The Brief-Therapy Alternative

Terry Kupers

Ending Therapy

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Terry A. Kupers, M.D.

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When Freud (1937) told the Wolfman his analysis would end one year hence, he opened the door to brief therapy, even though it was in this same essay that he debunked Otto Rank's attempt to shorten psychoanalysis. It seems that the first three years of the Wolfman's analysis were nowhere near as productive as that final year, when they worked under a strict time limit. Brief therapists, most of the prominent ones themselves trained as psychoanalysts, are essentially proposing that, in the treatment of certain conditions, the first several years of open-ended analysis are dispensable, and the whole therapy can be reduced to that time-limited and accelerated terminal phase.

There are three reasons for including a chapter on brief therapy in this discussion of termination. First, the time limits imposed by brief therapists tend to exaggerate certain termination issues. Second, it is an opportunity to make the discussion of termination more inclusive. That is, until now the discussion has been about psychoanalysis or long-term psychotherapy, and about the tendency for therapies to lengthen as time goes on and more conditions are considered amenable to therapeutic intervention. Brief therapy represents a countertendency, almost a backlash against the lengthening of therapies. Therefore, by including a chapter on brief therapy, I extend the scope of my discussion beyond the long-term variety of therapy. The third reason for including a chapter on brief therapy is that it serves to expose the contradiction between the clinical logic of termination and the fact that means more than clinical condition seem to determine the length of one's therapy.

The advent of brief therapy is consistent with the clinical logic of termination. The list of symptoms is circumscribed, preferably with an identifiable time of onset in the not-too-distant past. The diagnosis is of an acute and not-too-severe neurotic conflict or crisis, the method being inappropriate for psychotic conditions, severe character disturbances, and suicidal or substance-abusing clients. The theory borrows heavily from Freud's early work, especially his emphasis on oedipal conflicts. The technique is very specific, involving a sharp focus on certain issues, particularly as they surface in the transference. The termination of therapy is designed to work in the context of a time-limited and focal therapy. And the advocates of brief therapy certainly talk as if it is the treatment of choice in particular cases. All six steps of

the clinical logic are represented.

I will concentrate here on one particular kind of brief therapy, the kind that has emerged directly out of the psychoanalytic experience. I am referring to the brief therapy that Malan (1976), Sifneos (1972), Davanloo (1978), and Mann (1973) have popularized in the last decade. Gustafson (1986) provides a useful summary and some contributions of his own on technique. Theoretically, it is derived from psychoanalysis: the practitioner interprets the transference as an analyst would, or focuses on oedipal conflicts as Freud would. I could enlarge the subject matter by including other kinds of brief therapy, for instance, those informed by systems theory or those that make use of "paradoxical commands." But since I have been tracing a line of development of therapy from psychoanalysis, I will restrict the discussion to the one kind of brief therapy.

Brief Psychotherapy

Judd Marmor (1979) recounts the history of brief therapy. Freud had some brief cases. For instance, he saw conductor Bruno Walter for six sessions with a successful outcome in 1906, and he cured composer Gustav Mahler's impotence in a single four hour session in 1908. Ferenczi and Bank (1925) experimented with the technique of setting a time limit for therapy and not rescinding it. Leaving out much of the traditional analytic investigation of the past, they focused instead on the current problems and the transference relationship. Alexander and French (1946) made some major revisions of psychoanalytic theory in the interest of briefer therapy. They questioned the long-held assumption that long therapies are necessary to attain deep and lasting cures. They reduced the frequency of sessions, made the couch optional, became more active in the treatment process, advocated enough flexibility to fit the treatment strategy to the individual case, and experimented with interruptions in the treatment designed to diminish the client's dependency on the therapist. The current generation of brief therapists follow in the tradition of these pioneers.

The idea of brief therapy is to condense certain of Freud's lessons on technique into a concentrated method that can be articulated simply and taught easily, and that promises impressive reduction of symptoms after a very short course of therapy. Not everyone wishes to be in long-term therapy, not everyone wishes to sort through all the feelings about the therapist as a transference figure and about

leaving him or her, and even those who wish to cannot always afford the long hours of therapy needed to do so. The whole analytic process does not need to be repeated in every case. The therapist can concentrate the lessons of many analyses and longer-term therapies and offer the time conscious consumer a more condensed package.

The brief therapists select clients whose emotional symptoms are circumscribed. They find an unresolved developmental issue—preferably oedipal—that can be clearly linked to the current problem, make sure they select only clients who are able to make use of the therapist's interpretation of the link and are highly motivated to change, and then aim interventions at the circumscribed symptoms and their developmental roots, making particular use of transference interpretations to do so. According to Habib Davanloo (1978), "The major task of the therapist is to understand as quickly as possible the essential problems and make them understandable to the patient . . . we cannot wait for the material to bubble up" (p. 343).

Most of the brief therapists stress selection criteria, seeking the variables that correlate most strongly with successful outcome. Thus they exclude clients who have a history of psychotic decompensation, serious suicide attempts, significant drug and alcohol abuse, and impulsive acting out. Most insist that the potential client be able to make use of an interpretation offered during the initial interview. Peter Sifneos (1972) recommends the selection of clients who have had at least one meaningful and long-lasting intimate relationship. In other words, the best outcomes occur when the client is relatively healthy, insightful, motivated to change, and unlikely to fall apart or become overly dependent. They can be skimmed off the waiting lists in public clinics, or identified in private consulting rooms, and the brief therapy encounter will most likely be productive, while the waiting list shrinks or the private therapist quickly creates another opening in his or her busy schedule to see another client in need.

Some brief therapists literally view the entire therapy as a concentrated termination phase. This is James Mann's (1973) approach. Basing his version of brief therapy on psychoanalytic and phenomenological concepts of time, he sets a twelve-session limit, selecting a date for the final session at the beginning of treatment. He selects a focus for the therapy much as Malan, Sifneos, and Davanloo do, but then he links the focus—the circumscribed current problems as well as the related prototypic moment from childhood—to the universal issues of separation, loss, and the eventuality of death. He

feels each client, is some idiosyncratic way, is conflicted about separation and death, and experiences these conflicts in relation to time. By conducting therapy in the shadow of a strict time limit, the therapist helps activate the conflicts in the therapeutic setting and has an opportunity to show the client how such concerns are related to the presenting symptoms.

From the first session, Mann keeps focusing the client's attention on the number of sessions remaining—eleven after the first, ten after the second, six after the sixth, and so forth. The client's initial excitement about how much relief therapy will bring begins to wane sometime in the middle of the therapy, when she or he realizes that the symptoms are not entirely resolved and little time remains. Then the therapist points out the counterproductive ways the client has dealt with limitations and endings or losses in the past. And finally the therapist helps the client work through the impending loss of this therapeutic relationship. Thus, termination issues are identified from the first session and linked with the presenting complaints, and the whole treatment focuses on working through issues that the time limit intensifies.

Notice that Mann's approach to time is quite the opposite of Ferenczi's concept of "timelessness" (see chapter 2). According to Ferenczi (1927), "The completion of an analysis is possible only if, so to speak, unlimited time is at one's disposal. I agree with those who think that the more unlimited it is, the greater are the chances of quick success" (p. 82).

Compare Mann's (1973) stance:

> Any psychotherapy which is limited in time brings fresh flame to the enduring presence in all persons of the conflict between timelessness, infinite time, immortality and the omnipotent fantasies of childhood on the one hand, and time, finite time, reality, and death on the other hand. The wishes of the unconscious are timeless and promptly run counter to an offer of help in which time is limited. Thus, any time-limited psychotherapy addresses itself to child time and to adult time. At the least, this gives rise to powerful conflicting reactions, responses, and most of all, conflicting expectations. The greater the ambiguity as to the duration of treatment, the greater the influence of child time on unconscious wishes and expectations. The greater the specificity of duration of treatment, the more rapidly and appropriately is child time confronted with reality and the work to be done. (p. 11)

There is a reversal here. Analyst Ferenczi creates a state of timelessness in the consulting room in order to foster exploration of the timeless unconscious. Brief therapist Mann, by fixing a time limit and then confronting what he considers excessive dependency on the therapist, rules out that state of

timelessness. The contrast raises a question: Is brief therapy a shorter version or lesser quantity of the same basic entity we know as open-ended psychoanalytic therapy, or does the change in quantity mean a change in quality? In other words, isn't the very nature of therapy altered in the abbreviating, including its aims?

Therapy contains two quite different moments: open-ended exploration of the unconscious where timelessness is very relevant, and another moment where a technique-oriented and time bound onslaught against resistances is called for (Kupers, 1986). I illustrated these two moments in chapter 1, in Freud s case reports. Freud functioned more as a technician when he confronted Dora, detective-like, about her knowledge of oral sex. Later, he was more the explorer when he confessed that he would never have guessed the Wolfman's association of a butterfly with a woman's spreading her legs. The therapist, at one moment functioning as a technician, stresses sharp observation, accurate data gathering, rigorous psychodynamic formulation, exact diagnosis, precise interpretation, and objective measurement of outcome.

At another moment, the therapist functions as an explorer, being more interested in an unrestricted search for fantasies and meanings, in discovering what is unique, and what potential there is for growth and healing residing within the individual. The technician is cheered by the closeness of fit between the client's behavior and what theory would predict. It is the explorer who "surprises" (Winnicott, 1971b) the client and himself with the results. There are moments in any therapy when the therapist must be firm, insist' his or her interpretation is correct, and help the client look at the reasons for resistance. At other moments the therapist must back down or remain silent, let the client discover the meaning and be surprised by the discovery. The point is to fit the therapeutic approach to the needs of the client and the therapeutic moment rather than trying to fit the client into the single available approach. Ideally, the therapist combines the best of both approaches.

There is a tendency among brief therapists to stress technique over exploration. This is what the time limit accomplishes. After all, if the therapist seeks a thorough history in the first interview, quickly makes a dynamic formulation to inform a strategy of focal and sharp intervention, and ends the therapy soon after the presenting symptoms abate, there is little or no time to explore anything that is not directly related to the focus. This is in contrast to the open-ended time frame of longer-term therapy or analysis,

which provides an opportunity to explore in depth the individual's history, the contents of his or her unconscious, and the patterns of defense. Then the analyst can offer well considered interventions, and the shape of the new self will evolve out of the analytic process, not as prescribed by the analyst in advance. This is not to say that psychoanalysis is without problems—for example, the problem of interminability. The only point I want to make about this for now is that time-limited and open-ended therapies are quite different and that this difference is more than quantitative. Further on, I will describe how the two different therapies are distributed inequitably according to class.

I will mention one other concern I have. The advocates of brief therapy make it clear that their approach works only with a very select client population, for instance, people who seem unlikely to be harmed. Then the therapist can proceed to batter down resistances and facilitate rapid psychological change. Brief therapy utilizes this capability very effectively. Perhaps a therapist must be this aggressive if she or he expects big changes in a short time. But then the aggression itself is a variable to be considered in the evaluation of outcome. Some symptoms may be diminished, but other important issues will be ignored. For instance, the client might accept the therapist's insights without looking at feelings of discomfort in relating to such an insistent and intrusive therapist. Some of these feelings are suppressed, just as they were in earlier relationships with intrusive or intimidating parents, so the seemingly symptom-free client can leave therapy with little insight into this dimension of her or his difficulties in relationships. Often it is just this kind of insight that would permit a previously compliant individual to question his or her external circumstances. Winnicott offers an alternative approach. Many of his therapies are brief. Yet he is very much the explorer, permitting his clients to discover their own interpretations (Winnicott, 1971 a and b, Gustafson, 1983, and Kupers, 1986). In any case, brief therapy can be quite effective.

The Hospital Porter

I had the opportunity to treat a client with supervision by David Malan at the Tavistock Institute in London in the early 1970s (reported in Malan, 1976, pp. 321-25). The client, a twenty-five-year-old hospital porter, had lost at least one hundred jobs since graduating high school, usually because he fought the authority of supervisors. His marriage of several years was troubled because of his job instability, and because he drank excessively and was depressed when not drunk.

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The man was very bright. In fact, one reason for his depression was that he had done so little with his intelligence. He was very aware of the link between unresolved feelings toward his father and his trouble with authority figures. During his intake interview, the interviewer suggested that behind his overt hostility there might be a wish to restore a warm relationship he had once had with his father and lost. He was very moved by this interpretation, and this is what convinced us that this man might do well in brief therapy with a focus on his ambivalence toward his father and other authority figures.

Of course, the ambivalence emerged in the transference. First, he would express appreciation when I offered a helpful interpretation, and then he would attack me because I was not doing all I could to relieve his depression and make him feel better. As we explored the similarities between this kind of ambivalence and early feelings of disappointment in his father, a pattern of his work life became evident: he would drive a boss into a corner with his intellect, provoke the intimidated boss to threaten him with dismissal, say he did not care about the job, and end up being fired. By focusing on the self-destructiveness contained in this single dynamic, demonstrating its roots in early conflicts with father, and monitoring its repetition in the transference, we were able to work through the man's need to be belligerent at work. He began to hold down a steady job, and consequently felt less depression and less need to drink.

The termination of therapy was uneventful. We had agreed in advance on a date for the final session. Partly because the client had been selected and did not demonstrate serious "oral/dependency" issues, partly because the boundaries of the therapeutic relationship were clear from the beginning and the client was planning to end therapy at a predetermined date, and partly because we worked through the clients' mild feelings that he was not getting enough from his therapist, when the date approached the client was able to express appreciation for the gains of therapy, say that he would miss me , and then warmly say goodbye. The symptomatic relief was sufficient to call the therapy a success without our ever touching on the man's other conflicts and character traits. (Later he would return for more psychotherapy because of marital tensions).

When clients are well selected and proper therapeutic technique is employed, the gains from a brief course of therapy can be quite impressive. But there is another side to the picture.

The Social Uses of Brief Therapy

Remember, the brief therapists insist that successful outcome depends on proper selection of candidates. They explicitly warn against offering brief therapy to people suffering from a severe character disorder such as borderline character. In fact, failure often results when brief therapy is offered to this group. The client feels too much resentment about the time limitations and what she or he perceives as the eventual desertion by the therapist to benefit from what can be accomplished even within those parameters. Such clients might terminate therapy angrily and regress, or undo or sabotage all the gains that have been accomplished. Similarly, the brief therapists exclude alcoholics, ex-psychotics, and so on. There is a logic to this selection protocol. It takes a very special type of person to benefit from psychodynamic therapy offered in very small parcels.

In practice, the selection criteria differ from those the innovators recommend. For instance, in many mental health clinics—in the public sector, or the clinics of private health plans—an administrative decision is made that in light of budget limitations, and in order to distribute fairly the limited amount of available services, everyone who requests talking therapy will be assigned to a twelve- or a twenty-session course of brief therapy. Then, in spite of very clear selection criteria in the literature, the therapist in the public setting is faced with the prospect of seeing all clients who walk in—some of whom are suicidal, alcoholic, or borderline—in some form of brief therapy. The guidelines for practicing therapy break down, usually in the direction of employing more confrontation of resistance and permitting less unstructured exploration—that is, technique becomes even more dominant.

This scenario of grossly violated selection criteria is well known today. It occurs in public clinics, including county, state, and federal community mental-health centers; it occurs in large prepaid private health facilities; and increasingly, as private insurance companies limit the number of therapy sessions covered, it is occurring in the private clinician’s office. Many insurance companies in the United States pay half or two-thirds of a certain maximum allowable fee schedule for a strictly limited number of sessions of therapy, and many clients tell their therapists at the beginning that they cannot continue in therapy after their coverage runs out. Thus the therapist is pressured to offer some form of brief therapy —again regardless of clinical selection criteria.

The pattern developing in regard to brief therapy is reminiscent of the pattern involving crisis

intervention in the United States in the 1960s. Directors of the newly funded community mental health centers sought a therapeutic modality that could be offered to the large population their clinics were mandated to serve. The crisis-intervention model seemed to fit the spirit of the times, as well as the budget. The therapist and client have six visits to focus on the client's crisis, help the client ventilate the feelings or mourn, and then the symptoms should be sufficiently alleviated for the client to return to his or her prior level of functioning (Caplan, 1961). The therapist is instructed not to dwell on childhood histories, not to interpret transference reactions, and not to expect characterological change. The technique is quite a contrast to today's brief therapy (with the exception of Horowitz's work—see below), where transference interpretations are critical. The aim is merely a return to the prior homeostasis.

The crisis-intervention model can work very well. A woman complains she has been lethargic and unable to pursue her writing career since her mother died a year ago. The therapist tells her the problem is a morbid grief reaction, and she needs to pay attention to unresolved conflicts with her mother and unexpressed feelings. She does so for six weeks. With the therapist's support, she permits herself to think about her mother, recalls how much she hated her once, and feels the rage. At another time she remembers the loving way her mother waited for her to come home from school and gave her a snack to help her get through her homework assignment. She cries. She lets herself miss her mother. She may never work through all her complex feelings about her mother, but she works through enough to be able to continue in her life. This is a successful outcome.

In practice, a different fate awaited the model. Even during the 1960s' Kennedy-initiated "war on poverty," funding for mental-health services in low-income communities was never sufficient, and the simultaneous closing of state mental hospitals effectively flooded the newly built community mental-health centers with clients (see Chu and Trotter, 1974). Many centers routinely offered every new client six sessions of crisis intervention, and then the ones who were not cured would be assigned to group therapies. The figures seemed to work out. Every six weeks a therapist would have another slot open to accept a new client. The clinic waiting list would shrink. The only problem was that successful outcomes were more the exception than the rule. After all, not all the clients who requested services suffered from an identifiable loss or crisis, so there was no clinical logic to fitting them into a six-session therapy format. While the model could be shown to be effective when used with clients who fit its selection criteria, the outcomes in community mental-health centers were disappointing.

Like crisis intervention, brief therapy was developed to solve the problem of crowded waiting rooms and long waiting lists. But the innovators devised their methodologies for a small proportion of those waiting lists, insisting that unsuitable clients be offered other treatment modalities. Today clinicians are pressured by financial considerations to fit more clients into the brief therapy format. Administrators in public agencies, private health provider corporations, and insurance companies are happy: now they can give a rationale for a limit to benefits and train their staffs to practice only these time-limited techniques. Meanwhile, as in the case of crisis intervention, many clients who do not fit the selection criteria, even clients for whom brief therapy is contraindicated, will be offered only ten or twenty sessions. Thus the client, on the basis of means, is fit into the therapeutic modality rather than the other way around.

It is one thing for clinicians, confronted by an externally mandated time limit, to make the best of the situation by developing a technique to treat people in a shorter time frame, all the while protesting that it is inequitable and not the best way to conduct therapy. It is quite another to make an unfortunate restriction of services seem a virtue. Too often clinicians, when told that because of fiscal considerations they will have to treat certain clients in a much shortened time frame, go along happily, believing as they do that the innovations in therapeutic technique they come up with are a boon to society.

It is in this context that clinicians begin to enlarge their claims for the efficacy of brief therapy. For instance, consider the progression of Mardi Horowitz's research from 1976 to 1984. He and his group of clinicians-researchers at the University of California, San Francisco, have devised a very creative strategy for treating the after-effects of extreme and traumatic stress in people with very different underlying character structures (1976). They tailor their interventions to the particular personality of the stressed individual, providing one kind of intervention when the underlying personality is hysterical and a different intervention when it is obsessional or narcissistic—but each time, the intervention is aimed at the stress disorder, leaving the underlying character structure intact. Like crisis intervention, the aim is a return to the previous homeostasis, not a change of character. Horowitz and his group have enjoyed well-deserved acclaim for their success with posttraumatic stress disorder.

But soon they began to expand claims for the efficacy of brief therapy. They even outline a strategy for the brief treatment of the borderline character (Horowitz et al., 1984). In other words, if the brief,

intensive technique works in the case of posttraumatic stress disorders, perhaps it will work with deeper-lying and longer-held psychopathology. As if in direct rebuttal, Otto Kernberg, a pioneer of long-term therapy with the borderline character, comments (1984): "The expectation that our increasing knowledge will shorten the psychological treatment of severe character pathology and the borderline disorders may represent one more illusion about the process, technique, and outcome of psychotherapy," (pp. 252-53).

The point is that inequities in the distribution of psychotherapy services directly contradict the clinical logic of termination. According to that logic, people suffering from the most severe emotional disorders should undergo the longest and most deep probing therapy. In actuality, it is means and not clinical condition that usually determines the length and depth of one's therapy. Those who can afford private fees are encouraged to undergo long-term therapy—and of course theories evolve to explain why high-functioning but unhappy people, perhaps with a psychotic core deep within, should be in long-term therapy. Meanwhile, those of lesser means are relegated to time-limited therapy slots, regardless of the severity of their clinical condition—and other theories evolve to explain how brief therapy can alleviate the severe disorder. The contradiction is highlighted when some of the clinicians who practice and write about brief therapy, being psychoanalysts themselves, go from their jobs at universities or public clinics to their private practices in the suburbs, where they offer longer-term therapy or analysis to clients who have lesser symptoms but greater ability to pay.

In *Public Therapy* (Kupers, 1981) I described a double standard in mental-health-care delivery, whereby talking therapy is available to those who can afford the fees while those who cannot are medicated or involuntarily hospitalized when their problems get out of hand. Brief therapy occupies a middle position in this schema. It is generally available to people who work and have health coverage, but whose coverage is limited. Blue-collar, service, and clerical workers fit this description. Their health plans usually limit the number of therapy sessions covered—but unlike the unemployed, they have access to some talking therapy. Students fit the description too, since many university health services offer time-limited therapy services. More affluent people either have deluxe health insurance plans that cover more therapy sessions, or they can afford to pay private fees for the psychoanalysis or psychotherapy they elect to undergo.

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