

Clinical Implications of Research on Brief Dynamic Psychotherapy I. Formulating the Patient's Problems and Goals

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In this two-part series of articles, a model for understanding the process of brief dynamic psychotherapy is presented. The model suggests that patients enter therapy with an unconscious plan for how to get better. The therapist's interventions must be in accord with this plan for the patient to be helped by therapy. The plan concept is described, as are issues involved in inferring a patient's plan. Finally, the ramifications of the plan concept for the conduct of brief dynamic psychotherapy are discussed.

In this and the following article we focus on two broad questions: What is, or should be, the focus of brief dynamic therapy; that is, *what* do you work on? And then, how is this done; that is, *how* do you work on it? Our responses to these questions are based on research we have been conducting on brief dynamic therapy. Our work is, in turn, an outgrowth of the studies of psychoanalysis which have been conducted for the last 15 years by the Mount Zion Psychotherapy Research Group headed by Dr. Joseph Weiss and Dr. Harold Sampson (Weiss, Sampson, & the Mount Zion Psychotherapy Research Group, in press). We have taken the theory of therapy developed by Dr. Weiss on psychoanalysis and applied it to the study of brief dynamic therapy; and we have also borrowed heavily from the Mount Zion Research Group's methods for studying psychoanalysis in developing our studies of brief dynamic therapy.

The major points that we develop in this article are as follows:

1. Patients come into therapy, be it brief or long term, to get better, and they have an unconscious plan for how to do this.
2. If the therapist responds in accord with this plan, the patient will get better; if not, the patient will not improve or may even get worse.
3. Therefore, it should be the patient, not the therapist, who directs the course of brief therapy.
4. There are no universal themes or foci—such as separation or Oedipal conflicts—that should be pursued in brief dynamic therapy.
5. Similarly, there are no special or unique techniques for the conduct of brief dynamic therapy. For example, it is not necessary for the therapist to be more active, to make more interpretations, or to avoid certain issues merely because the therapy is time-limited.

We describe the plan concept further and say a few words about how to infer a patient's plan. We then discuss the ramifications of the plan concept for brief dynamic therapy and, in so doing, compare our theory and research findings with those of other brief therapy clinicians and researchers. In order to keep within the time allotted us and in an attempt to be as clinically relevant as possible, we tried to limit our discussion of the research supporting our ideas to a minimum. Thus, we want to stress at this time that our conclusions are both consistent with the theory of therapy developed by Dr. Weiss and have been supported by extensive empirical research.

What is a plan? In its simplest form, the plan concept states that the patient enters therapy with ideas, or a plan, both conscious and unconscious, for how to overcome his or her problems with the help of the therapist.

As developed by Dr. Weiss (in press), the plan concept assumes that a patient's psychopathology stems largely from unconscious pathogenic beliefs developed during childhood. A pathogenic belief may be viewed as a simple yet compelling unconscious theory formed in early childhood that warns the person who adheres to it against pursuing a particular goal. It indicates that the pursuit of a goal will in some way endanger oneself and/or someone else. Pathogenic theories develop in response to traumatic childhood experiences. Following a trauma, a child is confronted with an urgent problem—to prevent a recurrence of the trauma. Thus the child wants to know how and why the trauma occurred and what role he or she played in its occurrence. However, the child has neither the knowledge nor the experience to understand or solve these traumatic events. Consequently, the child is prone to make false generalizations about cause and effect when theorizing and to infer personal responsibility for any mistreatment or trauma to which he or she is subject, or for any trauma or suffering which parents, siblings, or other important relations endure.

The child's relationships with the parents or other significant early care givers are fertile ground for trauma because they are the first and most impor-

tant that a child experiences, and the child faces them without any prior knowledge about human interactions. Moreover, because of the child's dependency on the parents, any threat to this relationship is, by definition, traumatic. Thus, a traumatic experience during the pursuit of a developmental goal may cause the child to link the attainment of the goal with danger to one or both parents, as well as to himself. This occurs because the child, when trying to understand traumatic incidents, is prone to infer a causal relationship between personal actions, thoughts, or feelings and certain parental behaviors. A pathogenic theory thereby develops which warns the child against the danger—to self or others—of pursuing a particular goal. This perception of danger impedes the person's capacity to attain various developmental goals or leads to the renunciation of certain goals. These false ideas often endure because they have been repressed, and thus the person is unable to disconfirm them. They also persist out of fear—for instance, a person may be so convinced of his omnipotence that he is afraid to test various ideas.

Weiss has described two sequences by which a child may develop a pathogenic belief. According to one sequence, the child first attempts to gratify a certain impulse or to reach a certain goal and then experiences such attempts as being threatening to his or her ties with the parents. The child then develops a belief which causally connects attempts to gratify the impulse or to reach the goal with threat to parental ties. Thus, after intense conflict, the child represses the impulse or goal in order to retain the parental ties.

Weiss gives as an example of this sequence the classic situation where a boy comes to believe that, by his attempts to gratify his sexual impulses with his mother, he risks castration by his father. As is well known, the experience from which the boy infers such a belief may be highly distorted by projection. A boy whose parents are not at all threatening may develop castration anxiety as a consequence of projecting his rivalry onto his parents. However, a belief in castration can also be powerfully abetted by experience—such as actual abuse by a parent—which makes the idea of castration highly credible. Thus the intensity of danger experienced by the child is a function of both the child's wishes and actual experiences.

The second sequence described by Weiss for developing a pathogenic belief begins when the child experiences an inherently traumatic event, such as the illness of a parent, and then retrospectively blames himself or herself for the event. This occurs because of the child's tendency to take responsibility for whatever happens; the child concludes that the event was brought about by his or her attempts to gratify a particular impulse or to obtain a particular goal. For example, a boy, after his father's death, may conclude retrospectively that his hostility and competitiveness with his father brought on the latter's death. To avoid bringing on another such catastrophe, the boy may subsequently repress competitiveness and hostility.

Pathogenic beliefs are not gratifying; they are frightening and con-

stricting. Consequently, a patient has a strong unconscious wish to change these beliefs, to overcome the inhibiting feelings of fear, anxiety, and guilt which stem from them, and thereby to gain greater control of his or her inner and outer worlds. It follows that the psychotherapy patient has strong conscious and unconscious motives to work with the therapist to solve problems. The therapist's function is to help the patient understand the nature and ramifications of his or her unconscious pathogenic beliefs by interpretation and by allowing the patient to test them in the therapeutic relationship. The manner in which the patient will want to work to overcome pathogenic beliefs, solve problems, and achieve goals is what we refer to as the patient's "plan."

The plan is not an immutable blueprint or map that the patient will have to follow. Rather, it may be thought of as a broad direction or series of directions in which the patient wishes to go. The exact method or progression by which the patient's plan will be pursued will be determined by a variety of factors, including the patient's needs at any given time and the avenues for work and progress available to the patient within the therapeutic relationship.

The patient's needs affect the direction of the therapy by influencing the patient's decision about what he or she will focus on at any given time in the therapy. An example of this is an unconscious decision about what danger the patient will work to overcome at a given time, and what dangers he or she will defer working on until later. For example, a patient may first need to be assured that the therapist cannot be fooled or overwhelmed before confronting other issues.

During an intake interview with a patient seen through our brief therapy program, the patient noted that he had had problems with drinking, but felt that he was in control of the problem and, in fact, wanted therapy to deal with other issues. During the first session with his therapist, this patient continued to downplay his drinking, but when pressed by his therapist described a serious and long-standing problem. However, the patient continued to try to minimize the extent and seriousness of his drinking. The therapist confronted him with his denial and told the patient that he was an alcoholic. He also insisted that the patient would need to abstain from drinking for the therapy to be of any value. The patient agreed to try to do so. In the ensuing sessions, there was considerable discussion of the patient's drinking and other drug abuse. The therapist maintained his position that the patient was an alcoholic despite the latter's periodic obfuscation and denial. At one point, the patient launched a vicious verbal attack on the therapist, accusing him of not caring, of being overly critical and condescending, of being incompetent, and of expecting too much from the patient. The therapist weathered this onslaught, taking an exploratory stance but also maintaining a firm position concerning his diagnosis of the patient's drinking problem. The patient subsequently settled down and brought forth a wealth of important genetic information concerning his parents, as well as admissions of rather serious past criminal behavior. In light of this patient's pa-

thology, it is remarkable that the therapy progressed well, and he profited a great deal from the treatment. (It should be noted that had the true extent of his pathology been apparent in the intake, he probably would not have been accepted into brief therapy.)

After the therapy, the patient noted that he stayed in therapy, in part, because of the therapist's attitude toward his drinking. He reported that he had been able to fool previous therapists into overlooking or underestimating his alcohol abuse; and though he said he was angered when his therapist labeled him an alcoholic, he also felt he could trust him because of this. We concluded that the patient was able to continue with, and profit from, this treatment because he no longer felt in danger of being able to fool or overwhelm his therapist.

Just as the patient's needs will influence the direction of the therapy, so too will the therapist's responsiveness to certain issues. For example, if the therapist is unresponsive to the patient's plan, the patient will often shift from issue to issue or from topic to topic until hitting upon one with which the therapist can be helpful, or the patient might, in desperation, quit therapy. In our studies of brief therapy, we have seen many examples of this type of shifting, especially in cases that are not going well.

One young man entered therapy with the presenting complaint of wanting to overcome his inhibitions about intimate relationships so that he could make a commitment to, and marry, his girlfriend. However, when we studied the case, we concluded that the patient actually was unconsciously feeling compelled to marry his girlfriend. From his history, it was apparent that he felt extremely responsible for women, and he had difficulty extricating himself from relationships with them because of his fear that to do so would destroy them. It also became clear that his girlfriend, in fact, was not an appropriate choice for him. We concluded that what he actually wanted out of therapy was to overcome his feelings of responsibility for women. We felt that this patient would want to marry only after he had overcome his fear of being trapped by women which in turn would require his developing the capacity to leave them. Thus, we predicted that comments by the therapist about the patient's feelings of responsibility for others would be helpful to the patient. Instead, the therapist interpreted the patient's fear of getting close as a manifestation of an Oedipal conflict — that is, the patient was unable to commit to his girlfriend because he felt uncomfortable about being successful with women. This was not helpful to the patient, and the patient displayed gradually increasing signs of frustration and aggravation.

After a point, the patient changed the focus of what he talked about from the issues concerning his girlfriend to his feeling that he needed more time in therapy; and he requested that the therapist not end the treatment after sixteen sessions. In our view, this development was related to the patient's original goal for therapy. That is, the patient wanted to see if the therapist could limit her involve-

ment with the patient by ending therapy on time — or whether she would need to give in to the patient as the patient *felt* compelled to give in to women. The therapist passed this test by ending the treatment on time, and the patient profited from the experience. What this case illustrates is how a patient who is not being helped in a therapy — in this case because of the therapist's misinterpretations — will sometimes find other ways to get something out of the treatment.

An additional factor that influences the direction in which a patient may head in therapy — and this is particularly relevant for brief therapy — is the patient's sense of what can reasonably be accomplished within the treatment. A patient may enter therapy with a number of goals, but then focus on only one or two of them because of a recognition, either conscious or unconscious, that not all of the goals can be achieved.

A woman in her 50s entered therapy with a number of presenting complaints. Her husband had a fatal disease and had to be placed in a nursing home, though it was possible he could live a number of years. The patient wanted to work on how to deal with this loss and with the fact that she was, effectively, a widow though her husband was alive. In addition, she wanted to focus on a work inhibition that had stopped her from seeking employment. Because of the loss of income due to and expenses involved with her husband's illness, she was severely strapped financially and had to work. She also reported significant and long-standing problems with family members, poor self-esteem, and moderately severe feelings of depression and anxiety. Though all of this patient's presenting complaints were to some degree interrelated, during therapy she focused primarily on her work inhibition, and by the end of sixteen sessions had found employment and reported feeling less depressed and anxious. These improvements were maintained over the following year. She then elected to return to therapy, this time to an open-ended treatment. She explained that she had found the previous therapy very helpful, but that there had not been enough time to resolve all her problems. Thus, she had focused on work, as it was the most immediately pressing. She stated that in a longer-term treatment she wanted to focus on her problems with her family and with intimate relationships.

As may be evident, the plan concept has important implications for the idea of resistance. Recall that the patient's plan is, by definition, progressive; it is the patient's plan for how to overcome the obstacles inhibiting progress toward, or attainment of, goals. It is not a plan for seeking inappropriate gratification of infantile wishes, nor does the patient wish to suffer. What is often interpreted as resistance can, under the plan concept, be seen as a manifestation of a patient's inhibition about pursuing certain goals or as a form of testing.

A 60-year-old widow entered our brief therapy program with the presenting complaint that she was unable to have fun. She reported that recently she had

decided to take a vacation and had gone so far as to drive to a resort and check in, but then had decided she should not stay and had gone home. She was a very successful executive, but worked many more hours than she was paid for, frequently going to her job on weekends or even in the middle of the night. When she had time off, she often felt lost. At such times, she would usually call upon one of her grown children to see if she might baby-sit or perform some other chore for them.

The therapist learned that the patient had come from a very impoverished background and that her mother had been extremely passive and compliant to her rather brutish husband. The patient reported that her mother looked 60 when still in her 30s and had died in her 40s, apparently worn out by the effects of poverty, an abusive husband, and the need to care for more than ten children, both her own and those of relatives.

In the early hours of therapy, the patient responded to the therapist's questions, but with little elaboration. There were frequent silences as she seemed to wait for the therapist to ask her something. There were no spontaneous associations, and the patient took no initiative in presenting or discussing issues. When the therapist inquired about her thoughts during the silences, she would reply, for example, that she had been thinking about his shoes, and then say no more.

Rather than seeing this pattern as resistance, the therapist interpreted the patient's silence as a reflection of her discomfort over taking control and doing something good for herself. He noted that during therapy the patient was acting helpless just like her mother because she felt uncomfortable about getting more out of life than had her mother. Following this interpretation, the patient began associating more and exploring issues. She also confirmed the interpretation by recalling how her mother, after having a foot amputated, would hop around on one leg, waiting on her healthy but indolent husband.

An example of how what appears to be resistance can actually be a test is provided by the case of a young therapist who was seen through our brief therapy program.

The patient entered therapy because of his feeling that he was holding himself back in his profession by not being forceful enough because of self-doubts. Briefly, this patient spoke very little during the therapy, responding to the therapist's questions with curt statements or monosyllabic replies. There were many long silences. He spontaneously reported little information, essentially refused to associate, and responded to interventions by the therapist, if at all, with pessimistic denials or rebuttals.

The therapist learned that the patient's father was a chronically depressed, nay-saying, and pessimistic individual for whom the patient felt extreme pity and responsibility. The therapist thus inferred that the patient's behavior represented a type of test in which the patient was presenting him with the same form of behavior that the patient had experienced from his father as a child, and by which

the patient had felt overwhelmed and therefore traumatized. Thus, rather than being resistant, the patient was testing to see whether the therapist would be overwhelmed by this behavior as the patient himself had been. The patient kept this up throughout the therapy, and the therapist remained unswayed by it. The therapist interpreted the patient's discomfort over appearing strong or successful, and he maintained this line of interpretation even when it was roundly dismissed by the patient. At the posttherapy evaluations, the patient appeared greatly improved; however, he denied that the therapy had done him any good. Instead, the patient claimed that his improvement was due to an insight he had developed independently — about how he had been holding himself back out of concern for others.

Before discussing the ramifications of the plan concept for brief dynamic therapy, we will describe how we conceptualize the plan and how a patient's plan can be inferred. We will not be explaining how to develop plan formulations. To learn to do so requires extensive clinical training in our theory and concepts through case conferences and individual supervision.

For heuristic purposes, we think of the patient's plan as being composed of four parts or components.

The first component is the patient's *goals* for therapy. Goals are the attitudes, mood states, or behaviors that the patient wants to achieve or, if they are undesirable, renounce. These goals may be highly specific and concrete (e.g., "to get married") or more general and abstract (e.g., "the capacity to tolerate guilt" or "to feel better about oneself").

A patient's presenting complaints may not accurately reflect his or her goals for therapy. The patient may not be able to acknowledge his or her desires because, for example, they are unconscious or are experienced as being too bold or ambitious. Indeed, a patient's stated goals may bear no resemblance to, or even be directly contrary to, his or her real goals. An example of this is the case reported above of the man who stated that he needed therapy to help him commit himself to his girlfriend when in fact he wanted to be able to reject her. Therefore, the assessment of a patient's goals requires a dynamic formulation of the case.

The second component of a patient's plan are the *obstructions*. Obstructions are the irrational pathogenic beliefs—and the associated fears, guilt, and anxieties—which hinder or prevent a person from pursuing his or her goals. Typically, these beliefs are unconscious, at least in the early phases of therapy. These irrational beliefs act as obstructions because they suggest that certain undesirable consequences will occur if the patient pursues or attains a certain goal(s). Examples of obstructions include irrational beliefs in one's power to hurt others, vulnerability to injured self-esteem, fear of retaliation, the danger of catalyzing a repetition of a previous trauma, and the fear of being overwhelmed by an affective state such as fear or rage.

The third component of a patient's plan is *tests*. Tests, which we discuss in greater detail in the second paper, are trial actions carried out unconsciously by the patient in the relationship with the therapist. They are designed to appraise the danger or safety of pursuing a particular goal(s). When testing, the patient observes the therapist's behavior to see if it confirms or disconfirms an irrational expectation or false belief. Thus, one method by which a patient attempts to disconfirm pathogenic beliefs and irrational expectations is by observing the therapist's behavior in response to tests. For example, a patient who feels that he will hurt others if he is forceful might test this belief by observing whether the therapist is upset when he (the patient) argues with him or acts decisive and independent. The same patient might also test the therapist by turning passive into active and observing the therapist's reaction — for example, by acting hurt or upset when the therapist is bold or insightful.

From the patient's point of view, the therapist's response to a test can range from the extremes of either strongly failing the test (thereby tending to confirm the patient's pathogenic beliefs), to strongly passing the test (tending to disconfirm the patient's pathological expectations).

To more fully understand a patient's plan, the therapist may want to consider a fourth and final component — that is, the *insights* that will help the patient achieve his or her goals. These insights pertain to the nature and origins of the patient's pathogenic beliefs and are generally incomplete or unavailable to the patient at the beginning of therapy. A patient might obtain insight into the content of a pathogenic belief (e.g., an irrational feeling of omnipotent responsibility for the welfare of others), into the historical roots of a belief (e.g., when the patient acted independently as a child, her mother acted hurt), and even into his or her goals for therapy.

The various components of a patient's plan — the goals, obstructions, tests, and insights — are interrelated and reflect to varying degrees the nature and ramifications of the patient's pathogenic beliefs. A patient's plan can be inferred from the patient's history, symptoms and psychopathology, life situation, and behavior with the therapist in the early sessions. For example, the patient's childhood traumas provide important clues about the probable nature of the pathogenic beliefs, the dangers they foretell, the life goals the patient may have relinquished because of pathogenic beliefs, and even how the patient is likely to work in therapy to disconfirm pathogenic beliefs.

A female patient described her mother as chronically unhappy and complaining. She added that her mother had few friends, no social outlets, and was quite dependent on the patient. Thus, when the patient presented as depressed, pessimistic, and complaining of an unhappy social life, it was inferred that she might have felt responsibility for her mother's unhappiness and a subsequent need to take care of her mother and to inhibit her own wishes and goals.

In the case of the 60-year-old woman who was incapable of having fun (see above), it was suspected that the patient might have felt responsible for her mother's death, especially because it came at a time when the patient was developing her own life outside of home. It was inferred that the patient felt responsible for her mother's early demise, as if she should have taken better care of her mother and not have abandoned her. Thus, she developed an excessive need to take care of others and to inhibit her own pleasures to avoid a repetition of this event.

Aspects of the patient's plan may also be inferred from a patient's symptomatology. For example, the patient with the dying husband (see above) spoke of her inability to understand simple concepts or to learn new material which, in light of her obvious intellectual capabilities, was easily identified as a need to cover over her strengths. Similarly, the lifelessness of the woman who was incapable of enjoying herself, suggested extreme concerns about allowing herself pleasure or freedom.

The patient's presenting complaints and life situation may also imply particular pathogenic beliefs and goals.

As an example, take the patient who entered therapy with the avowed goal of making a commitment to his girlfriend and marry her. If he had implied through his account of his history and by his behavior with the therapist that he had been held back from competitive successes by Oedipal anxieties and guilt, then the patient's avowed goal—overcoming his anxieties about commitment and marriage—might well have been congruent with his unconscious goals. However, the patient's history in fact disclosed difficulties based on guilt in separating from a possessive and depressed mother, and he gave evidence that he was tied to his present girlfriend by an unconscious fear of hurting her if he chose to leave. Thus, it was suspected that his unconscious goal was to free himself from his attachment to his mother and to be able to choose, without guilt, whether he wished to remain with his present girlfriend, or to leave her.

The patient's behavior with the therapist—in particular the ways of testing the therapist and the favorable or unfavorable reactions to the therapist's comments—typically provide important clues to the patient's childhood traumas, pathogenic beliefs, and goals. As an example, we remind you of the case of the recalcitrant patient who disagreed with whatever his therapist said, yet improved. We suspected, based upon this patient's behavior, that early in his life he had experienced other significant people as being pessimistic and naysaying and that he had been traumatized and inhibited by this experience. Consequently, we predicted that in his therapy he too might act difficult and disagreeable in order to see whether his therapist would be traumatized by this behavior, as he had been as a child. He was encouraged by the fact that his therapist was not intimidated by his criticisms and complaints.

Patients will frequently coach their therapists in subtle or not so subtle ways. The intent of this may be to make the plan more clear — or to try and get the therapist back on the right track if he or she is straying.

During a session a patient stated that he had read that therapists often do not answer questions because they want to encourage patients to think for themselves. Later in the same session this patient — who was worried that his father would be shamed if he (the patient) was more successful in his job than his father had been in his occupation — began asking the therapist questions and acting extremely upset when they were not answered. The therapist held his ground throughout the hour, and at the beginning of the next session, the patient reported feeling better and spoke of an imminent advance at work. He then asked the therapist a simple question which the therapist answered. This was followed by a long silence which the therapist interrupted by asking what the patient was thinking. The patient replied that he was trying to recall what they had discussed the last session, but could not. He asked if the therapist remembered. When the therapist did not answer, the patient spoke more boldly of his plans for securing the advancement at work.

We will now briefly discuss the ramifications of the plan concept for brief dynamic therapy and compare our ideas and findings with others in the brief therapy literature.

Concerning the process of brief dynamic therapy, the plan concept suggests that it is the patient, and not the therapist, who should focus the treatment in brief dynamic therapy. The therapist's role is not necessarily to focus or direct the therapy, but rather to understand the patient's plan and respond accordingly. Of course, for certain patients it may be appropriate to be directive or to vigorously pursue a focus. The point is, such directive activity on the therapist's part is *not* a universally necessary or even helpful component of brief dynamic therapy; indeed, it can be quite detrimental to the patient. The level and nature of a therapist's activity must be dictated by the individual needs and goals of the patient and will vary considerably from patient to patient.

Similarly, we are not aware of any universal "themes" or issues that should be pursued in brief dynamic therapy. Mann (1973, 1981), for example, suggests that a primary focus of brief treatment is, or should be, on its time-limited nature, whereas Sifneos (1979, 1981) focuses his brand of brief therapy on Oedipal issues, separation problems, and grief reactions. In fairness, it should be emphasized that Sifneos and Mann select their patients based on their judgments that these issues are central to their pathology. The point to be made is that the themes or issues to be focused on in brief dynamic therapy should be those presented by the patient and not those selected a priori as necessary foci of a time-limited treatment.

Just as there are no universal themes or issues applicable to all therapy patients, so too there are no therapeutic foci or techniques that are universally

applicable to patients in brief dynamic therapy. In a review of brief therapy by Butcher and Koss (1978), a number of elements are listed as being common to most brief therapies. One of these is directiveness on the part of the therapist. Our research does not support the notion that directiveness is a uniformly necessary, or even valuable, component of brief dynamic psychotherapy. Indeed, one of the most disruptive forms of therapist behavior we have identified in our studies is being overly directive and intrusive. That is, some therapists, apparently in an attempt to direct and thereby facilitate the treatment, intervene to the point that the patient is virtually unable to get a word in edgewise. Not only does this prevent the therapist from learning what the patient's plan is, but it can make it very difficult for the patient to test. Moreover, this behavior on the part of the therapist may indeed fail significant tests if, for example, the patient would like to work on being more self-directed and independent.

One could argue that the idea of letting the patient take control and direct the focus of the therapy may sound fine—if the patient will cooperate by doing so. But what about the patient who is all over the map, does not appear clearly focused on any particular issue, and who may even ask the therapist to take greater control? To answer such a question, it is first necessary to understand *why* the patient is not taking control. The case of the woman who could have no fun illustrates how, by not focusing on a topic, the patient can, in fact, be working on a core conflict—in that case, the patient's inhibitions about allowing herself more. The point to be made about the degree of control that the therapist should take is that, in our experience, a patient's failure to take control reflects significant issues that need to be explored and resolved, and that the therapist who takes control will at best interfere with this process and at worse reinforce an obstruction.

Similarly, some therapists have stated that brief treatment should focus on the present and avoid issues of transference, while others have suggested an active focus on the transference (e.g., Malan, 1963, 1967a, 1967b). Some brief therapists consider interpretation to be the primary change-producing factor in brief dynamic therapy and suggest that the therapist maintain an active interpretive stance. Our research suggests that more important than the form or type of intervention is the accuracy of the intervention with respect to the patient's plan. This point will be more fully developed in the following paper on the role of the therapist in the therapeutic process.

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