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Brief Adaptive Psychotherapy

Handbook of Short-Term Dynamic Psychotherapy

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Brief Adaptive Psychotherapy

HISTORY AND CONCEPTUAL FRAMEWORK

Brief Adaptive Psychotherapy (BAP) was developed at Beth Israel Medical Center in New York in the early 1980s (Pollack & Horner, 1985). BAP was designed for patients with personality disorders, similar to those whom psychotherapists in private practice generally treat. Our patients meet the *DSM III-R* criteria for avoidant, dependent, histrionic, obsessive-compulsive, and passive-aggressive personality disorders. These are people who have problems in the areas of intimacy and work, generally with difficulties in forming lasting relationships and in realizing their vocational potential.

BAP is a short-term psychotherapy based on a psychoanalytic understanding of character, conflict, and defense (Reich, 1949). We have defined character as patterns of beliefs and behavior, adaptive or maladaptive. We chose to help patients change their major maladaptive patterns of beliefs and behaviors—those that cause pain or a lack of gratification—into a more adaptive framework. As a brief therapy, BAP differs from classical psychoanalysis in its techniques; instead of free association, the therapist actively maintains the focus, and instead of encouraging the transference neurosis, deals consistently with transferences as they appear within the pattern.

Heinz Hartmann's (1939) work on adaptation also provided a theoretical framework for our approach. He saw adaptation as the integration by the ego of beliefs, wishes, needs, and impulses with the demands of the external world and of the superego. The core issue of adaptation is reality (inner and outer)—a knowledge of reality and acting in accord with it to achieve the most gratification with the least pain. The failure of this integration by the adult ego leads to maladaptive patterns of behavior, which, in some cases, lead to the formation of a personality disorder.

Personality *traits* are not considered mental disorders. They may include such factors as innate temperament or cognitive style. *DSM III-R* defines personality traits as "enduring patterns of perceiving, relating to and thinking about the environment and one's self" (American Psychiatric Association, 1987, p. 335). However, these traits may become rigid in the service of an attempt at adaptation. When they become inflexible and maladaptive they are referred to as personality *disorders*. BAP was designed not to eliminate or radically change basic personality traits but to extricate these traits from their maladaptive rigidifications. When the traits serve adaptation, all is fine, but when they add to maladaptive patterns, they must be loosened and altered to serve reality. Maladaptive patterns manifest themselves through inflexible cognitive and emotional functioning, primarily within interpersonal relationships.

Adaptation takes place under the aegis of the ego. The ego, as used in this approach, is a psychological construct based on a structural division of the psychic apparatus into ego, id, and superego (Freud, 1958). The ego serves a number of psychological functions, such as relation to reality, defense, impulse control, and object relations (Hartmann, Kris, & Loewenstein, 1946; Beliak, 1958). The overall function of the ego is to organize, synthesize, and structure the demands of the inner and outer worlds of the individual and in this sense is the organ of adaptation (Hartmann, 1939). BAP is an ego psychological approach, exploring how the ego deals with wishes, beliefs, needs, and impulses, both adaptively and maladaptively. The ego in patients selected for BAP is a relatively healthy one. Thus, the patients bring to the therapy an ego doing essentially what it is supposed to do in the adaptation process, although it is working with thoughts, perceptions, feelings, beliefs, or wishes that have an element of conflict and reality distortion in them. Although these aspects of the system may have served adaptation at one time, they no longer do. Since the data the ego is dealing with are distorted in relation to the reality of the here and now, the attempted adaptation will also be distorted—that is, maladaptive.

The goal of BAP is to acquaint patients with their maladaptive patterns, enabling them to achieve insight into the origins and development of these patterns and to become aware of how the patterns prevent the achievement of their goals in life. In this sense BAP is a cognitively based treatment.

However, it was not clear at the outset how this primarily cognitive insight was going to help patients make the necessary changes in their lives. Examining the elements of the pattern in detail, and not settling for vague answers to confrontational questions, was found to be a useful technique for ultimately producing change. Insisting that the pattern be examined in detail resulted in resistance by the patient to the therapist's confrontations; this in turn, made the relationship between therapist and patient the central area of the treatment. The work of Merton Gill (1982), stressing the centrality of the patient-therapist relationship, became an important influence on the developers of BAP. We began to emphasize the patient-therapist relationship so that early resistance could be recognized, challenged, interpreted, and resolved. It became apparent that it was in the transference that the maladaptive pattern could be most clearly seen, explicated, and understood. It is in the transference that the patient's pathology will be most apparent to the patient and most available for real work.

THEORY OF CHANGE

We believe that a cognitive and affective understanding of the operations and origins of the maladaptive pattern (insight) allows patients to change enough so that they can construct more adaptive patterns and are better equipped to face adult lives and new relationships.

It is the task of the therapist to show the patient that the maladaptive pattern is not just something to be cognitively understood; it is the way the patient lives his or her life. As an active system that originated in the past, the maladaptive pattern is alive in the important relationships in the patient's current life and—most important for BAP—in the patient-therapist relationship.

The major work in BAP is in the transference. The transference work has an emotional impact on the patient, affording him or her the opportunity to see, to feel, and to change the aspects of the pattern that stand in the way of healthy adaptation. The therapist gives the patient the opportunity to experience cognitive and emotional conflicts and memories in a more benign setting that allows for a corrective emotional experience (Alexander & French, 1946). The transference is the stage on which the patient enacts the pattern, where both the therapist and the patient are the main dramatis personae, and where the maladaptive pattern provides the basic plot of their improvisations (Arlow, 1969a). Working in the transference lends affective strength to the insights that are developed about current relationships and the linkages to the origins of the maladaptive pattern in the past. Transference work allows patients to develop enough control over the operations of the pattern so that the pattern loses its rigidity and new situations can be approached more flexibly. Patients can develop newer patterns that are better suited to current reality. We try to give patients the

sense of having choices, so that rather than respond to a new relationship in the old manner they can stop, think, and choose other ways of responding. For example, patients who have always accommodated to the needs of others by putting aside their own needs, can now, having been helped to look at their motivations, act in a way that leads to satisfaction, as opposed to what generally ensued when their needs were put aside.

SELECTION OF PATIENTS

BAP was developed to provide a brief psychotherapy for the treatment of personality disorders. In our initial work, patients were limited to those who met the criteria for Axis II diagnoses of the Cluster C type, such as avoidant, dependent, obsessive-compulsive, and passive-aggressive, and the histrionic diagnosis in Cluster B *(DSM Ill-R).* We excluded those with more severe personality disorders, such as borderline and narcissistic patients. Other exclusion criteria were: a history of suicide attempts, a history of substance abuse, current psychoactive medication, organic mental impairment, and any Axis I diagnosis except for anxiety or affective disorders of mild to moderate severity.

BAP was designed to help patients develop insight into the operations of their maladaptive pattern. This works quite well with patients who have histrionic personality disorders. They use repression as a major defense,

causing gaps in their understanding of the origins and operations of the maladaptive pattern. The affective side of the pattern is generally clear and rarely presents problems. These patients will often repress historical and cognitive elements underlying the maladaptive pattern, but the repressed material often emerges during the course of treatment. As David Shapiro (1965) has pointed out, their style is characterized by their failure to put the pieces of their lives together so that insight can be attained. Therefore, a cognitively based therapy such as BAP would seem to be the treatment of choice for histrionic patients.

Obsessional patients use more cognitive styles of defense such as intellectualization, rationalization, and reaction formation. Often, these patients will say that they "understand it all" and will give the therapist a complete history, full of details, concerning the origin and operation of the maladaptive pattern. The therapist is inundated with unnecessary details and, along with the patient, may miss the forest for the trees. The task of the therapist is to concentrate on the affective aspect of the insight. In treating the obsessive-compulsive patient it is necessary that the therapist immediately relate the intellectualizing defenses to the therapeutic relationship. The therapist looks for affect as confirmation of the accuracy of interpretations.

We are now attempting to study the efficacy of BAP with narcissistic and borderline patients. Theoretically, it is possible to take as a focus of

treatment such phenomena as splitting, overidealization of the other, identification, excessive needs for attachment, and some forms of merging. The therapist must be more cautious and somewhat less confrontational than with healthier patients. A positive relationship with the patient is formed during the early sessions, and the patient's defenses are carefully pointed out to the patient as they are perceived. It is possible that courses of brief therapy alternating with planned periods without treatment may be successful for some of these patients. This type of treatment plan may afford patients some distance from the therapist, and thus help them cope with the fears of merging that often complicate ongoing treatment.

We have treated patients with mild to moderate depression who have not been actively suicidal. The technique has been the same: uncovering the pattern and making this the focus of therapy. With these patients the therapist must monitor the severity of the depression; though suicidal thoughts may emerge, these can often be dealt with as part of the pattern, but they must be explored thoroughly to evaluate the suicidal risk.

TECHNIQUES

BAP is a psychoanalytically based psychotherapy that uses the standard techniques of brief dynamic psychotherapy (Marmor, 1979). These include the maintenance of a focus, early and repeated work in the transference, and

a high activity level on the part of the therapist. The focus is maintained by keeping the patient from straying from the major maladaptive pattern. The pattern is always an interpersonal one and is explored in the present, in the past, and in the patient-therapist relationship. These three areas are repeatedly connected to one another through the use of questions, clarifications, confrontations, and interpretations. These interventions, especially clarification and confrontation, are used to intervene whenever resistance begins to interfere with the therapeutic process.

Sessions are fifty minutes long, face-to-face, once a week; the maximum is forty sessions. The rule of abstinence and therapeutic neutrality is followed (Greenson, 1967). The therapist does not self-disclose, reveal elements of his or her life, or give advice.

Evaluation

The goals of the evaluation session are to make a diagnosis, to exclude those patients who cannot tolerate a confrontational psychotherapy, and to explore the interpersonal relationships of the patient so that the major maladaptive pattern can be formulated. The therapist attempts to establish a positive therapeutic relationship and begins the exploration of the patient-therapist interactions. At the end of the evaluation the rules of the psychotherapy are discussed and a contract is made with the patient.

Although the evaluation often involves two separate meetings of about an hour each, it is better done in one session. This allows more continuity in obtaining a history of the present difficulty and past history. The longer interview is more stressful and provides a better picture of the patient's defensive structure. The task of the therapist is to get the history as directly as possible and not allow the patient to stray or become vague. When straying does occur, the therapist must confront the patient and his or her evasive tactics. This confrontation generally increases the level of resistance, and these new resistances must then be confronted by the therapist. The questioning and confrontation of resistance serves to illuminate the patient's defenses and the maladaptive pattern within the patient-therapist relationship. When the defenses become clearer the therapist can begin to link the defenses with the pattern, at first in a general way—for example, "You seem to have trouble telling me the details of what happens between you and your wife. Does this also happen in other circumstances?" Or "Did it also occur in the past when you had trouble telling your parents what your wishes were or what you were feeling?" This interaction can also proceed in the opposite direction. If a patient is talking about difficulties that arise in current and past relationships, the therapist should bring up how those difficulties are present in the therapeutic relationship. An example might be: "You have difficulty when you are angry with your wife and when you were angry with your mother. How will that work here when you get angry with

me?"

The therapist does not specifically seek affect, as in some short-term therapies (Davanloo, 1980). The use of repetitive challenges and confrontations as used by Davanloo is not a part of BAP. It is expected that affect will follow if the transference is made an integral part of the treatment.

It is important during the evaluation to get as much information as possible about the major maladaptive pattern. The therapist looks for links between the way the patient interacts with the major figures in his or her life and the way the patient interacts with the therapist. The patient may avoid aggression or sexuality, distance from others, intellectualize and avoid feelings, accommodate to whomever he or she is relating to, withdraw when certain issues are discussed, or behave in an excessively passive and dependent manner. The therapist must point out these mechanisms to the patient during the evaluation and then attempt to determine what underlies them. One looks for the wishes that these defenses oppose and the conflicts that exist, with the goal of finding the primary unconscious fantasy system (Arlow, 1969a, 1969b). Trial interpretations (Malan, 1976) are used to evaluate the patient's responses. A positive response from the patient might be an introspective, pensive glance, further information related to the pattern, questions as to whether he or she does the same thing in other situations, some obvious affect, or even disagreement that is not excessive, such as, "I

don't think that applies, but I'll think about it." Agreement by the patient without elaboration may indicate compliance or passivity, rather than an ability to work with the material. Clinically it is our impression that patients who respond favorably to trial interpretations during the evaluation process will do well in BAP.

Once the pattern is relatively clear to the therapist it is presented to the patient. It is not expected that all the elements of the pattern will be known by the end of the evaluation process. Indeed, the pattern is elaborated and enriched throughout the course of the treatment.

Therapeutic Contract

At the end of the evaluation or at the beginning of the first session, the therapeutic contract is discussed. Therapists are instructed to use their own words in establishing the contract; the following statement is one example.

> Therapist: Our goal will be to explore the pattern you have used and are using in your personal relationships. These are patterns that have not worked well for you, have gotten you into difficulty in your life, and have led to your coming here. By examining these patterns in detail, we will be able to see them more clearly and help you to develop new patterns that will work better for you and thus give you the opportunity to make changes in your life.
>
> During our work together, thoughts and feelings will emerge that are important. It is critical that you express them to me in as open a manner as possible. If there is something that is difficult for you to tell me, at least report the

reluctance, if not the actual material. What you are reluctant to talk about may have to do with your reactions to me. This should be discussed, because your reactions to me are often related to the very patterns that we want to examine.

We will set a fixed hour each week for which you will be responsible. Each session will last fifty minutes and there will be a maximum of forty sessions.

Do you have any questions or reactions so far?

Treatment

The therapeutic work proceeds directly from the evaluation. As was done in the evaluation session, the details of the maladaptive pattern and their underlying elements are explored. This work inevitably leads to the patient's resisting, generally using elements of the pattern, that is, the defensive structure. The therapist confronts the resistance, linking it to the pattern, especially in the transference. This serves two purposes. First it makes clear to the patient that the relationship between patient and therapist will be subject to exploration in the therapy. Second, it lends more immediacy to the treatment. It is easier for the patient to intellectualize if the therapy deals only with external and past relationships. Intellectualization may preclude the integration of cognitive and emotional issues and thus diminish the likelihood of insight. However, if there is pressure to explore the patient's pattern in the transference, distancing is less likely and the insight that is achieved is more likely to be both cognitive and affective.

Linking at least two examples of the pattern in an interpretation appears to be advantageous. An example of this is: "Whenever we talk about your relationship with your father and your anger at him, you become withdrawn, just as you do with your husband when he makes demands that infuriate you." As much as possible, interpretations of present and past relationships should come after examples have been explored in the transference. It is critical that the therapist be aware of the state of the transference at all times and that when possible he or she channel interpretations through the transference, for example: "Whenever we get close, you start becoming anxious and passive, just as you used to do with your parents."

Confronting the resistance generally reveals additional elements of the pattern, enabling the patient to get to underlying fantasies or beliefs and the conflicts they engender. The pattern usually is not fully elicited early in the therapy. Often in the beginning, it is rather sketchy, as in a tendency to avoid conflicts or a need to accommodate to another's wishes. As exploration of the pattern proceeds, especially within the transference, specific details about when and how the pattern operates begin to emerge. These may be elements such as: the patient avoids conflict of a particular nature or with a particular person; the patient may accommodate in an aggressive situation and be more assertive in a sexual situation; the patient may function at an adult level in a dyadic situation but became defensive when triadic or oedipal issues come to

the forefront. The therapist must always work at connecting the elements of the pattern until the unconscious fantasy system becomes clearer.

As BAP unfolds it is important to look for changes in the way the patient relates to the therapist and to other persons in his or her life. A common problem has been the reluctance of a patient to change, often because the patient refuses to change for the therapist's sake, in the same way as changing for the parent implied some loss of autonomy. This refusal to change often comes up during the middle of therapy and can be the basis of much of the later therapeutic work.

If the therapist adheres to the technique with a patient who meets the criteria for BAP, termination should pose no major problems. As in most therapies, the maladaptive aspects of the pattern often return in full force toward the end of treatment. When this occurs, it must be explored, interpreted, and linked to the transference and the impending termination. There are no clearly distinct phases in BAP. The therapy proceeds from the defense to the wish and from superficial to deeper levels as does any psychoanalytic therapy.

A problem with any short-term therapy is the lack of time to work through the insights achieved. The working through in BAP is part of the ongoing treatment. After an interpretation patients will often respond either

with affect or with data that support the correctness of the interpretation. The therapist then asks about other situations where this insight might apply, attempting to get the patient to apply what has been learned to other situations and to generalize the insight that has been gained. We have found that patients are able to do a good part of the working through on their own, between sessions and after terminating the therapy.

CASE EXAMPLE

The following case example demonstrates how treatment progresses in BAP. The material was transcribed from videotaped sessions.

The patient, a forty-year-old divorced woman who worked as an administrator in a law firm, sought treatment because she felt she had lost her energy, optimism, and sense of expectation following the break-up of a relationship she had had three years earlier. The man with whom she had the relationship was described as melancholic and gloomy. He was a Vietnam War veteran whose life reminded her of her early years in postwar Europe. She was more involved with his depression than she thought was appropriate, and she herself also became depressed. She did not understand why this man affected her so much and hoped that treatment would help her understand herself better.

The patient stated she "dabbled" in life and was unable to make any

lasting commitment or develop her full capabilities. She had had two previous experiences with therapy. One was practical and helpful when she came to the United States and needed to learn how to operate in a different culture. The other was three years before she came to us, when she saw a therapist several times. She felt he wasn't strong enough to help her, so she left treatment.

The patient was born to thirty-nine-year-old parents near the end of World War II in France. She remembered the poverty and destruction of the 1950s. She believed her particular cultural heritage was a gloomy one. She described both parents as having been overprotective and infantilizing, and she continued to experience them this way. Her mother was described as a charming and gracious person socially, but bitter, negative, and caustic within the family. Her father was talented but never really succeeded, ending up as a middle-level civil servant. The patient stated that her parents sent a double message to her and her younger brother: they were talented and special children, but they shouldn't try to do anything, as they would not succeed.

The patient had earned a teaching degree in France. She had been married and divorced and remained friendly with her ex-husband and his girlfriend. The patient had long-term friendships with a number of women. At the time she had a boyfriend; they were sexually intimate on a regular basis, but shared few other interests or activities. The patient tended to be

flamboyant in her style of dress and in the way she spoke. At the same time she was a perfectionist who devoted herself to her work and yet was often indecisive. She was compliant in her relationships with others and constantly worried about being rejected. The diagnosis was mixed personality disorder with histrionic and compulsive features.

The major maladaptive pattern was determined to be as follows: the patient ran from personal conflicts and from issues that were important to her. She did this by accommodating to others and by avoiding what was of importance to herself. Elements of this pattern could be seen in her difficulty sharing her emotions with others and in her seeking secrecy rather than openness. Underlying the pattern was a belief that others would disappoint and abandon her.

In the course of the evaluation, the therapist presented the patient with the following intervention: "You put things off socially and workwise. What is that all about?" The patient responded to this intervention with statements about feeling unsure of herself and her abilities, relating this to her basic insecurity. The therapist, to get the patient to be more specific, added, "Do you often feel you won't measure up?" The patient replied, "In social relationships I always get a vague feeling in the back somewhere, ever since I was a little girl." The therapist, having seen the patient's feelings of insecurity in interpersonal relationships in the present and past, asked, "How do you

feel about showing *me* your feelings of insecurity?" The patient agreed that it might be difficult. She continued talking about her reactions in many different relationships during her past. She. then stopped and expressed the fear that she might be confusing the therapist. The therapist replied: "You seem to be so worried about confusing me and my getting confused. Are you afraid that I, like the others in your life, will give up on you?" The patient responded affirmatively and the therapist then broadened the issue: "Do you often worry about others more than yourself?" At this point tears began to flow, the patient nodding in assent.

The therapist's repeated references to the transference throughout the evaluation interview enabled the patient to examine her relationship with the therapist from the beginning of their encounter, helping to clarify the pattern and showing the patient that the pattern was operative in all her relationships. Another example of this can be seen in an exchange at the end of the first evaluation session, after the time had been set for the next meeting.

Patient: Do you like your work?

Therapist: What do you mean?

Patient: Just a simple question.

Therapist: What does it mean to you?

Patient: I'm thinking . . . can you handle it. . . . Maybe I'm afraid I can't handle it.

Therapist: Will I be able to measure up . . . to look at what has to be looked at? Or will I fail you, abandon you?

Patient: I have felt abandoned at certain times.

Therapist: Like during the crisis with your ex-boyfriend and often during your childhood.

Patient: I have felt abandoned and totally on my own.

Toward the end of the evaluation the therapist presented the pattern to the patient. "I've observed that you have a tendency to move away from things and push them aside. You don't think through things yourself. The other thing is your strong sense of secrecy. It works here today and in your life. We have to understand this more fully."

The maladaptive pattern was agreed upon and the therapy begun. There were further interchanges on the themes of the patient's avoiding conflict and accommodating to others, but the underlying fantasy remained elusive at the beginning.

In the second therapy session the patient talked about her relationship with her ex-boyfriend. She made the point that when he would speak to her in a nasty way she would get a pain in her chest rather than be direct with him. The therapist then pointed out how the patient had difficulty being direct

with her, giving examples of her boyfriend's nastiness, instead of speaking of her own complaints about the therapist. At this point the patient complained of experiencing the pain in her chest. The therapist asked her feelings about the pain.

> Patient: Like I want to grasp for air, like it's very belittling, cutting, cutting down.
>
> Therapist: (*Trying to relate the pain to the transference*) Where do you think the belittling is coming from right now?
>
> Patient: From the memory of that time I spent with him and the way it made me feel at that time (*avoiding the immediacy of the transference*).
>
> Therapist: Therefore you have difficulty remembering something for that reason . . . is that what you're implying?
>
> Patient: Yeah, like I haven't thought about it for a while. I finally have managed to put it out of my mind instead of being obsessed with the whole thing . . . so the sharp edges of the whole experience are gone. Things are blurred. The whole thing was a break in my life. . . . It has something to do with my parents.

The therapist used this opportunity to link the anxiety with the defenses, showing the patient how they were operative in the relationship with the therapist and with her ex-boyfriend and how their origins had something to do with her parents. The therapist did this by using a reference to what was going on, saying: "Yet when I ask the question you can't answer, you get a pain and can't talk, like in the past."

The therapist continued to confront the patient with her reluctance to talk about matters of importance to her. The patient then started talking about her relationship with her parents and the deprivation she experienced with them. They did not provide her with an environment to come home to. They did not encourage her to go out into the world. The therapist then asked for a specific memory of when her parents could have given her more help:

> Patient: I remember a very, very old memory when I was little, before I was in school. I had a great desire to write. I would scribble things and ask my mother to tell me what it meant. She would just tell me it was nonsense, "You are too little to be able to write." She would completely do away with it. That's the earliest. Later, when I wanted to do things . . . when I was eight or nine I was dying to take ballet lessons, and my mother told me I had no talent and she didn't want to waste money on it. That was something I really wanted. She had no confidence in me, and I was cut off.

The patient went on to talk about her sadness. The therapist's only intervention was to point out her need to avoid feelings, especially sadness. The patient went on talking about her lack of confidence. She stated that she avoided sadness because she had to leave the session to go to work: "Outside, right after the session. I have to go to work. I don't want to have that vulnerable feeling there. It's a predatory environment and people just jump on you. I won't be able to defend myself." The therapist again pointed out her avoidance of feelings. The patient went on, "When I was growing up I would have the feeling, I never acknowledged it, but I always wished my mother would die, but then I felt guilty. They decided what was good for me. They

were powerful. . . but they can't help the way they are. But they paralyzed me. I was furious. Can I express my rage at them for not making me a free person?" The therapist answered that the patient had the opportunity to work on these conflicts in treatment, and then added, "But you feel I also won't provide the right environment here so that you could go out into the world . . . just like your mother." The patient stated, "It's a problem of trust and confidence. I can tell you I trust you, but. . ." The therapist then compared trusting her with trusting her mother and that her mother was not there for her, so she now held back with the therapist and with the world. The fantasy and belief systems were beginning to be unearthed, the pattern was clearer to the patient, and she was starting to work with the material. The emphasis of the treatment was the examination of the pattern and its operation in the transference, in the here and now, and its origins in the past.

The therapy continued and more details of the pattern were understood. At about the middle of the treatment, session 19, problems with the patient's reluctance to change came to the fore:

> Therapist: What did you want to say when you said, "How can I . . . ?" You didn't finish the sentence.
>
> Patient: What can I do to make the switch in my old brain, that part that is holding me back.
>
> Therapist: When you ask that, I feel you're asking me and I should be able to give you an answer.

Patient: For this and that and that and that. (*Laughing*)

Therapist: A couple of minutes ago you said you were waiting for a miracle. Waiting for, is the important point. You waited for your mother to get you out into life, but she said life is hard and she retreated. You did the same thing, and you sit and wait for someone to come, a guy, the authority you talked about last week, something here . . . me to take you somewhere and yet we know you're not of the age where any of us could take you anywhere. I can't speak to where you can go, but I can speak to what stops you from moving. You look to me and you look to other people.

Patient: I know that, I look to other people. I know that. I know what's wrong and what I should be doing. Yet I feel so totally powerless to change myself . . . to jump into the behavior more appropriate to the situation.

Therapist: What do you mean, you feel powerless?

Patient: I feel. . . very . . . I feel I don't have the strength and the energy. I feel very old.

Therapist: Not young? I expect you feel very young.

Patient: No. I feel very old.

Therapist: That's how you describe your mother . . . too old and tired, not having any spunk.

Patient: I feel that same way. It's funny . . . that's the weird thing. . . . I always thought I didn't want to be like my mother because I really don't like her and . . . I know I'm not like her but it's like part of me is like her.

Therapist: Staying like her is a way of hanging on to her. Hang on to that and you stay little—powerless, depressed, and defeated.

Patient: Well, I just want to know what I have to do to get rid of that situation.

> Therapist: You are looking for me to be your mother; I can't. You say, "My mother was old and tired," so you want me to take over. You wait for a miracle instead of changing what's inside of you.

The patient went on to talk about feeling sorry for her mother and other old ladies. She talked of her mother's unfulfilled life with a great deal of affect.

The therapist in this interchange confronted the patient with her fear of change and her feeling that change had to do with trying to eliminate her identification with her mother, who was old and tired. This was tantamount to killing her mother, and the patient had not been able to do that. Later in the therapy, the therapist was able to show the patient how in all important relationships she had played the part the other had chosen for her, rather than participate actively in the relationship.

The remainder of the therapy dealt more and more with the patient's taking responsibility for her life and starting to make commitments. Once the patient was able to show her feelings, she was able to form a close relationship with the therapist. The therapist was able to use the transference to help the patient understand, both cognitively and affectively, how she had been dependent on the outside world for her self-esteem and how she had kept to herself, as the patient put it, "in a cocoon, waiting for the right person to break it open and commit myself to life." Whether the instrument of this hatching was insight, a corrective emotional experience, or an identification with a new object cannot be stated with any certainty. We feel that insight

into the operations of the pattern and its origins contributed to a favorable outcome that was still present at follow-up four years later.

THE TRAINING OF THERAPISTS

We have trained psychiatrists, psychologists, and social workers who expressed an interested in learning the technique. For our research program we trained clinicians with an average of thirteen years' experience, but we have also trained psychiatry residents and psychology interns.

Our program consists of attending a weekly one-and-a-half-hour seminar where different videotaped sessions are reviewed and discussed. Each trainee receives one hour of individual supervision for each therapy session on his or her first two cases. We find that with the current training program, it generally takes one to two years for a person to become proficient in the technique.

COMPARISON WITH OTHER BRIEF DYNAMIC THERAPIES

BAP appears to be similar to Time-Limited Dynamic Psychotherapy as formulated by Hans Strupp and Jeffrey Binder (1984), although the two therapies were developed independently. Though both therapies make extensive use of the transference, BAP appears to make more transference linkages to both past and current relationships. A comparison of BAP with

Habib Davanloo's (1980) Short-Term Dynamic Psychotherapy reveals an equal emphasis on the transference. However, in general the Davanloo approach is a more active and confrontational therapy than is BAP, although both these forms of brief psychotherapy are quite active and confrontational relative to standard therapeutic techniques. BAP is a more cognitive therapy and uses the interpretation of resistance as it relates to the major maladaptive pattern, while Davanloo's approach focuses on confronting defensive behavior and eliciting affect.

BAP resembles Peter Sifneos's (1979) Short-Term Anxiety-Provoking Psychotherapy in being somewhat cognitively based. Sifneos handles the transference differently, quickly intervening so as to avoid the transferential resistances. He avoids the dependent transference, but thereby must leave untouched the longstanding characterological difficulties that BAP was designed to work with. Sifneos puts less emphasis on the patient's understanding of defensive operations than does BAP. In addition, Sifneos's focus is primarily an oedipal one; BAP is not limited to such a focus.

Most brief dynamic psychotherapies are of shorter duration than BAP. We believe that it is important for our therapy to be longer than the usual twenty sessions. Our patients all suffer from personality disorders and require a longer course of treatment to alter longstanding characterological patterns.

EMPIRICAL SUPPORT

The efficacy of BAP has been examined in a pilot study comparing a group treated with BAP with a waiting list control group (Pollack, Winston, McCullough, Flegenheimer, & Winston, 1990). Fifteen patients with long-standing personality disorders primarily of the *DSM III-R* Cluster C (avoidant, dependent, obsessive-compulsive, passive-aggressive, and mixed personality disorder) and histrionic disorder were compared with sixteen control patients. Significant differences at termination of therapy were found between the BAP and control group on two of three target complaints, the SCL-90, and the Social Adjustment Scale (see table 1). In addition, the BAP patients improved further on two of three target complaints from termination to follow-up at one to five years (mean follow-up time was 2.6 years) (see table 2).

TABLE 1

Analysis of Covariance for Global Outcome Measures between BAP and Control Group

	BAP N = 15 (39 weeks)	Control N = 16 (20 weeks)	Analysis of Covariance
Target Complaint One			
Admission mean	10.60	11.44	F = 26.60

Termination mean*	6.40	10.88	P = .000
Target Complaint Two			
Admission mean	9.80	10.88	F = 8.02
Termination mean*	6.80	10.25	P = .008
Target Complaint Three (N = 14)			
Admission mean	8.71	10.88	F = 3.10
Termination mean*	6.71	9.81	P = .09
SCL-90 Global Scale			
Admission mean	44.55	47.37	F = 13.29
Termination mean*	36.27	44.06	P = .001
Social Adjustment Scale			
Admission mean	2.06	2.15	F = 8.64
Termination mean*	1.74	2.17	P = .007

*Termination measures taken one month after actual termination.

Source: Pollack, J., Winston, A., McCullough, L., Flegenheimer, W., & Winston, B. 1990. Brief adaptational psychotherapy. *Journal of Personality Disorders, 4,* 244-250. Used with permission.

TABLE 2

Matched t-test of Termination Versus Follow-up for Target Complaints

	t-test (n)	Analysis of Covariance
Target Complaint One		
Termination means	6.40 (15)	F = 3.11
Follow-up means	4.86 (14)	P = .10
Target Complaint Two		
Termination means	6.80 (15)	F = 9.54
Follow-up means	3.71 (14)	P = .009
Target Complaint Three		
Termination means	6.71 (14)	F = 7.06
Follow-up means	5.00 (13)	P = .02

Note: Termination measures taken one month after termination; follow-up measures taken one to five years after termination (mean = 2.6 years).

Source: Pollack, J., Winston, A., McCullough, L., Flegenheimer, W., & Winston, B. 1990. Brief adaptational psychotherapy. *Journal of Personality Disorders, 4,* 244-250. Used with permission.

In another study (Winston et al., 1991) BAP was compared with Intensive Short-Term Dynamic Psychotherapy (ISTDP), based on the work of Davanloo (1980) (see table 3). BAP and ISTDP patients showed significant improvement on target complaints, SCL-90, and the Social Adjustment Scale compared with waiting list control subjects. Effect sizes for BAP ranged from .70 to 1.23. The two therapy groups were similar in overall outcome, but showed differences on several subscale measures. BAP patients' outcomes were significantly better on the anxiety and the phobic anxiety subscale of the SCL-90 while ISTDP patients' outcomes were significantly better on the depression subscale. These findings may indicate that a more cognitively based therapy such as BAP lowers anxiety more than ISTDP, which tends to focus more on affect.

TABLE 3

Admission and Termination Means and Effect Sizes for Global Outcomes across Groups

	BAP (N = 17)	ISTDP (N = 15)	Controls (N = 17)	Analysis of Covariance

*Target Complaint 1**				
Admission	10.47	10.08	11.69	F = 12.46
Termination	6.67	5.91	10.25	P = .0001
Effect Size	1.23	1.35	.46	SD = 3.10
*SCL-90 Global Score**				
Admission	44.55	43.77	47.38	F = 4.84
Termination	36.27	36.62	44.06	P = .01
Effect size	1.11	.96	.45	SD = 7.45
*Social Adjustment Scale**				
Admission	2.06	2.13	2.15	F = 6.68
Termination	1.74	1.76	2.18	P = .003
Effect size	.70	.80	–.07	SD = .45

Note: Effect size was computed by subtracting the termination mean (measured one month after actual termination) from the admission mean and dividing by the standard deviation of the

combined control and experimental groups.

*The scores of the two groups given therapy were significantly different at termination from those of the control group ($p < 0.05$, Duncan Multiple Range Test).

Source: Winston, A., Pollack, J., McCullough, L., Flegenheimer, W., Kestenbaum, R., & Trujillo, M. (1991). Brief psychotherapy of personality disorders. *Journal of Nervous and Mental Diseases, 179*, 188-193, © by Williams & Wilkins, 1991. Used with permission.

The results of these studies are encouraging since they indicate that BAP produces significant change in patients with longstanding personality disorders.

We examined a number of therapist and patient process variables using a coding system developed for videotaped psychotherapy sessions (McCullough, Trujillo, & Winston, 1985). BAP therapists are quite active, making approximately one intervention a minute. BAP therapists address current and past relationships an average of 11.5 times a session and the patient-therapist relationship an average of 8.3 times a session. These data indicate an interpersonal focus and active use of the transference; the results are in accord with the design of BAP and may help explain its efficacy.

CONCLUSION

We believe that BAP is an effective form of brief psychotherapy with wide applications. Because it is essentially a modification of standard psychotherapy techniques, BAP is generally well accepted, both by patients

and by therapists wishing to learn brief psychotherapy. We hope that our ongoing research will help in clarifying the essential elements of the technique as well as in identifying those patients for whom BAP will be the treatment of choice.

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