

# Efficacy of Short-Term Dynamic Psychotherapy

## *Past, Present, and Future*

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*The author outlines the history of brief dynamic psychotherapy, describes some of its characteristics, and addresses methodological requirements for assessing the efficacy of psychotherapy. Review of two major meta-analyses suggests that manual-based brief dynamic psychotherapy by trained therapists is likely to be as effective as other forms of psychotherapy and more effective than no treatment. More studies are needed that 1) compare brief dynamic psychotherapy with other forms of treatment for specific psychiatric disorders; 2) use theory-specific measures of outcome in addition to measures of symptoms; and 3) compare brief dynamic psychotherapy with long-term psychotherapy.*

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In the last few decades clinicians and researchers of varying orientations have embraced the shift toward brief psychotherapy. At the extreme, Talmon<sup>1</sup> even suggests one-session therapy. Three of the reasons for this change are modifications in community mental health systems; increased financial pressure from managed health care;<sup>2</sup> and growing awareness of the efficacy of short-term cognitive and behavioral therapies. Naturally, limiting the number of sessions may have negative implications for the comprehensiveness of treatment. Many health maintenance organizations (HMOs), for example, cover only 10 to 20 sessions per year, with increasing copayment after a predetermined number of sessions. The goals of HMO therapy are symptom relief and a return to normal functioning, as opposed to personality change. In a more positive light, HMOs have opened the doors of psychotherapy for patients who had previously been unable to pay for it,<sup>3</sup> a point often underemphasized by practitioners and researchers.

Although many practitioners have become aware of the data supporting the general efficacy of psychotherapy, few are aware that most of the data available regarding this

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effectiveness are derived from studies of brief psychotherapy. Smith and Glass,<sup>4</sup> in their comprehensive meta-analysis of the efficacy of psychotherapy, have shown that three-quarters of treated patients show more improvement than untreated patients. As Hoyt<sup>5</sup> pointed out, the average length of treatment reported in the meta-analytic study was 17 sessions.

The trend toward shorter treatment has not bypassed psychodynamic psychotherapy. Among psychoanalytically oriented clinicians, this trend may reflect the change in attitude toward the practicality and usefulness of traditional, long-term psychodynamic psychotherapy, psychoanalysis, and other prolonged psychotherapies. The desirability and practicality of brief therapy in terms of the patient's preference, time, and finances is unquestionable, especially among clients who are not mental health professionals. Mental health professionals, on the contrary, seem to prefer long-term therapy when they choose treatment for themselves. Another reason for the shortening of treatment may be the realities of clinical practice; many patients tend to stay in treatment for a relatively small number of sessions. For example, Garfield<sup>6</sup> reported that two-thirds of patients in therapy receive fewer than 10 sessions. Thus, dynamic therapists and trainees are often in the position of using techniques best suited to long-term treatment when treating patients who are not likely to stay in psychotherapy for an extended period of time. Therefore, it is not surprising that psychotherapists are showing an increased interest in briefer modes of psychotherapy. Because briefer therapy will fit the demands of the clinical world in the coming years, this interest is not likely to slacken in the 1990s.

In recent years, many forms of brief dynamic psychotherapy have emerged.<sup>7,8</sup> Crits-Christoph et al.<sup>9</sup> suggested that the more a psychotherapeutic system corresponds to the following criteria, the more likely it is to be called short-term psychodynamic therapy: 1) the theory underlying the explanation for

the disturbance is psychoanalytic in the wide sense of the term; 2) the techniques are for the most part psychoanalytically inspired; 3) treatment is time limited; 4) patients are selected for such treatment; and 5) a focus of treatment is developed and maintained.

#### HISTORY AND CHARACTERISTICS

Although Freud treated Katharina and Gustav Mahler in single several-hour sessions, with the development of analytic theory and a deeper understanding of the complexity of the mind, psychoanalytic treatment became longer and longer. Ferenczi and others attempted to shorten the length of psychoanalysis.<sup>10,11</sup> Later, Alexander and French<sup>12</sup> in their *Psychoanalytic Therapy* conceptualized the essence of psychotherapy as providing patients with a "corrective emotional experience." Alexander and French also recommended using weekly sessions instead of daily sessions because the sparser sessions allow the patient to apply what was learned during treatment to everyday experiences and because the less frequent sessions decrease the patient's dependence on the therapist.

Since the earlier days of psychoanalysis, there has always been a stream of analysts who have attempted to shorten therapy (Ferenczi, Rank, Alexander, and French, to mention a few). Most, if not all, psychodynamic clinicians nevertheless considered brief dynamic therapy an inferior form of psychoanalytic treatment, and many still hold this view. Malan's summary<sup>13-15</sup> of two major research projects with detailed descriptions of case material, however, might have led to the realization that brief dynamic psychotherapy can be valuable. He emphasized the importance of patient selection through the screening of inappropriate referrals and through trial interpretations. He also promoted the importance of defining and maintaining a therapeutic focus. Malan was among the first to show that short-term dynamic therapy can result in meaningful changes in personality

through concentration on and interpretation of the patient's focal issue.<sup>14,15</sup> The central conflict is addressed through delineation of impulse, defense, and anxiety (the "triangle of insight"), using interpretative techniques. Impulse, defense, and anxiety are repeatedly addressed by linking their expressions toward current significant others, the therapist (transference), and parents (the "triangle of person").

During the 1960s and '70s, the writings of Malan, Mann,<sup>16</sup> Sifneos,<sup>17</sup> and Davanloo<sup>18</sup> were the major force behind the development of contemporary brief dynamic therapies and toward the realization that brief therapy can provide more than merely support or crisis intervention. Their work showed that brief dynamic psychotherapy could make use of an "uncovering approach."<sup>5</sup> In fact, many therapists use clarifications and interpretations, focusing especially on the transference.<sup>15-18</sup> Nevertheless, most theorists recognize the importance of both the supportive and the interpretive or expressive components of dynamic psychotherapy.<sup>19</sup> The selection and maintenance of a treatment focus is one of the most prominent characteristics of these brief therapies.

An important characteristic of brief dynamic psychotherapy is the limited number of sessions, usually ranging from 12 to 40. In theory, treatment length is a function of the level of psychiatric severity.<sup>8</sup> As in many forms of treatment, in brief dynamic therapy a detailed assessment of the patient's problems is essential in selecting the most appropriate candidates for treatment. An important selection criterion for brief dynamic therapy is the therapist's evaluation of the patient's ability to create a good working relationship, along with his or her motivation for change in therapy.<sup>17</sup> First Malan, then Davanloo used the quality of patients' responses to therapists' "trial interpretations" early in treatment to select appropriate patients.

Although most brief dynamic therapies target general psychiatric problems,<sup>19,20</sup> some therapies are more specifically tailored to cer-

tain problems than others. For example, Horowitz's<sup>21</sup> Short-Term Dynamic Therapy for Stress Response Syndrome is designed specifically for patients who have encountered major stresses; the manual of Kernberg et al.<sup>22</sup> is intended for patients with a diagnosis of borderline personality disorder. An extensive comparison of the different models of brief dynamic psychotherapy can be found in Barber and Crits-Christoph<sup>23</sup> and in Gustafson.<sup>24</sup>

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#### STUDYING THE EFFICACY OF BRIEF THERAPY

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##### Methodological Requirements

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Most articles that address the requirements for conducting an adequate clinical trial emphasize determinants of external validity, such as patients' random assignment to treatment groups. This section focuses instead on the issue of the internal validity of the treatment. From a research perspective, one of the major problems with early psychotherapy studies is the lack of evidence that the therapists indeed did what they were supposed to do. In recent years, researchers have used three methods to ensure treatment fidelity: treatment manuals, adherence checks on the delivered therapy, and supervision of therapists.

During the 1980s, researchers interested in studying the efficacy and the mechanisms of change in dynamic psychotherapy also contributed to the theories of brief therapy. Scientific standards made it necessary to write detailed treatment manuals that clearly described and explained the therapeutic techniques. The term *treatment manual* is a poor choice because of the negative connotations associated with the word *manual*. Many people use manuals to operate their VCRs or to fix their cars, but not to create supportive relationships with other human beings. A better term might be *guidelines*.

Specific guidelines were first developed for cognitive-behavioral treatments by Beck

et al.<sup>25</sup> and later for psychodynamic therapy by Luborsky,<sup>19</sup> Strupp and Binder,<sup>26</sup> and Kernberg et al.<sup>22</sup> Horowitz<sup>21,27</sup> developed a 12-session format for subjects who have encountered major stress. These guidelines for therapists include detailed descriptions of the method for selecting patients for treatment (such as inclusion and exclusion criteria), goals of therapy (symptomatic relief versus resolution of underlying conflicts), theories of psychopathology, and specific descriptions of the therapeutic techniques recommended, together with examples of their implementation.

For the most part, treatment guidelines are supplemented by rating scales that enable clinicians and researchers to rate how closely the therapist follows the treatment manual (adherence ratings) and how skillfully the therapist applies the recommended techniques (competence ratings).<sup>28</sup> One way to ensure adherence is to supervise therapists both during the training phase of the study and during the clinical trials themselves. For example, one of the criticisms of the Treatment for Depression Collaborative Research Program was the lack of therapist supervision during the clinical trial.<sup>29</sup> Once treatment guidelines and adherence scales are developed and implemented, the issue of treatment integrity can be assessed and treatments can be compared for effectiveness.

In investigating the issue of adherence, Moncher and Prinz<sup>30</sup> reviewed 359 outcome studies published in major journals from 1980 to 1988. They found that compared with the studies published during the previous decade, these studies paid more attention to adherence and continued supervision to promote treatment fidelity. Moncher and Prinz also showed that, nevertheless, 55% of the studies completely ignored the issue of treatment fidelity (no use of treatment manual, supervision, or adherence check). Furthermore, only 5.8% of all studies published included all three of these components. Between 1986 and 1988 only 1 out of 8 published studies combined the use of treatment

manuals, therapist supervision, and adherence checks. On first thought, these numbers are surprisingly low, but one needs to keep in mind the delay between the time a psychotherapy study is planned and the time it is published; thus, psychotherapy studies published in journals between 1986 and 1988 are likely to have begun around 1980.

#### Meta-Analyses of Efficacy Studies

Two major meta-analytic studies have recently reviewed the evidence for the efficacy of brief dynamic psychotherapy.<sup>31,32</sup> Svartberg and Stiles's<sup>32</sup> meta-analysis includes 19 studies published in journals and indexed in *Psychological Abstracts* and *Index Medicus* from 1978 through 1988. All of these studies included brief dynamic therapy and at least one other treatment condition. In addition, treatment in these studies was time limited. Required components for a treatment to be called brief dynamic psychotherapy were the acquisition of insight or personality change and therapists' use of interpretation and focus on the transference. Svartberg and Stiles found that although brief dynamic therapy was superior to being on a waiting list, it was inferior to other psychotherapies at the end of treatment and at two follow-up periods.

In his meta-analysis, Crits-Christoph<sup>31</sup> included only those studies in which patients had been selected for treatment (because not all are appropriate for brief therapy). Further, he included only studies that used a treatment manual describing the specific therapeutic techniques in detail. Use of manuals has been shown to decrease therapist effects (significant differences between therapists in outcome studies, or nonindependence).<sup>33</sup> Finally, he analyzed only those studies in which therapists were experienced in the treatment they delivered and were no longer in training. In the past, many researchers have employed dynamic therapists without experience in time-limited treatment. Clinical experience indicates that many long-term dynamic therapists have difficulty in

adopting a brief model.<sup>5</sup> In summary, Crits-Christoph's meta-analysis included only studies in which brief dynamic psychotherapy was administered to a selected group of patients by relatively experienced therapists who were using specific guidelines.

Because of these different requirements, Crits-Christoph's meta-analysis included fewer studies (11, including 1 unpublished), but these studies tended to be more recent. Crits-Christoph's review also differs from Svartberg and Stiles's in that it includes 4 studies of interpersonal psychotherapy<sup>34</sup> (IPT), which is not a mainstream psychodynamic approach.\* Crits-Christoph,<sup>31</sup> like Svartberg and Stiles, found that brief dynamic psychotherapy was superior to being put on a waiting list, but, unlike Svartberg and Stiles, he found that brief dynamic therapy was as effective as other forms of psychotherapy. In a further analysis, Crits-Christoph<sup>35</sup> has shown that his results do not change if he takes out the 4 IPT studies.

The choice of studies, which is essential to meta-analysis, makes comparison of Svartberg and Stiles's and Crits-Christoph's meta-analyses difficult. In fact, only 3 studies are common to both. Thus, the different conclusions drawn are likely to be the result of the different studies included in the meta-analyses. Because Svartberg and Stiles did not select studies on the basis of whether they provided an appropriate and well-defined treatment by experienced short-term therapists, one may conclude that when one compares studies that have addressed the issues of treatment fidelity and the qualification of therapists (in addition to the usual requirements for a clinical trial, such as patient ran-

domization), as in Crits-Christoph's analysis, brief dynamic therapy is just as effective as other psychotherapies. These meta-analyses raised some important issues about the future of psychotherapy research on brief dynamic psychotherapy. These issues are addressed next.

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ON THE FUTURE OF  
OUTCOME RESEARCH  
IN BRIEF DYNAMIC  
PSYCHOTHERAPY

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In this section I raise issues relevant to the future of brief dynamic psychotherapy. It is important to note that, for the most part, these issues would also be relevant to questions about longer forms of dynamic psychotherapy.

**1. Efficacy of brief therapy for specific disorders.**

In general, the recent decade of research on psychotherapy efficacy has been characterized by an increased interest in comparing different psychotherapies for specific DSM-III-like diagnostic categories.<sup>36</sup> The most surprising aspect of this current literature, however, is its paucity of comparisons between brief dynamic psychotherapy (at least, non-IPT) and, for example, cognitive-behavioral therapy for specific, commonly found disorders such as depression, anxiety, and panic disorders. Cognitive therapy enjoys the well-founded reputation of being effective for the treatment of depression and panic disorders, whereas, at least in some circles, dynamic psychotherapy does not have this reputation. The latter impression appears to be unfounded; dynamic therapy has rarely

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\* The question of whether or not IPT is a form of dynamic psychotherapy can be answered at two levels. At the theoretical level, IPT seems to be quite different from "normal" dynamic psychotherapy. At the level of clinical practice, the answer might be different. In fact, the IPT therapists in the Treatment for Depression Collaborative Psychotherapy Program were experienced dynamic therapists; some of them were analysts. But there is no study yet that compares these therapists' actual actions during treatment with those of therapists from another dynamic psychotherapy project. Such a study will be needed.

been compared with cognitive therapy for depression and has never been compared with, for example, cognitive therapy for panic disorders. In the few cases where they have been compared,<sup>29</sup> as in the study by Thompson et al.,<sup>37</sup> a non-IPT brief dynamic psychotherapy was found to be as effective as cognitive therapy for depression in a geriatric population. Moreover, the methodological quality of this study was rated highly by both meta-analytic reviews.

**2. Guidelines for treatment of interpersonal problems.** Many dynamic therapists argue that dynamic therapy may be the treatment of choice for dysfunctional or self-defeating interpersonal relationships or for personality disorders. It is, therefore, very surprising that no study has ever examined this hypothesis. Whether brief dynamic therapy is successful in treating disturbances of the personality and whether brief dynamic therapy is more effective than other psychotherapy are important issues to investigate. Before studies can be conducted, however, researchers and clinicians need to develop guidelines for the dynamic treatment of specific diagnostic groups of patients. An example (but not from a brief dynamic psychotherapy perspective) is the effort of Kernberg and his colleagues to "manualize" their form of treatment for borderline personality disorder.<sup>22</sup> It is quite possible that therapies for some of the personality disorders may not be of a brief duration (that is, not under 20, or even 40, sessions), and longer term approaches may be needed. But only careful research will enable us to determine the relative impact of brief versus long-term treatment on these disorders.

### **3. Theory-specific measurement of outcomes.**

Psychodynamic clinicians and researchers hold that dynamic therapy leads to major changes in their patients' productivity, self-knowledge, underlying conflicts, quality of life, and, perhaps, personality (structural change). To examine the efficacy of brief dynamic therapy and to understand its mechanisms of change, one needs to measure outcome in a way that is theoretically relevant, in addition to measuring symptomatic improvement.\*

Robert Weinryb and colleagues' Karolinska Psychodynamic Profile<sup>38,39</sup> would be one way to assess structural change specific to dynamic psychotherapy, such as change in tolerance for anxiety and change in the quality of intimate relationships. But the field also needs specific measures of content that are more likely to be more sensitive to change than are structural measures of character.

**4. Measures for core conflicts.** Some other promising methods include measures of dynamic formulation, of central conflicts, or of maladaptive interpersonal patterns, based on clinician ratings of clinical material. Using these methods, one could assess patients before and after treatment<sup>39</sup> and examine changes in central conflicts. Barber and Crits-Christoph<sup>41</sup> have just reviewed the reliability and validity of these measures and concluded that their introduction has led to meaningful findings. One finding is that accurate interpretations of the core conflict or main theme lead to better outcomes.<sup>42,43</sup> Nevertheless, these clinician rating measures are in need of further psychometric validation<sup>41</sup> and tend to be very time-consuming. An alternative

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\* Short-term behavioral and cognitive therapists discuss symptoms at length with their patients, whereas many dynamic therapists do not. But it is not antithetical to dynamic therapy to emphasize symptoms. It would be interesting to see what would happen to symptomatic improvement if dynamic therapists put more emphasis on the relations between symptoms and underlying issues. For example, I have been strongly recommending that my therapists use the Core Conflictual Relationship Theme (CCRT) method<sup>40</sup> to make interpretations addressing the connection between the patients' CCRTs and their symptoms.

methodology is the use of self-report instruments such as the Inventory of Interpersonal Problems,<sup>44</sup> which is designed to assess the different kinds of interpersonal problems that people experience. Lorna Benjamin's Intrex is another self-report questionnaire that might be used to assess maladaptive patterns.

If brief dynamic psychotherapy is as effective as other treatments, it would be interesting to examine whether theoretically relevant measures of outcome will produce similar findings across different therapies. Imber et al.,<sup>45</sup> for example, stress the need in psychotherapy research to develop measures that address the distinctive rationales and procedures of specific psychotherapies. Valid theory-specific measures will also enable researchers to study the mechanisms and processes of change in specific forms of psychotherapy.<sup>46</sup> For example, future studies might examine the question of whether dynamic psychotherapy induces change in maladaptive (self-defeating) interpersonal patterns. If so, do other forms of psychotherapy induce these changes or is it specific to dynamic psychotherapy? Further studies would then examine whether change in maladaptive patterns is associated with prevention of relapse into depressive or anxiety disorders.

**5. Cost-effectiveness measures.** Emotionally distressed patients tend to use more medical services,<sup>47</sup> but the reverse tends to be true of patients who have had psychotherapy. Most therapists have more ambitious goals than just relieving symptoms. Dynamic therapists, for example, try to increase patients' self-understanding and improve their well-being. It is expected that increased self-understanding will lead to changes in various areas of life, including physical health. Cost offset studies have shown that psychotherapy reduces patients' overall medical expenses within the first few years following treatment. For example, Schlesinger et al.<sup>48</sup> looked at the claims submitted to a U.S. health plan for federal

employees between 1974 and 1978. They then compared patients who had a chronic disease (diabetes, asthma, hypertension, or ischemic heart disease) and had received mental health care versus those who did not receive such additional care. They found that 1) by the third year, the medical costs for patients who had also received mental health care were 39% lower than for those who did not; 2) there was a dose-response effect; that is, the more sessions patients had, the better the outcome; and 3) psychological services were ineffective when delivered for a small number of sessions (< 5). VandenBos and DeLeon<sup>47</sup> also report on findings that psychotherapy reduces the overall expenditure for health services.

If VandenBos and DeLeon are correct in concluding that psychotherapy reduces the overall expenditure for health services, then one needs to examine not only the efficacy of treatments, but also their overall cost-effectiveness. That is, one needs to examine not only whether patients who have been treated have fewer symptoms but also whether they use fewer health services. Indeed, HMOs are the ideal place to conduct medical offset research.<sup>47</sup> In addition, future outcome studies may benefit from the inclusion of a cost-effectiveness component. Unfortunately, adding such a component to an outcome study is likely to make the study more complex and more expensive.

As previously mentioned, some authors attribute the increased interest in brief dynamic psychotherapy to financial pressures from insurance companies. If this view is correct, then it is important to examine whether brief therapies lead to a major shift of cost away from psychotherapy to other medical or social costs, such as increased use of general practitioners.

**6. Comparing efficacy of brief and long-term dynamic psychotherapies.** It is surprising that very few studies have compared brief psychotherapy and long-term treatments. The results of Piper et al.,<sup>49</sup> who compared long-

term (24 months) with short-term (6 months) individual dynamic therapy and group therapy, suggest that long-term group and short-term individual dynamic psychotherapy are somewhat more effective than short-term group or long-term individual. In terms of quality of outcome, "long-term individual psychotherapy was not far behind" (p. 278). The authors acknowledged, however, that they did not use manuals or an adherence check. Unfortunately, the lack of studies has led to the verdict that long-term dynamic psychotherapy is not effective or worthwhile. Further studies comparing these two forms of therapy are now clearly overdue. This type of research will raise difficult questions. Researchers will have to decide which kinds of patients to target, whether random assignment is to be used (many people may be unwilling to get into long-term treatment), and how to address dropout rate (many patients may not stay after symptoms have been relieved). It is noteworthy, however, that Piper et al.<sup>49</sup> did not find differences in dropout rates across the groups. There are also conceptual difficulties; for example, we know that therapeutic dose influences outcome. Thus, comparing the efficacy of two treatments that differ in total length gives an a priori advantage to longer term treatment. Again, this concern did not materialize in a previous study.<sup>49</sup>

From a researcher's point of view, it is much easier to control a variety of therapeutic and nonspecific variables by using a well-specified treatment conducted in a time-limited framework. It is also much easier and faster to finish (that is, publish) a psychotherapy study if one uses a brief form of treatment. Finally, funding from NIMH or NIDA is available only for periods up to 5 years. Thus, it is not surprising that most research studies are in time-limited dynamic psychotherapy (notable exceptions are the Menninger Foundation and the Penn Psychotherapy Projects). In light of researchers' preference to study time-limited, short-term treatment, there is a need to compare the

efficacy of brief dynamic psychotherapy and long-term psychotherapy to examine whether or not shortened treatments lead to decreased benefits for the patients. Despite the trend toward briefer treatments, Ellen Frank and colleagues<sup>50</sup> work in IPT seems to indicate that booster sessions (less frequent sessions over long periods of time) tend to prevent relapse into depression. Similar findings have been shown with pharmacotherapy.

**7. *Developing empirical psychoanalytic models of psychopathology.*** Besides providing a detailed description of the techniques used in a treatment, manuals should include a specific description of the patient's psychopathology. To this end, psychodynamic researchers should consider the empirical study of psychopathology. Treatments derived from a sound analysis of the patient's psychopathology are more likely to be rational and, one hopes, effective. If dynamic therapy, for example, is more appropriate than other forms of psychotherapy for inducing change in the deep-rooted maladaptive interpersonal patterns of patients with diagnoses of personality disorders, then the treatment must be addressing specific issues in these patients that other treatments may not address. A detailed characterization of those patterns, such as that provided by Benjamin,<sup>51</sup> will help derive more rational treatment for those patients. Finally, increased knowledge of psychopathology may help us better match the problems patients bring to treatment with the different forms of psychotherapy, as discussed in the next item.

**8. *Matching patient characteristics to treatment.***

In the future, the efficacy of treatment may be best determined not by the objective quality of different therapies, but by examining the "fit" between treatment and patients' personality characteristics.<sup>31,52</sup> If we want to match the treatment to the personality of the patient, we need a comprehensive way of describing personality and psychopathology.

One helpful distinction made by Blatt<sup>53</sup>



is between anaclitic and introjective patients. Anaclitic patients tend to suffer from disruptions in the way they relate interpersonally and to use avoidant defenses. Introjective patients struggle with issues pertaining to self-definition, autonomy, and self-esteem. Blatt has shown retrospectively that among the patients who participated in the Menninger Psychotherapy Research Project, the anaclitic patients did better with psychotherapy, whereas the introjective patients improved more following traditional psychoanalysis. Future studies may come to examine, for example, whether anaclitic patients do better in brief dynamic or cognitive psychotherapy.

Piper and co-workers<sup>54</sup> have shown that patients who have a high quality of object relations, as assessed by independent observers from an unstructured interview conducted before treatment, do better in short-term dynamic psychotherapy than patients with a low quality of object relations. Future studies may examine, for example, the relative efficacy of brief and long-term dynamic psychotherapy for patients with a low quality of object relations.

Burke et al.<sup>55</sup> suggested matching patients with certain developmental issues to specific models of therapy. According to them, the different models of brief psychotherapy can be divided into three major approaches, each of which may be best suited to address a certain developmental issue or stage of adulthood. For example, dependent patients who struggle with the issue of "identity versus role confusion"<sup>56</sup> might benefit from Mann's<sup>16</sup> approach. No study has yet tried to address this prediction.

Future studies could also address more specific hypotheses, such as what kinds of patients are likely to respond to confrontative techniques rather than to a more supportive approach.<sup>19</sup> Because one of the characteristics of brief dynamic psychotherapy is the therapist's focus on a central conflict,<sup>23</sup> work is needed to address whether maintaining focus on the conflict is more effective than nondirective dynamic psychotherapy and, if

so, for which types of patients it is most effective.

**9. Funding problems and their implications for the future.** In contrast to pharmacotherapists who can apply to private drug companies for funding, psychotherapy researchers are mostly dependent on governmental money and a few private foundations for funding their research. At the same time, the requirements for a state-of-the-art psychotherapy clinical trial necessitate a major investment of money and time. For example, psychotherapy researchers need to supply evidence for the preliminary efficacy of their treatment and to have both a treatment manual and a therapists' adherence/competence scale. They are not likely to be funded until these qualifications are met. It is difficult to train experienced therapists without having some previous funding. Furthermore, all the necessary ingredients for a successful outcome study (for example, reliable assessment, use of experienced therapists, close supervision of therapists, and adherence ratings of audio/videotapes of sessions) are likely to make such a study expensive. Finally, in order to convince any meaningful group of clinicians or skeptical scientists that a certain approach is effective, one would need to replicate the study in different settings and with different therapists, which requires additional funds.

**10. Studying the prevalence of short-term treatments.** There are currently no data concerning the percentage of therapists who intentionally choose to use brief dynamic psychotherapy. Some of the reasons dynamic therapists do not use brief dynamic techniques deliberately are resistance,<sup>5</sup> fear of hurting patients, lack of training, and financial considerations. Except for therapists working in organizations such as student counseling centers and some HMOs, few psychotherapists deliberately choose to work with patients in a time-limited format. In view of managed care pressures, it would be help-

ful to have an estimate of the prevalence of the intentional use of brief treatments today. Such an estimate would contribute to the planning and development of future treatment programs, which will most likely require delivery of time-limited psychotherapy. Such an estimate will also help faculties in departments of psychiatry, clinical psychology, and social work plan adequate training programs.

**11. *The importance of training.*** Most if not all theorists who have developed and written about short-term treatment have been trained in long-term therapy and even psychoanalysis. It could be that without this experience they would not have been able to develop the briefer treatments. For example, experience and knowledge of psychodynamics could be helpful in defining what the focus for short-term treatment is in either dynamic or cognitive therapy. With regard to training new generations of therapists in brief dynamic therapy, one might speculate, on the one hand, that experience in long-term therapy could be helpful at speeding up the training process for therapists learning brief dynamic psychotherapy. On the other hand, experience in long-term psychoanalytic psychotherapy might bias the therapists and decrease their willingness to adopt an active stance. One research question to be examined, therefore, is whether or not prior experience in long-term treatment is helpful in becoming a short-term therapist. Henry et al.<sup>57</sup> recently reported on the results of the Vanderbilt II study. In that study, 16 licensed psychiatrists and psychologists received one year of training in short-term dynamic psychotherapy.<sup>26</sup> One of the findings was that the number of hours spent under supervision before the training began was inversely related to observed adherence to the learned model.

There is little work done on the training of therapists and on whether expert or novice therapists can be trained in a different form of therapy than the one to which they are accustomed. Recent results from the

Vanderbilt II study<sup>58</sup> seem to indicate that relatively experienced dynamic therapists can be taught a manual form of Strupp and Binder's<sup>26</sup> short-term dynamic psychotherapy. Nevertheless, the Vanderbilt authors worry because they found an increase in the number of therapists' hostile messages to patients as a result of training.<sup>58</sup> They concluded that the training may have helped therapists become more active without reducing the number of hostile messages. It remains to be seen, however, whether this nonsignificant result will be replicated by others.

The Vanderbilt II study provided some initial directions for answering the more refined question of what can be done to improve therapists' skills. Henry et al.<sup>58</sup> reported that trainees' improvement in skills specific to short-term dynamic psychotherapy was attributable to the teaching of one of the two supervisors. This supervisor was very active and directive. He emphasized the teaching of specific skills, the thought processes of the therapists, and the learning of basic concepts, and he provided trainees with specific feedback. Because only two supervisors were involved in the study, we need to be cautious about inferring too much from this post hoc analysis. Nevertheless, these results are provocative and await replication.

**12. *The limits of brief treatments.*** Like many new ideas (scientific or not), short-term treatment is now being taken to its limits. It would not be surprising, therefore, to begin to see a reaction to this trend, a pendulum swing in the other direction. We may already be in the process of learning that short-term treatment is not a panacea applicable to all patients for all psychiatric disorders. Learning which treatment is not appropriate for a specific patient is important, especially in light of the fact that few examples of differential efficacy have been shown in psychotherapy. Examples of longer treatment are provided by Marsha Linehan,<sup>59</sup> who is now using behavioral-dialectical therapy effectively with parasuicidal patients in a 1-year treatment. Ellen Frank

and her colleagues<sup>50</sup> have also demonstrated that maintenance interpersonal psychotherapy or pharmacotherapy are helpful at preventing recurrence of depression.

Several years ago, Howard and colleagues<sup>60</sup> showed that increased psychotherapy dosage (number of sessions) led to increased chance of patients' improvement. They recently used their model to examine how length of treatment influences different kinds of symptoms or signs.<sup>61</sup> Using a naturalistic sample of 702 patients in psychoanalytically oriented psychotherapy, they showed that patients with acute and chronic distress symptoms had at least a 60% chance of moving into the normal range after 1 year of therapy. However, the probability of recovery with character symptoms (such as hostility and paranoid ideation) was smaller and reached, at best, 50% after 1 year of treatment.

#### CONCLUSIONS

The proliferation of therapeutic systems of brief dynamic psychotherapy, many of them derived from different theoretical positions,<sup>7,8</sup> has not been matched by an increase in high-quality outcome studies. As I have noted, few outcome studies have addressed the internal validity of psychotherapy outcome research by ensuring treatment fidelity. The few methodologically sound studies that have examined the efficacy of brief dynamic psychotherapy indicate that it is clearly more effective than no treatment and as effective as other forms of psychotherapy. That is, one could conclude from the two meta-analyses reviewed in this article that brief dynamic therapy is effective when administered to a select group of patients by experienced therapists who have been trained to deliver a specific treatment. This finding is not unusual; many psychotherapy researchers have found that most psychotherapeutic treatments are equally effective.<sup>4,62</sup>

Now that the efficacy of psychotherapy in general, and brief dynamic psychotherapy

when delivered by trained therapists who apply well-defined treatment in particular, have been demonstrated, the field is slowly turning to more specific questions. The agenda for future research on the efficacy of brief dynamic psychotherapy is likely to include the following tasks:

1. Examining its efficacy for a variety of specific psychiatric disorders, such as generalized anxiety disorders and panic disorders.
2. Developing guidelines and treatments for patients who have interpersonal problems and/or personality disorders. In addition to the difficulties involved in developing specific guidelines for longer term treatment, the field of personality disorders is complicated by problems in the reliability and validity of diagnostic criteria for those disorders. Once guidelines are developed, a clinical trial for personality disorders will have to be conducted. In the not too distant future, a trial comparing, for example, Kernberg's psychoanalytic therapy with Linehan's dialectical behavioral therapy for borderline personality disorders is likely to occur.
3. Measuring theory-specific outcomes, in addition to symptoms, in outcome studies comparing different forms of psychotherapy.
4. Developing reliable and valid self-report measures of core conflicts that could be used easily in such studies.
5. Measuring the potential cost offset of using different forms of brief psychotherapy.
6. Examining the comparative efficacy of brief versus long-term dynamic psychotherapy, taking into consideration the above outcome variables.
7. Developing further the empirical psychoanalytic models of psychopathology.
8. Matching patients to treatment on the basis of their personality, level of functioning, or developmental stage.

9. Finding funds for research in light of both the small amount of money available for psychosocial research and the inherent limitations of current funding for examining the efficacy of long-term treatment, particularly for a comprehensive comparison of brief versus long-term dynamic psychotherapy for a variety of disorders.
10. Finding out the prevalence of the use of brief treatment by design.
11. Examining whether experienced therapists can be trained in brief dynamic psychotherapy and what techniques would be effective in training those practitioners.
12. Learning the limits of brief dynamic psychotherapy; that is, learning for which conditions or psychological symptoms we should recommend longer term treatments.

Other important dimensions of research in the area of brief dynamic psychotherapy that could not be included in this article are studies addressing the process of psychotherapy and the roles of patients and therapists in predicting outcome.<sup>63,64</sup> In a special section

in the *Journal of Consulting and Clinical Psychology* titled "Curative Factors in Dynamic Psychotherapy,"<sup>65</sup> researchers cover much of what has been learned about the process of brief dynamic psychotherapy. For example, much attention in psychotherapy research has focused on therapists' interpretations and their relations to outcome;<sup>66</sup> the importance of the therapeutic alliance to outcome;<sup>67</sup> developing measures of central conflicts or transference patterns;<sup>41</sup> and developing measures of patients' internalization of the therapist and treatment.<sup>68</sup>

In summary, brief dynamic psychotherapy has been shown to be as effective as other brief psychotherapies in the psychiatric disorders in which it has been studied. Because of the paucity of studies, however, much work is needed to validate the recent emphasis on recommending the use of brief psychotherapy for many disorders. I hope this article has raised some of the urgent issues that need to be addressed to assess comprehensively the efficacy of brief dynamic psychotherapy.

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