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BRIEF PSYCHOTHERAPY

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Brief Psychotherapy

Of all the psychotherapy that is practiced, most of it belongs under the general rubric of "brief psychotherapy." It is, therefore, of signal importance to define what is encompassed by this term: the scope it covers; the theory on which it is based; the techniques it uses; and, finally, its particular indications, limitations, and results.

The special significance of brief psychotherapy is social as well as medical. Not only is it the most commonly employed psychological modality for the treatment of a host of emotional difficulties, but also—increasingly—it has been seen as a vehicle for making psychotherapeutic help available to broad segments of the population. The great concern that has emerged during the past two decades over the distribution of medical services, both in this country and abroad, has further increased the practical as well as the scientific interest in this form of treatment.

History of Brief Psychotherapy

Brief psychotherapy is not a new discovery. This deserves emphasis, because in the recent climate of great social interest in this form of treatment, it often has been looked upon as a special creation of the last few years. As a matter of fact, all psychotherapy is a relatively new development. If we exclude the ancient world, when psychotherapy was practiced among the

Greeks by priests in the Aesculapian temples and was an integral part of organized religion, we can say that psychotherapy as a secular undertaking did not exist until the end of the eighteenth century, when Mesmer first practiced hypnosis in Paris. But in this form of treatment the physician still acted upon the patient, through injunctions and suggestions, much as in traditional organic therapy. Modem psychotherapy really began in Vienna in the early 1880s. Here, for the first time, the hypnotic state was employed not to "order away" symptoms (as Mesmer and others had done) but to create a special climate in which the patient was listened to. In the now famous case of Anna O. (1955), we find that Josef Breuer, her physician, visited her daily and listened to her recite her symptoms, lie observed that as she recalled, with feeling, the events associated with the onset of her symptoms, these subsided and disappeared. This was the cathartic method, discovered by Breuer (1955) and later developed by Freud into a complex instrument that he called psychoanalysis.

The earliest forms of psychotherapy, therefore, were in fact instances of brief psychotherapy. The longer forms of psychotherapeutic treatment, preeminently psychoanalysis, were developed later. Thus psychoanalysis and brief psychotherapy share their early history (Hunter, 1953; Schmideberg, 1949). For example, in the case of Elizabeth Von R. (Breuer, 1955), Freud demonstrated the therapeutic value of the device of confrontation, which is extensively used in current brief psychotherapy. He pointed out to Miss Von

R. that she was in love with her brother-in-law and that this longing, which she had repressed, was the basis for the leg pains that had begun after a long walk she had taken with him. Dora (Freud, 1953), the patient from whom Freud learned so much about transference, was in treatment only three months. In the case of the Wolf-Man (Freud, 1955), Freud first introduced a time limit. This technical device, which Rank later emphasized in his system of treatment, has become an important part of the armory of brief psychotherapy. Even after becoming established as a psychoanalyst, Freud continued to use brief psychotherapy, when indicated, as in the cases of Gustav Mahler (Jones, 1955), the composer, and Bruno Walter (Sterba, 1951), the conductor.

Later, as psychoanalysis increasingly concerned itself with the resolution of longstanding personality malformations, treatment became more lengthy and required several years rather than just a few months. Concurrently as analytic treatment grew in length, a number of workers, impelled by practical considerations, felt the need to try to shorten treatment. At this point psychoanalysis and brief psychotherapy began to diverge with regard to their aims and methods. Thus, the contributions of some of the early "deviationists" from psychoanalysis (particularly Adler, Stekel, and Rank and later, to some extent, Ferenczi and Homey), with their emphasis on current adaptation and on therapeutic activity, bear directly on brief psychotherapy. In the 1940s Franz Alexander (1946) and his colleagues at the Chicago

Institute for Psychoanalysis made a systematic study of the application of analytic principles to brief treatment. Their now-classic book, *Psychoanalytic Therapy,* is a milestone in the development of this subject. At about the same time, from a nonanalytic viewpoint (although strongly influenced by the work of Otto Rank), Carl Rogers (1951), a clinical psychologist, addressed himself to the role of nondirective techniques in his "client-centered psychotherapy," a form of brief treatment. During the 1950s a considerable effort was made to separate more sharply classical psychoanalysis from all other forms of psychotherapy, and a number of important papers (Gill, 1954; Gitelson, 1942; Rangell, 1954; Stone, 1951) appeared that were aimed at resolving this issue.

Most recently, during the 1960s, there has been a great resurgence of interest in brief psychotherapy. This interest developed not only from a renewed scientific impetus to understand its basic principles, but also from an intensified awareness of its social significance and of its potential for broadened delivery of psychiatric care. Outstanding among recent writings is Malan's A *Study of Brief Psychotherapy* (1963), a detailed and sophisticated clinical and research effort. Wolberg's (1965) *Short-Term Psychotherapy* offers a practical and comprehensive review of the topic. Many other books and papers have appeared as an outcome of this interest. A good number have centered on the application of psychoanalytic concepts to brief psychotherapy (Alexander, 1946; Bellak, 1965; Castelnuovo-Tedesco, 1962; Koegler, 1967; Lewin, 1970; Malan, 1963; Sifneos, 1972, Strupp, 1960), but

significant contributions have also derived from the crisis model (Aguilera, 1970; Bellak, 1965; Caplan, 1964; Caplan, 1965) and that of behavior therapy (Phillips, 1966; Wolpe, 1969; Wolpe, 1966).

What Is Brief Psychotherapy?

The term "brief psychotherapy" attempts to define the process of treatment purely in terms of its overall length, but it is not possible to do justice to its complexities solely in terms of its duration. Actually, brief psychotherapy is often used to refer to one or more of the following somewhat overlapping variables: (1) the *length* of the treatment, from inception to termination; (2) the *frequency* of the therapeutic sessions and the *duration* of each session; (3) the *intensity* of the treatment, which depends on item 2 as well as on the particular techniques employed; and (4) the *goal* of treatment, which is often expressed in terms of polarities, even though, in reality, various blendings of the following alternatives are the common occurrence: "supportive" or "suppressive" as contrasted with "insight-oriented," "expressive," or "exploratory" (Knight, 1952).

In reviewing the literature, one soon discovers that the term "brief psychotherapy" is quite elastic in its meaning. Generally it is used synonymously with "short-term" psychotherapy, whereas the term "crisis therapy" is reserved for the briefest forms of intervention. Gill (1954) has

pointed out, appropriately, that one should recognize not only "brief" and "longterm" psychotherapies but also those of intermediate duration. It is important to emphasize that there is a wide range of time alternatives, and that the dividing line between the various forms is not a sharp one. Most writers in the field consider "brief" any treatment extending from ten to twenty-five sessions and spread out over a period of three to four months, whereas others allow forty or fifty sessions and sometimes more, or permit the span of treatment to range up to six months or even a year if the sessions are sparse and the climate remains non-intensive (Alexander, 1946; Malan, 1963; Pumpian-Mindlin, 1953). Sometimes, when indicated, treatment may be limited to five sessions or less (Alexander, 1946; Castelnuovo-Tedesco, 1962; Jacobson, 1968; Jacobson, 1967; Knight, 1937; Saul, 1951; Socarides, 1954). Treatment then often falls under the general heading of "crisis therapy" (Aguilera, 1970; Bellak, 1965; Caplan, 1964; Caplan, 1970; Caplan, 1965; Sifneos, 1966), especially when the difficulty is associated with a fairly clear-cut external predicament. The reason that brief treatment generally is not allowed to extend beyond the limits just stated is that, otherwise, the focus inevitably broadens beyond the current predicament to include a study of the patient's fundamental and longstanding ways of reacting, i.e., a study of his personality and character.

The frequency of the visits generally is once or twice a week. More frequent and even daily sessions may be needed occasionally, if the patient is

at first highly distressed and symptomatic or if he has difficulty maintaining adequate continuity. However, as soon as he becomes more comfortable, the frequency of visits would be decreased to once or at most twice per week. The reason why great frequency of visits is to be avoided is that (as will be discussed in more detail later) it intensifies the transference, an occurrence that is not considered desirable in brief psychotherapy.

The duration of each visit generally is the standard fifty-minute hour, but shorter treatment periods also have been tried and are satisfactory under certain circumstances (Castelnuovo-Tedesco 1962; Castelnuovo-Tedesco, 1965, Mandell, 1961). An example of a briefer time period is the *Twenty-Minute Hour* (Castelnuovo-Tedesco 1962; Castelnuovo-Tedesco, 1965), which was introduced as a model for supportive work by the general physician. Optimally, the length of the psychotherapeutic session should be geared to the goals and the methods of the treatment. Periods of fifty minutes are desirable when the treatment is insight-oriented and aimed at the interpretive analysis and working through of conflicts. Shorter periods usually are adequate when the treatment is primarily supportive and based mainly on catharsis, clarification, and simple reassurance. However, psychiatrists are inclined to arrange their schedules in forty-five to fifty minute units and tend to adhere to this format even in situations where shorter visits would accomplish the purpose just as well. By the same token, the ability of patients to work in treatment varies considerably. Some are able

to function in an insight-oriented way and achieve considerable self-understanding, even in the context of short time periods.

To return to matters mentioned earlier: brief psychotherapy may or may not be intensive, may be primarily supportive or insight-oriented, may stay on the surface, or may, in some cases, deal with surprisingly "deep" issues. This varies not only with the characteristics of patients whose needs and capacities differ considerably, but also with the characteristics of therapists, whose skill and clinical boldness similarly cover a wide range. These variables all contribute to defining the nature of the process and the final result.

Fundamental Issues of Brief Psychotherapy

Although brief psychotherapy cannot be defined solely in terms of its duration, time, nonetheless, has a distinct influence on the treatment. Of necessity, the brevity of the treatment affects its scope, helps to select its goals and methods, and serves to establish its priorities.

Inevitably, the emphasis is practical and pragmatic and centers on taking care of first things first. The treatment, therefore, is anchored in the present, and its main thrust is to relieve the patient's suffering—in particular, his most pressing symptoms—as promptly and expeditiously as possible. It tends to be predominantly symptom- and/or situation-oriented (Pumpian-

Mindlin, 1953), and it makes no attempt to modify or reorganize the patient's basic personality or to disturb well-established defensive patterns. Sometimes treatment goes well beyond symptomatic relief: under certain circumstances (depending on the presenting symptoms, the vigor and effectiveness of the patient's personality, the favorableness of his social circumstances, and the skill of the therapist), modification of some sectors of the personality can take place. When this occurs, however, it is an unexpected plus rather than something specifically anticipated or deliberately planned. The principal task of brief psychotherapy is to bring about symptomatic relief and/or the resolution of a situational predicament. When character change is specifically looked for, the therapist should consider one of the longer and more intensive forms of treatment.

Brief treatment is indicated especially where the patient's distress is not so much the expression of a long-standing neurotic struggle as of particular circumstances that have impaired his endurance and rekindled an internal conflict that was previously dormant or at least adequately managed. The goal of the treatment is not so much to bring about a new level of organization, i.e., to "change" the patient—as to restore the one that existed before his acute difficulties began. It is fundamentally restitutive in its intent (Knight, 1937). Nonetheless, from the recent literature on crisis invention comes the reminder that a crisis regularly presents the individual not only with an inescapable demand or burden but also with a new opportunity. As

Caplan (1965) says, "During this period of tension, the person grapples with the problem and develops novel resources, both by calling upon internal reserves and by making use of the help of others."

Again, although there are important differences between what various patients accomplish during brief treatment, time ultimately defines the limits for the working through of conflicts and the boundaries of the treatment process—in sum, it defines just how far one can go. Much of the working through, in fact, is left for the patient to accomplish on his own after treatment has stopped, whereas in longterm psychotherapy (and particularly in psychoanalysis) termination is deemed possible only after substantial working through has been achieved.

Another fundamental characteristic of brief psychotherapy is that the focus is on the present but also on interpersonal issues (Pumpian-Mindlin, 19653; Semrad, 1966; Sifneos, 1972), i.e., on key relationships that the patient is not negotiating to advantage at that particular time, so that the relationships have become a source of difficulty. The interpersonal focus is readily understandable to the patient because that, typically, is where he feels his distress and centers his complaints. It is also consistent with the therapist's plan to avoid restructuring the patient's personality and to confine his efforts to a sector that is manageable in the limited time available.

Finally, there is the matter of the therapist's attitude toward brief psychotherapy. To be effective, he must be able to free himself of therapeutic over-ambition (Fuerst, 1938) and to regard this modality as the best treatment for some cases rather than as the second best. Often enough, as Coleman (1949) observes, "the patient contents himself readily with limited treatment objectives when the therapist can allow him to do so."

Techniques of Brief Psychotherapy

Every psychotherapeutic modality inevitably develops a range of techniques designed more or less consciously to serve its ends. In the case of brief psychotherapy, there is fairly general agreement that considerable flexibility is a prime requisite for this type of treatment. For many therapists, indeed, it has been part of the appeal of brief psychotherapy that it permits and even encourages versatility and individuality of style and gives the therapist the opportunity to take a very active part in the treatment process. Semrad (1966) observes, "Styles vary so much that sometimes they may almost appear to be different techniques." However, while there is a wide variety of approach, so that one cannot speak of a "standard technique" (as in the case of psychoanalysis), over the years a number of principles have nonetheless accrued to its practice, to which most writers on the subject appear to subscribe.

The Strategies of Brief Psychotherapy

The principal goal of brief treatment is to achieve maximal effectiveness in the context of brevity and economy of time. Time, within limits, decides what is feasible and what is not. Several fundamental and interrelated processes are involved.

1. Emphasis is deliberately on the present and on the interactions that are shaping it, because these are the most fluid and readily accessible. Attention is focused on the patient's major current conflict(s) and the main object relationship(s) involved in the current upset. Although the contributions of the past are not totally neglected, the focus primarily is on the present ("What ails him now?") rather than on the past ("How did he become what he is?") or the future ("Where is he going?" and, "Is his life fulfilling its basic goals?").

2. Transference reactions (the tendency of the patient to re-experience feelings and attitudes toward the therapist that were once part of the patient's relationship to the key figures of his childhood, such as parents, siblings, and so forth) are discouraged. In particular, a full transference neurosis is not considered desirable and does not develop, in part because time is insufficient and in part because of specific steps taken to prevent it. These include avoidance of fantasy material, emphasis on reality and the 'here and now,' and, at times, the deflection of particular feelings toward the

therapist onto an important current figure (Pumpian-Mindlin, 1953). The regressive state, which is part and parcel of a full-fledged transference, not only does not serve the aim of promoting a rapid re-compensation but is actually detrimental to it.

Despite the therapist's efforts to discourage the development of transference reactions, they do, of course, occur. They are then recognized and dealt with, especially if they are negative but fairly superficial (as, for example, expressions of doubt, disappointment, and mild resentment). On the other hand, negative responses that appear related to deep-seated paranoid and depressive anxieties usually are left untouched, for fear of stirring up issues that cannot be settled in the time available. Also untouched and deliberately unresolved are the positive transference reactions, i.e., feelings of special liking—inasmuch as these support the goals of treatment and promote an atmosphere in which the patient is especially responsive to the therapist's influence. Some authors (Gutheil, 1944; Lewin, 1970; Malan, 1963), in particular, stress that they work quite actively with the transference. They regard it as a critical therapeutic factor in brief psychotherapy nearly as much as in the longer forms of treatment, to be exploited to the fullest within the time available rather than bypassed.

3. During treatment the patient typically demonstrates a range of defenses, i.e., characteristic responses, that serve to contain various anxieties,

both deep and superficial. The therapist addresses himself mainly to the more superficial ones, which are readily accessible and closely related to the current material. On the other hand, defenses of long standing, especially those frozen into the character, cannot be usefully approached and should be circumvented. Brief psychotherapy and character analysis are a different order of business, not to be confused with one another.

The Tactics of Brief Psychotherapy

It is proverbial that all is fair in love and war, and—one might also add—in brief psychotherapy. Typically, brief psychotherapy has been recognized as an unabashedly expedient affair. Thus every device has been used that might help achieve the desired results quickly (Schmideberg, 1949; Wolberg, 1965). The tendency generally has been to regard the situation in brief treatment as highly idiosyncratic and as favoring (at times even requiring) boldness, enthusiasm, and an individualistic style. In fact, enough instances have been recorded in the literature to establish the appeal of an approach that encourages decisive and dramatic interventions. Here, perhaps, the all-time classic story is the one about the late N. Lionel Blitzsten (Orr, 1961) who, quickly guessing the meaning of a singer's acute aphonia, thrust a wiener at her mouth and made her scream, thus freeing her voice and enabling her to proceed with the next performance. Stekel's (1950) writings also contain a number of examples that attest to the value, in particular instances, of a

dramatic brief interaction.

Other authors (Castelnuovo-Tedesco, 1962; Gill, 1954), on the other hand, have pointed out that the flair for the dramatic and, more generally, the usefulness of manipulative interventions have perhaps been overemphasized, and that there is also much room in brief psychotherapy for quiet and detailed interpretive work. This is especially true in situations that do not require the resolution of an acute crisis. Thus, Gill (1954) says, "I believe we have failed to carry over into our psychotherapy enough of the non-directive spirit of our analyses. I do not refer to the emergency situations where active interventions seem unavoidable and where the essential goal is supportive but to the less urgent problems seen over longer periods of time with more ambitious goals."

Now let us look more closely at the technical aspects of brief psychotherapy and the way in which the element of time influences the initial evaluation and onset of treatment as well as goal setting and termination.

Initial evaluation and onset of treatment are less sharply differentiated from one another than in the longer forms of psychotherapy (Malan, 1963; Pumpian-Mindlin, 1953; Semrad, 1966). Brief therapy truly begins right off, with the first contact; history-taking is generally more limited and tends to confine itself predominantly to the current predicament. Although the

therapist will seek some general background information to help place the presenting complaint in an understandable historical context, he will not pursue anamnestic material in great detail, especially that which pertains to childhood development. History-taking, like treatment itself, remains centered largely on the present. This is made possible, in part, by the fact that the typical candidate for brief psychotherapy generally presents himself as having a specific "problem" clearly in the present and quite directly interpersonal in nature. Moreover, the therapist from the very beginning helps to circumscribe the task by coming to grips interpretively with the material the patient brings him (Schmideberg, 1966). This kind of participation begins right away, during the first hour. An initial "wait-and-see" attitude is not consonant with the pace and the goals of this form of therapy. The experienced therapist generally has an immediate intuitive conviction, based on a very early perception of "movement" on the part of the patient, that the case is "right" for brief treatment. If he does not quickly achieve this spontaneous conviction, it usually means that the case is not suitable for brief treatment and that the patient is likely to require more time. The patient's responsiveness to the therapist's first interventions will confirm the correctness of the initial impression (Pumpian-Mindlin, 1953). Relevant here, of course, is Semrad's (1966) dictum that "one must really understand the patient before he will believe that he is understood." Another positive prognostic clue is whether the patient initially presents his difficulty as an

interpersonal problem rather than, primarily, as a concern over symptoms (Pumpian-Mindlin, 1953).

Even when the therapist does not announce a specific time limit, he conveys that the treatment will be brief by addressing himself to a circumscribed problem that is generally the particular interpersonal predicament that the patient has brought in. Thus from the very beginning, and quite spontaneously, brief treatment is likely to assume a tone of "problem solving" (Pumpian-Mindlin, 1953; Semrad, 1966) that is absent in cases where the difficulty is more diffuse, more centered in the personality's inner workings, and likely to require more time. A specific time limit may be employed in some cases where the presenting problem is highly circumscribed and where the patient is strongly motivated to find a resolution to that problem, yet is unlikely to wish to involve himself in a more far-reaching exploration. The time limit tends, then, to stimulate the patient's motivation and helps him make the most of the time available. An unconscious resistance to entering into a more binding treatment relationship is bypassed when the patient is, in effect, reassured that treatment will last just so long and no longer.

The time limit is employed primarily in situations where the treatment can be expected to be quite short (five to ten sessions). Once a specific time limit has been announced, one adheres to it, and both patient and doctor use

it as a goal to work toward. This also means that termination of treatment can be considered as soon as the presenting problem has been favorably modified to some extent. Frequently one does not wait for its resolution but will be satisfied if the patient, in response to its clarification, appears to be working in the right direction and is showing increasing mastery of the initially troublesome situation. Malan (1963) emphasizes the importance of the patient experiencing some grief over termination. This is clear proof that the treatment has touched him in a significant way.

As mentioned earlier, the technical devices used in practice (and advocated in the literature) as applicable to brief psychotherapy, cover the widest range (Strupp, 1960; Wolberg, 1965). To be more specific, one might list the following:

1. Rapidly establishing (and then maintaining) a warmly positive relationship (Schmideberg, 1949). A number of devices are known to affect the quality of the relationship, for example, a time limit, the frequency and duration of sessions, the "role" adopted by the therapist, his degree of activity, and focusing on the healthy aspects of the patient (Bandler, 1959; Pumpian-Mindlin, 1953) and on the positive features of his current reality while bypassing old issues left over from the past. In short, the time-honored Meyerian principle of emphasizing assets and deemphasizing liabilities has an important place here.

2. Ventilation and emotional catharsis. It is generally recognized that much of the benefit that the patient obtains in psychotherapy (especially the brief forms) derives from the opportunity to unburden himself of painful emotions (mainly over situations that have evoked resentment, guilt, or shame) in a setting of benevolent acceptance.

3. Reassurance, suggestion, and (occasionally) hypnosis (Rothenberg, 1955; Wolberg, 1965). These represent a spectrum of devices that use the therapist's "authority" to allay the patient's anxiety and persuade him. According to Ferenczi (as quoted by Oberndorf, 1946), suggestion "consists of influence on a person through and by means of the transference manifestations of which he is capable." Thus the effectiveness of these approaches is limited by the patient's need and willingness (at any given time) to be persuaded, reassured, and so forth.

4. Exhortation, counseling, advice, and environmental manipulation. All these devices have a place in helping the patient cope more effectively with his external reality.

5. Explanations and pedagogic remarks. These devices also promote greater mastery, by informing the patient where he is handicapped by misinformation. They help to "spell out" the nature of the difficulty and the aspects of it that he should try to accept or modify.

6. Drugs. Sedative, tranquilizing, and antidepressant drugs have a place in controlling and altering distressing emotions that impair the patient's effectiveness. Their role is that of auxiliary aids to psychotherapy. Their use is described in detail elsewhere in this *Handbook.* It will suffice to say that drugs are of value particularly in helping to control the more acute and emergent manifestations of distress.

7. Desensitization by counter-conditioning techniques (Phillips, 1966; Wolpe, 1969; Wolpe, 1966). These techniques can prove helpful especially for phobias and other focal anxiety responses. It is an axiom of behavior therapy that symptomatic behavior is not the outcome of emotional conflict but the result of conditioning which, in turn, makes it amenable to treatment by deconditioning techniques. The symptom is seen as a circumscribed phenomenon, essentially unrelated to the patient's character structure. Therefore, the treatment that is applied can be quite brief. During the past fifteen years a considerable literature has developed in this area. The reader is referred to it for a more detailed account of its contribution.

8. Interpretive techniques (Alexander, 1946; Gutheil, 1944; Malan, 1963; Pumpian-Mindlin, 1953; Rothenberg, 1955; Sifneos, 1972). These techniques originally derived from psychoanalysis, are the standard armory of what is generally referred to as "dynamically oriented psychotherapy." They include clarifications (of feelings, thoughts, and attitudes),

confrontations, and interpretations proper. Clarifications summarize and sharpen the meaning of what the patient has just said without, however, going beyond the largely conscious aspects of the particular material. Interpretations, instead, try to capture meanings beyond the patient's immediate awareness and beyond the material that he has just discussed. Confrontations serve to remind the patient of some aspect of reality that he appears to be neglecting at the moment.

Interpretations tend to be used somewhat differently in short-term than in long-term treatment. They are ". . . couched in more general terms . . . not related . . . necessarily [to] specific historical conflicts and difficulties in the patient" (Pumpian-Mindlin, 1953). Their goal often is to bring material into harmony with the ego, as for example when "interpreting to the patient the underlying motivation for an act or thought which has hitherto appeared to him senseless" (Pumpian-Mindlin, 1953). Moreover, interpretations are addressed primarily to preconscious rather than to unconscious material and are stated mainly in terms of object relations rather than of drives and impulses (Pumpian-Mindlin, 1953).

9. Dream Analysis. This is not one of the usual tools of brief psychotherapy, both because emphasis is placed chiefly on reality and because many therapists are not trained in the techniques of dream analysis. However, in the hands of the skilled therapist, a dream occasionally may

prove a very useful starting point for the analysis of a crucial current conflict (Gutheil, 1944).

The factors that influence the choice of techniques include the preference of the individual therapist and his level of training, as well as the requirements of the particular case. Some brief psychotherapy can be carried out by relatively untrained therapists who depend on simple methods and a rudimentary theoretical orientation, since time is short and it is possible to stay close to the surface. Thus, one purpose of the *Twenty-Minute Hour* (Castelnuovo-Tedesco, 1962; Castelnuovo-Tedesco, 1965) was to offer a simple technique that could be managed safely and effectively by the occasional psychotherapist. On the other hand, situations do often arise in brief treatment that are unexpectedly complex and demanding of skills, and this makes the task variable and highly uneven. The two basic mainstays for much of the brief psychotherapy that is carried out are a positive relationship and adequate catharsis. Many therapists add (in varying proportions) such manipulative devices as suggestion, exhortation, advice, environmental manipulation, drug-giving, and, occasionally, desensitization. Still others—especially those who are analytically trained—rely on interpretive techniques that can be used, with appropriate modifications, as in the more intensive forms of long-term treatment. Such therapists emphasize insight and self-understanding and try to go as far in this direction as time and the opportunity for working through of conflicts will allow. The outcome

depends, among other things, on the accessibility of the conflict, on the patient's ability to work collaboratively with the therapist and identify with the latter's efforts, and on the time available for working through.

An important question for the therapist is whether to use predominantly interpretive or predominantly manipulative techniques. Over the years, brief psychotherapy has acquired a reputation as a form of treatment where, in the interest of economy and expediency, manipulative techniques naturally reign supreme. On the other hand, a number of analytic therapists (Castelnuovo-Tedesco, 1970; Gill, 1954) have pointed out that one should distinguish the extent to which manipulative devices may actually be needed at a given time to stabilize an otherwise uncertain treatment situation, from the extent to which they mainly represent the therapist's predilection. Waelder (1940) has summarized the issue quite simply: "The therapeutic method of making conscious unconscious material . . . is most effective in cases where the ego is really mature. The less the ego has grown to the maturity it might be expected to attain, the more deficient the ego system is, the more it will be necessary to try to influence the ego . . . [by applying] a certain amount of direct *educational* influence."

Indications and Limitations of Brief Psychotherapy

When we try to state the "indications" of brief psychotherapy, we are in

effect attempting to define its scope. It soon becomes apparent, even if it is not apparent already, that its boundaries are fluid and variable rather than subject to sharp definition, and that the decision as to the appropriateness of brief psychotherapy in any given case rests on a whole range of factors that we will try to canvass step by step.

Right at the start it should be made clear that brief psychotherapy has much to offer a variety of patients and that, for some, it is specifically the treatment of choice. At the same time it should also be underlined that it is not suitable for all patients and all conditions, and that there are some for whom it is distinctly unsuitable. Moreover, decisions about the appropriateness of brief psychotherapy often cannot be made on clinical grounds alone, i.e., on the specific features of the patient's disturbance. Extraneous factors inevitably play a role as well. In private practice the patient's finances must be considered, as must be in public clinics the wish to spread the therapist's limited time among many patients. Finally, there is the therapist's personal preference, which definitely tips the scales for one or another mode of treatment. Some therapists tend to steer patients toward intensive long-term treatment because that is their *métier,* while others are inclined to make short shrift of every problem. Thus some patients may be "undertreated" while others are "over treated." Ultimately one would agree with Gillman (1965) that "Selection [for brief psychotherapy] must not be based merely on the absence of some criterion for psychoanalysis, or because

a particular therapist needs to feel the power of directive therapy and quick cure, or because the predilection is for more limited goals rather than getting to the bottom of things."

The question of the indications for brief psychotherapy is a complicated one, because it cannot be divorced from the issue of treatment goals or from the therapist's orientation toward these goals. In speaking of the indications for brief psychotherapy, we are referring to those conditions and situations where this mode of treatment can be expected to provide reasonably stable and predictably positive results. It seems preferable to speak here of the limitations rather than of the contraindications to brief psychotherapy. One cannot define contraindications that are absolute; rather, one describes a number of emotional states where success by these methods is increasingly less likely. On the other hand, the range of indications can be broadened considerably beyond what will be discussed below. In practice, a wide spectrum of patients are treated with brief psychotherapy, including many patients that would be declared unsuitable by more stringent criteria. Therefore it would be unrealistic and arbitrary to attempt a list of "treatable" and "untreatable" conditions. Instead we will consider the principles that determine how accessible patients are to brief treatment and that form the basis for the clinical decisions that are made in each case.

In keeping with what has been said above—namely, that standards and

criteria for case selection vary among different therapists and that sharp categorizations are not possible—we will first try to account for the group of patients who are most likely to profit from brief psychotherapy, later adding in those with whom results tend to be more doubtful. We are dealing with relative indications or, put otherwise, with a gradient of probabilities.

Suitability of Patients

Brief psychotherapy probably is best limited to patients of reasonably mature personality and adequate motivation whose emotional disturbance is focal, acute (rather than chronic), of less than extreme intensity, and associated with fairly apparent situational factors.

It seems desirable to break down this definition into its component parts, so as to be able to expand on each clause. (1) What is meant by "patients of reasonably mature personality" is that such patients, although troubled, show at least fair ego strength and are not involved in a major regression. (2) "Adequate motivation" is important because brief treatment is successful only when the patient is well motivated to resolve his difficulties (Malan, 1963)9. Inadequate motivation may exist when the presenting problem is trivial or too overwhelming or when particular transference attitudes (see below) hinder the development of a therapeutic alliance. (3) Our description of the emotional disturbance as "focal, acute, of less than

extreme intensity, and associated with fairly apparent situational factors" means that the difficulty is circumscribed and affects a segment rather than most of the ego's functions. Moreover, it is of relatively recent onset and, although painfully severe in some instances, is not of such extreme intensity as to have overwhelmed the patient's adaptive capacities. Finally, the struggle is not primarily limited to the intrapsychic domain but has instead been externalized and tied to a specific and identifiable external situation. In other words, when the patient comes for treatment he has already chosen some key person in his environment (often a spouse, a boss or a coworker) to serve as the "transference"[1] object onto whom he tries to displace some aspects of his infantile struggles (Castelnuovo-Tedesco, 1962). In these cases, not only is the neurotic conflict already full-blown, but a "transference" has developed and is being elaborated toward a key figure in the person's current environment. Thus, typically, the patient complains that he is in a quandary and seeks professional help to try to resolve it. The doctor, then, provides this help by interpreting the patient's conflict in the context of the displacement that the patient has created. This situation differs from the typical one in intensive analytic psychotherapy (and particularly psychoanalysis) where the transference develops gradually as the treatment unfolds and is kept centered on the person of the therapist as much as possible. Not infrequently the patient in analysis also tries to "externalize" the problem through acting-out, while the analyst, by consistent interpretation, seeks to bring the focus back

onto the doctor-patient relationship.

The suitability of patients for brief psychotherapy can be considered further in terms of the following factors:

Ego Strength

It is desirable that the patient's ego still be reasonably competent and, in particular, that there be no serious impairment of its synthetic, integrative, and adaptive capacities. The most direct evidence for this is to be found in the patient's continued capacity to function in his accustomed social role (Castelnuovo-Tedesco, 1962) and to sustain meaningful relations with people (Pumpian-Mindlin, 1953). Although when first seen the patient may be under considerable stress, as evidenced by anxiety, depression, and other symptomatic manifestations, he still retains good adaptive resilience and is not in the throes of a major and incapacitating decompensation. In the typical case, according to Pumpian-Mindlin (1953), ego functions might be described as "crystallized" rather than as "amorphous," at one extreme, or "calcified," at the other. We have already indicated that brief psychotherapy depends for its effectiveness on the patient's capacity to ally himself with the therapist, to marshal his own adaptive resources, and to bring them quickly to bear upon the presenting problem. Therefore, the more serious the patient's regression and the greater the impairment of his adaptive capacities, the less is the

likelihood that he will be able to profit from brief psychotherapy.

In this category of persons who are not grossly incapacitated and who respond well to brief treatment we include, primarily, *psycho-neurotic* patients. Some are trying to cope with particular crises (for example, grief following a loss, illness, hospitalization, or surgery) or with periods of maturational transition (for example, leaving home for the first time, marriage, pregnancy, changes in occupational status, or aging [Semrad, 1966]). Generally, they see their previous functioning as fairly satisfactory, or at least not so uncomfortable as to require a prolonged therapeutic commitment. Not infrequently, however, brief treatment is also employed as a first-stage procedure for sicker patients in an acute turmoil, to be followed later by a more prolonged psychotherapeutic intervention with broader goals.

Symptomatology

The presenting symptoms bear some relationship to the patient's suitability for brief treatment, but not an overly close one. The simpler symptomatic manifestations—anxiety, depression, or minor hysterical conversions—usually respond quite well (Castelnuovo-Tedesco, 1962; Fuerst, 1938; Gutheil, 1944; Semrad, 1966), but there is evidence also that mild obsessive symptoms can show a good response as well (Sifneos, 1966). In

contrast, more complicated symptoms such as phobias or deep-seated hypochondriacal preoccupations are less likely to be significantly affected by a brief course of treatment. However, more important than the symptomatology or the diagnosis is the patient's accessibility and his capacity for rapid involvement with the therapist (Malan, 1963). This depends on the depth and character of the patient's psychopathology, as well as on his motivation and typical transference attitude.

Typical Transference Attitude

Patients also vary in terms of what might be called their typical transference attitude—the basic "stance" that they characteristically present toward human relationships and that they bring to the treatment situation, where it inevitably influences the course of treatment. Thus, Stekel (1950) emphasizes the importance of noting, early on, whether the patient shows a "willingness to be cured."

Patients who generally respond very favorably to brief psychotherapy and are able to make the most of the opportunity are those who demonstrate a "latency type transference", i.e., who readily take a posture as "father's (or mother's) helpers." They identify strongly with the therapist's efforts and get to work tidying up the neurotic predicament (Castelnuovo-Tedesco, 1962). Seeking a therapist often is an expression of the patient's readiness to arrive

at certain solutions, as one observes with some couples who consult a marriage counselor when they already have decided to "save" their marriage. On the other hand, some patients bring with them transference attitudes that are quite maladaptive and in conflict with the goals of brief treatment. For example, some would rather oppose the therapist than assist him, while others need to feel coerced or oppressed and wish to prove that the treatment is really for the benefit of the therapist and at his request. Some, who are full of feelings of entitlement, sit back and wait for the therapist to perform the therapeutic miracle. Still others, inhibited by mistrust and fears of being hurt, remain protectively aloof. It should be made clear that these attitudes do not necessarily mean that these patients are sicker or more incapacitated than those who present with more adaptive attitudes, but simply that they are less suited (occasionally quite unsuited) for brief psychotherapy. Long-term treatment often is required in these cases precisely because the patient is unable, for a variety of reasons, to become engaged quickly in the therapeutic task. Relevant here is Berliner's (1941) statement that "the quick removal of a symptom . . . is best achieved under a state of positive mother transference to which persons with an oral disposition are particularly inclined . . . They absorb friendly transference influences readily . . . They are easy to guide, in contradistinction to people of anal disposition. However, the result of this guidance remains superficial. The old ambivalence is always ready to get the upper hand . . . Symptoms of oral

disposition . . . require great caution and their quick disappearance must be judged with reservation."

Limitations of Brief Psychotherapy

The limitations of brief psychotherapy are most readily observed with the following categories of patients who share a distinct impairment of the ego's synthetic and integrative functions and whose responsiveness is typically, though variously, diminished. They are likely to respond unimpressively to brief treatment, and some soon prove distinctly unsuited. Here we specifically include *psychotic* patients, those with *major character disorders* of long standing (especially those with poor impulse control, such as alcoholics, drug addicts, and the severely unstable and self-destructive), and those with chronic, severe, and *disabling psychosomatic illnesses* (such as ulcerative colitis, rheumatoid arthritis and the like). With psychosomatic patients, sharply focused psychotherapy may be very helpful in alleviating the distress associated with hospitalization and in clarifying the issues surrounding a particular exacerbation of the illness; yet such efforts often also serve to underscore the need for more definitive longterm treatment, which then must be arranged.

Brief psychotherapy also tends to be inappropriate or of limited value in the special categories that follow. Deeply depressed patients with persistent

or recurrent suicidal urges generally do not find, in brief treatment, either enough protection or enough time to resolve their difficulties. Schizoid patients, typically bland and detached, simply do not make sufficient contact with the therapist to achieve much benefit when time is short. Neurotic patients with difficult or negativistic transference attitudes have already been discussed. However, one might also include here those patients who are markedly dependent and need the continuing support of an extended relationship, as well as those who derive strong secondary gain and neurotic satisfaction from their symptoms and therefore are unlikely to part with them easily (Wolberg, 1965). In conclusion, longterm treatment is called for whenever a focal time-limited approach will not suffice or whenever there is a clear and patent need for personality reconstruction.

Not all authors would concur with the foregoing statement of indications, which they might regard as too stringent. Wolberg (1965), for example, says, "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." But then he too allows that certain conditions—for example, pronounced dependency and immaturity, major character disorders with persistent acting out, and near-psychotic states with massive anxiety—sharply prejudice the outcome. Similarly, Burdon (1963) believes that ". . . almost all patients can profit from brief psychotherapy . . . [and that] a therapeutic trial . . . [is] indicated in most cases . . . ," although he

later acknowledges that the optimal indications for brief psychotherapy are in the range of those given above. Wolberg (1965) reports that he has also used short-term methods to advantage in treating patients with serious chronic disorders, including obsessive compulsive neurosis and borderline schizophrenia. Other authors (Gitelson, 1942; Koegler, 1967) likewise report a favorable response in some severe cases—including, again, instances of borderline schizophrenia. Malan (1963) is of the opinion that patients with disturbances of moderate severity actually may do better than mildly ill patients, especially if they are highly motivated and work well in interpretive therapy. Nonetheless, his evidence would suggest that the poorest therapeutic results were obtained with the sickest patients. Relevant here is Berliner's (1941) observation that "the feasibility of short treatment does not depend on the duration of the illness but on the depth of the neurotic disposition."

A case certainly can be made for offering each patient an initial therapeutic trial of brief psychotherapy, inasmuch as our ability to predict therapeutic outcome is imperfect; at times one is pleasantly surprised by a patient's unanticipated responsiveness. Jacobson (1967), for example, estimates that of 3000 patients who presented themselves at a major crisis center, "approximately two thirds . . . were considered improved" after a course of up to six visits. Thus it is common policy in public clinics, which have an obligation to provide some service to all comers, to introduce each

new patient to a course of brief treatment (either individually or in a group setting) in the hope that such a course will suffice in most cases. Nonetheless, it must be kept in mind that as the criteria for patient selection are broadened, the likelihood of a definitive therapeutic result inevitably decreases.

Because a good prognosis in brief psychotherapy has been linked to the presence of substantial ego integrity, the question sometimes is asked whether patients who are ideal candidates for brief treatment are not the very same who generally are considered best suited for intensive analytic psychotherapy or psychoanalysis. And if so, the question continues, is it not just a matter of the therapist's personal predilection whether in some cases he recommends short-term or long-term intensive treatment? While it is true that this characteristic, i.e., substantial ego integrity, enhances the prognosis with any form of psychotherapy, these two groups of patients in fact still differ in some important ways. Primarily, brief-psychotherapy patients tend to have disturbances that are more focal and easily circumscribed, and their suffering is not so deep, persistent, or pervasive as to sustain or justify a therapeutic effort of several years' duration.

The question also arises as to what one can do when an adequate response to short-term treatment is not obtained. The principal alternatives are either long-term treatment or the repetition of one or more courses of

brief psychotherapy. Long-term treatment, in turn, may either be intensive and aimed at significantly modifying chronic character pathology, or primarily supportive and non-intensive (either individual or group) and aimed at "carrying" the patient at a tolerable equilibrium so as to prevent critical decompensations. The decision here rests, of course, on the clinical characteristics of the individual case and, not infrequently, also on external factors that determine the availability of professional time. The choice between repeated courses of short-term treatment and some form of long-term treatment should include some judgment of how the patient will manage the regressive trends that, in varying degrees, accompany long-term treatment. The choice also reflects the therapist's preference. Repeated courses of brief treatment are often the approach of choice for many poorly-compensated patients, who should not be exposed to a prolonged dependent transference with its attendant risks of a serious regression. On the other hand, such repeated courses also find favor with therapists who are basically skeptical of the accomplishments of long-term treatment and who believe that the main contribution of psychotherapy is to provide support when the patient is in a crisis.

Brief Psychotherapy: Some Conclusions

As noted at the outset, brief psychotherapy is not new. It has actually been with us from the very beginnings of psychotherapy proper. But it is true

that in the last one or two decades its place in the therapeutic armory has been consolidated and its importance, both social and medical, realized as never before. There has been an increased appreciation of its scope, capabilities, and its essential techniques, thanks to our greater understanding of transference, crisis, and ego mechanisms, and of the multiple internal and external forces that facilitate or hinder adaptation. The scope and significance of brief psychotherapy can be gathered by considering not only the range of patients to whom it is applicable, but the range of therapists by whom it is practiced. Paradoxically, it is a form of treatment that at times presumes the most complex psychotherapeutic skills, slowly garnered through intensive work with patients; yet at the same time it also is practiced, usually quite safely and with substantial effectiveness, by the relative beginner. Brief treatment also stands, Janus-faced, at the center of a very controversial question not yet resolved to everyone's satisfaction: whether psychotherapy truly heals (by altering and reversing fundamental psychopathology) or mainly palliates (by providing, predominantly, consolation and support). At any rate, despite uncertainties and controversies, there is no question about the vitality and importance of this complex field. It represents the treatment of choice for many patients and, frequently, the only available treatment for many more. Technically, it has come a long way in almost a century since Anna O. became the first beneficiary of this new method and appreciatively named it "the talking cure" (Breuer, 1955).

Bibliography

Aguilera, D., J. M. Messick, and M. S. Farrell. *Crisis Intervention: Theory and Methodology.* St. Louis: Mosby, 1970.

Alexander, F. and T. M. French. *Psychoanalytic Therapy.* New York: Ronald, 1946.

Bandler, B. "Health Oriented Psychotherapy," *Psychosom. Med.,* 21 (1959), 177-181.

Bellak, L. and L. Small. *Emergency Psychotherapy and Brief Psychotherapy.* New York: Grune & Stratton, 1965.

Berliner, B. "Short Psychoanalytic Psychotherapy: Its Possibilities and Its Limitations," *Bull. Menninger Clin.,* 5 (1941), 204-213.

Breuer, J. and S. Freud. (1895) "Studies on Hysteria," in J. Strachey, ed., *Standard Edition,* Vol. 2., pp. 1-305. London: Hogarth, 1955.

Burdon, A. P. "Principles of Brief Psychotherapy," *J. Louisiana Med. Soc.*, 115 (1963), 374-378.

Caplan, G. *Principles of Preventive Psychiatry.* New York: Basic Books, 1964.

----. *The Theory and Practice of Mental Health Consultation.* New York: Basic Books, 1970.

Caplan, G., E. A. Mason, and D. M. Kaplan. "Four Studies of Crisis in Parents of Prematures," *Community Ment. Health J.,* (1965), 149-611.

Castelnuovo-Tedesco, P. "The Twenty-Minute 'Hour:' An Experiment in Medical Education," *N. Engl. J. Med*., 266 (1962), 283-289.

----. *The Twenty-Minute Hour: A Guide to Brief Psychotherapy for the Physician.* Boston: Little, Brown, 1965.

----. "Brief Psychotherapeutic Treatment of the Depressive Reactions," *Int. Psychiatry Clin.,* 3 (1966), 197-210.

----. "Decreasing the Length of Psychotherapy: Theoretical and Practical Aspects of the Problem," in S. Arieti, ed., *The World Biennial of Psychiatry and Psychotherapy,* Vol. 1, pp. 55-71. New York: Basic Books, 1970.

Coleman, J. V. "The Initial Phase of Psychotherapy," *Bull. Menninger Clin.,* 13 (1949), 189-197.

Freud, S. (1901) "Fragment of an Analysis of a Case of Hysteria," in J. Strachey, ed., *Standard Edition,* Vol. 7, pp. 7-122. London: Hogarth, 1953.

----. (1918) "From the History of an Infantile Neurosis," in J. Strachey, ed., *Standard Edition,* Vol. 17, pp. 7-122. London: Hogarth, 1955.

Fuerst, R. A. "Problems of Short Time Psychotherapy," *Am. J. Orthopsychiatry,* 8 (1938), 260-264.

Gill, M. "Psychoanalysis and Exploratory *Psychotherapy," J. Am. Psychoanal. Assoc.,* (1954), 771-797.

Gillman, R. D. "Brief Psychotherapy: A Psychoanalytic View," *Am. J. Psychiatry,* 122 (1965), 601-611.

Gitelson, M. "The Critical Moment in Psychotherapy," *Bull. Menninger Clin.,* 6 (1942), 183-189.

----. "Psychoanalysis and Dynamic Psychiatry," *Arch. Neurol. Psychiatry,* 66 (1951), 280-288.

Gutheil, E. A. "Psychoanalysis and Brief Psychotherapy," *Clin. Psychopathol.,* 6 (1944), 207-229.

Hunter, R. A. and I. MacAlpine. "Follow-up Study of A Case Treated in 1910 by 'The Freud Psychoanalytic Method,' " *Br. J. Med. Psychol.,* 26 (1953), 64-67.

Jacobson, G. "The Briefest Psychiatric Encounter," *Arch. Gen. Psychiatry,* 18 (1968), 718-724.

Jacobson', G. F. "Some Psychoanalytic Considerations Regarding Crisis Therapy," *Psychoanal. Rev.,* 54 (1967), 649-54.

Jones, E. *The Life and Work of Sigmund Freud,* 2 Vols. New York: Basic Books, 1955.

Knight, R. P. "Application of Psychoanalytic Concepts in Psychotherapy: Report of Clinical Trials in a Mental Hygiene Service," *Bull. Menninger Clin.,* 1 (1937), 99-109.

----. "An Evaluation of Psychotherapeutic Techniques," *Bull. Menninger Clin.*, 16 (1952). 113-124.

Koegler, R. R. and N. Q. Brill. *Treatment of Psychiatric Outpatients.* New York: Appleton-Century-Crofts, 1967.

Lewin, K. K. *Brief Encounters: Brief Psychotherapy.* St. Louis: Warren H. Green, 1970.

Malan, D. H. *A Study of Brief Psychotherapy.* London: Tavistock, 1963.

Mandell, A. G. "The Fifteen-Minute Hour," *Dis. Nerv. Syst.*, 22 (1961), 1-4.

Oberndorf, C. P. "Constant Elements in Psychotherapy," *Psychoanal. Q.,* 15 (1946), 435-449.

Orr, D. W. "Lionel Blitzsten, the Teacher," in *N. Lionel Blitzsten, M.D., Psychoanalyst, Teacher, Friend,* 1893-1952, pp. 21-69. New York: International Universities Press, 1961.

Parad, H. G., ed. *Crisis Intervention: Selected Readings.* New York: Family Service Assoc. Am., 1965.

Phillips, E. L. and D. N. Wiener. *Short-term Psychotherapy and Structured Behavior Change.* New York: McGraw-Hill, 1966.

Pumpian-Mindlin, E. "Considerations in the Selection of Patients for Short-term Psychotherapy," *Am. J. Psychother.,* 7 (1953), 641-652.

Rangell, L. "Similarities and Differences between Psychoanalysis and Dynamic Psychotherapy," *J. Am. Psychoanal. Assoc.,* 2 (1954), 734-744.

Rogers, C. *Client-Centered Therapy.* Boston, Houghton Mifflin, 1951.

Rothenberg, S. "Brief Psychodynamically Oriented Therapy," *Psychosom. Med.,* 17 (1955), 455-457.

Saul, L. "On the Value of One or Two Interviews," *Psychoanal. Q.,* 20 (1951), 613-615.

Schmideberg, M. "Short-Analytic Therapy," *Nerv. Child,* 8 (1949), 281-290. Semrad, E. V., W. A. Bin-stock, and

B. White. "Brief Psychotherapy," *Am. J. Psychother.,* 20 (1966), 576-599.

Sifneos, P. E. "Psychoanalytically Oriented Short-Term Dynamic or Anxiety-Provoking Psychotherapy for Mild Obsessional Neuroses," *Psychiatr. Q.,* 40 (1966), 271-282.

----. *Short-Term Psychotherapy and Emotional Crisis.* Cambridge: Harvard University Press, 1972.

Socarides, C. W. "On the Usefulness of Extremely Brief Psychoanalytic Contacts," *Psychoanal. Rev.,* 4 (1954), 340-346.

Stekel, W. *Conditions of Nervous Anxiety.* New York: Liveright, 1950.

Sterba, R. "A Case of Brief Psychotherapy by Sigmund Freud," *Psychoanal. Rev.,* 38 (1951), 75-80.

Stone, L. "Psychoanalysis and Brief Psychotherapy," *Psychoanal. Q.,* 20 (1951), 215-236.

Strupp, H. H. *Psychotherapists in Action.* New York: Grune & Stratton, 1960.

Waelder, R. "The Goal of Psychotherapy," *Am. J. Orthopsychiatry, 10 (1940), 704-706.*

Wolberg, L. R. *Short-Term Psychotherapy.* New York: Grune & Stratton, 1965.

Wolpe, J. *The Practice of Behavior Therapy.* New York: Pergamon, 1969.

Wolpe, J. and A. A. Lazarus. *Behavior Therapy Techniques.* Oxford: Pergamon, 1966.

Notes

1 The term "transference" is enclosed in quotation marks because, traditionally, it has served to describe the displacement of feelings, originally experienced with significant figures of one's childhood, to the therapist in the course of psychoanalytic treatment. Similar displacements, however, can occur spontaneously also onto other current, extra-

therapeutic figures.