Brief therapy – base metal or pure gold?

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ABSTRACT This paper attempts to think about the ambivalence felt by the profession towards brief psychodynamic therapy. Drawing both on the historical context of psychoanalytic psychotherapy and the discussion of clinical material, a model of brief psychodynamic therapy is outlined. Some of the advantages and difficulties of brief therapy, particularly in educational and public sector settings, are described.

KEYWORDS Brief therapy, history of psychotherapy, adolescence, education, public sector therapy

In 1906, the eminent conductor, Bruno Walter, curiously at a time in his life when he was able to 'enjoy a comfortable middle class existence . . . and become a contented bourgeois . . . [enjoying] matrimonial happiness, the birth of our children [and] an economically untroubled existence', was 'attacked by an arm ailment':

> Medical science called it a professional cramp, but it looked deucedly like an incipient paralysis. The rheumatic/neuralgic pain became so violent that I could no longer use my right arm for conducting or piano playing. I went from one prominent doctor to another. Each one confirmed the presence of psychogenic elements in my malady. I submitted to any number of treatments, from mudbaths to magnetism, and finally decided to call on *Professor Sigmund Freud*, resigned to submit to months of soul searching. The consultation took a course I had not foreseen. Instead of questioning me about sexual aberrations in infancy, as my layman's ignorance had led me to expect, *Freud examined my*

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arm briefly. I told him my story, feeling certain that he would be professionally interested in a possible connection between my actual physical affliction and a wrong I had suffered more than a year before.

Instead, he asked me if I had ever been to Sicily. When I replied that I had not he said that it was very beautiful and interesting, and more Greek than Greece itself. In short I was to leave that very evening, forget about my arm and the Opera, and do nothing for a few weeks but use my eyes. I did as I was told. Mindful of Freud's instructions . . . [he went to Sicily] . . . I endeavoured not to think of my affliction. I was aided by the powerful and exciting effect of my first meeting with Hellenism, which burst upon my eye and soul from every side. . . . In the end my soul and mind were greatly benefited by the additional knowledge I had gained of Hellenism, but not my arm . . . When I got back to Vienna I poured out my troubles to Freud. His advice was to conduct –

'But I can't move my arm'

'Try it at any rate'

'And what if I should have to stop?'

'You won't have to stop'

'Can I take it upon myself the responsibility of possibly upsetting a performance?'

'I'll take the responsibility'

And so I did a little conducting with my right arm, then with my left, and occasionally with my head. . . . There were times when I forgot my arm over the music. I noticed that at my next session with Freud that he attached particular importance to my forgetting . . . I tried to familiarise myself with Freud's ideas and to learn from him. . . . So, by dint of much effort and confidence I finally succeeded in finding my way back to my profession.

(Walter 1947, italics added)

In a short time Bruno Walter had overcome his neurosis. The whole treatment consisted of five to six interviews.

This, of course, was in no way atypical of a psychoanalytical consultation at that time: in 1908 Gustav Mahler's treatment consisted of one four-hour session. The early training analyses, including Freud's own self analysis, were very brief. As Garcia has pointed out, the majority of contemporary analytical psychotherapists may well have approached Walter far differently from Freud: 'more in line with Walter's own expectations, that is, what Walter calls soul searching, or what we would call intensive dynamic therapy. Despite (*or I suspect because*) of being the founder of psychoanalysis, Freud was far from being an inflexible despot when it came to its therapeutic application. He happened to believe that psychoanalysis as a therapy was at best first among equals' (Garcia 1990). Garcia has termed Freud's treatment of Walter the 'neglect and counter-stimulation' technique,

in many ways similar to the way in which contemporary brief therapists deal with resistance, therapeutic passivity and dependence. In this sense Freud was the original brief therapist.

How has it come about that, as psychoanalytic therapists, we are now so suspicious, uncomfortable and uneasy with the idea of brief treatment, and have come to regard it as somehow an inferior and diluted version of the real thing, often to be used only when we have no choice or because our funding agencies demand it of us?

If we look at modern-day brief therapists who advocate a great deal of activity on the part of the therapist, a confidence in technique and outcome which is conveyed to the patient where resistances are attacked directly, and material is encouraged, we can see this is very similar to the early Freud. What changed of course was the 'problem' of resistance and transference, and how to deal with it. Free association, defence analysis, the transference neurosis ensured that therapies became longer and longer, more rigorous and less overtly challenging or supportive. The rest, as they say, is history. Davanloo (1978) suggests that something has gone badly wrong in that, as he puts it, 'we have lost the art of curing people briefly'.

He goes on to suggest that in response to these problems (e.g. Breuer's treatment of Anna O, where she developed a phantom pregnancy believing Breuer to be the father and he retreated in alarm) therapists have become passive in technique, in accepting the increasing length of treatment, and 'in their ability to explain, not merely to a lay audience but also to themselves what happens in the analytic process'. Seen from one perspective, therapeutic passivity, regression, free association, required longer time to analyse. Equally, if it was longer it had to be more rigorous; what other rationale could there be for it? It would appear that the more we learn, or know, about psychoanalysis, the more we have come to accept a certain inevitability that therapies will become longer, when in fact we could infer that our increasing knowledge should make them shorter.

This development, coming when it did, accompanied grandiose claims as to the efficacy and necessity of psychoanalysis. In my own field of education the recommendation was made that all teachers be psychoanalysed before being allowed into the classroom. But, as Davanloo suggests, therapeutic passivity was not the only choice available: therapy could have become more active and briefer. There is a long and honourable tradition of brief psychoanalytic psychotherapy which did try to counteract passivity in technique by becoming active but met, and still meets, with a great deal of resistance. It is unfortunate

that much of the literature on brief psychoanalytic psychotherapy still appears to believe that the aim and purpose of short-term work is to convince the patient of the necessity for longer-term therapy. One of the difficulties of viewing brief therapy in this historical context is that it becomes merely a footnote or a lesser branch of applied psychoanalysis, rather than something different, separate but of equal value. Despite this, it is interesting to note the current rediscovery, and interest in, the early brief analysts such as Ferenczi.

The talk on which this paper is based was given at a time when the agency in which I work, a student counselling service, had gone, because of the overwhelming demand and the length of the waiting list, from routinely offering students a minimum of six sessions, to being unable to guarantee students more than an initial consultation and one follow-up session. I was beginning to understand what Freud may have meant by the death instinct: all living organisms return to a state of homeostasis: psychoanalysis – psychotherapy – brief therapy – minimalist therapy – no therapy. I mention this partly in jest but there is a very real issue here which I would like to return to later.

In student counselling nationally the average number of sessions is around four. This clearly makes our work rather different in form from most of the literature in psychodynamic brief therapy, where anything from a dozen to forty or fifty sessions are the rule. It may well be that we need to distinguish between a brief consultation which may take four sessions, and brief planned focal therapy which can take considerably longer, although both have pre-set time limits. If we look at the literature on selection criteria for brief therapy, theorists divide into two camps: the conservative and the radical, differing essentially on the issue of pathology. Conservatives believe that brief therapy can help, but only in limited situations, while the radical position is that brief therapy is able to benefit a much wider set of problems and patients. (At its most extreme it appears to share the hubris of the early psychoanalysts that brief therapy can cure everything.)

In general, brief therapy looks towards a circumscribed problem, motivation, psychological mindedness, intelligence, a capacity to establish relationships, flexibility of defences, an Oedipal focus, a capacity to form a treatment alliance, a capacity to reflect, some recognition that problems have an emotional content, a certain introspection (if not curiosity) about oneself, and a capacity to tolerate frustration or anxiety. Contra-indications may include, among the conservative group: severe pre-genital problems, exclusively borderline pathology (involving extreme difficulties around the frustration

of the time limits) difficulties with termination because of deep-seated or complex problems regarding loss, exclusive reliance on projection, massive denial and a major reliance on acting out in dealing with psychological conflicts.

So what we are left with is a patient who is relatively healthy, well-functioning, with a well-defined and circumscribed area of difficulty, who is intelligent, psychologically minded and well-motivated for change. Where are they? Essentially, as therapists we are all looking for the same patient who is proving to be continuously elusive. These criteria would 'gladden the heart of any therapist', long or short term, if only the patients would play their part.

I would place myself more within the radical position, in part out of a belief that brief therapy can transcend all but the most severe pathology, but also because in student counselling we have no choice but to be in the radical camp. The high level of demand, together with the fact that counselling in educational settings is generally open access and needs to take into account the educational calendar, ensures that brief therapy is the treatment of necessity. Additionally, the majority of students only want (as opposed to what their therapists think they need) brief counselling. Having said that, I note with some trepidation (given the four session framework) that David Malan, of the radical brief therapy camp, advocates a guideline of twenty sessions for 'an ordinary (straightforward) patient with an experienced therapist', and thirty sessions for 'an ordinary patient with an inexperienced therapist' (Malan 1992). When I waver in my conviction I reach for Winnicott who talks about strict time limits, without recourse to diagnostic categories, the importance of surprise, play, process and metaphor, in these brief consultations. Infuriatingly, Winnicott, as always, does not tell us how to do it.

Going back to our elusive patient who rarely appears. At the university counselling service where I work we cannot control who walks through the door: on average some 750 students per year. We have no filter and are an open access service to all matriculated students of the university. We do not have the choice of assessing on the basis of pathology or problem, and our goals are necessarily modest, although not, I hope, insubstantial or superficial. I also suspect that, working in this context and setting, I would not necessarily want the choice for reasons which I hope will become clear. If I had the choice I might have ruled out Jeffrey.

Jeffrey, a 20-year-old second-year physicist, was referred by his GP who described him as significantly depressed and becoming

increasingly socially withdrawn: staying in his room, not eating and from time to time engaging in minor acts of self harm (cutting his arm with a blunt knife). He was arousing a great deal of anxiety, with his GP wanting him to be seen as soon as possible, which contrasted with Jeffrey himself who clearly did not want to be seen at all, urgently or not. I was confronted by a pale, gaunt, ascetic young man, who clearly did not want to be either at Oxford or in my consulting room. He was passive, morose and significantly uncommunicative in the initial consultation.

I saw him for a total of three sessions over a five-week period and the story which we laboriously pieced together ran as follows. Born in the north of England, he moved frequently in his first few years, his father being a systems analyst in a computer firm, before eventually settling in a small town in the north of England. He lived, seemingly uneventfully, with his parents and younger sister, until his father died suddenly when Jeffrey was aged 14. Jeffrey threw himself into his academic work, watched over by a mother who became increasingly 'pushy'. He did not want to be at Oxford and suspected nefarious forces were conspiring to push him here: mother and his school, which he thought had an informal link with his college. While academically successful in his first year, he consciously avoided making new friendships or taking part in the many activities which Oxford has to offer. Interestingly, what was very striking in his description of his current life, was that he would have nothing to do with anything associated with the university, but would occasionally attend social events in the town (rather than gown) which appeared to give him the comfortable, yet not wholly pleasant, experience of maintaining an identification with home.

He was angry and dismissive of the 'ritual, pomp and stuffiness' of Oxford and wanted nothing to do with it. He continued with a desultory relationship with a girlfriend at home, who appeared to provide only comfort and relief from his sufferings in Oxford rather than any substantial pleasure. It also, of course, gave him reason not to engage in any social activities in college. He was becoming uninterested in work, but felt trapped. He was almost compelled to be here but didn't want to be; it was of interest that when this was said I was unclear whether he was referring to Oxford or the consulting room. It will come as no surprise to learn that he was also passive and reluctant to engage in the process of therapy, other than to be in the consulting room. When I commented on this he mentioned being temperamentally shy and self-effacing, 'a bit like his father'.

His father had attended a provincial university and hated it. Eventually, Jeffrey thought, his father had worked himself to death doing something he did not enjoy. It was as though Jeffrey was at Oxford for his father, not only because he was doing something without enjoyment, but also because, while it was his mother who was experienced as being the 'pushy' Oxbridge parent, he believed his father would have been quietly proud of him. But in order to maintain an identification with him, Jeffrey took great pains both to dislike the place and to avoid engaging in anything associated with it, which might indeed be fatal. For, by engaging with it, he ran the risk of betraying his father's memory. His impotent anger and resentment, turned primarily against the self, was something he could not let go of; it was a perverse way of keeping his father alive in a moribund state. His dead father accompanied him everywhere. He knew his father didn't like physics either, and would, had he been alive, have felt exactly the same as Jeffrey.

Jeffrey could not let go of his resentment because it combined an attack on himself via his detachment (an unconscious equation of working hard and 'being in the world' = killing people), resentment of others (who had live fathers or mothers who hadn't been able to keep fathers alive), as well as maintaining an identification in fantasy with a father who hated university, would have been proud of him, but who was dead. Living would mean psychologically burying his father and coming to terms with the loss. By the end of our third session he was doing just that: playing in a college band, in the college football team and occasionally doing some physics.

What happened? Was this a transference cure or a flight into health? I think neither. I was very active with him: I was not going to be the dead father whom Jeffrey attempted to keep alive via paralysis in our sessions. I told him we had a limited number of sessions; he was forced to choose if and how to use them and their frequency (this transference to how little or much is available and how the student perceives and uses it is a very important and helpful therapeutic tool). The initial frustration and anger at the limited work (understandably somewhat muted in Jeffrey's case) set the tone. In part through my activity, Jeffrey was angry that I had disturbed his melancholy reverie, and that I was modelling or implying an alternative way of identifying with his father which involved being alive (or active). I attempted to link the mute anger/passivity and frustration with anxiety (i.e. what was the nature of the anxiety being defended against?). What would happen if Jeffrey lived? Would father or father's

memory die? Was the only possible link and source of identification with his father a foreclosure of his own development?

He was annoyed with me for not colluding with this in our sessions. I was not going to have dead sessions. What was central, I think, was this issue of passivity/anger and its expression in three linked areas: first, the process of sessions: the here and now/what was going on, or not, between us; second, his developmental history (his family, his background, his dead father and what attachment to Oxford/another place might represent); and, third, his current functioning (his conscious effort to have no part in Oxford life or to socialize). Since his father's death, he wanted to maintain an illusion of stasis and paralysis in all these areas, not least his therapy. Metaphorically, in sessions, we were continuously addressing these three themes at once. For instance, when we talked about the process between him and me, I was aware that we were also addressing the other two sides of this triangle, that is, his past history and his current life outside the consulting room.

The issue of loss in relation to Jeffrey is, I think, interesting. Losing me, as something to be worked through, did not exist partly because he never really had me. The setting, being active, pointing out what he was attempting to do with the process and how that may link with his past and present life, addressed issues of loss and possible meanings of his deadness.

Now this is not an atypical consultation in student counselling. Why does it seem to work, given our limited goals and time? Partly, I think, because it is appropriate for the context in which we work and also singularly appropriate for the adolescent/young adult's developmental drive. Many young adults, having just left home and their families, do not necessarily wish, or dare I say need, to be pulled back into what can be experienced as a regressively frightening (or comforting – which can be equally problematic at this age) relationship. At a time in their lives when they need to go out and face and actively master the world, we run the risk of encouraging them to enter into a long-term regressive therapeutic relationship which might be experienced by the young person as a tyrannical demand that can be met only by a defeated or hostile compliance. However difficult it is for us as therapists to accept, real life happens outside the consulting room.

The issue of context is, I think, an interesting and important one, and brings up the subject of transference. I would wish to distinguish between tra[illegible]ence as ubiquitous (that is it is everywhere)

and the transference neurosis, which is a specific illusion of the therapeutic setting. Therapists, despite our occasional protestations, can actually be quite active in either encouraging or discouraging this. In these brief consultations, I do not encourage a transference neurosis; what I work with, as with Jeffrey, is the transference to education, to one's own development, joining and leaving an institution, the institution itself and what we as counsellors might represent in it, and to the setting. If transference is ubiquitous then one can even have a transference to brief therapy, and a countertransference of course too. This then becomes the process of encounters with students: not who I am (or what the student or patient neurotically invests in me or turns me into), but what the setting, or I in that setting, may stand for. Transference to setting is what becomes important; feelings about receiving help, limited help, not being encouraged to regress, issues about ending that are in evidence from the beginning, become the predominant themes for the therapy.

In education, I think one is particularly fortunate in this area, as education is about developmental fluidity: in education, you cannot stand still so the setting actually enables active brief interventions. I suspect that this may also be true of other public sector psychotherapy settings where you can use the transference to the setting, or limited time, as facilitative.

So, in some senses, these brief consultations are the most productive use of the adolescent/young adult's developmental drive. Following Erickson (1981), if indeed it is true that one of the major paradigms at this stage in life is intimacy or isolation (that is, working out where you are on that continuum), then the young person's wish not to make too great a commitment (having just left their families, and we must not forget that going to university remains one of the most acceptable reasons for leaving home), rather than being seen as a problem, becomes not merely much more understandable, but a potential solution, and can be fostered by a non-regressive partnership in brief work. In this sense it would be important for the therapist to recognize the need to take themselves out of the limelight, however difficult that may be for them at times, and assume a more oblique, third-party role. Students, and young adults generally, may need a haven away from the intimacy of the family which they have frequently just left, as well as the intensity of the tutorial or teaching relationship which can be experienced as particularly intrusive.

What about technique? I think the major issue lies in discovering and agreeing a central focus very early on: moreover, a central focus with which all material can be either linked or associated. This is necessarily frustrating for the therapist who has been trained in longer-term work as it means jettisoning all material not directly associated with the focus. The focus must encompass the 'triangle of insight' (Flegenheimer 1982): that is, the current life situation, linking with the past history, linking with what is happening in the room, the active present if you like. If we see this as a triangle it links with another psychodynamic triangle: the impulse, the defence against it and consequent anxiety. This becomes the focus of the work. Some brief therapists would say that, if the focus cannot be determined, or if it is vague or diffuse, then brief therapy is contra-indicated, but I sometimes think diffuse vagueness is a condition of adolescence, so it merely becomes part of the process.

Therapeutic activity maintains the focus, prevents regression and helps to keep the emotional tension high. As Davanloo has said, 'we can't wait for the material to bubble up' (1978). Regression and dependence are minimized by sitting facing each other, the spacing of appointments, with, as often as not, the student choosing how regularly to meet (and the psychological significance of the outcome of that decision discussed), and knowledge that the treatment is finite, which deals with the ambiguity over the ending of the treatment and any anxiety around it.

It is important to believe, and in some way communicate this to the student, that a great deal can be achieved in such a short space of time. Additionally, especially in a university counselling service, we must guard against it being merely cerebral: counselling must never replicate a tutorial. It must make, or attempt to make substantial emotional contact with the student, otherwise it becomes yet another intellectual exercise, approached and dealt with by the student in the same way. The feelings towards the process have to be central; they may well be characteristic ways of relating to people in one's current life; they demonstrate how they have been used towards other people in the past; and how dysfunctional and inappropriate they may be. Consequently, early manifestations of the transference (especially to the setting and process as opposed to the neurotic transference) have to be interpreted and one has to speak to the student's conscious ego (often to prevent the development of an incipient transference neurosis and to put the student on guard against dependency and regression) as well as etaphorically to the unconscious.

A further potentially problematic area if you have been trained in longer-term work is the concept of working through. Clearly in brief work there is little of this process found in longer-term therapy; in some senses the working through begins after the therapy is finished, but I have a sneaking suspicion that this is no different from long-term therapy. Working through begins after the last session. After all, life can be seen as an extending period of working through: we get on with the process of continually having to metabolize our emotional experiences. However, as a psychotherapist trained in long-term therapy I am never entirely free of a psychodynamic superego. Consequently, I always allow for the possibility for the student to return. In that sense it becomes a 'topping up' rather than a working through model: a short burst of intensive work with the option of coming back for a 'topping up' at some later date. This also aids the student's transference to the setting: they can hold us as a potential sanctuary, if they so wish, throughout their academic careers. It always surprises me how few students need 'topping up' and reinforces my anxiety that 'topping up' is more about reassuring myself than being helpful for the client. I think it is possible, even in such a short therapy, for the client to internalize the experience, and for a different version of themselves to emerge. However, doing so is risky both for the therapist (which I will come to later) and for the student. The student risks being surprised about himself. For many students like Jeffrey, the possibility of discovering alternative scripts or different ways of viewing their lives is potentially rather exciting. In that sense intelligence can help; it is a somewhat maligned and distrusted concept in psychotherapeutic circles, partly because it is often confused with intellectualization which is a defence. Students who can put 2+2 together in their academic lives, and who frequently present with being unable to do that in their emotional lives can, often, with minimum input, make the connection.

David Malan (1992) has suggested that with Oedipal patients separation and dependence are less likely to be issues, whereas with pre-Oedipal ones, loss and separation are constant factors, but that both are amenable to brief treatments. Again, we need to think of the context and the goals of any individual treatment. We know that with brief therapy we are not engaged in character analysis or long-term psychotherapy. But, having said that, I think the approach transcends pathology.

Take Julie for instance. A 36-year-old D. Phil. student, within a chapter of finishing her thesis, who presented with depression and

an inability to write, which after four years on her thesis was clearly a major problem. Briefly (and when writing this I found the brevity a problem because I had to leave out a lot of what I considered to be the interesting bits; not unlike the frustration of brief therapy), she was the eldest child of a humble West Country family. Her father died when Julie was 13, and she and her younger brother had been brought up from that time on by her midwife mother who had never remarried. She did well at school and was an academically successful undergraduate despite disliking the university and becoming severely depressed in her final year, leading to in-patient, and subsequently day-patient, hospitalization. During her twenties she had been a teacher and worked in publishing, but suffered a further depressive episode just after she became engaged to be married. She required further psychiatric treatment and the marriage was called off. Subsequently, in her early thirties, she had had three years of counselling, which had clearly been helpful, but. . . . She struck me as having been an unconsciously depressed woman for some considerable time which led me to wonder whether depression can be characterological rather than necessarily related to loss.

I offered her four sessions which immediately provoked barely concealed frustration; within a short space of time we were into the issue of whether, had she been more interesting, lively and engaging, I would have offered her more (i.e. would her father still be alive had she been able to be more interesting, lively or engaging – his loss was still a source of great distress and bemusement to her). This was a constant theme in our work, but only peripherally linked to what became the central focus. In my initial consultation with her, she had mentioned 'Time is running out' and 'feeling physically sick' in relation to her thesis, which, together with other linked material, led me to suggest to her that her thesis was the baby she had never had, which made her reluctance to relinquish it understandable. Over the last four to five years she had so tenderly nurtured it; no wonder she didn't want to let go of it. This was a phantom thesis baby as opposed to the real baby she in reality wished for. Relinquishing this baby would be like killing it off. We can see how this therapeutic focus spoke to many aspects of this woman's life: issues of creativity and procreativity, ambivalent competition with her own mother over babies and careers (mother was not at all academic) and the pervasive issue of loss, including the risk that she would ruin any potential successful relationship which might produce a real baby. This latter carried with it the danger of having to replace her fantasized and

foreclosed relationship with her father. Her history, her presenting problem (work), her current life and relationships (which by her own account she called 'sterile and barren') and her relationship with me were able to be addressed in this limited focus and time; for example, what sort of baby could we produce in four sessions? Would it be good enough and vital enough to continue living beyond our limited time together, and would she have to, and could she, relinquish it at the end of our time?

I had to continue to work with her frustration towards me. The limited time and what that represented, but also the limited self which she was able to present to me, which we both recognized as necessary in preventing a form of attachment developing: at one point she mused about the loss of her father and her capacity to be infatuated by men, to which I said, 'And we don't want that to happen here given the limited time available', to which she replied, 'No, I can't allow that to happen'. The 'I' in that sentence referring, I think, to us both (speaking to our conscious egos).

A few weeks after finishing with Julie, I read in the university gazette that she had completed her thesis. Clearly my goals were modest. The inability to complete her thesis was what she brought, but I hope that, in addressing that, we were also addressing, if not working through, fundamental conflicts and dilemmas in her life. Counselling in university settings gives people a taste of seeing, thinking and feeling about themselves in new ways, all within metaphors of education and development.

I am a great believer in what can be achieved in these brief, surprising, psychodynamically informed interventions, but I do want to express some concern about their use. The danger exists, particularly if it is seen merely as an aid to solve the problem of crowded waiting rooms and long waiting lists, of fitting the patient into a therapeutic modality rather than the other way round. It also runs the risk of reinforcing the belief that it is not the best that we can offer and less than the patient needs. The emphasis then becomes more on technique than exploration or reflection. When looking at some of the literature in preparing this paper, I felt frequently uneasy at the technical onslaught against resistance employed by some authors which had the flavour of indoctrination rather than play, and we know indoctrination leads to compliance. Patients can incorporate their therapists in a manner analogous to pets resembling their owners. I was also conscious of the possibility of therapeutic sadism in some of these approaches.

We run the risk, as Terry Kupers says in *Public Therapy* (1981), of coming close to the position where open-ended talking therapy is available to those who can afford it, while those who cannot are either hospitalized, medicated or offered a form of 'brief therapy', which is viewed by practitioner and patient alike as expedient and second best. We are almost, as far as I can see, currently in that position in Britain with long waiting lists for any sort of public-sector reflective emotional help. This brings with it the issue of whether therapy is about adaptation or change. (I think this applies to long-term therapy too, but is more concentrated in shorter-term therapies.) Certainly it is an issue in working with students within a university counselling service: is our task to return students to the academic treadmill as soon as possible (without questioning the wider institution's complicity in provoking, or at least reinforcing, the symptom) or allowing for, and protecting, some space for personal and developmental issues to be addressed? It is a very delicate balance, but I do think that these brief psychoanalytically informed interventions can address both. For some students of course this is not possible, and a constant dilemma for us is how to manage the small minority who need something else. Equally an ongoing debate for us is the issue of who sets the framework or boundaries for, among other things, the length of treatment: the institution or the therapist? Certainly, while Freud said that the definition of mental health was to 'love and to work', student counsellors need to consider inverting that maxim. To 'work and to love' may be equally important. We do need to recognize the importance of the student being able to function academically, not merely from the institution's point of view, but also from that of the students for whom academic work may be a major source of both pleasure and self-esteem. The potentially problematic area for us is at what point do we say enough is enough, and that the student's emotional and developmental needs take precedence over their academic ones.

As I mentioned in relation to Bruno Walter, the earliest brief therapists were psychoanalysts, but it is less so now. I would regard myself as being in the psychodynamic tradition and view the model of the four-session consultation as essentially a psychodynamic one. But it is not an easy option and involves a great deal of unlearning; little in the longer-term psychodynamic trainings prepares us for this work other than to view it as a diluted version of the real thing, only to be thought about when the possibility of longer-term work is not an option. Viewing the goal of brief therapy as 'helping the patient

realize their need for longer-term work' is a particularly unfortunate version of this. It also comes dangerously close to indoctrination. This carries with it the danger of ignoring, or denying, the very real differences between brief psychodynamically informed therapy and psychoanalytic psychotherapy. These brief consultations are not about depth (although I do wonder about the ripples that can be caused by therapeutic surprise), or about the nature and length of any existing disturbance. Indeed, given the partial focus, the more disturbed patient can potentially make more use of it than of longer-term therapies, where issues of loss of control and facing one's own psychotic anxieties can be quite frightening and lead to decompensation. Equally, because it conveys, among other things, therapeutic hope, doesn't pathologize, and doesn't procrastinate in the sense of recognizing that life needs to be experienced and not lived in the consulting-room, brief therapy can also be attractive for those who, for cultural or social reasons, are suspicious of longer-term psychotherapy. The problem for the therapist is: how can we risk being active without impingement or seduction? One of the main dangers for the therapist in brief work is that the anxiety about being active can lead the therapist to not being active enough and losing the focus.

Can we risk paying what feels like selective attention and neglect seemingly meaningful material? It requires resilience and the willingness to take charge of the therapeutic setting. Not least of the difficulties is the seemingly promiscuous nature of the work; seeing so many people in such a short space of time imposes its own discipline and demands. Psychotherapists need to be able, if not to transcend their trainings, then at least to consider the possibility of entertaining alternative ways of thinking about problems and ways of working. If a patient says, 'Can I be helped in such a short space of time?' (Flegenheimer 1982) and the therapist, for whatever reason, shares this ambivalence, then the prognosis will indeed be bleak. Brief therapy cannot merely be a concentrated version of psychoanalysis. In other words, brief therapy has to be the treatment of choice, which in many settings and with particular client groups it is, and we have to be flexible in thinking about some of our uncritically accepted beliefs. If brief therapy is to be the treatment of choice it then has to be the choice of treatments. Conversely, of course, over-zealousness in espousing the cause of brief therapies can lead to the same kind of hubris as the psychoanalysts of fifty or sixty years ago claimed in relation to analysis.

I believe, particularly with adolescents and young adults, more specifically in education, for reasons that I have outlined, that brief consultations allow the young person to proceed with age-appropriate tasks, while longer-term therapy (unless specifically indicated, needed or wanted by the young person) carries with it the danger of stultifying the maturational process (Flegenheimer 1982). What makes this a psychodynamic as opposed to any other form of consultation? Essentially, I would say, knowledge of developmental theory (what stage people are at in their lives), of transference (and its varied manifestations), a belief in the unconscious, the use of metaphor and symbol as powerful modes of thinking and communication, a belief in repetition which needs to be grasped rather than continually re-experienced, the central themes or leitmotifs which recur in a person's discourse, the use of the relationship as the paradigm for the central conflict and its potential link with the presenting problem, and, in deference to the early Freud, the subversive nature of surprise for both patient and therapist. This echoes Freud's comment to Walter that sometimes we need to be able to see, not merely feel.

When Freud talked about alloying the 'pure gold' of psychoanalysis with copper in order to meet the anticipated large-scale demand for psychoanalysis, the copper he was referring to was suggestion and hypnosis, not brief psychodynamic therapy with its emphasis on focus and time limits. Somehow as psychodynamic brief therapists we cannot shake off this implied historical paradigm: psychoanalysis as pure = large-scale demand = dilution of purity because of expedience = brief therapies. The unfortunate aspect of this is that psychotherapists, because of their trainings, are eminently equipped to engage in brief therapy; I myself do not think I could do this sort of work without the training I had, but it requires the positive conviction that it is the treatment of choice in certain situations. What we must not do is to regard it as somehow second rate, but I believe that part of the problem is that at some level, consciously or unconsciously, we are encouraged to do so by the history of our profession. We are invited to see long-term therapy as rigorous, intensive and thorough, while short-term work is viewed as insubstantial and superficial, rather than being able to accept that these are different modalities; with some similarities no doubt, but essentially different; not better or worse, just different. As psychotherapists, we enshrine, if not encourage, the notion of difference in our work with patients, but often appear unable to value that, or become dismissive of it, between ourselves. In the final analysis, whether we are

engaged in long- or short-term psychotherapy, what matters is, as Nina Coltart (1992) has said, 'trust in the process, in our technique, in our patients' and, by definition, in ourselves.

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