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Series Preface

Some might argue that in the contemporary clinical practice of psychotherapy, evidence-based intervention and effective outcome have overshadowed theory in importance. Maybe. But, as the editors of this series, we don't propose to take up that controversy here. We do know that psychotherapists adopt and practice according to one theory or another because their experience, and decades of good evidence, suggests that having a sound theory of psychotherapy leads to greater therapeutic success. Still, the role of theory in the helping process can be hard to explain. The following narrative about solving problems helps convey theory's importance:

> Aesop tells the fable of the sun and wind having a contest to decide who was the most powerful. From above the earth, they spotted a man walking down the street, and the wind said that he bet he could get his coat off. The sun agreed to the contest. The wind blew and the man held on tightly to his coat. The more the wind blew, the tighter he held. The sun said it was his turn. He put all of his energy into creating warm sunshine and soon the man took off his coat.

What does a competition between the sun and the wind to remove a man's coat have to do with theories of psychotherapy? We think this deceptively simple story highlights the importance of theory as the precursor to any effective intervention—and hence to a favorable outcome. Without a guiding theory, we might treat the symptom without understanding the role of the individual. Or we might create power conflicts with our clients

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and not understand that, at times, indirect means of helping (sunshine) are often as effective—if not more so—than direct ones (wind). In the absence of theory, we might lose track of the treatment rationale and instead get caught up in, for example, social correctness and not wanting to do something that looks too simple.

What exactly is theory? The *APA Dictionary of Psychology* (Second Ed.) defines *theory* as "a principle or body of interrelated principles that purports to explain or predict a number of interrelated phenomena" (VandenBos, 2007, p. 1081). In psychotherapy, a theory is a set of principles used to explain human thought and behavior, including what causes people to change. In practice, a theory creates the goals of therapy and specifies how to pursue them. Haley (1997) noted that a theory of psychotherapy ought to be simple enough for the average therapist to understand, but comprehensive enough to account for a wide range of eventualities. Furthermore, a theory guides action toward successful outcomes while generating hope in both the therapist and client that recovery is possible.

Theory is the compass that allows psychotherapists to navigate the vast territory of clinical practice. In the same ways that navigational tools have been modified to adapt to advances in thinking and ever-expanding territories to explore, theories of psychotherapy have changed over time. The different schools of theories are commonly referred to as waves, the first wave being psychodynamic theories (i.e., Adlerian, psychoanalytic), the second wave learning theories (i.e., behavioral, cognitive-behavioral), the third wave humanistic theories (person-centered, gestalt, existential), the fourth wave feminist and multicultural theories, and the fifth wave postmodern and constructivist theories. In many ways, these waves represent how psychotherapy has adapted and responded to changes in psychology, society, and epistemology as well as to changes in the nature of psychotherapy itself. Psychotherapy and the theories that guide it are dynamic and responsive. The wide variety of theories is also testament to the different ways in which the same human behavior can be conceptualized (Frew & Spiegler, 2008).

It is with these two concepts in mind—the central importance of theory and the natural evolution of theoretical thinking—that we developed the APA Theories of Psychotherapy Series. Both of us are thoroughly fascinated by theory and the range of complex ideas that drive each model. As

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university faculty members who teach courses on the theories of psychotherapy, we wanted to create learning materials that not only highlight the essence of the major theories for professionals and professionals in training but also clearly bring the reader up to date on the current status of the models. Often in books on theory, the biography of the original theorist overshadows the evolution of the model. In contrast, our intent is to highlight the contemporary uses of the theories as well as their history and context.

As this project began, we faced two immediate decisions: which theories to address and who best to present them. We looked at graduate-level theories of psychotherapy courses to see which theories are being taught, and we explored popular scholarly books, articles, and conferences to determine which theories draw the most interest. We then developed a dream list of authors from among the best minds in contemporary theoretical practice. Each author is one of the leading proponents of that approach as well as a knowledgeable practitioner. We asked each author to review the core constructs of the theory, bring the theory into the modern sphere of clinical practice by looking at it through a context of evidence-based practice, and clearly illustrate how the theory looks in action.

Each title in the series can stand alone or can be grouped together with other titles to create materials for a course in psychotherapy theories. This option allows instructors to create a course featuring the approaches they believe are the most salient today. To support this end, APA Books has also developed a DVD for each of the approaches that demonstrates the theory in practice with a real client. Many of the DVDs show therapy over six sessions. For a complete list of available DVD programs visit the APA website (http://www.apa.org/videos).

A common assumption about psychodynamic psychotherapy is that it is a model best suited for long-term clients, yet the marketplace for psychotherapy has increasingly moved toward short-term therapy. In *Brief Dynamic Therapy, Second Edition*, Dr. Hanna Levenson outlines a model of psychodynamic practice that fits the reality of short-term therapy, called *time-limited dynamic psychotherapy*. Dr. Levenson places this approach in the context of other brief forms of psychotherapy and shows how significant change can occur in a short amount of time. She explains this

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integrative, empathic approach by using clinical illustrations and drawing from research studies on the efficacy of brief therapy. This second edition offers an update to the research literature and provides new discussions on emotional transformation and outcome efficacy of the approach. Readers will learn much from this pragmatic book, which offers clear steps for effective short-term psychodynamic clinical work that is brief, focused, and deep.

—Jon Carlson and Matt Englar-Carlson

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Introduction

WHAT IS BRIEF THERAPY?

To set the stage for defining brief therapy, I'd like to tell the story of what happened when I began one of my first real jobs in clinical psychology almost 40 years ago. I was hired by a Veterans Affairs (VA) Medical Center to start a program to train third-year psychiatry residents and psychology predoctoral interns how to do brief therapy. At the time, the outpatient psychiatry department was being flooded with Vietnam veterans seeking help. The clinicians, who were used to seeing their clients for extended periods of time (sometimes decades), were getting burned out. More and more patients were being added to their rosters, but no one was terminating. In my employment interview with the then Director of the Outpatient Service, he let it be known that although it seemed briefer forms of intervention might be warranted, they "would never work at the VA because the veterans thought of the VA as home." Not an auspicious way to start a new position!

http://dx.doi.org/10.1037/0000043-001
Brief Dynamic Therapy, Second Edition, by H. Levenson
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The model of training I used back then involved a fixed upper limit of 20 sessions—not for some totally theoretical reason, but mainly because the trainees' rotation at the site was 6 months long. I figured that within that amount of time, trainees and clients would have approximately 20 weeks available in which to do therapy. The training was designed to mirror the time-limited nature of the therapy; we met concurrently for a 3-hour seminar/consultation weekly for 21 weeks.

I stayed at the VA for 20 years, heading up what came to be known as the VA Brief Therapy Program. During that time several hundred trainees and (some staff) completed the program. When I retired from the VA, I was still using the same 20-session model. However, the length of most of the treatments provided by my colleagues located in other VA psychiatry inpatient and outpatient services had become increasingly shorter and shorter for the same financial ("cost-effective") reasons that caused therapies to become briefer in the private sector. As time went on, my colleagues would often make referrals of complex cases to the Brief Therapy Program knowing that those clients would be seen for a longer period of time in my "brief" program than elsewhere. The moral of the story is that often what is considered brief is, to some extent, in the *eyes of the beholder* (and reflected in the Zeitgeist).

To further underscore the point, I remember one of my first brief therapy cases when I was an intern at a training site with a reputation for psychoanalytically oriented, long-term therapy. After a couple of sessions, I needed to tell the client that I would only be able to see her for 3 months. I practiced saying it over and over so that my voice would not betray the guilt I felt in not giving her "enough." When I finally worked up the courage to tell her, she exclaimed, "Is it really going to take that long?"

EVERYONE DOES BRIEF THERAPY

If you are a practicing therapist or studying to be one, I know you are probably doing brief therapy. In a national survey of almost 4,000 mental health professionals, Levenson and Davidovitz (2000) found that almost 90% of psychologists do some form of therapy that is *designed to be time-*

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limited and focused, and psychodynamically oriented therapists conduct one quarter of all the planned brief therapy in the United States.[1] In addition, everyone does *unplanned brief therapies* because most clients choose to stay in therapy a brief amount of time, whether or not the therapist has other ideas. For example, Olfson and Pincus (1994) found that 70% of outpatients in the United States were seen for 10 or fewer sessions. Over the years, it has been well documented that most people who enter therapy (even those treatments that are designed to be long term and open-ended) drop out by the eighth session (Phillips, 1987; Rau, 1989; Wierzbicki & Pekarik, 1993), with a median treatment length of approximately six sessions (Garfield, 1994). As remarked by Muran and colleagues (2009), "these high dropout rates are comparable to those found over 50 years ago" (p. 234). Budman and Gurman (1988) termed these *premature terminations* as *brief therapies by default* (as compared with *brief therapies by design*). We tend to forget that long before third-party payers began setting limits on treatment, clients themselves did.[2]

Most people who are coming for therapy are in emotional pain, and they want to have this pain alleviated as soon as possible. They are not fascinated by their psyches, nor do they seek mental health perfectionism. Sometimes clients experience their needs for immediate relief at variance with their therapists' goals for "problem resolution." Oftentimes, too, clients feel adrift in open-ended therapies where they do know what the goals are or how the process will benefit them. "Where are we going?" "What are we doing?" "Am I making progress?" are frequently asked questions.

Having said this, I need to make an important point with regard to *how brief* brief therapy can be. "Since the advent of psychotherapy, one of the most common questions has been, 'how much psychotherapy is enough'"

[1] This does not mean, however, that these therapists felt competent to do brief therapy. In fact, Levenson and Davidovitz (2000) found that half of the psychologists doing therapies that were planned to be brief never had any course work in the subject. And those psychodynamic therapists who were doing short-term work were less skilled and trained in it than their colleagues from other orientations.

[2] Swift, Callahan, and Levine (2009) discuss theoretical issues and empirical findings regarding the definition of "premature termination." For example, who is considered a "dropout" may be based on not completing a specified number of sessions, therapist judgment, or leaving therapy before one has attained clinical improvement. These authors found a dropout rate of 77% when they used the criterion of clients' discontinuing treatment before achieving clinically significant change.

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(Cameron, 2006, p. 147). When we speak of brief dynamic psychotherapy today, the usual time frame is considered to be anywhere from eight to 25 sessions (Koss & Shiang, 1994; Shapiro et al., 1994). This must be distinguished from what has been called *ultra brief therapy* or *managed care therapy*. In examining a national database of more than 6,000 patients, Hansen, Lambert, and Forman (2002) found that the average number of sessions patients received through managed care organizations or employee assistance programs was less than five! As stated by Levenson and Burg (2000) in their discussion of training psychologists in the era of managed care, the empirical basis of such ultra brief therapies is minimal or unsupported. Therefore, the reader should keep in mind that when I am talking about brief dynamic therapy, I am referring to therapy that relies on the development of a meaningful therapeutic relationship.[3] But brief dynamic therapy is about so much more than just limited time. It is neither condensed long-term therapy nor what you do when you can't do "real" (i.e., long-term) therapy. The following section explicates the parameters that are core to brief dynamic therapies.

QUALITIES THAT DEFINE BRIEF DYNAMIC PSYCHOTHERAPY

When we talk about brief dynamic psychotherapy, to what are we referring? Are there essential characteristics that brief dynamic psychotherapies have in common and that also distinguish them from more open-ended or longer term models? A number of years ago, I (Levenson & Butler, 1994) did a content analysis of as many publications as I could find addressing this topic. After doing an up-to-date review of more recent articles, chapters, and books on the topic for this book, I found the same fundamental qualities discovered previously. Some of these qualities are mentioned repeatedly in the literature and, therefore, appear to be quite essential in defining brief dynamic psychotherapy; others are less frequently reported and

[3] Although there is literature on brief dynamic therapy as applied to groups and couples, my focus in this book is chiefly on individual psychotherapy.

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seem more peripheral.[4] These characteristics might be conceptualized as a consensual, operational definition of short-term dynamic psychotherapy and are listed below in two main categories: those qualities pertaining to the *brief features* per se and those germane to the *psychodynamic aspects*.

Modifications to Make Therapy Briefer

Limited Therapeutic Focus and Goals

The chief factor distinguishing brief from long-term dynamic psychotherapy is its circumscribed focus. Even before mentioning the concept of time, writers agree that "articulating a clinical focus or foci is a hallmark characteristic of all brief psychotherapy approaches" (Messer & Warren, 1995, p. 126). Therapists need a central theme, topic, or problem to guide the work when time is limited. Yogi Berra, former catcher for the New York Yankees known for his idiosyncratic use of the English language, captured the essence of this quality: "If you don't know where you're going, you will wind up somewhere else."

Joseph Weiss (1993) wrote about this definitively in his book on how psychotherapy works:

> When I was a student at the San Francisco Psychoanalytic Institute, a prominent teacher advised me to avoid formulating the patient's problems, especially at the beginning of treatment. He assumed that in general it is possible to formulate a case only after a prolonged period of exploration, and so that if the therapist develops hypotheses about the patient too early, he risks the premature closure of his mind. *I now believe that this advice is wrong*. (emphasis added, p. 70)

Binder (2004), in his excellent book outlining the competencies of the brief dynamic psychotherapist, perceptively delineated two different

[4] One author (Binder, 2004), however, has challenged whether these qualities are unique to time-limited approaches, arguing that they are characteristic of good psychotherapy in general regardless of length. Although I am basically in agreement with Binder that a well-delivered brief dynamic psychotherapy is basically good sound therapy, it is helpful to observe that brief dynamic approaches are likely to delineate more limited treatment foci and more specific goals than their longer term counterparts.

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therapeutic skills having to do with focusing. The first is the ability to discern what will constitute the focus of the work, and the second is how to track and maintain this focus throughout the therapy.

Related to, but distinct from, therapeutic focus is the concept of limited goals. The aim of brief dynamic psychotherapy is not "cure" once and for all. Rather, the therapy should provide an opportunity to foster some changes in behavior, thinking, and feeling, permitting more adaptive coping, improved interpersonal relationships, and a better sense of one's self. Brief dynamic therapy is seen as an opportunity to begin a process of change that (hopefully) continues long after the therapy is over. Clearly both therapist and client need to accept limits.

Time Limits and Time Management

Naturally, the amount of time is the obvious variable that defines an approach as *short-term, brief*, or *time-limited*. The issue of time is the second most frequently mentioned brief therapy criterion. Most modern brief dynamic clinicians set 12 to 20 sessions as the upper limit of brief therapy (Barber et al., 2013; Levenson, 1995). Usually, the *limiting* or *rationing* of time is used conceptually to accelerate the therapeutic work, either by raising the patient's awareness of the existential issues of finite time and mortality (e.g., Mann, 1973) or by encouraging therapist activity and adherence to a focus (e.g., Horowitz & Marmar, 1984).

Although it is most customary for psychodynamically oriented short-term therapists to use the traditional weekly 50-minute "hour," many experiment with the frequency, duration, and number of sessions. Brief dynamic therapists have felt that limiting the length of the therapy encourages individuation, autonomy, and positive expectations. Also there is some intriguing evidence that providing time limits actually might encourage those clients who otherwise might terminate "prematurely" in an open-ended format to stay in therapy longer (Hilsenroth, Ackerman, & Blagys, 2001).

Recently, brief dynamic therapists are moving away from conceptualizing therapy merely in terms of a specific amount of time and are instead addressing ways to make every session count regardless of length of treatment. These models are categorized as *time-attentive* or *time-efficient*,

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where the notion of "brevity" is more an attitude in the therapist's mind that affects the work. Also, brief therapists are comfortable with the idea of rendering help for short periods throughout the client's life cycle (Budman & Gurman, 1988; Cummings, 1995). For example, I have been in practice long enough (40 years) that I have seen some clients for three or four different brief therapies at various stages in their lives.

Unfortunately, with today's economic belt-tightening, time limits have been used increasingly for administrative and monetary reasons instead of therapeutic ones. In the worst of situations, there may be no therapeutic rationale for the number of sessions clients receive—such decisions being driven solely by the financial bottom line (Levenson & Burg, 2000).

Selection Criteria

The importance of selection criteria is a controversial subject in the brief dynamic psychotherapy field. Early in the history of psychoanalysis, as psychoanalytic treatments became progressively longer, Freud (1953) put forth the possibility that treatment might be shortened, but only for psychologically healthier patients. Thus, early practitioners of brief dynamic therapy emphasized rigorous patient selection (choosing those who were psychologically minded, highly motivated, and of above average intelligence, for example). Current short-term therapists tend to take a more process orientation and judge if lengthening the therapy is warranted as the work progresses.

Therapist Activity

Brief dynamic psychotherapy requires the therapist to be an active participant in the process. However, *activity* is only needed to the extent necessary to maintain the *focus*, foster a *positive alliance*, and make progress within a certain amount of *time*. Thus, activity is integrally related to the aforementioned aspects of focus and time. Many clinicians, when learning brief therapy techniques, become confused that therapist activity means confrontation, advice giving, and/or outright direction. What it more appropriately entails is an awareness of the goals of the work and a plan of how to get there, while being sensitive to the client's presentation and the context

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of the clinical material. Thus, therapist activity can range from *supportive interventions* (e.g., reassurance, strengthening of adaptive defenses) to more *exploratory* ones (e.g., interpretation, confrontation) depending upon factors (e.g., strength of the therapeutic alliance) emerging in the session as well as client characteristics (e.g., psychological health, quality of interpersonal relationships).

Therapeutic Alliance

The strength of the therapeutic alliance, especially from the client's perspective, has long been shown to be one of the major factors predicting outcome (Horvath, Del Re, Flückiger, & Symonds, 2011; Martin, Garske, & Davis, 2000; Zilcha-Mano, Dinger, McCarthy, & Barber, 2014). Although various researchers define the alliance somewhat differently, it is generally thought of as comprising the emotional bond between therapist and client and an agreement on the goals and means to accomplish those goals. The quality of the alliance early in therapy has been shown to predict client dropout and the amount of "work" done in sessions (e.g., Piper et al., 1999). Heinonen and colleagues (2014) found that therapists who had an engaging and encouraging relational style fostered working alliances especially in short-term therapies. Thus, although forming a positive alliance as quickly as possible is important in all therapies, it is of critical importance in brief therapy where the therapist might not get many opportunities to repair ruptures in the therapeutic relationship.

Rapid Assessment/Prompt Intervention

The therapist's ability to formulate the client's case and begin intervening quickly is also imperative. When I was an intern at the aforementioned setting famous for its psychoanalytic training program, we spent approximately 3 months getting a full history and developing an understanding of the client's dynamics prior to accepting the client for treatment. Today those 3 months could constitute the total time frame allotted for an entire therapy.

Termination

The brief therapist must be willing to terminate with clients in a considered manner. Because the therapy is short-term, termination is woven

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into the fabric of the work from the beginning. If the ending of a brief dynamic therapy is handled poorly, previously good therapeutic work can be undone. Training in this final phase of treatment is of the utmost importance. However, it has been my experience that many trainees (even those almost finished with their professional education) have never seen the beginning, middle, and planned ending of one case!

Optimism

In their book on *Models of Brief Psychodynamic Therapy*, Messer and Warren (1995) considered how the psychoanalytic vision of human reality is more "tragic" (with people seen as trapped and suffering), whereas briefer approaches are characterized by a more "comic" outlook. "The brief therapist approaches therapy in a more optimistic spirit, believing that worthwhile change is achievable within the set time limit" (p. 42).

My colleagues and I have compared the attitudes of short-term to long-term therapists (Bolter, Levenson, & Alvarez, 1990) and found that the brief practitioners are more likely to believe that psychological change occurs outside of therapy and that setting time limits intensifies the therapeutic work. In another study, Levenson and Bolter (1988) examined the values and attitudes of psychiatry residents and psychology interns before and after a 6-month training in time-limited dynamic psychotherapy and found that, post-training, students were more willing to consider using brief therapy, more positive about achieving significant insight, more expectant that the benefits would be long lasting, and less likely to think that extensive "working through" is necessary. Also, they were more willing to be active and to believe that clients would continue to change after the therapy was over. Similarly, experienced therapists became more positive and optimistic toward brief therapy following a daylong workshop on the topic (Neff, Lambert, Lunnen, Budman, & Levenson, 1996).

Contract

The final major difference between shorter term versus longer term dynamic therapies concerns setting up a therapeutic contract. This contract is "neither legalistic nor necessarily written" (Hobbs, 2006, p. 120). The degree of specificity of such a contract varies, but at the very least there is

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an understanding at the outset of the therapy that the work will be limited in time and/or focused in scope.

Modifications of Psychoanalytic Concepts and Techniques

Brief dynamic therapy relies on major psychoanalytic and psychodynamic concepts such as the importance of childhood experiences and developmental history, unconscious (or out-of-awareness) determinants of behavior, the role of conflict, transference–countertransference phenomena, the therapeutic alliance, and repetitive behavior. However, postmodern, brief dynamic therapists eschew highly inferential psychoanalytic concepts (e.g., Oedipus complex, psychosexual stages of development).

Also the brief dynamic therapist is more likely to emphasize the client's *strengths* and resources in dealing with real-life issues rather than fostering regression and fantasy. Therefore, such psychoanalytic methods, such as free association or lying on the couch, are not used. Another major modification of psychoanalytic technique is that there is more emphasis on the here-and-now of the client's life than the there-and-then of childhood. For many modern brief therapists, interpretation (especially transference interpretation) plays a less central role, and insight, though still important, is not considered the panacea.[5]

Not only are traditional psychoanalytic interventions modified, but techniques from other theoretical approaches such as experiential-process therapy and cognitive-behavioral therapy may be incorporated (Abbass, 2015; Fosha, 2000; Lilliengren et al., 2016; McCullough & Magill, 2009; Safran & Muran, 2000). In brief dynamic treatments, the understanding of clients in terms of psychodynamic theory is decoupled from the exclusive use of dynamic techniques. The brief dynamic therapist may be thinking psychodynamically but feels free to use a variety of intervention strategies. The next chapter presents these (and other) modifications in an historical context.

[5] However, the definition of what constitutes "insight" is quite complex. The reader is referred to a book edited by Louis Castonguay and Clara Hill (2007) on insight in psychotherapy for more information.

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SUMMARY AND INTENT

In summary, short-term psychodynamic psychotherapies can be described as treatments of limited duration in which therapists are active in maintaining a circumscribed focus with limited goals while using a framework of basic, psychodynamically derived concepts with wide-ranging techniques.

While I have presented some general characteristics that distinguish short-term from long-term orientations, there is no single approach called *brief dynamic psychotherapy*. As becomes obvious in the following chapters, there is quite an array of approaches that all fit within this rubric. In an effort to make brief dynamic therapy concepts come alive for the reader, I refer to a particular brief dynamic therapy—time-limited dynamic psychotherapy (TLDP)—throughout the text to illustrate ways of formulating and intervening in a timely manner. It is my intention to use TLDP as a vehicle for introducing the reader to the applicability of brief dynamic approaches for today's practicing clinician. TLDP is a model with which I am quite familiar from clinical (Levenson, 1995, 2003; Levenson & Strupp, 2007), training (Levenson & Burg, 2000; Levenson & Evans, 2000; Levenson & Strupp, 1999), and empirical (Levenson & Bein, 1993; Levenson & Overstreet, 1993) perspectives. It is an integrative short-term approach that interweaves major principles of time-sensitive clinical work. I hope it will capture the breadth and depth of what brief dynamic psychotherapy can offer.