicle for autonomy, independence and self-direction for the patient. The issue of how external controls are transformed into internal ones is one of the basic issues of psychotherapy.

6.2.6 UNIVERSAL FEATURES OF THE HELPING RELATIONSHIP

Casement (1985) maintains that while there are many caring professions, the psychodynamics of any helping relationship may be universal. Frank (1961) set out to isolate in the therapeutic relationship, factors common to all forms of therapy, and found that the same techniques keep recurring under different guises, suggesting that, despite their superficial differences, different therapeutic approaches may all be variations of a few underlying themes. He claimed that many forms of current treatment embodies rediscoveries of age-old healing principles and suggested that these common features contribute importantly to the effectiveness of therapy. The features comprise persuasive healing forces, as above, including persuasion and suggestion, but also faith, placebo effects and hope. In addition, the brief therapist provides further hope through the belief that treatment can be concluded in a set period of time.

6.2.7 SPECIFIC AND NON-SPECIFIC FEATURES

A prevailing discussion in relation to the therapeutic relationship and the change process, is concerned with the two aspects, the specific, i.e. the technical characteristics as belonging to specific therapeutic approaches, and the non-specific, or what has been called the placebo effect. In this respect, Gustafson (1984) explains that while a successful brief therapy must arouse the very disturbance it seeks to remedy, in doing so, often the

verbal, or interpretative mode, will not be sufficient to correct it. The non-verbal climate or atmosphere matters more. How a patient and therapist "fit" together, is of the essence. Marmor (1979) has pointed out how the non-specific elements contribute extensively to therapeutic outcome. They comprise elements such as catharsis and tension release, with the expectation of help; cognitive learning in addition to gaining insight; covert and overt operant conditioning, including a corrective emotional experience; identification with the therapist, and the practice and rehearsal of new adaptive modes. In addition, the therapeutic alliance, now under discussion, is also seen as a non-specific element. In brief dynamic therapy, both aspects are of significance, and it would be difficult to tease out one as being more or less influential than the other. While specific techniques are significant and have a relationship to outcome, research by Strupp (1980a; 1980b; 1980c; 1980d) has found that the alliance and cathartic and other non-specific effects, is of the essence in determination of outcome in brief therapy.

6.2.8 WEAKENINGS AND REPAIRS OF THE RELATIONSHIP

An interesting contribution comes from Lansford (1986) who researched the working alliance in brief therapy. She studied the "weakenings and repairs of the working alliance" and how these were related to change in therapy. She found that in keeping with Mann's (1973) ideas about the importance of a stage of resistance in the middle phase of therapy, this middle stage also corresponded with more weakenings and repairs in the therapeutic relationship. The success of dealing with the weakening of the alliance, also corresponded with work on the "focus" which centred on the patient's "chronic and enduring pain". If these weakenings were successfully repaired and resolved, one could say that the person had been able to change what was most painful or difficult in his life. In her

view, this building and repair of the working alliance would have been the central work of therapy. This has important implications for brief therapy, regarding the quality and use of the relationship and its importance for outcome.

6.2.9 SUPPORTIVE AND DYNAMIC ASPECTS OF THE RELATIONSHIP

The question about whether the therapeutic relationship can be both supportive as well as dynamic, is a topic of some argument in the literature. Crown (1988) asserts that there are differences in using either a dynamic, or a supportive approach, and that if therapy is dynamic, it cannot be supportive, or if supportive, it cannot be dynamic. He explains that, while dynamic therapy attempts to understand how the past has led to the present problems, and uses transference and the "triangle of insight" (i.e. where the patient's relationship to the therapist is related to a similar situation with an important figure in the patient's past), supportive therapy has an emphasis on problem-solving and adaptation in the present.

This dichotomous viewpoint is challenged by other contributors eg. Greenberg (1986) and Ornstein (1986). Greenberg (1986) asserts that supportive therapy is usually clearly defined and used whenever the client's adaptive capacity is inadequate to cope. The supportive therapist emphasizes the patient's strengths, and searches out previous successful adaptation, encouraging the patient to describe such times of self-reliance. Indeed, in the midst of insight-giving dynamic therapy, the patient may require these supportive techniques to enhance his capacity for growth and change. Dynamic therapy, while focusing on pathology, its antecedents and patterns, is however, ultimately supportive. Ornstein (1986) maintains that the strengthening of the ego which occurs through supportive therapy, is not just a by-product of the treatment process, but

the very essence of it. In many cases, the client's inability to deal with demands of reality is the expression of conflict, or developmental arrests, thus usually ego support as well as dynamic work, would be necessary. Thus to separate "supportive" forms of help directing towards "real" problems, from those that aim at the "uncovering of hidden material" is arbitrary (Ornstein, 1986). In brief dynamic therapy, both dynamic and supportive aspects are significant in promoting client change.

6.3 TRANSFERENCE AND COUNTERTRANSFERENCE

Marmor delineates two major facets of the relationship: the one an unconscious one, i.e. the transference and countertransference elements (discussed further below), and secondly, a conscious one, which are the real attributes of the patient and therapist, and the way in which their personality attributes mesh. In this respect, Burton points out how the reality aspects of the alliance, with the therapist as a "firm loving model", has its own healing rationale (1976: 322). The significance of other reality factors, such as socio-cultural factors and value differences have received extensive attention in the literature, for example in Garfield and Bergin (1978).

6.3.1 TRANSFERENCE

Transference has been defined as "unconscious repetition of the past in the present, in which contemporary figures are endowed with the qualities of significant figures in the unremembered pastIt is present in everyday life, and manifests itself most strongly under conditions of emotional conflict." (Fraiberg, in Lieberman, 1982: 53)

Salzman maintains that transference enables the clinician to understand why the client responds to another in an interpersonal context in a "distorted, excessive and contradictory fashion" (1976: 30). The client's

understanding of this distortion allows him to explain this in terms of his own individual history but also lays the groundwork for change.

Major emphasis has been placed in the brief dynamic literature on the technical management of the transference. Malan (1979) maintains that it is a crucial dimension for understanding the patient, as the past conflicts become revived in the here and now in front of the therapist's eyes. He asserts that the parent-transference link was the most important therapeutic tool in brief dynamic therapy and was primarily responsible for its successful outcome. Some major theorists, eg. Malan (1973; 1976; 1979) and Davanloo (1978) use two conceptual triangles in their therapeutic work: the triangle of conflict, which links defenses, anxiety and impulses of feelings; and the triangle of insight, which links the transference with past and present relationships, including the relationship with the therapist, as acted out in the present. For example, in relation to the transference-parent link, if the client was overly protective towards the clinician, this would be assessed for its significance in relation to earlier behaviours and patterns from the client's childhood.

Mann, who focuses on separation-individuation conflicts, maintains that this recurring life crisis is the substantive base on which brief therapy rests. "The hallmark of separation anxiety lies in the ambivalence experienced originally in the mother-child relationship" (1973: 26). Mann believes that in brief therapy, with the impending termination of therapy, there will always appear two concurrent contexts: the one the feeling that existed in relation to an earlier figure and now experienced with the therapist, and secondly, the displacement of the same feelings and behaviour which surrounds the conflict situation for which the client sought help in the first place.

Saari (1986) points out how people continuously act out unconscious memories without being able to resolve them. Freud called this the "repetition compulsion". Saari maintains however, that this acting out can also be seen as an attempt at mastery of those old situations. Thus, there is an active element involved in this as well. Gustafson refers to the patient "tempting" the clinician to repeat earlier events to test out whether this is in fact different. If the clinician does not fall for it, and is not provoked by the patient, then a "new ending" is possible (1984: 108). The "different" responses of the therapist towards the patient provides an opportunity for distortions to be given up.

The necessity of promoting positive transference is recognized by most major brief dynamic therapists. It is important that the client sees the therapist as being a likeable, understanding and encouraging figure, whom he can readily internalize. The client must believe that the therapist can help him. This is important if goals are to be accomplished in a short period of time.

Malan (1976) believes that negative transference be interpreted and worked through early; it can be present from the first session, eg. when the patient arrives already having endowed the clinician with certain qualities. The clinician needs to deal with this pre-therapy transference, which is seen as a resistance, in order to clear the path to a positive alliance.

Mann (1973) proposes that the process of the therapy causes changes in transference: that at first the clinician is an intensely positive transference figure, as the client goes through the "golden sunshine" phase. Later, towards termination, negative transference emerges, which has to be resolved, in order to experience the therapy as a maturational process.

Delvey refers to two models of transference, one he terms the classical model, where transference occurs when experiences from the past are displaced onto new persons in the present (1985: 583). The clinician helps the client to experience a connection between the present and past behaviour. In the second, called the container model, clients seek a repository for unwanted feelings, which they were never "taught" to manage. The goal of the clinician containing the feelings of the client, is maturation: the patient is helped to modulate his feelings, and to manage them by watching the clinician, through modeling. Both models would be utilized in brief dynamic therapy.

However, the transference of the more "structured" personalities who see others as whole and separate, must be different in quality from transference of under-structured personalities, who regard the images of the other person as somewhat merged with their self-images (Blanck and Blanck, 1987). Thus, because most borderlines sees the object in the present as the same as from the past, and feelings are not "transferred" but continued, the writer believes that the container model is more appropriate as a general rule, as combined with a focus on reality issues. This could indicate that more "time" may be required than the brief model would allow, especially for the more severely disturbed client.

Thus, transference and interpretation is widely used in brief dynamic therapy, and is seen as a potent curative method. There is, however, a continuum among the brief dynamic therapists in relation to the practice of working intensively with the transference, and interpreting actively, or in acknowledging it, but not working with it actively. For example, some may divert away from the transference, into the patient's everyday relationships. Ornstein (1986) points out that in the earlier days of ego-psychology it was recommended in social work literature, that the

transference had to be "managed" and "regulated" instead of being understood and interpreted, which is the practice today among clinical social workers.

While the traditional model of transference would require that the transference process not be intruded on by, for example, family members, the brief model ought to deflect from the sacredness of this, to allow for progression, rather than regression. In brief therapy, there is a tendency to avoid intense transference, and to take measures to diminish the intensity, through structuring of the therapy. Thus, the current situation and the relationships which impinge on the patient, are utilized in understanding the link between past, present, as well as the transference situation within the therapeutic alliance.

6.3.2 COUNTERTRANSFERENCE

Gurman and Razin (1977) point out how the definition of countertransference has been subject to controversy and discussion. This is in relation to whether the term should be reserved for the original, specific definition based on Freud's view that it is concerned with the unconscious response of the therapist to the patient's transference; or whether it should involve all the conscious and unconscious responses, rational and irrational, of the clinician. This latter broader view, in which it is also used as a means to understand the patient, is usefully applicable to brief dynamic therapy. In an early paper, Winnicott distinguished the "repressed" feelings of the clinician from what he called the "objective counter-transference", or the clinicians's "love and hate in reaction to the actual personality and behaviour of the patient, based on objective observation" (1949: 70). This dual reaction is also recognized by later writers who have referred, as did Winnicott, to the informational value of this objective countertransference in therapeutic work.

Casement explains that the therapist is trained, and supervised, so that he does not respond inappropriately to a patient as a "transferential object" (1985: 9). However, he argues that the clinician tends to develop an attitude, not unlike a transferential relationship, to his own theoretical orientation or clinical experience, eg. when there are elements of similarity between a current clinical situation and others before it. This can result in the clinician responding to these new clinical phenomena with a false sense of recognition. He suggests that the clinician use a "binocular vision" as suggested by Bion, where he follows the client with one eye, in relation to what he does not know, and with the other eye, in relation to what he knows, thus creating a "creative tension" between the knowing and not knowing (1965, in Casement, 1975: 5). This is particularly relevant to the brief method. The writer believes that, in attempting to find the themes of the current problems that clients bring, it is important that the clinician have an open mind, so as to not to impose "premature understanding" on the client. Mutual goals in relation to the focus of work are thus necessary.

Klar and Frances (1984) maintain that the brief model limits the development of the more classical countertransference, in that there is less regression, and more focus on the realistic base of the alliance. On the other hand, they make the important point that the nature of the brief contact magnifies the personal reaction to the patient, in both its positive and negative aspects.

Davanloo (1978) has pointed out how the particular characteristics of the clinician, his objectivity, his value system, his clinical maturity, his empathic capacity, his conscious and unconscious needs, could all influence the process of evaluation and selection of clients.

In brief therapy, ambiguity and resistance to setting time limits could be due both to the client as well as to the therapist: the dynamics reverberate with the clinician as well, and expose him to his own unconscious conflicts of the same nature (Mann, 1973). Mann further believes that it is the inability to face termination that often accounts for interminable treatment, and that in some cases of long-term treatment, the painful separation phase is often worked through raggedly. Martin and Schurtman (1985) have referred to the termination anxiety as it affects the therapist, and mention aspects such as fearful expectations of leave-taking, stemming from his own flawed separation; or guilt feelings because of a perceived sense of abandoning the client, or as Applebaum (1975) notes, a fear that he is cheating the client of the time he needs. A therapist may also begin to doubt his own competence when the patient starts to act out as part of termination.

The clinician's own attitude towards directive work and providing limits to the patient, needs to be explicit. His motivations for preferring to do brief rather than long-term work for specific clients needs to be understood, so that he is not amiss in denying more ongoing forms of support and help to some clients who may require this. This would also pertain to accepting more dependency and regression in the client where this is needed.

Thus, the issue of countertransference plays an important role, in terms of client selection as well as in the process and outcome of brief therapy.

The question remains whether brief therapy can bring about enduring change. In order to explore this facet, it is necessary to reflect on the dimension of "time" in respect of relationship issues and therapy.

6.4 TIME DIMENSION AND BRIEF DYNAMIC THERAPY

The question whether relatively brief psychotherapy can bring about lasting change in the patient must be addressed. Stierlin (1968) explains that this question gives rise to differences in opinion. On the one side are therapists who argue that there exist no short-cuts to effecting structural change, as such change needs time: time to develop a transference neurosis and time for a working-through, and without this time, lived through and worked through, by both partners in the alliance, any ensuing change is superficial. On the other hand, there are others who argue that a long time spent in therapy is often unnecessary, and not seldom harmful, for it causes the patient to become regressively stuck.

Lengthening factors in therapy, as discussed in Chapter Four, were challenged by Malan (1973) and shortening factors were introduced, viz. an active focal approach, therapeutic activity and involvement, a tackling of the negative transference, as also the therapist's enthusiasm, which was regarded as an important aspect of therapeutic behaviour. In relation to the latter, it was pointed out how in the earlier stages of his career, a therapist usually achieves some quick and dramatic successes which later seem to become unreachable.

Applebaum (1975) uses Parkinson's Law to explain the rapid results of brief therapy. He proposes that the therapist and client shrink the time to complete the task, knowing in advance that little time is available. He argues that in groups for example, predictable patterns emerge, whether the groups meet for a few hours or a few years and that a similar pattern occurs in individual therapy. Endings have psychological impact, and he cites the simile of a man carrying a weight at the limit of his strength, which he drops only at the point of destination. Further, there is the clinical observation that patients take advantage of endings to offer a

view of themselves which seems to have been held in abeyance during the long period of testing to that point.

In therapy, the therapist sells time to his patients, and he is usually quite explicit about this, in relation to appointments and time allotted to patients, thus on a conscious level, there is a set of conditions in regard to their time. However, as Mann (1981) points out, clinicians tend to ignore the conscious and unconscious meaning and experience of time in their patients as well as in themselves. In long-term treatment, both patient and therapist experience treatment as timeless, and only when termination is raised, does it become an issue. It is asserted that the greater the ambiguity as to the duration of treatment, the greater the influence of regressive, infantile, dependent wishes.

6.4.1 TIME DIMENSION AND THE SELF-CONCEPT

Mann (1973; 1981) states that the issue of time is loaded with experiences and symbols and fantasies of the past, and that the emotional determinants of time are inescapably related to the early nurturing objects. For the child, there is an experience of infinite time, or timelessness. He explains that there is evidence for the presence of a sense of timelessness residing in the unconscious of all individuals. This can also help to explain the repetitive nature of ingrained conflicts.

In taking a psychiatric history, there is a review of the patient's past, present and future, with the general goal that the patient face up to his past so as to gain mastery over the present (Mann, 1981). There is the issue of transference which links the past with the present in a most cogent manner - Casement has referred to the potent "sense of reality and immediacy" of the transference (1975: 7).

Mann (1973) asserts that the meaning of time becomes intensely highlighted in the brief therapy framework, with its limitations imposed. Further, he maintains that the recurring life crisis of separation-individuation is the substantive base upon which the treatment rests, and that throughout life there are numerous experiences that revive repeatedly the experience of loss and the anxiety related to the separation-individuation crisis.

Mann (1981) has found that the "time-bound image" of the self which becomes the focus of therapy, is usually a persistent, negative self-image. Some illustrative central issues would be: "you are a big man who has achieved very successfully, and yet, when you are alone, you feel helpless (A 35 year old man with an acute phobia), or : "you seem to be a decent sort of man and you have tried to please others, yet you feel and have always felt that you are not wanted." (A 25 year old man depressed and given to unpredictable and impulsive fights with his wife.)

There is however, a deep-seated rebellion against time and a resistance to termination, thus the special attention needed to this and the feelings attached to it, which then evokes previous object relationships and experiences in relation to separation and individuation. Thus, issues of self-image, and object loss are linked and both become worked on in Mann's framework. Applebaum (1975) explains how separation and individuation are universally important developmental issues and becomes elaborated in the treatment according to each individual's central conflicts, defenses and character.

Marmor (1979) describes how setting of time limits has certain consequences: firstly, there is a central emphasis on separation and individuation, as discussed earlier. Thus, the expectations are clear for the client. Secondly, there is a respect for the client's autonomy, and thirdly, the very process is a therapeutic act which encourages the

client's self-confidence. The necessity for the clinician to deal directly with termination and explore the client's feelings is stressed. This is particularly important in view of the above information regarding the re-evoking of the conflicts which could remain "stuck" if termination issues remained unresolved.

6.4.2 TIME DIMENSION AND RELATIONSHIPS

Within his "general theory of human relationships", Stierlin (1979) points out how there are both enduring and changing elements in a given relationship. He delineates five perspectives which bring to light what is important in a given relationship. These are (i) moment-duration, (ii) sameness-difference, (iii) stimulation-stabilization, (iv) gratification-frustration, and (v) closeness-distance. In discussing only the first, the moment-duration, Stierlin explains some differentiating aspects of brief and long-term relationships. In relation to this "time" dimension, brief and long term therapies are seen as instances within a panorama of possible relationships. He delineates future-bound , enduring relationships on the one side, and casual momentary relationships on the other, representing two ends of one scale into which various types of relationships could be fitted. The mother-child relationship as a "future-bound relationship" can be the most enduring kind (Stierlin, 1979: 362). In this latter kind of relationship, there is deep commitment, regressive experiences can be shared and there is a commitment to the working through of difficulties that will arise. In such relationships, growth processes of a special kind may occur as these depend on the ongoing internalization of the other's image and values. Casual momentary relationships on the other end of the scale, seem to lack the elements just described and in general, they appear much less formative than the future-bound relationships.

However, at closer inspection, relationships of casual appearance may also show features of depth and intensity, and have formative impact. In considering the moment-duration, these relationships can stand out "on account of a seemingly unsurpassed sharpness, freshness and intensity of experience and yet are enduring affairs" (Stierlin, 1979: 362). Such a relationship appears to owe its intensity and meaningfulness to the fact X that it has no future. Stierlin adds that it is often the most intimate and best-guarded aspects of one's private life which one dares to and seeks to reveal in the absence of a future-bound relationship.

Thus, rather than seeing improvement in clients as "transference cures", or as being superficial changes, these changes can be viewed from a different light. It implies that we must allow for experiences of intensity and emotional impact from brief relationships, which can lead to enduring change, as has also been found in case studies, eg. Malan (1976) and Sifneos (1973), where improvement and resolution of conflicts have been maintained.

6.5 ACTIVITY OF THE THERAPIST

6.5.1 CONTRACTING

Both the client and the therapist have their own expectations of therapy and these have to find a congruency within the alliance in order for there to be a common base from which to function, according to Salzberger-Wittenberg (1970). One of the facilitating ways to provide this is through contracting, which plays an important role in brief dynamic therapy.

Horn-George and Anchor (1982) found that the perceptions of the therapeutic relationship differed in long versus short-term therapy: they found that therapists and clients in long-term therapy dyads were more "phenomenologically" congruent in their feelings towards therapy and each

other, as well as in perceptions of the goals and processes, than were therapists and clients in brief therapies. Thus, it would seem that expectations need to be clarified early, in order to enhance congruency.

Preceding the treatment contract, there is the intake or consultative interview, which may be extended to two or more sessions. From the data obtained, a formulation of the central problems and conflicts is defined and a contract is made. This would encompass definition of the time limits, either in number of sessions, or in number of months, in which therapy will occur; if appropriate, fees will be discussed. It also is concerned with defining the focus of work, which has to be decided mutually. (see below). The client's expectations of the therapy needs to be clarified. This is regarded as essential, in view of the fact that differences in expectations between client and clinician are seen as factors contributing to drop out, or early termination of therapy by the client (Hoffman, 1985).

Contracting with the client provides a structure, and a form of containment, as well as sense of predictability. As termination approaches, there may be reason to extend the original contract or to develop a new one. Mann (1973) would for example, offer extended sessions where for eg. a client was embarking on a divorce while undergoing therapy.

The definition of a focus is one of the essences of brief dynamic therapy. This area will now be addressed.

6.5.2 FOCAL ACTIVITY

The brief dynamic therapist maintains that rather than trying to deal with all aspects of the patient's personality, he would choose to select and focus on those problems most centrally related to the major symptoms and complaints.

Brief therapy further assumes, as argued by Strupp (1981) that supplying the patient with a missing piece (from his development), will allow him to resume development and complete the puzzle. "A complete working through of the puzzle is not necessary; the patient will work out the rest on his own over time" (Gustafson, 1984; 936). However, this may not be the case for all patients, some of whom may be missing pieces that take a longer time to recover, as described by Balint (1968, in Gustafson, 1984) in his work on "basic faults", and who may need to have longer therapy.

6.5.2.1 Central Conflict Identification

In attempting to limit the length of therapy, brief therapists attend to a central conflict in therapy. This represents a noticeable departure from the open-ended, approach of long-term therapy. Applebaum (1975) explains that this focal activity helps to prevent a passivity of the therapist.

This central conflict identification can be limited to understanding the present stresses affecting the patient, or as a link in a chain going back to childhood. It can usually be crystallized within the first two sessions.

As described in Chapter Five, the therapist's orientation will be decisive in directing his way of working with the focus. For example, Malan (1976) will always use the triangle of insight, in working with the transference and past relationships, and connecting the two to discern what the abiding

conflict is that the patient is struggling with, and how his object relations are distorted by the conflict. Mann's approach is to discern the self-image and separation-individuation issues. As Rasmussen and Messer indicate, either approach could be deemed feasible for a patient; while the approaches may differ, they may represent "two kinds of narrative truth each with its own appeal within the analytic space. Each therapy helps patients understand at a cognitive and emotional level something about their dilemma and a plausible background for it" (1986: 183). Each version thus has a coherence, however either could be applied to a particular patient.

In the first few sessions, the patient may disclose painful experiences, problems in relationships, unwanted behaviours, and these indicate in the patient's terms, the goals for treatment. The therapist will modify these, and reframe the problems, sharing this with him, linking together in new ways what he has communicated, and expressed in the form of an interpretation (Doctor, 1982).

As discussed earlier, in Chapter Five, the client's history and early memories help to form a dynamic picture and assists in arriving at a focal problem, as well as clarifying the psychosexual level at which the client is prone to define object relationships. It can also offer clues to transference paradigms (see example given earlier of the writer's own clinical experience).

6.5.2.2 Focal Conflict and Developmental Stage Framework

The life-stage framework is an important aspect to consider in relation to stage-specific tasks, hazards and challenges, with the assumption that developmental "snags" occur, when clients do not fulfil stage-specific tasks, eg. aging, or mid-life tasks. These can often coincide with, or be

superimposed on more basic central conflicts as well, eg. a client at mid-life stage of life may be struggling with separation-individuation issues, when older children want to leave home. Or in relation to Oedipal conflicts, a patient in early adult stage, may experience conflicts at work in relation to authority and control, or competitiveness, which can be discerned to be a focal conflict in relation to male figures, and competitiveness. In this case, the latter issues would become the focus of work. In this manner, within the developmental framework, the dynamic focus is maintained, and the client's inner and more basic conflicts will be worked with, which had become re-evoked at a certain life-stage. This, i.e. work with a focal conflict, and interpretation to allow insight to be obtained, has been claimed by various contributors, eg. Sifneos (1978) and Malan (1979), to be a most important curative aspect of therapy.

6.5.2.3 Focal Work with Vulnerable Patients

Leibovich (1981; 1983) maintains that focal work can be especially useful for more disturbed personalities as well, eg, borderlines. It offers a manageable segment of reality to work with, and enables them to achieve a sense of purpose. The activity of the clinician also is important as it strengthens the patient's self-determination and separation, while also being supportive, whereas the time element, and the circumscribed short-time commitment, allows for a more tangible and accessible purpose. The "controlled reality" of the framework of time-limited work, the focus, and the demarcation of the boundaries of the relationship, helps in providing a containing environment for clients with borderline personalities who fear closeness and engulfment.

6.5.2.4 Formulation of Focus Related to Length of Therapy

The ease with which a focal conflict can be elucidated from the problems that the client brings, can have important bearings on the length of time the client is taken into therapy. This interesting point is made by Binder, Henry and Strupp (1987), who propose a working assumption that the more precisely a problem area can be monitored, the tighter a time period may be set for treatment. Conversely, more ambiguous and complicated problem areas are likely to require more time in which to formulate a problem area. A focus and organizing theme should be attempted, which would demarcate the area of therapeutic work, and the clinician needs to keep on this track within sessions. In this manner, progress should be the aim of each session, thus to prevent passivity and lethargy from setting in.

6.5.2.5 Focal Work and Systemic Factors

The systemic aspect of a focal problem is underlined by Gustafson (1984) who maintains that every focal recurrent problem implies an unsolved family problem. Indeed, the patient may be as active as any other family member in maintaining the organization of the family, and inviting a certain "attitude" from the family. With his new capability gained from his brief individual therapy, and with the support of the clinician, the patient can create change in his context as well. Indeed, a major change at the personal level will interact with other broader levels of organization as well, such as the existing close relationships, family and work contexts.

6.5.3 USE OF INTERPRETATION

Interpretation is widely used in relation to the transference as well as to the focal activity. The activity of the clinician consists of offering interpretations to encourage links to be made, and these need to be personally meaningful to the client. It needs to be used within the context of a particular moment in therapy, thus the timing is of great importance.

The question can be asked how the therapist comes to choose the specific interpretations that he does. Winokur, Messer and Schacht cite Schafer and Edelson's suggestion that "the therapist must lead patients to a vision of themselves which is both different from their current vision and also implicit in that vision" (Winokur, Messer and Schacht, 1981: 140). Typically, the therapist would accomplish that process by focusing the content of his interpretation on material which appears to be just out of awareness, and can be seen as a "logical" interpretative extension of whatever the patient has been talking about. Strupp (1981), however believes that any interpretative activity can become effective only to the extent that a conflict becomes alive in the transference, i.e. sufficient feelings have been mobilized and the patient is struggling with the conflict in the here-and-now.

There are a few important aspects related to interpretation that need to be explored: Traditional long-term therapists believe that interpretations can only be made gradually, and that the consequences of premature, too frequent or too deep interpretations are inevitably negative. However, from reports of research studies, (Malan, 1976; Sifneos, 1978) it is used successfully.

In relation to the above aspect, there is a contribution from Winokur, Messur and Schacht (1981) which is useful: they suggest that the brief therapists make rapid links, of both genetic as well as concurrent events, with transference interpretation. In this way, the patient's feelings are not allowed to develop into a crystallized attitude (transference neurosis) and the disorientation and regression that can follow, is avoided. In addition, the clinician actively disconfirms the patient's transference view of him by explicitly disclaiming a position given to him by the patient. The patient is encouraged to participate actively and is helped not to regress to a passive stance of dependency. There is a sense of partnership: "let's look at that", and encouragement of self-observation. The interpretations are usually couched in terms of the client's adaptive modes of managing feelings and impulses in relation to significant persons and of making coherent sense out of events, rather than on unconscious aspects.

6.5.4 EVALUATION AND TREATMENT ARE LINKED

The two aspects of evaluation and treatment are linked in brief therapy. From the first session, the clinician must be both gathering information, and testing hypotheses. Evidence of problem-solving, changes in attitude, and altered behavioural patterns suggest a change in the patient. Also, in relation to the therapy relationship, there may be evidence of more independence and less reliance upon the clinician. The evaluation should be tied to the assessment which was done in the first place, to evaluate growth and change that has occurred.

6.5.4.1 Follow-up Sessions

Marmor (1979) has the practice of leaving the door open for a follow-up visit after three or six months, if the patient desires. Mann (1973) also plans a follow-up contact, after a number of months. Bennett (1984) proposes however, that a high percentage of patients, including clinicians, seek additional therapeutic help at various times in their lives, whether they had long or short therapies in the first place, and that this does not mean that therapy was a failure. He believes that empirical data suggest that therapy is not viewed by the client as a definitive or curative process, but one which has use and value at times of need.

Bennett cites examples of intermittent therapy in which the patient will come for therapy, to resolve issues when they are developmentally relevant, thus he views treatment and returning to treatment in the light of adult development stages and life transitions (1984: 176).

6.5.5 USE OF DREAMS IN BRIEF DYNAMIC THERAPY

The use of dreams in brief therapy has received little attention in the literature, but, according to Hersh and Taub-Bynum (1985), it can provide a rich clinical resource which facilitates the therapeutic process in brief dynamic work. They recall Wolberg's work (1965) in which he stated that in brief therapy, dreams are important for (i) identifying conflicts, (ii) recognizing what environmental events are significant, (iii) understanding from the patient's view, what is going on in the relationship between himself and the clinician, (iv) detecting early resistances, (v) providing a window on the progress of therapy, and on the patient's view of future problems. In particular, Wolberg emphasized the importance of dreams as signalling the development of negative transference, which can then be diffused early. The manifest content of the dream, should be worked with

and related to current experiences. Dreams also provide access to conflicts and denied or disowned feelings that might take longer to reach in other ways. Merrill and Cary (1975) found in addition, that dreams can signify a transitional phase in therapy of decreased resistance, and frequently help to move a case along.

Dreams are an invaluable aid to a patient's inner life, especially in brief treatment, as the writer also found in her own clinical experience. For example, a patient, mentioned earlier, who suffered severe psychosomatic symptomatology, appeared to be alexithymic. This manifested in her difficulty in expressing her feelings and her inner most needs. When the writer encouraged her to report on any dream material, in an attempt to encourage her to explore other dimensions (not only the affective one, which she struggled with), she presented a dream in therapy. This was a significant one, relating to pets and an injured one, which was previously lively and energetic, but was currently lame and could not walk. This dream was presented with concurrent sad affect and a sense of loss, with disowned feelings pertaining to self coming through. In offering this dream and exploring associations related to it, it led to the beginning of insight and to marked improvement of long-standing symptoms.

In working with dreams, it is recommended that the manifest content of the dream material be worked with, and be related to the everyday experiences of the client.

6.5.6 USE OF METAPHOR TO EFFECT CHANGE

The clinician can use creative interventions to generate change, as described by Siporin. Figurative language can be used: images, anecdotes, stories, jokes, parables, myths and paradoxical statements all use metaphor to organize and express complex ideas and feelings. It can also be used to help clients to gain new perspectives and "helps synthesize contradictory elements in a situation" (1988: 181). Metaphor also carries multiple levels of meaning. It can also help resolve client resistance to change and enables the clinician to "speak to the client's conscious and preconscious" (Siporin, 1988: 182). Siporin points out how metaphorical communication has become increasingly popular in many different therapies, including the psychoanalytic approach. He maintains that clients come in with overwhelming situations, and the clinician needs to be creative in his approach, even though he may adhere to a particular framework of therapy.

6.5.7 COGNITIVE ASPECT OF BRIEF DYNAMIC THERAPY

Goldberg and Green (1986) place emphasis on the cognitive aspects of brief dynamic therapy in order to explain the change process which occurs. There is no long gradual exposure to fears and resistances, thus the concept of "working through" as would occur in long-term therapy, may not be as valid in explaining the change process. There is however repeated exposure, which is more subtle than in behavioural therapy, but which, nevertheless, is one of the active elements involved in change. A similar learning process occurs as would be seen in behavioural treatment. Dollard and Miller (1950, in Goldberg and Green, 1986) hypothesized that therapy was a process that reversed early learning experiences by gradually exposing the patient to more and more previously feared thoughts, needs and fantasies, within the context of a trusting relationship. Frank (1961) elucidated that there is a cognitive aspect in all therapy, as the patient

is supplied with "new" information about himself, or with a new way of conceptualizing what he already knows, which helps him to develop a more workable assumptive world.

The "didactic" component of treatment is especially emphasized in the brief dynamic models. New learning to deal with conflicts, as well as problem-solving and the development of new attitudes are encouraged in an effort not only to enhance insight, but also for the patient to learn to utilize it when therapy comes to an end. This is an approach particularly emphasized by Sifneos (1981) who researched the cognitive aspects of his brief dynamic therapeutic work and concluded that the cognitive aspect was as important as the affective element in relation to the change process.

6.5.8 FLEXIBILITY OF THERAPEUTIC TECHNIQUES

While a coherent conceptual scheme, such as is proposed in this dissertation, i.e. dynamic framework, is necessary, there are some dynamic workers who incorporate other techniques, according to the needs of the patient. Adjunct methods can be used as well: such as medication, for example, in severe depressive or anxiety states, or in incipient or overt psychosis; or cognitive-behavioural techniques, for example, in cases of phobic disorders; or the use of paradoxical techniques to deal with situations of extreme resistance, where the dynamic approach had little effect. An example of the latter is where change through insight may be blocked by resistance, for example, through acting out behaviour. Held (1984) asserts that in the face of client resistance, it is important that the clinician make use of "newer" techniques in order to further client change. She maintains that the use of strategic techniques would be quite compatible with any framework, and gives an example of a clinician treating a borderline patient in an objects relations framework, who utilized strategic techniques to meet the client resistance. Diamond (in Held,

1984) maintains that choosing interventions that minimize resistance, regardless of theoretical underpinning, is a crucial aspect of therapy.

While there are some therapists who would feel that this approach would take it out of the dynamic framework, the writer believes that in all cases, the clinician has to be sensitive to the needs of the patient, and in this case is not departing from the dynamic framework, but using his insights to tailor technique to the client's need. Or, in other cases, some patients who have less verbal ability, or a more concrete thinking style, may have to be accommodated differently with flexibility of technique. Weiner and Crowder (1986) have drawn attention to the fact that clients with a concrete cognitive style of thinking, would need for eg. task-assignment, advice, and paradoxical intervention, which are actually in their best interests, and can produce lasting change, without conscious insight. The writer maintains that, in any case, it is imperative that the clinician have a clear dynamic understanding of the client conflicts and vulnerabilities in order to make any kind of strategic or other intervention palatable and acceptable to the client.

6.6 ADVANTAGES AND LIMITATIONS OF BRIEF DYNAMIC PSYCHOTHERAPY

The advantages and limitations of brief dynamic therapy can now be addressed - this can also be seen as a distillation of aspects discussed earlier. In choice of therapy, it is important for the clinician to be aware of both the limiting as well as the beneficial features of this method, so as to make an informed decision.

6.6.1 ADVANTAGES

- a) Brief therapy instils hope, as there is a promise of an encapsulated, manageable time period in which the client can expect to see some improvement. This thus, makes therapy even more hopeful (see earlier section on techniques and universal features of therapy) especially if the client is not wanting a long term commitment.
- b) This very expectation of improvement, can build its own self-fulfillment, which itself can lead to gains.
- c) The time period itself can cause more effective working and commitment both from the client as well as from the clinician, and serves to obviate some of the passivity, and stagnating effects which can be present in some long-term therapy.
- d) Regression and dependence is kept to a minimum as a goal of treatment, and autonomous behaviour is encouraged.
- e) Working with a focal issue and conflict has been found to be an effective manner to treat patients, as the resolution of this conflict which is usually a longstanding central problem, can cause change in other areas of client functioning.
- f) Mastery of a manageable section of reality is conducive to a furthering a sense of competence for the client.
- g) The transference neurosis is avoided, and although transferential issues are not bypassed, they are worked with in a purposeful manner.
- h) More patients can be dealt with in a mental health system and thus the trained personnel can be spread around more evenly and efficiently, to

deal with clients in need. These are important reality needs which need an ethical and responsible response from mental health personnel.

6.6.2 LIMITATIONS

- a) From most of the research conducted on brief dynamic therapy, it appears that, on the whole, clients need to have an initial capacity to engage rapidly in a relationship with the clinician. Thus, there are inherent limits in this for the client who does not possess this readily available capacity for trust.
- b) Severe disorders, such as severe depression, psychoses, and some personality disorders, would be less early managed in this model. In these cases, more regression may have to be tolerated and dealt with. In addition, the client may have to have access to a supportive relationship with a clinician on a long term basis.
- c) Client resistance may not always be dealt with satisfactorily, as the method relies on the use of insight in order to effect change. Other methods may have to be incorporated to deal with resistance.
- d) As the brief method relies on the clinician having skill to identify a central conflict, which is an important curative technique, this could be a limiting factor where the clinician does not have sufficient training.
- e) Termination issues have to be dealt with sensitively and well, and the lack of time to deal with issues may result in some unresolved situations, especially if the clinician is not sufficiently responsive to the client's unexpressed needs.
- f) While brief therapies offer important techniques, it could cater to unrealistic expectations for cure and to promote impatience for dependency,

as well as advocating using firm strategies too boldly. These would have to be avoided.

g) It is a method that is "hard" on the clinician, as he has to be actively involved, and to attend to focus and technique actively, and it thus calls for an involved commitment.

6.7 CONCLUSION

This chapter has discussed the technical aspects of brief dynamic therapy. It covered relationship factors including transference and countertransference, the time dimension, activity of the therapist, including focal activity, use of interpretations, contracting, dreams, metaphor, cognitive aspects involved in change, as well as the necessity for the clinician to have a flexibility of approach to treatment, while adhering to a dynamic approach and conceptualization. The advantages and the limitations of this method of therapy were addressed.

It is stressed that in order to practice effectively in this method, the clinician needs to have an informed approach. The following section which covers an empirical study, will explore the use and attitudes towards this approach and will elucidate among other aspects, the extent of this informed approach in practice.

SECTION THREE

CHAPTER SEVEN

RESEARCH DESIGN AND METHODOLOGY

This chapter will discuss the research methodology and design utilized in the study.

7.1 RESEARCH OBJECTIVES

The objectives of the study are:

- a) to explore the current practice of brief dynamic psychotherapy among a group of psychotherapists in Cape Town in order to discern trends in its use, and attitudes towards its use in practice.
- b) to explore factors which would be facilitating or limiting in relation to the practice of brief dynamic therapy.

The study addresses the following RESEARCH QUESTIONS:

- (i) whether the attitudes and perceptions of the clinicians in respect of brief dynamic therapy are influential in its practice?
- (ii) whether the self-perceived skill of the therapist is a factor influential on practice?
- (iii) whether there are trends in relation to the clinical setting and the practice of brief dynamic therapy?
- (iv) whether the selection of clients plays a role in the practice of brief dynamic therapy?

(iv) what the attitudes and perceptions in relation to technical aspects of brief dynamic therapy are, eg. use of tranference, use of dreams, use of focus?

(v) what the attitudes and perceptions in relation to the characteristics of brief dynamic therapy are, including its curative potential?

vi) whether any variables could be ascertained for further study?

vii) whether any findings could be extrapolated in relation to training for brief dynamic psychotherapy?

7.2 RESEARCH DESIGN

The study utilizes an EXPLORATORY-DESCRIPTIVE design. Exploratory studies lead to insights or hypotheses but however do not test them, according to Selltitz, Wrightsman and Cook (1976). It provides description, often with an intention of providing content for further research. In the writer's opinion, there is a need for the exploration of this method of therapy locally, prior to other more explanatory studies being undertaken.

This study was exploratory also in that research was undertaken by means of a literature review to gain insight into the field of brief dynamic psychotherapy, its practice, selection criteria and specific technical aspects related to its use. The exploratory research comprised two different aspects: firstly, a literature review was completed. As this is a complex field, and can be extrapolatory of much of general therapeutic principles, the writer had to do a careful overview and selection of material in order to utilize the relevant contributions in relation to the brief dynamic method. The initial stage of the exploratory research was of great value and instrumental in formulating theoretical principles and served to construct the questionnaire.

Secondly, empirical research was undertaken as the second exploratory stage. The dual method facilitated the writer to explore more thoroughly the use of this method as currently practised. As it is an exploratory-descriptive design, its purpose was to formulate theoretical generalizations from the theoretical and the empirical analysis.

7.3 ASSUMPTIONS OF THE STUDY

The first assumption is that brief therapy is practised by clinicians.

The second assumption is that planned brief dynamic therapy is not frequently practised.

The third assumption is that there are various factors, which are determinants of the use of this method in practice. These could be factors residing in the attitudes and perceptions of the clinician towards this method of therapeutic practice. There are also factors pertaining to the client systems, which determine whether the clinician will engage in brief dynamic therapy.

7.4 METHOD OF STUDY

7.4.1 SAMPLE

The writer needed to choose a population of clinicians, who would be practising psychotherapy, as well as be a group which would have representatives of psychiatrists, psychologists and social workers. She considered using lists of all registered professionals of the three groups in the local area. However, there were a few factors which made this prohibitive. Firstly, there were a few social work associations and to have selected only one association would have caused some difficulties in representativeness; to have used all, would have meant lengthy negotiations. Secondly, the total number of members from all three groups,

psychiatrists, psychologists and social workers would have been large and to have employed random or stratified sampling from these lists would have caused practical problems. Thirdly, a convenient sample which would also represent "typical" respondents for the purposes of the study was required. As the study was an exploratory one, it was decided to use purposive sampling, a non-probability sampling method, as described by Grinell (1985: 145). In using purposive sampling according to Bailey (1978), the researcher has the advantage of using research skills and prior knowledge to choose respondents.

It was decided to limit the population to fully paid up members of a local psychotherapy association where all three groups of clinicians were represented. Membership of this association would indicate that members were involved in practising psychotherapy. While there were 53 members in the association, the writer who is a member had to be omitted from the study, and three members who were out of the country, were also omitted, as forwarding addresses were unknown.

Questionnaires were mailed to all other members of the association, other than the four mentioned above. Thus a total of 49 questionnaires were sent.

7.4.1.1 LIMITATIONS OF THE SAMPLE

The population selected for study were all practising clinicians, either in private practice, or in hospital, or agency employment and were seen as a suitable group to study for that reason. The group was convenient and available, and purposive sampling was used, as described above. This non-probability method was limiting, in that not all members of the entire population of local therapists had an equal opportunity of being selected, but only those who were members of this group. Another limitation was that

not all professional groups were equally represented in this association, for example, numbers of clinical social workers in the association, as opposed to other groups, was lower. This could have had an effect on the results obtained.

7.5 RESEARCH TOOLS

7.5.1 REVIEW OF THE LITERATURE

The first step involved doing a computer search of international articles related to brief dynamic therapy. The PSYCHOINFO and MENTAL HEALTH ABSTRACTS data bases were searched using the terms "brief therapy", "brief dynamic therapy", "short-term therapy", "short-term dynamic therapy", "time-limited therapy". This search yielded a large amount of literature, i.e. 400 articles, abstracts of which had to be sifted through and from which a smaller number of articles was selected. Current journals were perused to research associated articles, and micro fiche was explored to trace relevant work.

While the literature was informative, it was also ambiguous, and the field of study became wider and deeper the further it was explored. While the literature and models were interesting it appeared necessary that an empirical study was also going to be needed in order to test out some of the dimensions which were being found in the literature. Furthermore, it was the practice that was being explored, as well as the theory, and both needed to form a coherent whole.

7.5.2 QUESTIONNAIRE

Several factors were influential in the development of the questionnaire (Appendix 4), namely:

- A decision had to be made whether to do a mailed survey, or to do interviews through a face to face contact. Bailey (1978) discusses the various advantages of survey method, as opposed to the interview method. Advantages which pertained to this study were: greater assurance of anonymity, considerable time-saving in comparison to the many hours involved in face to face interviewing and travel time, questionnaire could be completed at the respondent's convenience, and there could be considerable financial saving. These had to be weighed against the possible disadvantages of this method, eg. that response rate could be low, which could lead to a difficulty with generalizability; that there would be a possibility that some questions would not be answered, and that the sample who responded could be biased to being motivated and curious, as opposed to those who did not. Also the difficulty of not obtaining first spontaneous responses, or obtaining a response set would also have to be considered (Cozby, 1981: 51). However, on balance, the survey method was opted for in this study.
- The literature survey had provided guidelines for which aspects would be most relevant to explore and these had to be couched in such a way as to be meaningful, without being lengthy.
- Questions had to be posed in such a way so that they would not be ambiguous.
- A necessity to present the questions in such a manner so that clinicians using both brief and long-term approaches would be able to reply to them.

- The importance of being sensitive to intruding on the privacy of the respondents as their method of work and thus their livelihood was being explored.
- Questions could be relatively "sophisticated" and technical, as it was being aimed at a professional population.
- The convenience of closed ended questions had to be balanced with the informative flexible responses of open ended questions and a compromise was reached, with both being used, although mainly favouring closed ended questions. Open questions were utilized for more controversial topics such as the selection of patients for brief dynamic therapy.
- As attitudes were being explored in the second section of the questionnaire, a five category Likert scale which measured degrees of agreement or disagreement, was utilized. Two and three category scales were utilized for the rest of the questionnaire, where finer gradations of response were not required.
- Questions had to be carefully placed in an order, especially in section two, where use of techniques, skill and client selection were being researched, so as to prevent contamination of response.
- The purpose of the study was carefully described in a covering letter, (Appendix 3) and anonymity and confidentiality was assured.
- The questionnaire had to have content and face validity and needed to contain an adequate number of items to represent the topic being explored. The pilot study enabled the questions to be evaluated by professionals, in order to test out whether it measured what it intended, thus ensuring content validity.

7.6 QUESTIONNAIRE ADMINISTRATION

7.6.1 TESTING THE QUESTIONNAIRE

Questionnaires were drafted and were piloted on six members, two social workers, two psychologists and two psychiatrists. The writer was present and invited comments and criticisms on the questionnaire. Several ambiguous questions were identified and adapted for the final draft.

7.6.2 ADMINISTRATION OF THE QUESTIONNAIRE

The questionnaire, with a covering letter and a stamped, self-addressed envelope, was sent to 49 members of a local psychotherapy association. A return date was given and a the writer's appreciation for co-operation in replying, was conveyed prospectively on the questionnaire.

7.6.3 LIMITATIONS OF THE QUESTIONNAIRE AND ADMINISTRATION OF THE QUESTIONNAIRE

1. It was difficult to capture in questionnaire form a realistic reflection of the actual method of work conducted by the respondents.
2. Bias could have been present in the self-report, eg. a faking good effect could have been present in the manner in which respondents answered, especially as it was concerned with the conduct of their own professional practice.
3. As the writer/researcher is a social worker, and the purpose of the study, as outlined in the covering letter was to explore brief dynamic therapy, with reference to the clinical social worker, this could have had an effect on the response rate from members from other professional affiliations.

4. The writer/researcher is a member of the association herself, and this could have had an effect on the return rate, which was good (65%). This could also have had an effect on the manner in which respondents replied to the questionnaire.

5. Three respondents returned the questionnaires with notes that they were unable to complete it, as they only conducted long-term therapy. As the three did not complete the questionnaire, while they are counted in respondents in replying, the absence of data within the questionnaire caused a problem in data analysis and their forms were thus not utilized in this respect.

7.7 DATA ANALYSIS

The results and the discussion will follow in the next section. Data were presented quantitatively in the form of figures and tables. Data was also analyzed qualitatively in evaluating and discussing results. The exploratory descriptive design format is thus fulfilled, through both quantitative presentation and the qualitative discussion of the findings.

7.8 LIMITATIONS TO THE STUDY

The specific limitations to the questionnaire have been dealt with in Section 7.6.3. Further limitations to the study are the following:

1. The population used in the study was confined to one association of clinicians. Not all practising therapists in Cape Town belong to this association, thus any generalizations must have these considerations attached to it. Furthermore, the number of clinical social workers in the association only comprise one fifth of the total number of members, thus this factor could must also be taken into consideration of the findings.

2. The number of the sample studied was small, i.e. 49 members, of which 32 responded, i.e. 65%. This small sample presents thus limitations for generalizability purposes.

3. The study relied on a survey of opinions and attitudes of the clinicians orientation and practice, and thus was not based on actual scrutiny of cases, nor direct observations of how they practised in reality. Thus, this self-report data was not ideal, and could be subject to some inconsistency. However, a study which would have allowed direct observations of practice would have involved many complex considerations which could have taken it out of the scope of this dissertation and its goals.

7.9 CONCLUSION

The overall research and planning of the study has been presented. Methods used to implement the study have been described and discussed. The limitations of the study have been highlighted so that the results which will now be presented, can be evaluated in the light of the methodological limitations of the study.

CHAPTER EIGHT

RESULTS

8.1 INTRODUCTION

"A stone in the pond produces ripple effect in long term" - response to open question No. 18, by respondent No. 20.

This section will delineate the findings of the survey and will concurrently discuss and evaluate them. The results will be presented in bar graphs and tables. In view of the amount of data obtained, only the central data will be dealt with in the commentary. More extensive data will be presented in a table or graph form, however some data, for example those relating to open questions, will be discussed, rather than tabulated. All tables and graphs relate to the questionnaire (Appendix 4), and follow a conceptual, rather than a numerical format. It will, however, be specifically indicated which questions from the questionnaire are being addressed, for example, Ques.1: One, refers to Question 1, in Section One. Questions will be analyzed and evaluated individually, and where appropriate, in combination. The writer wishes to draw to the reader's attention that there is no attempt to offer a statistical interpretation, nor to reflect on the validity of the responses. However, there is an attempt to offer trends and themes, as well as to draw comparisons between the responses.

8.2 RESPONSE RATE:

A total number of 49 questionnaires were mailed, and 32 were returned, representing 65% of the initial mailing, which is considered a good return rate (Bailey, 1976).

8.3 IDENTIFYING DATA OF RESPONDENTS (Table 1 (A))

This section will contain a summary and a short discussion of the profile finding of respondents. In the next section, there will be an evaluation of this and data in relation to the practice of, and the attitudes towards, brief dynamic therapy.

8.3.1 PROFESSIONAL REGISTRATION: (Ques. 7: One)

The final sample consisted of 13 psychologists (45.7%), 7 psychiatrists (24.%), 6 social workers (21%) and 3 medical doctors (10%) engaged in psychotherapy. As mentioned in the previous chapter, three returned forms could not be processed, thus a total of 29 questionnaires was analyzed. In terms of generalizability of findings, there are limitations, firstly, in respect to total sample number, and secondly, in terms of representative spread of professional affiliation. However, in terms of the latter, the writer would hope to demonstrate that there are sufficient universal features related to therapy and brief therapy, which could be seen as belonging to factors other than having to reside in differences in relation to professional affiliation.

8.3.2 AGE, MARITAL STATUS and GENDER, OF RESPONDENTS: (Ques. 1, 2, 3: One)

Twenty two members, (76%) were in the age range 30 to 49, there were no members from 20 to 29 and only a small number, 2, (7.6%) in the oldest age range 60 and above. There were no respondents in the youngest age range. Gender representation was nearly equal, and the majority of the clinicians were married.

TABLE 1(A)

	N	%	(N=29)
Age			
20-29	-	-	
30-39	11	38	
40-49	11	38	
50-59	5	17	
60 and over	2	7	
<hr/>			
Gender			
Male	15	52	
Female	14	48	
<hr/>			
Marital Status			
Single	9	31	
Married	16	55	
Divorced	4	14	
Widowed	0	0	
<hr/>			
Professional Registration			
Psychiatrist	7	24	
Psychologist	13	45	
Medical Doctor	3	10	
Social Worker	6	21	
<hr/>			
Educational Qualification			
Honours	3	10	
Masters	15	52	
PhD	1	3	
MBChB	2	7	
Psychiatry	8	28	

TABLE 1(A) contd.

Length of Professional Practice as a Therapist

1-5 yrs	8	27
6-10 yrs	11	38
11-20 yrs	9	31
21-30 yrs	0	0
over 30 yrs	1	3

Setting of Practice

Private	16	55
Hospital	8	28
Both Priv/Hosp	4	14
Agency	1	3

Urban	27	93
Rural	2	7

Full/Part-time

Full	13	45
Part	16	5

Place of Training**Study Units**

University of Cape Town	18
University of the Witwatersrand	6
University of Pretoria	3
Rhodes University	2
University of Stellenbosch	2
UNISA	1
University of London	1
Bar Ilan University	1
Total	34

8.3.3 PLACE OF TRAINING AND EDUCATIONAL QUALIFICATION: (Ques. 4, 5: One)

It was found that many clinicians had undergone training at more than one university, eg. a first degree at the University of Cape Town, and a second degree at Witwatersrand University. In order to rate this attendance at more than one university, each such period of study was designated as a "study unit". The majority of respondents had undergone training at the University of Cape Town, with a fair representation of graduates from other universities, such as Witwatersrand University and University of Pretoria. (see Table 1 (A))

More than half the respondents had Masters degrees (52%), either in psychology or clinical social work, 27.5% had psychiatry specializations, and 6.8% had Honours qualifications. The respondents who had Honours qualifications were social workers who possessed a fourth year, or a psychiatric social work qualification.

8.3.4 LENGTH OF PROFESSIONAL PRACTICE AS A THERAPIST: (Ques. 6: One)

The majority of respondents, i.e. 11 (38%) had been practising for a period of 6 to 10 years, with 9 (31%) members having been in practice for a period of 11 to 20 years. 8 members (27%) had been practising from 1 to 5 years, and only 1 member (3.4%) had been practising for over 30 years. These findings are of interest in relation to training for brief therapy and in relation to ease of, or resistance to, learning new skills, for example, for brief dynamic therapy. These will be discussed below, and implications of this will be explored in the next chapter.

8.3.5 SETTING: (Ques. 6: One)

The majority of respondents (55%) were in private practice, with 27% employed in a hospital setting, 14% had joint private and hospital appointments, and 4% were employed in an agency setting. Full and part-time representation was nearly equal. The setting could influence the method utilized as pointed out by Budman and Gurman: for example, keeping a given "slot" of time filled on a continual basis for the private practitioner, could play a part (1983: 280). In addition, practitioners in hospital settings, under-represented in this sample, often have to deal with pressured work environments with consequent less time to spend on cases. The low percentage of agency work practice could also be influential on the results, as agency clinicians are subject to pressure and large caseloads, and there is an awareness of time as a factor in planning.

8.4 ENGAGEMENT IN BRIEF DYNAMIC THERAPY: GENERAL FINDINGS: (Ques. 1, 2, 3, 4, 16: Two)

TABLE 1(B)

PRACTICE OF BRIEF DYNAMIC PSYCHOTHERAPY

	N	%	(N=29)
Whether Engaged in Brief Dynamic Psychotherapy			
Yes	14	48	
No	15	52	
Whether Practice Includes Brief and Long-term Patients			
Yes	27	93	
No	3	7	

Average No. of Sessions if Engaging in Brief Therapy

No. of Sessions	N	%
1 - 5	5	17
6 - 12	10	34
13 - 20	6	21
21 - 40	4	14
Non-responders	4	14

Whether Trained in Brief Dynamic Psychotherapy

Yes	10	34
No	17	59
Unsure	2	7

Whether Skilled in Brief Dynamic Psychotherapy

Strongly agree	1	3
Agree	5	17
Unsure	8	28
Disagree	14	48
Strongly disagree	1	3

DISCUSSION

The study indicated that a majority of respondents (52%) do not practise brief dynamic psychotherapy, while 48% do. However, 59% of the total population were not trained in the method. Only 20% considered themselves as skilled. See Table 1 (B). However, an interesting feature was that the vast majority of respondents, i.e. 27 members (93%), replied that their practice did include both brief and long-term patients. This raises the curious question whether the brief therapy was indeed planned to be so, or

was so from default. The literature (Budman, 1981) has found that while unplanned brief therapy is in fact common, what is new is the concept of brief therapy by design, not default. On the other hand, this majority response could indicate that if therapists were indeed seeing some patients briefly, they could be adhering to another theoretical orientation (see Finding 8.6 below). Ten respondents (34%) indicated that if engaged in brief therapy, 6-12 sessions would be the average length of therapy, while 7 (17%) would use 1-5 sessions., and only 4 (14%) would use a longer period of therapy: 21-40 sessions.

8.5 PROFESSIONAL REGISTRATION, PRACTICE AND TRAINING: (Ques. 7: One, and 1, 2: Two)

TABLE 2(A)

PROFESSIONAL REGISTRATION AND PRACTICE OF BRIEF DYNAMIC PSYCHOTHERAPY

	(N=29)		
Engaged in BDP	Yes	No	Total
Psychiatrists	4	3	7
Psychologists	5	8	13
Medical Drs	2	1	3
Social Workers	3	3	6
	14	15	= 29

TABLE 2(B)**PROFESSIONAL REGISTRATION AND TRAINING IN BRIEF DYNAMIC PSYCHOTHERAPY**

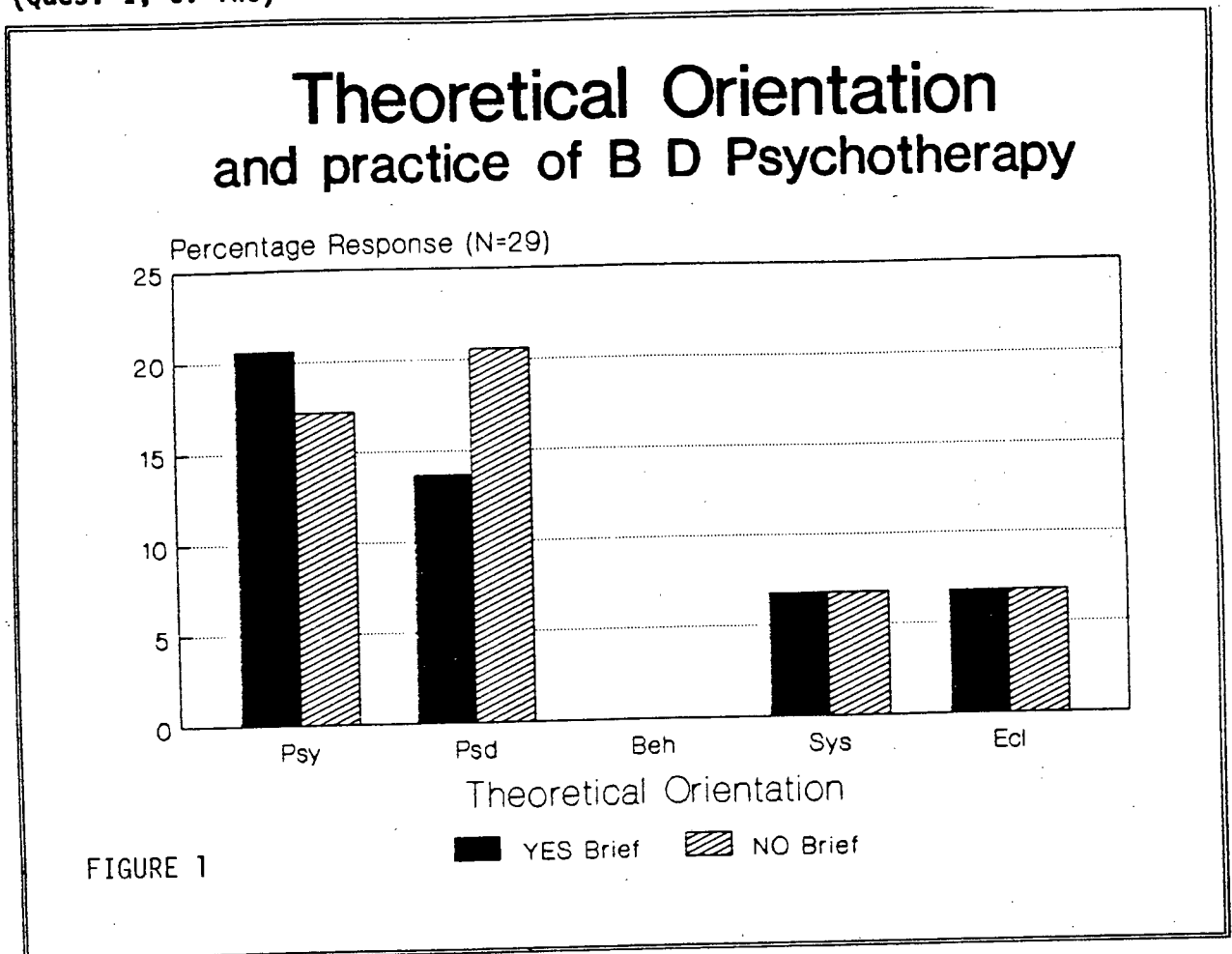
	(N=29)			
Trained	Yes	No	Unsure	Total
Psychiatrists	1	6	-	7
Psychologists	7	5	1	13
Medical Drs	1	2	-	3
Social Workers	1	4	2	29
	10	17	2	29
%	(34%)	(59%)	(7%)	(100%)

DISCUSSION:

There do not seem to be any differences between professional affiliation and whether or not the clinician was trained, or practised brief dynamic therapy. Social workers are divided in terms of whether they do or do not practise, and while most psychologists do not, more psychiatrists did practise this method of therapy. (Table 2(A)). The majority of respondents (59%) consider themselves to be untrained. Of these, most social workers and most psychiatrists consider themselves to be untrained, whereas most psychologists consider themselves to be trained. (Table 2(B)). It appears, however, that adherence to a professional group was not automatically the decisive factor, in relation to being trained or in practising this method of therapy. This correlates with literature findings, which has called for training in this model of therapy for all groups of clinicians, thus assuming that no specific training in a professional affiliation automatically prepared the clinician for brief dynamic work. Even though most clinicians have a brief internship as part of clinical training, there is no concurrent automatic training of brief dynamic therapy, as will be indicated below.

8.6 THEORETICAL ORIENTATION AND PRACTICE OF BRIEF DYNAMIC THERAPY:

(Ques. 1, 5: Two)



DISCUSSION:

The majority N=21 (72%) replied that their theoretical orientation was psychoanalytic/psychodynamic, with only 10% adhering to a systems/structural approach, and 17% to an eclectic approach, i.e. a total of 27% of respondents practised methods other than dynamic therapy. Of the 21 respondents who reported that their theoretical orientation was psychoanalytic/psychodynamic, 95% (N=20) were involved in both brief and long-term therapies. However, only 35% (N=7) consider themselves to have been trained to do brief dynamic therapy. Thus, 65% of those analytically or dynamically oriented practitioners in this survey, who practised brief therapy, did not receive specific training to do so. This holds out some implications for training which will be discussed in the following chapter.

8.7 SKILL, SELF-PERCEIVED: (Ques. 16: Two)

Practice of B D Psychotherapy and Self-Perceived Skill

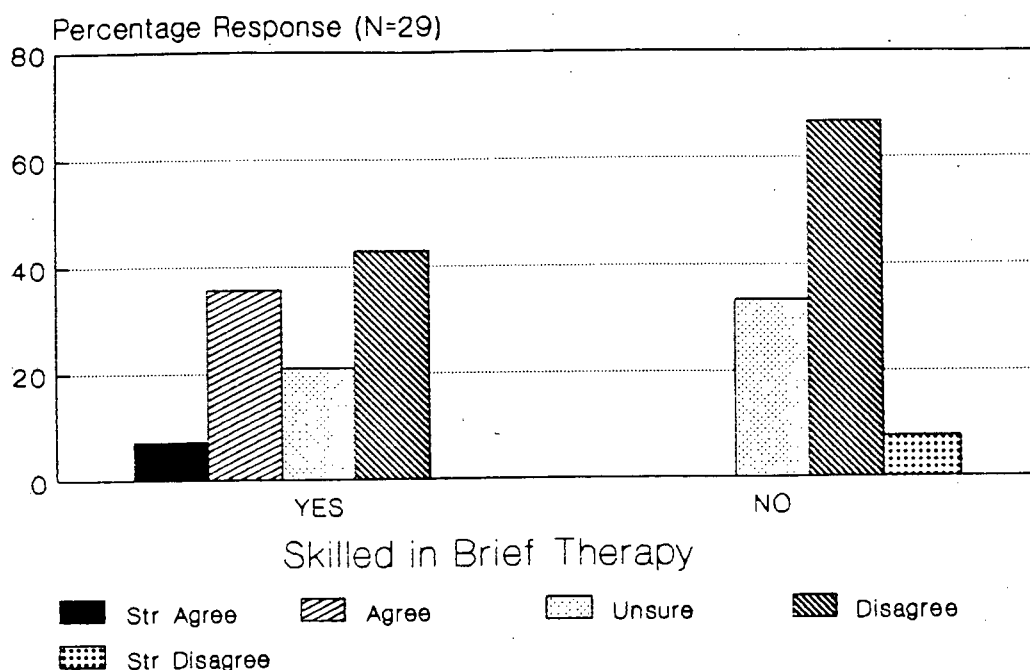


FIGURE 2

DISCUSSION:

Of the total population, only a small percentage (20%) reported themselves as being skilled or very skilled in the method, while 52% perceived themselves as unskilled, and 28% were unsure. This seems to correspond with views by Budman (1981) that a skill deficit in brief therapy may be an important aspect which influences the use of this method. This also coincides with findings by Singh that therapists' familiarity with a particular psychotherapeutic intervention was associated with more favourable attitudes towards that technique (1976, in Burlingham and Behrman, 1987). This also corresponds with a research study by Burlingham and Behrman (1987) in which they found that therapist skill was an

important predictor of favourable attitudes towards time-limited therapy versus time-unlimited therapy.

8.7.1 SELF-PERCEIVED SKILL AND PROFESSIONAL REGISTRATION: (Ques. 7: One, and 16: Two)

TABLE 3

SELF-PERCEIVED SKILLED IN BRIEF DYNAMIC PSYCHOTHERAPY AND PROFESSIONAL REGISTRATION

Skilled:	(N=29)				
	Str agree/ Agree	Unsure	Str dis/ Disagree	N	%
Psychiatrists	0	3	4	7	24
Psychologists	4	1	8	13	45
Medical Drs	1	1	1	3	10
Social Workers	1	2	3	6	21
Total	6	7	16	29	100%

DISCUSSION:

Of the professional affiliations, nil out of 7 psychiatrists, 4 out of 13 psychologists, 1 out of 6 social workers, and 1 out of 3 medical doctors perceive themselves as skilled in brief dynamic therapy. Thus, all professional affiliations are affected by perceived lack of skill, which indicates that this is a common feature evident across the board in clinical training. This has implications for training for all professional affiliations.

8.8 YEARS OF PRACTICE AND ENGAGEMENT IN BRIEF DYNAMIC THERAPY: (Ques. 8: One, and 1: Two)

Years of Practice and Engagement in B D Psychotherapy

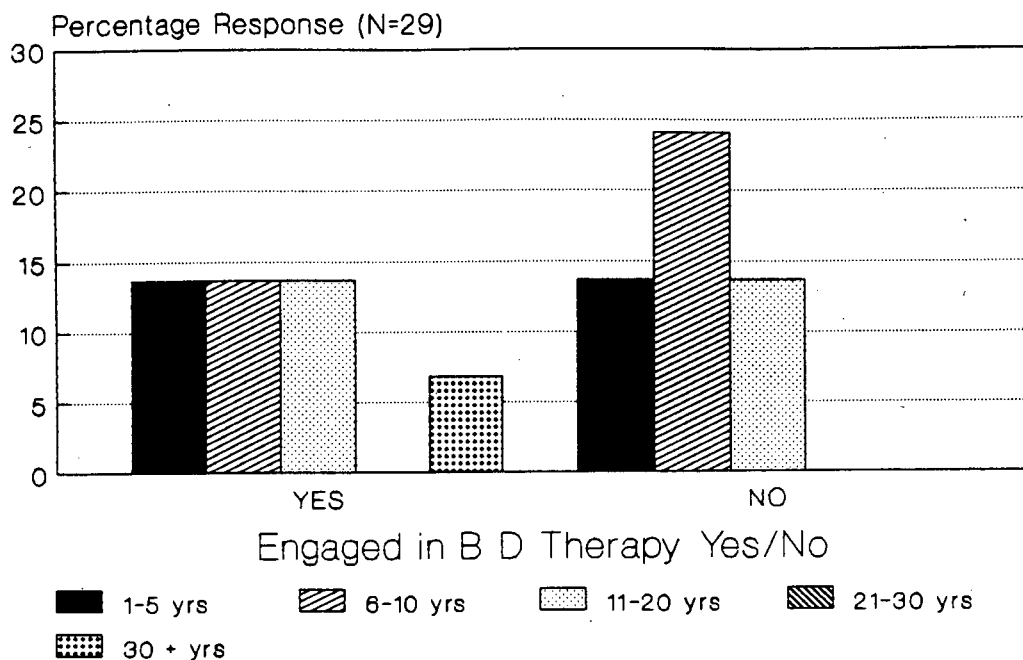
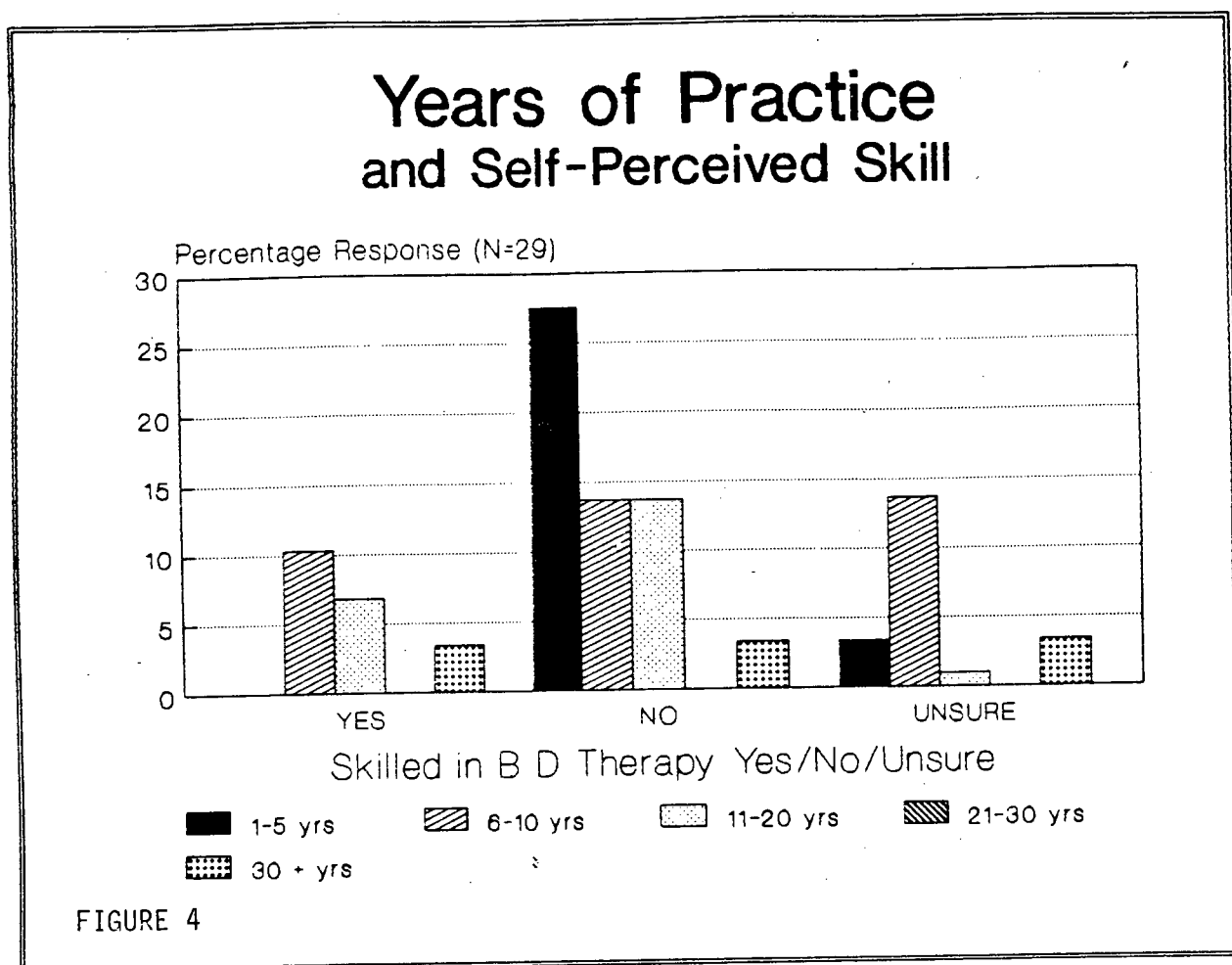


FIGURE 3

8.8.1 YEARS OF PRACTICE AND SELF-PERCEIVED SKILL OF THERAPIST: (Ques. 6: One, and 16: Two)



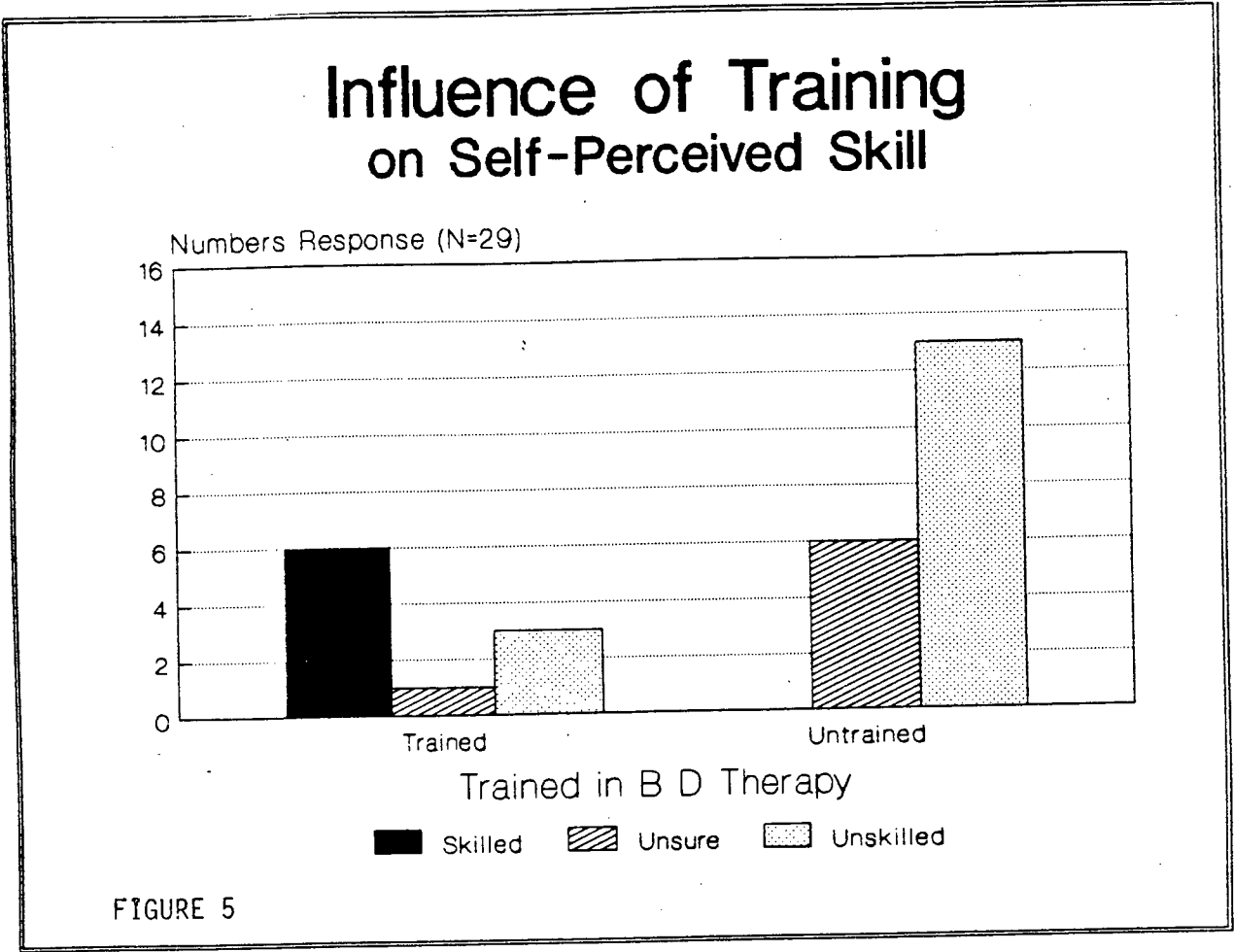
DISCUSSION:

Trends indicate that there is no relationship of years of practice and whether or not the clinician practised brief dynamic therapy (Figure 3). There does however, appear to be a relationship of years of practice with the clinician's self-perceived skill in brief dynamic therapy. In this respect, 50% of the total number of clinicians who perceived themselves to be unskilled, had only been practising from 1-5 years. Thus, it appears that a general lack of confidence as a clinician from lack of experience, is a factor in self-perceived ability. It is also possible that the more

experienced clinician had learnt his skills "on the job", from years of practice, rather than from being trained. It is also possible that new practitioners lacking in experience could either practise more open-ended therapy, due an insecurity about gaining results from a shorter method of therapy (however this is not bourne out by this study), or practise brief but unplanned therapy (which would seem to be the likely possibility as evident from the results). This would have implications for training.

8.9 TRAINING, EDUCATIONAL INSTITUTION, AND TRENDS IN PRACTICE

8.9.1 INFLUENCE OF TRAINING ON SELF-PERCEIVED SKILL: (Ques. 2, 16: Two)



DISCUSSION:

Of the brief dynamically trained clinicians (N=10), 6 perceived themselves as skilled, while 3 did not, and 1 was unsure. None of the untrained clinicians (N=12) considered themselves to be skilled, whereas 5 were unsure. This finding correlates with the Vanderbilt Study (Strupp 1980c), where it was found that clinicians who were untrained in brief dynamic therapy performed no better than untrained volunteers, even though the professional group of clinicians had had previous long-term therapy training. Thus, the fact that the clinicians had had previous training had made no real difference when it came to performance in brief therapy. This also indicates an awareness on the part of the local clinicians that the training that they did receive did not equip them for brief dynamic therapy. This has implications for training.

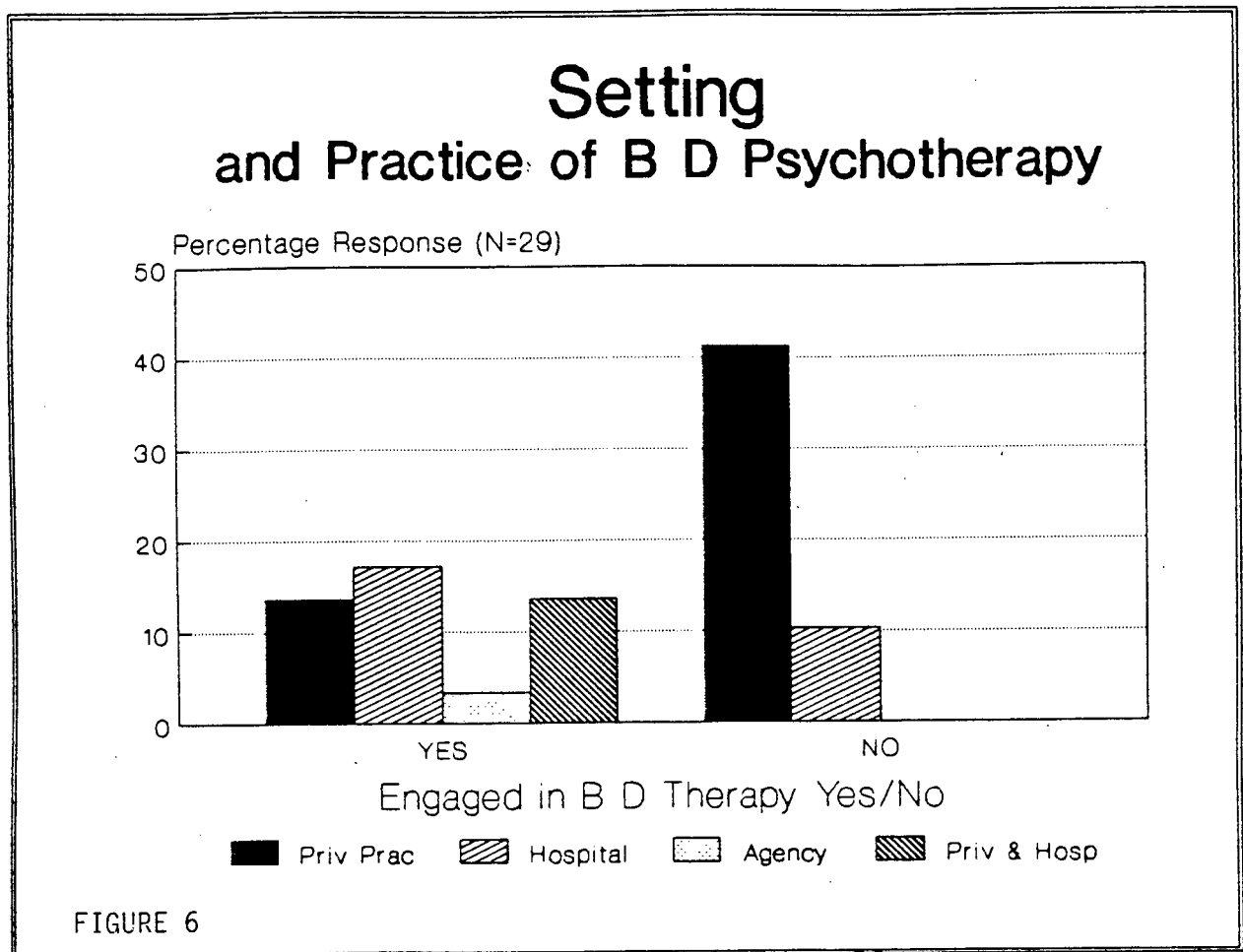
8.9.2 TRAINING INSTITUTION AND USE OF BRIEF DYNAMIC THERAPY: (Ques. 4: One, and Ques. 1: Two)

As explained earlier, as many clinicians had undergone training at more than one university, each such a period of study was designated as a "study unit". The survey findings indicated that the highest percentage of study units was at University of Cape Town (12 out of 18 total study units) for clinicians who did not engage in brief dynamic therapy. Witwatersrand University, on the other hand had the highest percentage of study units (5 out of 7) for those who did engage in brief dynamic therapy. Training institutions thus could make a difference in terms of orientation and practice, with findings indicating that graduates from Witwatersrand University were more inclined to practise brief dynamic therapy than those from University of Cape Town. This finding would, of course, need to be substantiated from more in-depth surveys examining, inter alia, course content, and internship training protocols.

8.9.3 ADDITIONAL SPECIALIZED COURSES AND USE OF BRIEF DYNAMIC TRAINING:
(Ques. 6: One, and 1: Two)

Not all clinicians had additional specialized training. Only 12 out of 29 had undergone such training. In relation to use or not of brief dynamic therapy, there was an equal number of clinicians who had undergone such specialized training and practised brief therapy (6 respondents) and those who did not practice it (6 respondents). Additional training of the 12 respondents were in the area of psychoanalytic long-term training (7 respondents), in Gestalt therapy (2 respondents), in Transactional Analysis (2 respondents) and Encounter groups (1 respondent). There was no evidence that brief modalities were included in additional specialized training.

8.10 SETTING AND PRACTICE OF BRIEF DYNAMIC THERAPY: (Ques. 9: One, and 1: Two)



DISCUSSION:

A large majority of clinicians who did not practise Brief Dynamic Therapy were in private practice. While the total number of clinicians in private practice was 16 (55%), 12 (75%) of those, did not practise it, whereas only 3 (19%) of 8 in hospital practice did not. Of those clinicians that did practise Brief Dynamic Therapy, only 4 were in private practice, and 5 were in hospital practice, whereas 4 combined hospital/private practice. These findings are of interest, as in comparison with the earlier finding, i.e. that most (93%) clinicians have both long and short-term cases, it appears that only a small percentage actually plan for it. The higher incidence of planned brief dynamic therapy in hospital settings, as opposed to private practice, indicates, as pointed out above, that the setting, eg. long waiting lists, and more highly pressured work environment could promote planned brief therapy. Other factors as pointed out by Budman (1983), including value systems and economic factors could be influential and interactive in private practice (see earlier discussion in Chapter Four).

8.10.1 URBAN OR RURAL: (Ques. 10: One)

The vast majority (92%) worked in an urban environment, opposed to 8% working in a rural one. It is suggested by Palazolli that brief therapy, albeit a brief family systems/strategic approach which she followed, was a suitable modality to utilize with clients who lived far away (in Hoffman, 1981: 286). Sessions held were planned as well as spread out between sessions. Van Wyk (1987) considered that a brief modality would be a valuable asset for the clinician working in rural areas. Bearing in mind that the majority of respondents work in urban areas, this setting could thus be another influential factor decisive on method of work.

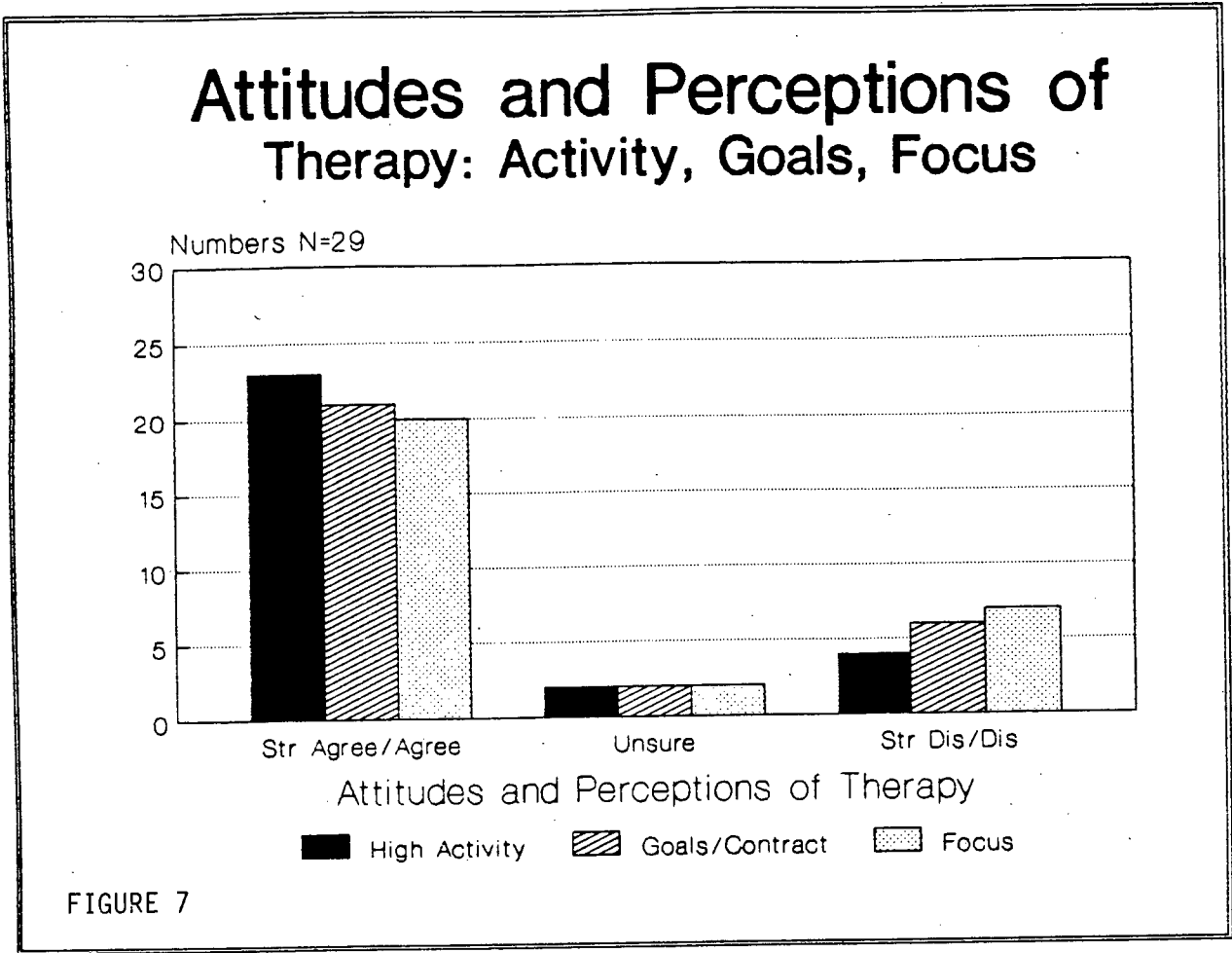
SECTION TWO

DESCRIPTIVE DATA IN RELATION TO PRACTICE OF BRIEF DYNAMIC PSYCHOTHERAPY

A number of particular aspects were explored: firstly, to obtain general practice and attitudinal trends; and secondly, to discern whether certain therapeutic techniques, traditionally used in long-term therapy, could be found useful for brief dynamic therapy as well.

8.11 ATTITUDES AND PERCEPTIONS OF ROLE OF THERAPIST

8.11.1 HIGH THERAPIST ACTIVITY, GOALS-SETTING AND FOCUS: (Ques. 15, 6, 7: Two)



DISCUSSION:

The majority of respondents (N=20) (69%) agreed or strongly agreed that using a FOCUS is important in therapeutic work. However, 7% were uncertain, and 24% disagreed. In relation to HIGH THERAPIST ACTIVITY, the majority (72%) agreed or strongly agreed that it was an important aspect of dynamic therapy. These findings seem to indicate that the potential for using a brief model is there, even for those who were not practising it, as therapists who would favour a non-directive, free associative form of therapy would be more inclined to have a built-in resistance to working in a more active manner, as is required in a brief dynamic model. From the literature, it appears evident that all the major brief dynamic therapists use a focal form of therapy, as well as high therapist activity, without necessarily departing from working within a dynamic framework. The use and technical specifics of focused and therapist activity has been discussed more fully earlier in Technical Aspects of Brief Psychotherapy.

GOAL-SETTING and the use of the CONTRACT in therapy, was agreed or strongly agreed on by the majority of the respondents (N=21) (71%). However, 7% were unsure, while 21% disagreed. This majority response again reinforces the above discussion regarding a potential for brief dynamic therapy, which uses contracting and goal-setting within a time-limited framework.

8.11.2 ATTITUDES AND PERCEPTIONS OF ROLE, OF THERAPISTS ENGAGED AND NON-ENGAGED IN BRIEF DYNAMIC THERAPY: (Ques. 1, 5, 6, 7: Two)

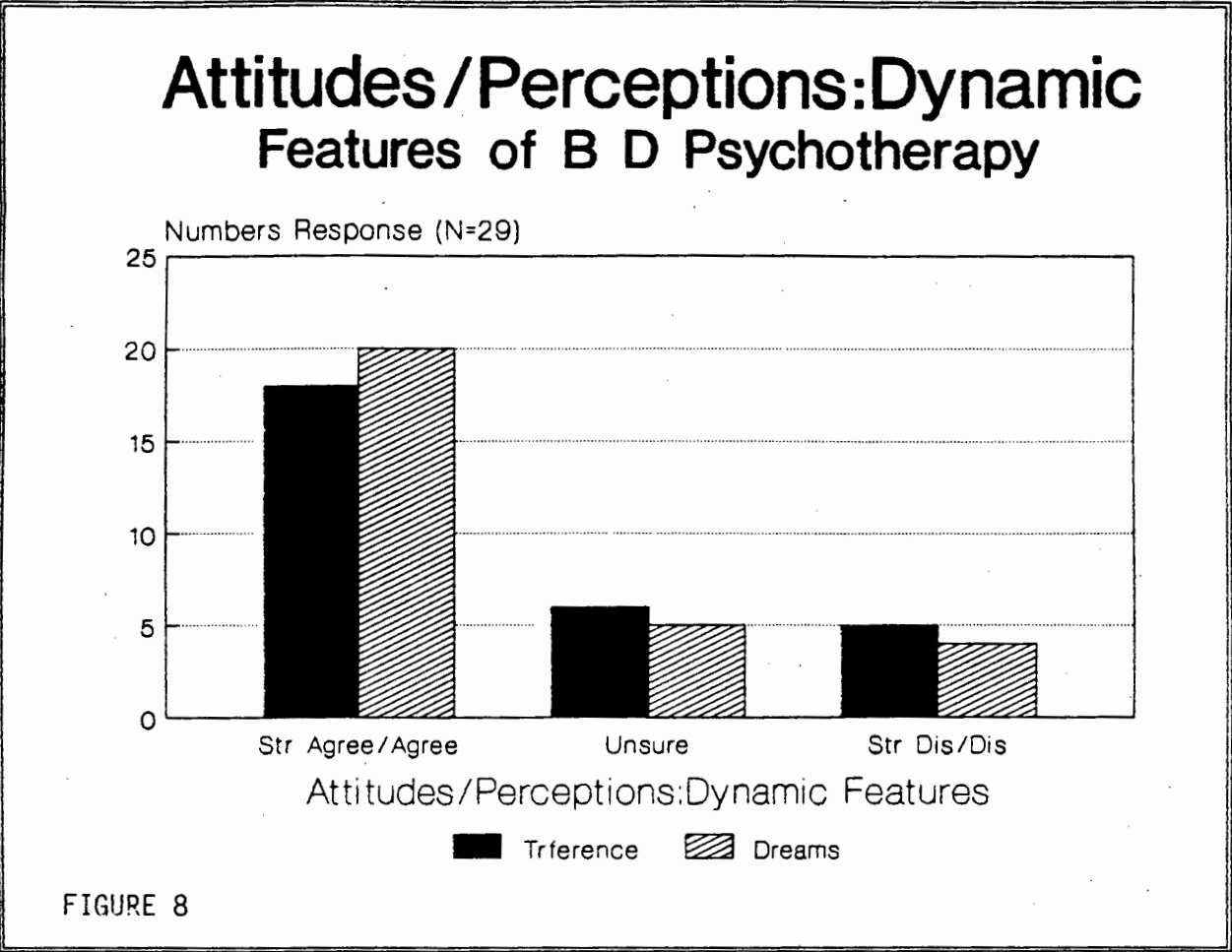
TABLE 4

(N=29)						
Engaged in BDP:	Yes			No		
	Str agree/ Agree	Unsure	Str dis/ Disagree	Str agree/ Agree	Unsure	Str dis/ Disagree
High activity	11	-	2	12	1	2
Goals/ contract	10	1	4	11	1	2
Focus	9	-	6	11	2	1

DISCUSSION:

There is no difference found between attitudes of practising and non-practising clinicians of brief dynamic therapy, in relation to therapeutic activity. Thus it would appear that on the whole, the general approach is one contrary to non-directiveness and lack of focus. This would indicate as stated above, of a "readiness" existent in relation to use of self, and less resistance to being active in therapy. These attributes would be important for shorter forms of therapy.

8.11.3 ATTITUDES AND PERCEPTIONS OF CLINICIANS IN RESPECT OF DYNAMIC
FEATURES OF BRIEF THERAPY: (Ques. 8, 9: Two)



DISCUSSION:

The majority (65%) agreed or strongly agreed that working with TRANSFERENCE issues is possible in brief dynamic therapy. However, 17% were unsure, and (17%) disagreed or strongly disagreed with it. The findings in relation to the majority opinion correlates with the literature on brief dynamic therapy, where working with transference issues is a vital part of the curative value of this method. This is discussed earlier in Chapter Six.

The majority (20) or 69% agreed or strongly agreed that working with DREAMS in brief dynamic therapy is possible. 17% were unsure, whereas 13% disagreed or strongly disagreed with that assumption. It appears that the

majority of the respondents from their personal experience have found that it is possible to work with dreams, although according to the literature, there is actually little written on it. However from the scanty number of articles available, it appears that dreams, discussed fully earlier, contain a rich source of potential for brief therapy, in particular where manifest meaning is kept in mind and is related to current experiences.

8.11.4. ATTITUDES AND PERCEPTIONS OF CLINICIANS ENGAGED AND NON-ENGAGED IN BRIEF DYNAMIC THERAPY, TOWARDS ITS DYNAMIC POTENTIAL: (Ques. 1, 8, 9: Two)

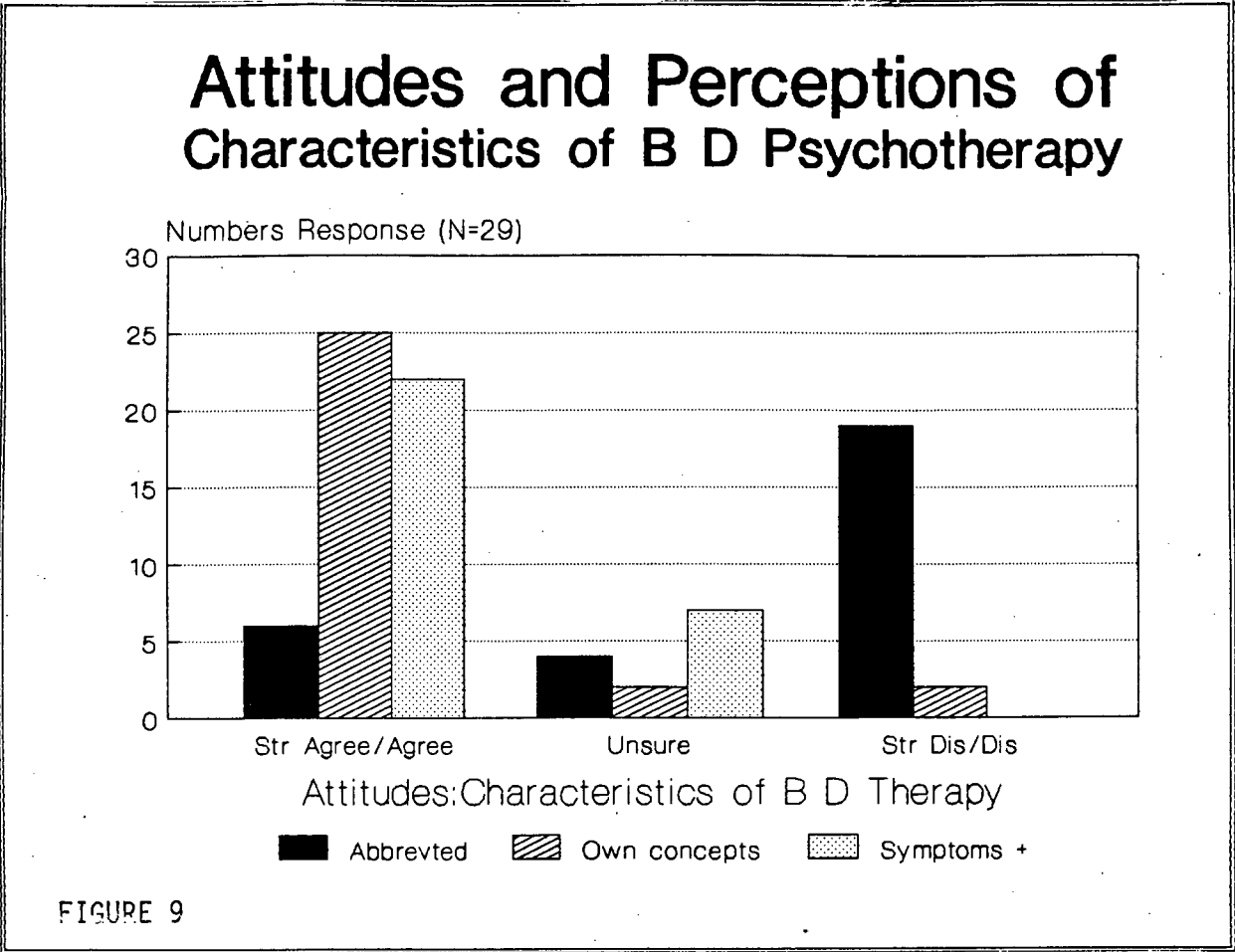
TABLE 5
Engaged in BDP: (N=29)

	Yes			No		
	Str agree/ Agree	Unsure	Str dis/ Disagree	Str agree/ Agree	Unsure	Str dis/ Disagree
Trans- ference	11	1	2	7	5	3
Dreams	12	-	2	8	5	2

DISCUSSION:

Of those clinicians who do practise brief dynamic therapy, a large majority agreed that transference and dream material can be worked with, while a small number disagreed. Of those who do not practise, a high number are unsure of the potential of the dynamic techniques for the brief method, while a small number disagreed. These latter findings contradict the findings of the literature, in relation to the positive curative potential of both transference and dream material in brief dynamic therapy.

8.11.5 ATTITUDES AND PERCEPTIONS OF CLINICIANS IN RELATION TO
CHARACTERISTICS AND POTENTIAL OF BRIEF DYNAMIC THERAPY: (Ques. 12,13,14: Two



8.11.6 ATTITUDES AND PERCEPTIONS OF THERAPISTS ENGAGED AND NON-ENGAGED IN
BRIEF DYNAMIC THERAPY, IN RELATION TO ITS CHARACTERISTICS AND POTENTIAL:
(Ques. 1, 12, 13, 14: Two)

TABLE 6 (N=29)

Engaged in BDP:	Yes			No		
	Str agree/ Agree	Unsure	Str dis/ Disagree	Str agree/ Agree	Unsure	Str dis/ Disagree
Abbrev form	3	-	11	3	4	8
Own concepts	12	-	2	13	2	-
Symptoms plus	13	1	-	9	6	-

DISCUSSION:

The findings indicate that clinicians engaged in brief dynamic therapy are better informed than those who are not engaged in it. This applies to appreciating it as a treatment method with its own parameters and concepts rather than as an abbreviated form of long-term therapy. It is also applicable in respect to the curative expectations of it in terms of offering more than symptomatic relief. In respect of the latter, a larger number of those non-engaged in it, were unsure of its curative potential. This contrasts with those engaged in it, who believe that it offers more than symptomatic relief. These findings are important, as the expectations of the clinician in terms of what he believes in and what works, are regarded as important predictors of outcome.

However, in relation to the total population and the CURATIVE aspect, the majority (75%) agreed that more than symptom relief was possible, whereas nearly a quarter of the total sample (21%) were uncertain. The large response in favour of this, indicates that there is a sufficient degree of hope in its ability to be more than only symptomatically curative. This also presages well for training purposes, as a positive attitude towards a method, is regarded in the literature, to be an important aspect of "motivation" to learn it, as will be discussed in the next chapter.

SECTION THREE

8.12 ATTITUDES AND PRACTICE IN RELATION TO SELECTION OF PATIENTS: (Ques. 10, 11: Two)

This section (which provided for open responses on the questionnaire) will provide some insight into the attitudes in relation to the potential and limitations in the patients for this method of therapy.

8.12.1 INCLUSION CRITERIA: (Ques. 10: Two)

In relation to the inclusion criteria, the responses on the whole appeared to coincide with the literature findings on selection of patients for brief dynamic therapy. However, what the writer also found was a conservatism in relation to selection, which does not take cognizance of the later more surprising aspects of the potential as cited in the literature, for example, work by Horowitz (1986) and Leibowitz (1981) in relation to brief dynamic work with more vulnerable patients. Perhaps this conservatism relates to possible risk factors involved in brief work, as discussed earlier in the Chapter on Selection of Patients.

While the percentage (90%) which agreed or strongly agreed with the question in relation to inclusion factors, (i.e. whether certain patients can benefit from it), is not in itself informative, as the question is almost perfunctory, what is of interest are the open responses which is attached to the question. In this open section, some of the comments were: "emotionally mature individuals with strong egos" in crisis or in loss situations; patients with "healthy egos" with "capacity for insight", "the more clearly defined the problem the better", "integrated personalities with acute life crises", in situations of "reactive adjustment", those with "reasonable ego resources and specific focus", and similar responses.

Thus, there was an overwhelming response in favour of advocating this method of therapy for patients with reasonably good ego strength, with capacity for insight, and who had an absence of severe pathology and where the focus could be clearly defined. This therefore corresponds closely with the literature and indicates that there is an awareness of the method and of the patients who could benefit from it, even though there is a conservatism in attitude, as mentioned above. One clinician replied that whereas some patients may ask for brief therapy, they often need much more.

This brings to mind the comment from the literature to the effect that, whereas the idea of brevity may exist in the mind of the client, the clinician may have another viewpoint about it!

8.12.2 EXCLUSION CRITERIA: (Ques. 11: Two)

For the question which tapped attitudes about exclusion criteria for brief dynamic therapy, a high percentage (86%) agreed or strongly agreed that there were patients who would be regarded as unsuitable for this method of therapy. Open responses again were of interest and included for example the following: "major underlying problems", "with weak egos including with immature personalities, psychoses, severe neurosis, subnormals", "those suited to long-term analysis or those suited to behaviour modification", "severe personality defects or intrapsychic conflicts", "abnormal or retarded or psychopathic personalities", "severely disturbed patients,, eg. with acting out behaviour, with alcohol or substance abuse or history of psychotic episodes" "depending on level of object relations, and degree/fragility of ego defenses, level and type of psychiatric disturbance", "childhood trauma, projected into present in form of repetition compulsion, obsessives etc., often divergent thinkers and analytical people require less structure", "long-standing problems needing exploration of past, also needs to develop relationship".

These findings also coincide with those in the literature in relation to exclusion criteria, especially in relation to psychoses, severe depression, severe personality disorders, patients with limited ego resources and poor relating ability. As discussed above however, the potential which the literature describes for the more disturbed patient, but who is apsychotic, is not referred to. Also, in contradiction to the findings, there is evidence in the literature that obsessives/compulsives can benefit greatly from the brief method, and has been found by Salzman (1985) to be the

therapy of choice. The defined time limits and its meaning for the obsessive, who uses time in his own confined manner, makes for some surprising curative effects.

SECTION FOUR

8.13 TRAINING ISSUES AND VIABILITY FOR SOUTH AFRICAN SOCIETY: (Ques. 17, 18: Two)

The respondents' views in relation to self-perceived SKILL has been dealt with earlier, where it was found that only a minority percentage (20%) considered themselves to be skilled or very skilled in this method. Thus, the majority perceived themselves to be unskilled. Closely related to this aspect, is the question of TRAINING. The majority of respondents (N=24) (82%) agreed or strongly agreed that training schools in the field of clinical service rendering should include in their curriculum a course/modality in brief dynamic therapy. In relation to its viability for South African society, 76% agreed or strongly agreed that it was a viable modality, with 17% uncertain about it. Open responses to the latter question indicated some useful pointers towards its use. For example, responses included: "in view of the high cost of psychotherapy, this would be a particularly cost-effective in South Africa", "don't know enough about the model", "it's cost-effective, avoids dependency, promotes clients resolving problems and issues independently", "worried about use of focus, as problem may become over-simplified" "yes, for financial reasons and according to patient's wishes, but decision must be made on accurate psychological judgement, otherwise open to abuse, or therapist may be unable/unwilling to tackle difficult/painful issues, or quick money", "lack of trained professionals and needs of community make this viable, but needs thorough training", "whereas brief psychotherapy can't transform personalities, it can help to prevent derailment in relation to organized

personalities, especially during high stress periods" and "clients often need some kind of minor adjustment to get them going again not major intrapsychic changes: a stone in the pond produces ripple effect in long term".

Thus, there is an awareness of its potential as a modality for South Africa. A recent social work publication, Snyman (1987) discusses time-limited intervention in various settings, such as private practice, industrial and health care settings, which do lend themselves to brief intervention. Mann (1973) has referred to its suitability for different socio-economic groups, due to its specificity and focused approach. Koss (1980) considers both the advantaged as well as the disadvantaged client as a candidate. The selection criteria as discussed earlier in Chapter Five, would become the determinants for suitability.

SECTION FIVE

8.14 CONCLUSIONS

The central findings from the survey, limitations of which have already been discussed, in terms of sample size, in terms of self-reported mailed questionnaire, and representativeness of professional groups, have been presented. In the latter respect however, the findings in relation to engagement in brief dynamic therapy, in terms of attitudes and skill development, in terms of selection of patients, and in terms of need for training, do not show any differentiation in terms of the different professional groups. In terms of generalizability of findings, despite the sample size and its purposive quality, there is some validity in considering that there could be a replicability in a larger population group studied, especially if drawn from similar professional groups and training schools and if spread across similar work settings. The main findings, which were presented in this chapter, in tables, graphs and evaluated in discussion, can now be summarized.

8.15 SUMMARY OF FINDINGS

1. A minority of therapists surveyed in this study, practise brief dynamic therapy, as defined in the questionnaire, i.e. using "time" as a factor in dynamic therapy.
2. A small minority of respondents (one third) are trained in this method of therapy.
3. A majority of respondents do not perceive themselves to be skilled in this method of therapy.
4. A vast majority work with both brief and long-term patients in their caseloads. As a minority however are trained, or perceive themselves as skilled or practise brief dynamic therapy as defined, this correlates with the literature findings that while brief therapy is prevalent, it is usually or often conducted due to drop out, or is unplanned.
5. Trends thus indicate that the majority of clinicians are not using planned brief dynamic therapy, but brief therapy by default.
6. A surprising finding is that the clinicians, in contrast to viewing brief dynamic therapy as "superficial", or assuming that they "knew" how to practise it, admitted to a skill deficit. It is possible that this survey could have stimulated interest in this method, which would be a positive residual of this study. This could help to counteract what Binder and Smokler (1980) point out is a "casualness" with which this method of therapy is undertaken by clinicians who are trained primarily in long-term therapy.
7. The majority (two-thirds) of clinicians who responded, use a psychanalytic/psychodynamic theoretical framework. Of these, nearly two-

thirds who practise brief dynamic therapy, are not trained and do not consider themselves skilled in the method.

8. Only a small percentage use a systems, or an eclectic approach to treatment. Despite the sample limitations, this finding points to a steady maintenance of the dynamic mode of orientation and treatment in Cape Town.

9. The majority consider that using more active techniques such as using a focus, and contract, are suitable in terms of use for dynamic therapy.

10. While a small majority consider that curative aspects of brief dynamic therapy, such as symptom relief is possible, there is substantial though a minority percentage who are uncertain of its benefits.

11. The majority consider that "traditional" techniques, such as working with transference and with dreams, is possible in brief dynamic therapy.

12. There were no notable differences between members of different professional affiliations, in relation to self-perceived skill, training, or practice of brief dynamic therapy. Therefore there are indications that cross-professional commonalities exist.

13. Setting played a part in use of this method of therapy: most private practitioners were not engaged in brief dynamic therapy as defined, with time as an integral part of treatment. More hospital based clinicians were engaged in it than private practitioners.

14. Generally, clinicians who had less clinical experience (in years) perceived themselves to be less skilled in this method. Thus there is some relevance for the argument that more experienced clinicians perceived themselves as more able to perform brief dynamic therapy. However, the literature has found that doing long-term therapy is not the same as the brief method, and that specific training is required.

15. The findings indicated that no one group valued this method of therapy more or less than another group. This contradicts the findings in the literature which claimed that psychiatrists felt that brief dynamic therapy was of less benefit than the social worker or psychologist.

16. In relation to effectiveness in terms of selection criteria and benefit to client, the responses to open questions were consistent, in terms of suitability and unsuitability. On the whole the method of therapy was seen to be of value for certain clients, but there were limitations and restrictions placed on its use. This correlates with the majority, but not all, of the literature findings.

17. A good majority consider that it is a viable method to use in South African society.

18. A good majority consider that training schools should offer a course/modality in brief dynamic therapy.

19. Trends apparent in theoretical orientation, and in use of therapeutic self, indicate that there exists a good potential for receptivity to training for this method.

20. Differing attitudes towards the dynamic potential as well as the techniques, as well as curative potential were apparent, between those clinicians who were trained and those who were untrained.

21. From the findings of this study, lack of training, and skill deficit, are seen as the most important limiting factors, which could be influential in the attitudes towards, and use of this method of therapy in practice. Thus, in view of the findings, in terms of deficits in training across all professional groups, the last chapter will explore the important aspect of training for Brief Dynamic Therapy.

CHAPTER NINE

IMPLICATIONS FOR TRAINING

9.1 INTRODUCTION

This chapter will discuss the implications for training for clinicians. These implications will be informed from both the theoretical input from the analysis of relevant literature, as well as from the analysis of the empirical study of a sample of local clinicians engaged in therapeutic work.

9.2 NEED FOR TRAINING FOR BRIEF DYNAMIC PSYCHOTHERAPY

The previous chapter has indicated that there is a need for training in brief dynamic therapy. This deficit in training, as well as a self-reported skill deficit in the majority of the respondents are seen as important limiting factors in practice. As delineated earlier, Burlingham and Behrman (1987) found that therapist skill was an important predictor of attitudes towards a therapeutic method.

This need for training corresponds closely with the findings in the literature. The literature has emphasized that, that due to the current need, in communities, and clinics, and due to the push for accountability, especially in terms of cost-effectiveness, the training is, and will become even more so, a mandatory item to be considered in any program which is concerned with educating and training clinical workers. In particular, this dissertation emphasizes the need for training of clinical social workers in this method.

9.2.1 ARE THE SPECIFIC TECHNIQUES SELF-EVIDENT?

The question must be asked whether clinicians can undertake brief therapy without the benefit of systematic instruction. This usually happens according to Binder and Smokler (1980), when the training program's didactic curriculum teaches long-term psychotherapy, while the service needs of the in-patient and out-patient placements require time-limited therapy to be done in most cases. The writer asserts that brief therapy by default is not planned brief therapy, for the important curative aspects inherent in the brief dynamic method, i.e. using time as a factor in therapy, and specific techniques as discussed earlier, are not given rein without this intentionality. The selection factors are also specific for this approach as has been discussed earlier. Budman argues that "good brief therapists are made not bornevidence exists that when one takes experienced therapists unfamiliar with brief psychotherapy and asks them to do brief therapy, they do no better than novices" (Budman 1981: 465). He regards this as not suprising, as many of the behaviours most encouraged for those trained as long term therapists, eg. low therapist-activity, or a non-directive stance, run counter to some of the common elements in brief therapy. As discerned from the results in the previous chapter, the majority of the respondents in the empirical study, did perceive themselves as having a skill deficit, which could indicate either a good level of awareness of the differences between the two approaches, or could be a residual feature of having been made aware of it through the study itself.

9.3 TRAINING CONSIDERATIONS

In considering training for this method, a number of aspects, as evident both from the literature as well as from the empirical study, need to be taken into account:

1. In relation to trainee suitability, the question can be asked whether a new graduate, or an experienced one would be more suitable for this method of training, and what the rationale is for the choice.
2. The expectations of the trainee will have to be considered, and whether he has a built-in resistance to learning this method, for personal reasons, or from his previously learned assumptions about the helping role.
3. The content of the didactic instruction in relation to what is to be taught, and for how long, and the format of instruction, individual, or group, has to be considered.
4. Supervision, and the structure and format of supervision is another important consideration.
5. Outcome studies, in relation to training and outcome and effectiveness of training of brief dynamic therapy programs, could be another dimension to consider, in order to evaluate what the residual features of such programs are.

This chapter will address itself to these aspects.

9.4 THE TRAINEE AND BRIEF DYNAMIC THERAPY

The question about which student is most suited to training in this method is an important one. Mann (1973) suggests that long-term training and experience is necessary in order to develop clinical acumen for brief work, to both assess the patient's suitability and to make early diagnoses of the central issues. In contradiction to this, Sifneos (1978) has found that therapists who have undergone long-term training are difficult to retrain. He prefers inexperienced ones, whom he regards as better students because of their enthusiasm and interest in observing immediate results. Bellak and Small (1978) argue that it is easier to teach this method to relatively

inexperienced professionals for several reasons, including the fact that novices have less to unlearn and will not be hampered by previously learned long-term therapy assumptions and habits. From the empirical study which forms part of this dissertation, it was found that the less experienced therapists felt themselves to be more unskilled in this method, as opposed to the more experienced ones. This could indicate that the less experienced therapists had less learned habits and were more open to learning, than the more experienced therapists, who believed that they possessed the skills just because they had practised longer as therapists. While this latter opinion can be argued as resulting from genuine ability due to longer experience of working, it can also be argued that it spells resistance to learning a relatively new method

However, a compromise is stated by Winokur and Dasberg (1983) who have found through their research, that this approach can be applied to both groups, novices and experienced therapists, but that each group would require a somewhat different emphasis in training. While the basic training (discussed below) would be similar, the differences would arise in focus: for the novice group, there would be an emphasis on a theoretical rationale and an opportunity to practise skills, while the emphasis on the experienced group would be on the working through of the resistances. (discussed below).

9.4.1 TRAINEE EXPECTATIONS

The expectations of the trainee is considered to be an important factor in training (Schneider and Pinkerton, 1986). These expectations can include the following important dimensions:

- a) motivation to learn the technique of brief dynamic psychotherapy. In this respect, he must have some understanding of the value of a brief

approach, and have a desire to learn the model. Sifneos (1978) would consider a lack of prejudice on the clinician's part to be an important consideration, which is allied to motivation. Wolberg (1965) would ask for a flexibility in approach and attitude. In the empirical study findings, there appeared to be some, though not widespread, flexibility in attitude: in relation to views about therapeutic techniques, eg. therapist activity, setting of goals, and use of focus. These can be argued as forming some receptivity toward more active forms of therapy by less than half of the respondents. In addition, the value of the brief model was appreciated, although there were some built-in limitations in relation to suitability of clients. However, most respondents thought that the method should be taught in training schools, which could point to some attitudinal motivation to learn.

b) personal attributes of the trainee: these would include the following:

(i) learning to feel comfortable with an active form of therapy, which does not mean presenting himself in an authoritarian manner. This aspect can also refer to the compatibility of technique with personal or working style. This aspect is discussed further under supervision issues, as it would be an important dimension to consider.

(ii) feeling satisfied with establishing modest goals, in some cases. This would involve setting realistic expectations, without having preconceptions that unlimited success must be achieved. This contrasts with some of the values and expectations of the therapist who works in an open-ended manner, as discussed in Chapter Four.

(iii) ability to establish a rapid and positive therapeutic relationship. This is regarded as an important dimension for working in a brief mode.

(iv) capacity to make a rapid and early assessment. This aspect will be discussed more fully below and will involve specific training in order to develop such skills of assessment.

(v) a readiness for training in brief psychotherapy. It is pointed out that, while it can be introduced in the graduate program, students should already have had solid coursework grounding in psychodynamic assessment, interviewing skills and dynamic theory, in order to help with the assessment and therapy process. Supervision, which will be discussed below, bears a special responsibility, especially for trainees of limited experience.

9.4.2 TRAINEE RESISTANCES

A number of resistances have been identified in the literature in respect of attitudes towards brief therapy. Both the beginning-level student, as well as the experienced long-term therapist show resistance to becoming brief therapists. However, the long-term therapists' show of resistance is more sophisticated, is more rooted in previously acquired practical and theoretical knowledge, and is more affected by their professional identity as therapists, since their identities are more firmly established.

Two basic types of resistances were identified by Winokur and Dasberg (1983). They were described as "quasi-intellectual resistances" and "emotional resistances proper".

a) The "quasi-intellectual" resistances are described as including existent positions toward brief therapy based on previously learned theoretical assumptions. These would include assumptions as noted previously (Chapter 4) for example, that neurotic problems derive from experiences which are deep-rooted and take time to reach and repair; that a therapeutic alliance takes time; that transference takes a long time to

develop, or that for real cure to occur, the patient must regress; and that symptom substitution will occur if there is rapid improvement in an area. Other views are that a disrespect of the client's autonomy was evident, or that the therapist was omnipotent. Winokur and Dasberg (1983) maintain that often very strongly held opinions have emotional underpinnings, for example, therapists concerned about the omnipotence issue could have problems with their own power. All the resistances need to be discussed intellectually, in relation to the alternative assumptions held by the brief models (see Chapter 4).

b) "Emotional resistances proper" are described as difficulties of a more purely emotional kind. These would encompass firstly, resistances associated with learning something new. Winokur and Dasberg (1983) point out how trying to learn something new can result in an inevitable period of relative intellectual confusion and on the practical level, a sense of incompetence.

Secondly, an important emotional resistance is described as one which is associated with the intrinsic technique of brief therapy: it concerns the time limit and with the trainees having to cope with their own difficulties over separation. Thirdly, anxieties occur over therapist activity, related to conflicts over power and authority, anxiety over undertaking to accomplish specific goals, and anxiety about their ability to make rapid assessment of the patient's dynamics. Ekstein and Wallerstein have referred to the trainee's resistances toward learning to be a psychotherapist (1972, in Winokur and Dasberg, 1983). In training for brief therapy, the resistances of the trainees can be handled by the supervisor expecting change while providing empathic support through a good supervisory relationship, similar to the change expected from the client in therapy (see Supervision Issues below).

9.5 TRAINING PROGRAM CONTENT

The internship or practicum offers a special opportunity to train professionals in brief dynamic therapy, as the writer found through her own internship experience. The limited period of the practicum, with the fact that clients are usually treated for circumscribed time periods, are cogent reasons for this. While the literature that addresses teaching of this method of therapy is limited, there are some recent contributions which offer some guidelines.

Schneider and Pinkerton (1986) postulate that it is likely that the majority of internship training programs and university-affiliated practicum sites have the basic ingredients to provide training. These include practitioners who could be motivated to learn it, clients whose expectations fit within a brief mode, a time-limited period of residence, and hopefully supervisors who are willing and supportive of educating in this mode. In relation to choice of model, Clarkin et al (1980)) found from a survey, that the dynamic model was the easiest to teach due to the established theory and techniques.

Two training programs offered by Winokur and Dasberg (1983) appear to be comprehensive as well as circumscribed. For a full discussion, the reader is referred to their work, however a few guidelines are as follows:

They offer a sequence of didactic seminars, which tail off into group supervision, which is then followed by individual supervision. The didactic seminars include:

- a) Discussion of literature.
- b) Practice of specific skills via clinical exercises and role play.
- c) Working through students' intellectual and emotional resistances to the new approach.
- d) Explicit use of parallel phenomena as a didactic lever (discussed under Supervision Issues below).

Two different seminars were held : one comprised 12 sessions and was guided by Mann's (1973; 1981) time-limited therapy. The second comprised 30 sessions, and followed the work of Malan (1976). In the first sessions a learning contract was established and basic topics in the literature were examined. These incorporated discussion of theory, selection, evaluation, definition of a focus, problems of technique and termination. A "honeymoon" phase generally prevailed especially in the new therapists, similar to that experienced with the client at the beginning phases of work. The more experienced trainees recognized the need to make basic attitudinal changes, and on the whole motivation to learn was important (similar to motivation criteria of the clients themselves). Resistances did however appear particularly in the experienced long-term clinicians as mentioned above in Section 9.4.2.

The middle phase involved primarily clinical exercises, including the study of patient selection criteria, determination of the central treatment issue and studying the treatment agreement and phases of treatment. The last part of the program focused on group supervision of actual cases of the participants practice, with individual supervision offered as well. The authors have found that the seminars proved most effective in providing the conceptual schema and basic skills required for practice.

Another program which is offered at the Smith College School for Social Work is reviewed by Fisher (1981). The training program consisted of three parts: firstly, a continuous case conference in which literature was discussed and trainees viewed videotapes of time-limited therapy; secondly, individual practice in which they attempted to apply the treatment model; and thirdly, supervision of their practice. The trainees considered that role modeling, and watching a senior clinician, was an important part of their learning process. In their subsequent practice, the trainees found that what was most residual from the training program, was their ideas about establishing a focus and specifying a termination date.

Budman and Gurman (1983) make the point that the high degree of activity, planning and participation required from the trainees in therapy, results in it being emotionally demanding. The presence of a peer group support is important when they start to treat patients, where concerns as well as resistances can be worked through.

9.6 SUPERVISION ISSUES

There are a number of issues in supervision that need to be addressed. The following are of importance:

a) Person-Technique Blend:

The affinity between a therapist and a technique is a dimension which needs to be recognized. It is often no chance that particular approaches are particularly congenial to particular therapists. Thus, one can ask whether a therapist who has found one approach congenial, eg. a model in which there is a gradual emergence of themes, could comfortably adopt the role of a more active therapist, who uses a focused approach and sets time limits. (Strupp, 1981) This is not a question which has easy answers, and there does not seem to be any solution to this apparent in the literature. The

writer believes however, that there is some variety available within the brief models of dynamic therapy, which could find an answering response among therapists of differing personality and working styles. For example, the work of Mann (1973; 1981) although strictly time-limited (12 sessions), indicates that his stance is less confrontative, and more "containing", without being highly interpretive. Malan (1976; 1979) on the other hand, is more interpretive, active and focused, but is still less anxiety-provoking than for example, Sifneos (1978; 1981), who is highly interpretive, confrontative and active. However, the importance of being able to set limits, including time limits, and being able to accept that as a working assumption, would be an important aspect of therapist intention. This could become an important limiting factor in choice of method if the therapist regards this aspect as unacceptable.

b) Parallel Processes in Teaching and Learning:

The recurrence of parallels between the teaching and the therapy situations is pointed out by Dasberg and Winokur (1984). This situation has also been identified by Ekstein and Wallerstein who identified that therapists bring similar defensive patterns and anxieties to both supervisory and therapeutic relationships (in Dasberg and Winokur, 1984). They advocate that the supervisor focus on these patterns as they emerge in both relationships as a way of promoting growth in the trainee. Searles used the term, parallel process, to refer to those times when the trainee re-enacts aspects of his relationship to the patient with the supervisor, a phenomenon which she called "reflection process". It was specifically seen as a resistance or acting out of the trainee of the patient's problems because the trainee was unable to conceptualize it (in Winokur and Dasberg, 1984).

Dasberg and Winokur assert that similar parallel processes are found in their group training programs, and that the changing attitude of the students to the program parallels the changing attitude of the patient. For example, in the beginning the trainees idealize their teacher, in a "honeymoon phase", which later gives way to doubts and resistances to the approach in the middle phase, whereas the last phase in both teaching and therapy situations is characterized by separation difficulties, with denial, and other defences (1984: 186).

The trainee also needs similar attributes as the patients, in relation to high motivation, tolerance for negative affect and commitment to change. The teacher needs to deal actively with resistance when it arises and to be supportive as well, similar to the clinician's behaviour in his therapeutic role.

The supervisor's modeling a therapeutic stance becomes an implicit experiential model for therapeutic behaviour. This, as well as pointing out the parallels, and the transference and countertransference, is seen by Dasberg and Winokur (1984) as a way to facilitate the learning process.

c) The goals of supervision:

These would be to teach the trainee the operations for successful work in this modality. Having adhered to the client selection variables and suitability through assessment and diagnosis (as discussed earlier in Chapter Five), the trainee has to learn how to build a positive therapeutic relationship. He needs to learn how to be active and to maintain a focus and to hold a steady direction on the therapeutic work without allowing the client to become too anxious, or to feel overcontrolled (Schneider and Pinkerton, 1986). He needs to learn to define treatment goals and use time-limits. As well as promoting insight through use of interpretation,

he may also incorporate other techniques, which may also include problem solving, environmental management, and teaching of coping skills, including stress management. While these would be considered ancillary to the dynamic process outlined, they would be part of the technical repertoire to be used in brief therapeutic work. Finally, the trainee needs to learn how to use his own reactions and countertransference, in an informative way, so as to promote client change.

9.7 OUTCOME STUDIES

Empirical data on training programs are sparse, however Haimovitch (1984) evaluated a 20 week program given to trainees with a variety of professional backgrounds: psychiatrists, psychologists and social workers with a work experience ranging from two to eight years post degree. Results after the program revealed that there was a significant increase in some, but not all, of the skills necessary for the effective practice of brief dynamic therapy. Some of the more complex skills including interpretation of defence, and transference-past-present links (see section on Techniques in this dissertation) were more difficult to master. Individual differences among trainees indicated that not everyone benefited equally from this kind of training.

The awareness in training schools and residency programs to the need for training in this method is increasing (Clarkin et al, 1980). This corresponds with the mental health systems pressures, the enduring results from outcome studies of the treatment, and the dictates of the client population itself, through their early termination or dropping out of longer term therapy.

9.8 CONCLUSION:

This chapter has explored training in brief therapy, and discussed a number of aspects, such as trainee selection and expectations as well as resistances. Program content was outlined following on guidelines from the literature in relation to areas to be covered. Supervision issues were also discussed.

9.9 FURTHER RESEARCH POSSIBILITIES:

Brief therapy offers a unique proving ground for testing the efficacy of techniques. The empirical study and a review of the literature has indicated some areas which could be the subject of further research.

a) Both the empirical as well as literature surveys indicate that on the whole, it is with the more motivated, competent patient, that the brief dynamic method has the most success. While the contributions in relation to the more disturbed patient, is available and increasing, there is still too little evidence of success with these patients, or those with poorer prognosis that make up the bulk of caseloads in practice. While the task-centred model would have more success with these clients, some criticism has come from the literature that this method often presumes more competence in the client, in order to utilize task-centred activity. Future research that would focus on innovative techniques with more difficult and disturbed clients would make a meaningful contribution to the therapeutic field.

b) Research that would indicate the best match between patient type and technical modality would make a substantial contribution towards the efficacy of therapy. There has been some beginning efforts made in this direction (White, Burke and Havens, 1979).

c) Research studies have indicated that brief therapy methods are emotionally demanding of the therapist (Koss, Butcher and Strupp, 1986). This could therefore lead to increased resistance, and thus to decreased usage. Exploring these resistances and the effect on clinicians' practice would be a useful area to research and would be a natural outcome from this present study.

d) A survey similar to the present one could be undertaken with a larger sample of practitioners, in order to test out on a larger scale, the results obtained, regarding use of and attitudes towards brief dynamic therapy.

e) Research to discern the relationship between time, therapy and outcome need to be continued. Questions which could be addressed are the comparison between benefits from long-term therapy, and brief therapy. In particular, whether continuous therapy is necessary, or whether when offered more circumscribed focused therapy, linked with a developmental stage framework, what the residual benefits for the client would be and how they are maintained.

CHAPTER TEN

SUMMARY AND CONCLUSION

This study has explored brief dynamic psychotherapy as conducted with the individual adult client. In Chapter One, the rationale for this study was outlined and objectives defined. The rationale emanated from a number of aspects, including evidence from studies which showed that the large majority of clients remained in therapy for brief periods of time, whether they were seen in private practice or in community mental health clinics. The societal need for briefer forms of treatment through the insistence of third party payers, as well as a need for trained personnel to be spread around more evenly, was a further spur to explore this method. The writer's own clinical experience and interest, was an additional motivating factor for this study. The study aimed to explore how the insights of the psychoanalytic tradition could be made palatable for use and consumption in a brief model. This could also hope to offer an alternative to the task-centred model, the "traditional" brief model of intervention for the clinical social worker. Further objectives were to explore the use of this model of intervention among a sample of local clinicians in order to discern factors which were influential in practice.

A historical overview was presented in Chapter Two, where it was seen how the brief dynamic model, while in use in the early days of psychoanalysis, became "lost" as therapy became longer, and the goals of therapy became more ambitious, including aiming to make major personality changes through long-term treatment. The resistance in the traditional psychoanalytical schools was a strong factor to counter, yet the early theorists and therapists persevered with outlining their motivating factors for briefer forms of intervention. In so doing, the very nature of therapy underwent

change, with the interaction between clinician and client receiving attention, with all the potential it contained for accelerating the change process through greater therapist activity. In Chapter Two, the social work approach to the brief model of dynamic treatment was outlined, with the conclusion that social work did not make its own any dynamic model of brief intervention. It was pointed out how a recent nationwide survey in the United States of America, had found that only a small minority of dynamically oriented clinical social workers actually utilized brief models of intervention in practice.

In Chapter Three the essential compatibility between the individual and the systems model was given, with the view that change at the individual client level, promised change in wider levels too, and that any intervention, both individually or systemically, essentially offered a new solution, which could be approached from an individual dynamic level, or a systems level. There was thus a need for clinical workers to be aware of and to work on the individual level of intervention.

Chapter Four examined and compared brief and long-term models of treatment, both from a technical, as well as from an assumptive level, with the hope that clinicians embarking on therapy with clients would be aware of the assumptions and values which underlie each approach, and which are often influential on the clinician's view of the human personality and the healing process. A plea was made that it was client factors (rather than previously assumed, and often jealously guarded views, which could often resonate with personal factors), which should be decisive in choice of therapy.

Chapter Five dealt with selection procedures for brief dynamic therapy: a complex area, requiring that the clinician possess specialized knowledge. It was pointed out that in addition to the traditional classical assessment

procedures, further assessment guidelines as particularly relevant to brief therapy were necessary. These were concerned with client motivation, with performance criteria in the first few sessions: these would indicate the client's ability to relate, to use insight and to work on an emotional level, as well as an assessment of how the client could tolerate the time limits.

Chapter Six covered the technical aspects of brief dynamic therapy, including both the specific, and the non-specific areas which are intertwined to produced the facilitating change conditions. These explored relationship factors in brief dynamic therapy, including transference and counter-transference, as well as specific interventive procedures utilized in the model. The need for these specific interventions as well as a certain therapeutic flexibility according to client need, was stressed.

In order to obtain evidence from the field in relation to the use of this therapeutic method in practice, as well as to discern the attitudes towards it, an empirical study was conducted as discussed in Chapter Seven. The writer formulated a questionnaire, which would tap usage, as well as attitudes towards specific features of this model. A group of local clinicians was surveyed through the closed and open ended questionnaire. While there were limitations to the sampling, as well as to the questionnaire, there were some findings obtained which were of interest. These are fully discussed in Chapter Eight. The main findings obtained indicated that brief dynamic therapy was practised by the minority of respondents, although a large majority in fact had brief therapy clients in their practices. Thus planned brief dynamic therapy was not common. The factors which could limit use of this model appear to be the lack of training and the self-perceived skill deficit. Selection of clients, and inclusion and exclusion factors were also factors to be considered, however

most therapists had a positive view that this method could be useful for clients, taking into account the specific limitations in respect of very disturbed clients. Most respondents considered it to be a useful method for South Africa, and most thought that it should be included in a clinical training program.

Chapter Nine discussed training implications. These were concerned with trainee suitability, expectations and resistances, program content and supervision issues. It was proposed that the post-graduate internship or practicum offered an ideal period for training in this method, due to the trainee potential to learn, the client need, as well as the availability of supervision, both peer-group as well as individual. The training deficit was seen as an important area and a recommendation was made in the last chapter, for specific training for all professional groups.

This dissertation, while limited in relation to focusing on only brief dynamic individual therapy, and not on other brief models, set itself the task of exploring in particular this model, which it saw as occupying a particular paradoxical position, which did not seem to apply to other brief models of therapy. It was indicated however, from the respondents in the research conducted, that dynamic therapy was in fact the model most widely practised. It becomes thus a challenge to counter the assumptions that if it is dynamic, it has to be long, or that if it is brief, it is necessarily superficial, or a stopgap. If this study can hope to identify some of the apparent resistance to the brief dynamic mode, and could have a residual effect in sensitizing to the need for planned dynamic therapy training, in order to guide clinicians to utilize the time that their clients actually spend in therapy, in the most useful way, it will help to close an accountability gap. Further, if it can hope to motivate for training in this method then it will have met its set objectives. There are still many

unresearched potentials in this method, which could resonate with the whole therapeutic change process. In conclusion therefore, this study would hope to stimulate further interest into the brief model of dynamic psychotherapy.

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APPENDIX 1**MAJOR DIFFERENCES BETWEEN PSYCHOANALYSIS, BRIEF PSYCHOTHERAPY,
AND CRISIS INTERVENTION METHODOLOGY**

	Psychoanalysis	Brief Psychotherapy	Crisis Intervention
Goals of therapy	Restructuring the personality	Removal of specific symptoms	Resolution of immediate crisis
Focus of treatment	1. Genetic past 2. Freeing the unconscious	1. Genetic past as it relates to present situation 2. Repression of unconscious and restraining of drives	1. Genetic present 2. Restoration to level of functioning prior to crisis
Usual activity of therapist	1. Exploratory 2. Passive observer 3. Nondirective	1. Suppressive 2. Participant observer 3. Indirect	1. Suppressive 2. Active participant 3. Direct
Indications	Neurotic personality patterns	Acutely disruptive emotional pain and severely disruptive circumstances	Sudden loss of ability to cope with a life situation
Average length of treatment	Indefinite	From one to twenty sessions	From one to six sessions

(Aguilera and Messick, 1973: 26)

APPENDIX 2

COMPARATIVE DOMINANT VALUES OF THE LONG-TERM AND SHORT-TERM THERAPIST

Long-Term Therapist	Short-Term Therapist
1. Seeks change in basic character.	Prefers pragmatism, parsimony, and least radical intervention and does not believe in notion of "cure".
2. Believes that significant psychological change is unlikely in everyday life.	Maintains an adult development perspective from which significant psychological change is viewed as inevitable.
3. Sees presenting problems as reflecting more basic pathology.	Emphasizes patient's strengths and resources; presenting problems are taken seriously (although not necessarily at face value).
4. Wants to "be there" as patient makes significant changes.	Accepts that many changes will occur "after therapy" and will not be observable to the therapist.
5. Sees therapy as having a "timeless" quality and is patient and willing to wait for change.	Does not accept the timelessness of some models of therapy.
6. Unconsciously recognises the fiscal convenience of maintaining long-term patients.	Fiscal issues are often muted either by the nature of the therapist's practice or by the organizational structure for reimbursement.
7. Views psychotherapy as almost always benign and useful.	Views psychotherapy as being sometimes useful and sometimes harmful.
8. Sees patient's being in therapy as the most important part of patient's life.	Sees being in the world as more important than being in therapy

(Budman, 1983: 279)

CONFIDENTIAL QUESTIONNAIRE

Dear Colleague

Enclosed please find a confidential questionnaire.

I am a registered social worker, completing my postgraduate specialist training in clinical social work (M. Soc. Sc.) at the University of Cape Town. Part of the requirement for academic studies is the completion of a dissertation.

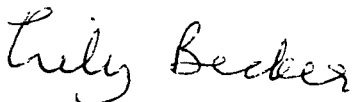
The enclosed questionnaire forms part of an empirical study which I am undertaking, evaluating brief dynamic psychotherapy with special reference to the Clinical Social Worker. This is a study under the supervision of senior staff of the School of Social Work.

The aim of the research is to explore the practice of brief dynamic psychotherapy as an intervention model possibly used by local therapists in Cape Town. The study will examine the general attitudes towards and use made of the brief model of dynamic therapy with individual clients. Questionnaires are being directed to local practitioners. It is hoped that the information elicited will provide some guidelines as to the use of such an approach in practice.

The most valuable way in which you can assist is to draw on your personal experiences in answering these questions. Your responses will be completely confidential and the manner in which the information will be integrated into the thesis will not compromise this confidentiality in any way.

The questionnaire may take up to 20 minutes to complete. Your co-operation in this survey will be most appreciated. If there should be any queries, please contact me at 650-3491 during office hours, or 77-4054 after hours.

Yours sincerely



LILY BECKER

CONFIDENTIAL QUESTIONNAIRE

Please indicate your response by ticking the appropriate square.

<u>PROFILE OF RESPONDENT</u>		<u>SECTION ONE</u>
1. Age in years:	20-29	<input type="checkbox"/>
	30-39	<input type="checkbox"/>
	40-49	<input type="checkbox"/>
	50-59	<input type="checkbox"/>
	60 and over	<input type="checkbox"/>
2. Marital Status:	Single	<input type="checkbox"/>
	Married	<input type="checkbox"/>
	Divorced	<input type="checkbox"/>
	Widowed	<input type="checkbox"/>
3. Gender:	Male	<input type="checkbox"/>
	Female	<input type="checkbox"/>
4. Place of Training:	University (please specify):	<input type="checkbox"/>
	College (please specify)	<input type="checkbox"/>
	Other (please specify)	<input type="checkbox"/>
5. Educational Qualifications:	Honours Degree	<input type="checkbox"/>
	Masters Degree	<input type="checkbox"/>
	Ph D	<input type="checkbox"/>
	MB Ch B	<input type="checkbox"/>
	Psychiatry qualification	<input type="checkbox"/>
	Other, please specify	<input type="checkbox"/>
6. Additional Specialised Training, e.g. Jungian Institute, Gestalt, etc	Please specify	<input type="checkbox"/>
7. Professional Registration	Psychiatrist	<input type="checkbox"/>
	Psychologist	<input type="checkbox"/>
	Medical Doctor	<input type="checkbox"/>
	Social Worker	<input type="checkbox"/>
	Other, please specify	<input type="checkbox"/>
8. Length of professional practice as a therapist	1-5 years	<input type="checkbox"/>
	6-10 years	<input type="checkbox"/>
	11-20 years	<input type="checkbox"/>
	21-30 years	<input type="checkbox"/>
	Over 30 years	<input type="checkbox"/>
9. Type of practice:	Private practice	<input type="checkbox"/>
	Hospital	<input type="checkbox"/>
	Both private/hospital	<input type="checkbox"/>
	Agency	<input type="checkbox"/>
	Other, please specify	<input type="checkbox"/>

10. Urban or Rural Practice: Urban ☐
 Rural ☐
 Both ☐
11. Full or part time: Part time ☐
 Full time ☐

SECTION TWO

PRACTICE OF BRIEF DYNAMIC PSYCHOTHERAPY

Dynamic Psychotherapy is defined as therapy in which consideration is given to the intrapsychic processes and psychogenetic aspects of the patient's condition. It also encompasses working with the transference, using interpretations and promoting insight into conflict and disturbed functioning.

Brief Dynamic Psychotherapy is defined as dynamic therapy, as described above, in which the number of sessions in therapy is defined and contracted and where this "time" factor becomes an integral part of treatment. Some other features include establishing and working with a central therapeutic focus or conflict, therapist activity and directiveness, and modified goals in therapy.

1. On the basis of the definition, do you engage in brief dynamic psychotherapy with patients?
 Yes ☐
 No ☐
 Unsure ☐

2. Have you been trained in brief dynamic psychotherapy?
 Yes ☐
 No ☐
 Unsure ☐

3. Do you find your practice includes both brief and long-term therapeutic approaches?
 Yes ☐
 No ☐

4. If engaging in brief therapy, what is the average number of sessions which you have with patients?
 1-5 sessions ☐
 6-12 sessions ☐
 13-20 sessions ☐
 21-40 sessions ☐

5. How would you describe your theoretical orientation?

- Psychoanalytical ☐
- Psychodynamic ☐
- Behavioural/Cognitive ☐
- Systems/Strategic/Structural ☐
- Eclectic ☐
- Other, please specify ☐

---o0o---

6. It is important to have a focus in therapy.
(By focus is meant defining and working with a central conflict in the patient's situation).

- Strongly agree ☐
- Agree ☐
- Unsure ☐
- Disagree ☐
- Strongly disagree ☐

7. Using a contract and setting relatively specific goals/objectives is important in therapy.

- Strongly agree ☐
- Agree ☐
- Unsure ☐
- Disagree ☐
- Strongly disagree ☐

8. Transference issues can be dealt with in brief dynamic psychotherapy.

- Strongly agree ☐
- Agree ☐
- Unsure ☐
- Disagree ☐
- Strongly disagree ☐

9. Dreams can be worked with in brief dynamic psychotherapy.

- Strongly agree ☐
- Agree ☐
- Unsure ☐
- Disagree ☐
- Strongly disagree ☐

10. There are specific kinds of patients who would benefit from brief dynamic psychotherapy.

- Strongly agree ☐
- Agree ☐
- Unsure ☐
- Disagree ☐
- Strongly disagree ☐

Please comment:

.....
.....

11. There are specific kinds of patients who would be considered unsuitable for brief dynamic psychotherapy.

Strongly agree ☐
 Agree ☐
 Unsure ☐
 Disagree ☐
 Strongly disagree ☐

Please comment:

12. Brief dynamic psychotherapy is an abbreviated form of long term therapy.

Strongly agree ☐
 Agree ☐
 Unsure ☐
 Disagree ☐
 Strongly disagree ☐

13. Brief dynamic psychotherapy has its own special concepts and techniques.

Strongly agree ☐
 Agree ☐
 Unsure ☐
 Disagree ☐
 Strongly disagree ☐

14. More than symptom relief is possible with brief psychotherapy.

Strongly agree ☐
 Agree ☐
 Unsure ☐
 Disagree ☐
 Strongly disagree ☐

15. High therapist activity (e.g. interpretations, formulation of plans, keeping therapy focused) is an important aspect of dynamic psychotherapy.

Strongly agree ☐
 Agree ☐
 Unsure ☐
 Disagree ☐
 Strongly disagree ☐

16. You consider yourself as being skilled in the brief dynamic psychotherapy model.

Strongly agree ☐
 Agree ☐
 Unsure ☐
 Disagree ☐
 Strongly disagree ☐

17. Training schools in the field of clinical service rendering should include in their curriculum a course/modality in brief dynamic psychotherapy.

Strongly agree ☐
 Agree ☐
 Unsure ☐
 Disagree ☐
 Strongly disagree ☐

18. Brief dynamic psychotherapy is a viable approach in South African society?

Strongly agree ☐
 Agree ☐
 Unsure ☐
 Disagree ☐
 Strongly disagree ☐

Please comment:

Thank you for your assistance in completing this questionnaire.

Would you please return the completed questionnaire in the enclosed, self-addressed, reply paid envelope to ensure that it is received before 21st June 1988.

LILY BECKER