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Brief Relational Psychoanalytic Treatment

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In this article I describe an approach to brief psychoanalytic treatment that is consistent with many of the key principles of the relational tradition. In this approach the treatment process is conceptualized as an ongoing cycle of therapeutic enactment, disembedding, and understanding, enactment and disembedding. Particular emphasis is placed on the use of countertransference disclosure for purposes of facilitating the collaborative exploration of relational scenarios that are being unwittingly enacted between patient and therapist. The influence of the brief time frame on the treatment process is explored and differences between the current approach and other approaches to brief psychoanalytic treatment are examined. A case is presented to illustrate the approach, and a number of questions are explored regarding the nature of change in short- versus long-term treatments.

BRIEF PSYCHOTHERAPY HAS ITS ORIGINS IN FERENCZI AND RANK'S (1924) pioneering attempt to counter the trend toward longer analyses that was emerging at the time. Their innovation also reflected their interest in the experiential and relational aspects of treatment. Over the years, a number of different models of brief psychodynamic therapy have been developed (e.g., Mann, 1963; Balint, Ornstein, and Balint, 1972; Sifneos, 1972; Malan, 1973). By and large, however, these developments have been considered outside the pale of mainstream psychoanalysis; in some respects, they have been devalued in the same way that the supportive aspects of treatment

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were viewed as inferior to the pure gold of psychoanalysis during the heyday of classical theory.

Currently, however, the psychoanalytic scene is undergoing tremendous ferment, and long-cherished theoretical and technical assumptions are being questioned (e.g., Mitchell, 1997). At the same time, there are powerful economic and societal pressures at play that make it advisable to ask serious questions about what short-term approaches can and cannot offer as well as what their role should be (if any) within contemporary relational thinking.

Over the last 15 years, I and my colleagues (most notably Chris Muran) have been developing an approach to short-term psychoanalytic treatment that is theoretically and technically consistent with many of the central principles of the relational approach. A primary impetus for developing the approach has been an interest in consolidating, refining, and empirically testing principles relevant to resolving problems in the therapeutic alliance and potentially pernicious transference–countertransference enactments (Safran et al., 1990; Safran, 1993a, b; Safran, Muran, and Samstag, 1994; Safran and Muran, 1995, 1996, 1998, 2000). Beginning in the mid-1980s at the Clarke Institute of Psychiatry of the University of Toronto, and continuing at Beth Israel Medical Center in New York in 1990, we have been conducting research to evaluate the effectiveness of the treatment and to investigate the process through which change takes place, thereby helping us to refine the treatment model. At this point we have evidence that the treatment (Brief Relational Therapy, or BRT) is as effective as two more standard forms of brief psychotherapy for personality disordered patients (cognitive therapy and a more traditional form of brief psychodynamic therapy based on the approaches of Strupp and Binder, 1984, and Luborsky, 1984). In addition, we have evidence that there are significantly fewer treatment dropouts in BRT than in the other two treatments. Moreover, we have preliminary evidence that BRT is more effective than the other two approaches for patients with whom therapists find it difficult to establish a therapeutic alliance.

Some of the key features of BRT are that: (1) it assumes a two-person psychology and a constructivist epistemology (or, to be more precise, what Hoffman, 1994, refers to as a dialectical constructivism); (2) there is an intensive focus on the here-and-now of the therapeutic relationship; (3) there is an ongoing collaborative exploration of the patient's as well as the therapist's contributions to the interaction;

(4) it emphasizes in-depth exploration of the nuances of patients' experience in the context of unfolding therapeutic enactments and is cautious about making transference interpretations that speculate about generalized relational patterns; (5) it makes intensive use of countertransference disclosure; (6) it emphasizes the subjectivity of the therapist's perceptions; and (7) it assumes that the relational meaning of interventions is critical (see Mitchell, 1988; Aron, 1996).

Before describing the BRT approach in detail, I briefly describe the major existing approaches to brief-term psychodynamic therapy to provide a background to help me to highlight the distinguishing features of BRT. In their authoritative book on brief psychodynamic therapy, Messer and Warren (1995) categorize existing approaches according to Greenberg and Mitchell's (1983) distinction between drive/structural and relational viewpoints. According to Messer and Warren the drive/structural schools of thought include those of Malan (1963), Sifneos (1972), and Davanloo (1980). These approaches all subscribe to variants of an ego-psychological perspective and emphasize the interpretation of wish–defense conflicts as a central ingredient of change. They tend to be confrontational in nature and by and large assume a one-person psychological perspective, with little attention to the therapist's contribution to the enactments that take place.

Messer and Warren (1995) categorize the standpoints of Luborsky (1984), Horowitz (1991), Weiss and Sampson (1986), and Strupp and Binder (1984), as relational. They reason that these four approaches can be thought of as relational inasmuch as they all conceptualize psychopathology in terms of recurrent maladaptive patterns of interpersonal behavior. In these models problems are conceptualized as resulting from disturbances in relationships with early caretakers that resulted in internal object relations that pattern subsequent interpersonal relationships.

While there is no doubt that, on a continuum, these four approaches are more consistent with a relational perspective than are those designated by Messer and Warren (1995) as drive/structural, in certain respects they fall short of a full-fledged relational model. It is beyond the scope of this article to provide a comprehensive critique of these approaches from a relational perspective. In brief, however, none of them takes completely seriously the implications of a two-person psychological perspective or of a constructivist epistemology, and none makes the extensive use of the therapist's countertransference as a

source of information (and a potential focus of self-disclosure) that has come to be characteristic of relational approaches. Strupp and Binder (1984), to a greater extent than the others, do emphasize that the therapist is a participant/observer and that his or her feelings provide an important source of information; but even they demonstrate a tendency to view the therapist as someone who can step outside the interpersonal field to develop a more or less accurate formulation of the patient's core themes. This stance contrasts sharply with the more radical view of contemporary interpersonal and relational theorists who argue that the therapist is always unwittingly participating in an enactment that he or she can at best understand only partially (Levenson, 1983; Mitchell, 1988; Aron, 1996; Renik, 1996).

The Dynamic Focus

A central principle in all of these approaches (both drive/structural and relational) involves the formulation of a dynamic focus early on in treatment (typically within the first three sessions). This emphasis on developing a case formulation early in the process is viewed as critical given the brevity of the treatment. The understanding is that a focus of this type makes it possible to shorten treatment length by providing the therapist with a heuristic theory for guiding intervention in a systematic fashion. The focus thus becomes a thread that links apparently unrelated experiences together for both the therapist and the patient and allows the patient to gain some insight into and mastery over a central underlying theme in a brief period of time. It is the establishment of a dynamic focus and the consistent interpretation of that focus over time, as it emerges in a variety of different contexts, that facilitates the working-through process and allows the patient to integrate treatment changes into his or her everyday life.

Although short-term therapists recognize that any dynamic focus is provisional and subject to revision, there is an inherent tension between using such a focus to guide one's interventions and certain tenets of a more constructivist/relational perspective. Formulating a dynamic focus within the first few sessions of treatment is premised on the assumption that the therapist can stand sufficiently outside the interaction to arrive at an assessment of the patient's characteristic theme; an assessment that is not shaped by the therapist's unwitting participation in the interaction. From the perspective of a two-person psychology, this is, of course, impossible.

To be fully consistent with the implications of a two-person psychological perspective, it is important that any case formulation emerge gradually over time through the process of disembedding from whatever enactment is being played out between therapist and patient. In this process the therapist's understanding of the patient emerges only through his awareness of the nature of his own participation in the enactment, and this awareness always follows enactment (Levenson, 1983; Aron, 1996; Renik, 1996; Mitchell, 1997). Therapy thus consists of an ongoing cycle of enacting, disembedding, and understanding; and this understanding is always partial at best.

Awareness and the Focus on the Present Moment

This understanding of the therapeutic process is an important part of the guiding philosophy behind BRT. An important question that we have had to struggle with is, how to reconcile this principle with the time constraints of a brief-term treatment? There are two dimensions to this issue. The first concerns the question of how to maximize the possibility that patients are able to take something home with them, given that there is not a clear, tangible focus that they can use to organize their experience and help them to gain a sense of mastery over their dilemmas. The second concerns therapists' anxieties about needing to offer something substantial to patients within a limited amount of time.

For the first dimension, we replace the *content* focus of a dynamic formulation with a *process* focus on moment-to-moment awareness. That is, at the beginning of treatment, we attempt to strengthen the therapeutic alliance by providing patients with a clear rationale that emphasizes the importance of developing the ability to observe their internal processes and their actions in relationship with other people as those actions are taking place. This emphasis on actively enlisting patients' collaboration in the task of self-observation is similar in some respects to Gray's (1994) close process monitoring, but with an important difference. While Gray primarily emphasizes the task of self-observation in order to facilitate defense analysis, we emphasize the importance of learning to observe one's own internal processes more

generally, as well as one's own actions as they unfold in interaction with others.

At the outset of treatment, we explain to patients that the therapeutic relationship is an important crucible for developing these capacities. Furthermore, we make it clear that therapy is a process in which patients and therapists work together to explore what is being unwittingly enacted in the therapeutic relationship, and we actively enlist their help in this process of collaborative exploration. An important point to highlight here is that the emphasis is on developing a generalizable skill of self-observation rather than on gaining insight into a core theme and mastering it. Thus we provide patients with a sense of something tangible that they can take away from the treatment, even if it is more abstract and nebulous than a sense of mastery over a particular theme. This emphasis on the development of awareness skills (or what Fonagy and Target, 1998, refer to as the ability to mentalize) also helps us to negotiate a thorny conceptual issue. If one takes the implications of a two-person psychology seriously, there is no guarantee that enactments taking place in therapy will parallel other relationships in the patient's life. Moreover, to the extent there is a parallel, it will be partial at best. Thus, rather than emphasizing extratransference links, we encourage patients to monitor, through this type of ongoing awareness, the extent to which relational patterns (both personal and intrapsychic) they have discovered through the exploration of therapeutic enactments also occur in other relationships. Our aim is that the patients refine their understanding of the nuances of their own relational patterns and associated internal processes. This process of monitoring their relational patterns between sessions constitutes an important form of working through.

With regard to the second dimension, that is, therapists' anxieties about the lack of a definitive focus, we attempt to take seriously Bion's (1967) remarks about the importance of approaching every session *without memory and desire*. This entails an attempt to let go both of one's preconceptions and of one's desire for things to be a certain way, and hence an acceptance of things as they are, a presentness and mutuality. To the extent that therapists can experience this state of mind, it increases the possiblity of relating to patients as subjects rather than as objects (Buber, 1958).

This prescription is, of course, in many respects an unattainable ideal. It is one, however, that nevertheless provides a useful corrective to the sense of purposeful striving that naturally emerges for therapists and that tends to become intensified in short-term therapy. The task for the therapist in BRT is thus not to let the time limit narrow the range of possibilities, but rather to attempt to realize the world of potential that resides in each moment of interaction by investing in it fully. The time limit need not be ignored in order to allow this type of investment in the moment. Instead, an ongoing awareness of the time limit intensifies this investment.

Therapists are also encouraged to help patients cultivate this type of heightened awareness of the present moment. In the same way that patients in classical theory are understood to develop an observing ego through identification with the observing ego of the analyst (Sterba, 1934), one of the implicit goals of BRT is that patients develop a heightened awareness of the present moment through identification with the therapist's stance. The hope is that the patient will become, in William Blake's words, better able "to see a world in a grain of sand . . . eternity in an hour."

Termination

Termination is an ever-present reality that colors the experience of patients and therapists alike at conscious and unconscious levels. As in other forms of short-term therapy, the therapist and the patient in BRT set a time limit at the beginning of treatment (e.g., 30 sessions), and that time limit becomes a critical part of the therapeutic frame. All approaches to brief dynamic therapy emphasize the importance of helping patients to work through the meaning of termination. Our approach, however, most resembles Mann's (1973) stance in the degree of emphasis we place on termination as one of the central issues in treatment. We agree with Mann that the process of dealing with separation-individuation and loss is a central and ongoing struggle in life and that the time constraints of brief-term therapy bring this struggle into relief. We find it useful to broaden this conceptualization by thinking of human existence as entailing an ongoing dialectical tension between the need for agency and the need for relatedness (Winnicott, 1965; Bakan, 1966; Blatt and Blass, 1992; Aron, 1996; Safran and Muran, 1996, 2000). On one hand, the need for agency or for self-definition is in conflict with the need for relatedness. The process of self-assertion is intrinsically threatening to relatedness to the other.

True individuation takes place in the context of a secure base, and true relatedness (as opposed to symbiosis) presupposes the attainment of individuation and the capacity for intersubjectivity (Benjamin, 1988). This dialectic becomes highlighted whenever tensions emerge in the therapeutic relationship, and it is brought into relief in particularly accentuated form in the context of termination.

We have found that patients tend to deal with tensions in the therapeutic relationship in two broadly different ways, which correspond roughly to Balint's (1968) distinction between philobatic and ocnophilic modes of relating. Patients who favor the need for agency over the need for relatedness are more likely to present in an overtly aggressive or confrontational fashion. Others, more inclined to favor the need for relatedness over the need for agency, present in a more dependent, compliant, or deferential fashion. Working through tensions in the therapeutic relationship and conflicts around termination can provide valuable opportunities for patients to learn to negotiate conflicting needs for agency and relatedness in a constructive fashion without disowning either of the two needs.

Another central principle of BRT involves reminding patients of termination periodically throughout the treatment and exploring their feelings about it. The purpose of this reminder is not to goad them into changing more quickly. Rather, it heightens issues that are already there in latent form, thereby bringing to the surface conflicts and transference–countertransference dynamics that would often take considerably longer to emerge in long-term treatment. In response to reminders of the time limit, one common theme is for patients to become more aware of, and begin to explore, whatever frustration, disappointment, and anger they have about not getting from therapy what they hoped for. A second common theme involves the exploration of the difficulties patients have in trusting and opening up to the therapist, given the time constraints.

The exploration of the first theme can lead in various directions. When a patient begins treatment with an aggressive or counterdependent stance, the therapist's work often is to survive the aggression and ultimately work toward an exploration of the dependency and vulnerability that is being defended against (Winnicott, 1965). When a patient begins treatment with a dependent, deferential stance, the therapist's task is more likely to be to help the patient to access angry feelings that are defended against, thereby giving him or her an opportunity to learn that the therapeutic

relationship can survive that aggression. This, of course, is a simplification, since patients often present with features of both styles; but the distinction has some heuristic value.

Difficulties that patients have in opening up and trusting because of the time limit need to be carefully explored. On one hand, all relationships are transient; we never know when an intimate will disappear from our lives whether through death, or a falling out, or some other circumstance beyond our control. Exploring patients' fears of abandonment in this context can open the door to an experientially real understanding of the enduring attitudes (often unconscious in nature) that prevent them from opening up and finding intimacy in everyday situations. This type of exploration can help a patient take the risk of investing in the relationship with the therapist despite its limitations (and despite the pain of loss that such an investment will inevitably entail).

At the same time, the legitimacy of patients' concerns about the time limit needs to be acknowledged. In the same way that a therapeutic stance of abstinence and neutrality will have an inevitable impact on patients' experience, a predetermined time limit is more than just a symbolic reminder of the transience of all things; it is a form of abandonment. It is thus important that therapists accept patients' reluctance to invest in the therapeutic relationship because of the time limit as well as to validate and empathize with any pain and sadness that emerge through the exploration of feelings about termination. It is also critical for therapists to empathize with and validate feelings of anger that emerge in anticipation of abandonment by them, as well as the feelings of disappointment and resentment that patients experience around having not gotten what they hoped for from the treatment.

Optimal Disillusionment

Dealing with patients' feelings about termination is often a critical turning point in the treatment. As such theorists as Ferenczi (1931), Balint (1968), and Winnicott (1965) suggested, it is common developmentally for people to learn to dissociate aspects of their organismically based need or bodily felt experience because of a failure of others to be optimally attuned to their needs. As a result those

people learn to relate to others through a false self-organization. As Winnicott (1965) in particular emphasized, it is the therapist's failure that allows for the reenactment of the type of traumatic experience that is the byproduct of the inevitable failure of a patient's parents to be optimally responsive. And this reenactment, in turn , provides an opportunity for a reworking of patients' relationships to the other and to their own needs in a new, constructive fashion. In BRT, the ongoing reminder of the time limit often heightens patients' awareness of their disappointment with the treatment and the therapist. Even though patients, at a conscious and rational level, may limit their expectations and hopes for what can come out of a brief treatment, at an unconscious level they commonly harbor fantasies that the treatment will change their lives in a fundamental way. These fantasies take different forms for different patients, but all fantasies, at some level, reflect an idealized state of unity and perfection that in reality can never be attained.

If therapists can respond to patients' disappointment or resentment as a legitimate response to limitations both of the treatment and of their own (the therapists'), they can help their patients to access dissociated wishes and needs. Empathizing with these needs, even if they cannot be fulfilled, is critical, since it helps patients to begin to accept them as valid and legitimate. At the same time, acknowledging the limitations of the treatment and of one's own ability to be helpful, in tandem with empathizing with patients' disappointment, helps them to begin to accept the limitations of the other and to begin relinquishing their pursuit of an idealized and unattainable goal (Safran, 1999). If therapists are to be able to tolerate patients' needs and disappointment in this context, they have to work on their own fantasies of omnipotence and relinquish some of their narcissistic strivings. This process of struggling with our own fantasies of omnipotence is, of course, critical for therapists in long-term treatment as well, but, in brief-term therapy, conflicts of this type are heightened for therapists, in the same way as they are for patients.

Therapeutic Metacommunication

The use of countertransference disclosure plays a central role in the treatment. We have been influenced in this respect by the work of

such theorists as Ehrenberg (1992), Bollas (1987), Tansey and Burke (1989), and Maroda (1991), as well as Kiesler (1996), from whom we borrow the term *therapeutic metacommunication*. Metacommunication consists of an attempt to disembed oneself from the relational configuration that is being enacted by taking the current interaction as the focus of communication. The term metacommunication is thus broader than the term countertransference disclosure. Attempting to understand an enactment often involves countertransference disclosure, but it can also involve other acts as well (e.g., sharing observations, asking questions, speculating). Unlike a traditional transference interpretation, in which the therapist offers a conjecture about the patient's unconscious dynamics or the significance of the current interaction, efforts at metacommunication attempt to decrease the degree of inference; such efforts are as much as possible grounded in the therapist's immediate experience of some aspect of the therapeutic relationship (either the therapist's own feelings or an immediate perception of some aspect of the patient's actions). The objective is to initiate an explicit exploration of something that is being unconsciously enacted.

Principles of Metacommunication

1. Explore with skillful tentativeness and emphasize one's own subjectivity. Therapists should communicate observations in a tentative and exploratory fashion. The message at both explicit and implicit levels should be to invite patients to engage in a collaborative attempt to understand what is taking place, rather than to convey information with objective status. It is also important to emphasize the subjectivity of one's perceptions, since doing so encourages patients to use therapists' observations as a stimulus for self-exploration rather than to react to them either positively or negatively as authoritative statements (Aron, 1996). Bollas (1987) for example, suggested prefacing observations with such phrases as, "What occurs to me . . ." or "I'm thinking that . . ."

2. Do not assume a parallel with other relationships. A therapist should be wary of prematurely attempting to establish a link between the configuration that is being enacted in the therapeutic relationship and other relationships in the patient's life. In addition to being inconsistent with a two-person psychology, interpretations of this type can be experienced by patients as blaming and can serve a defensive

function for therapists (e.g., Epstein, 1977; Carpy, 1989; Gabbard, 1996). Instead the focus should be on exploring patients' internal experience and actions in a nuanced fashion, as they emerge in the here-and-now.

3. *Ground all formulations in the awareness of one's own feelings and accept responsibility for one's own contributions.* All observations and formulations should take into account what the therapist is feeling. Failure to do so increases the risk of a distorted understanding that is influenced by unconscious factors. It is critical to take responsibility for one's own contributions to the interaction. We are always contributing to the interaction in ways we are unaware of, and an important task is to clarify the nature of this contribution in an ongoing fashion (Levenson, 1983; Renik, 1996). In some situations, the process of explicitly acknowledging responsibility for one's contributions to patients can be a particularly potent intervention (Gill, 1982). First, this process can help patients become aware of inchoate feelings that they have difficulty articulating. For example, acknowledging that one has been critical can help a patient to articulate feelings of hurt and resentment. Second, by validating the patient's perceptions of the therapist's actions, the therapist can reduce his or her need for defensiveness.

4. *Start where you are.* Metacommunication should be based on feelings, intuitions, and observations that are emerging for the therapist in the moment. What was true in one session may not be true in the next, and what was true at one moment may change at the next. Two therapists will react differently to the same patient, and each therapist must begin by making use of his or her own unique experience. So, for example, while third-party observers may be able to adopt an empathic response toward aggressive patients, therapists cannot conceptually manipulate themselves into an empathic stance they do not feel. They must begin by fully accepting and working with their own countertransference reactions.

5. *Focus on the concrete and specific and the here-and-now of the therapeutic relationship.* Whenever possible, questions, observations, and comments should focus on concrete instances in the here-and-now rather than generalizations. This focus promotes experiential awareness rather than abstract, intellectualized speculation. For example, "I am experiencing you as pulling away from me right now. Do you have any awareness of doing this?"

6. *Metacommunication and disembedding take place at the same time.* It is not necessary that therapists have a clear formulation prior to

metacommunicating. In fact, thinking out loud about the interaction—putting into words subtle perceptions that might otherwise remain implicit—often helps the therapist to disembed from the configuration that is being enacted. Moreover, telling a patient about an aspect of one's experience that one is in conflict over can free the therapist to see the situation more clearly. This type of disclosure can constitute what Symington (1983) refers to as the analyst's act of freedom. For example, by acknowledging to the patient one's feelings of being stuck or hopeless, one can reopen for oneself an analytic space that had previously been collapsed (e.g., Gabbard, 1996).

7. *Attempts to metacommunicate can function as new cycles of an ongoing enactment.* For example, a therapist articulates a growing intuition that the patient is withdrawing and says, "It feels to me like I'm trying to pull teeth." In response, the patient withdraws further, and an intensification of an enactment ensues in which the therapist escalates attempts to break through and the patient becomes more defended. It is critical to track the quality of patients' responsiveness to all interventions and to explore their experience of interventions that have not been facilitative. Did the intervention deepen the patient's self-exploration, or did it lead to defensiveness or compliance? Exploring a patient's construal of an intervention that is not facilitative helps to refine the understanding of the enactment that is taking place. This emphasis is very much consistent with the contemporary Kleinian sensitivity to the way in which patients use (or fail to make use of) interpretations (e.g., Joseph, 1989). We emphasize the importance, however, of understanding patients' construal of the meaning of failed interventions in their own idiosyncratic terms, rather than privileging the role of envy or aggressiveness in our formulations.

Case Illustration

Ruth contracted to receive 30 sessions of treatment from me as part of an ongoing brief psychotherapy research program. She was an attractive, young-looking 52-year-old woman who had been divorced for 16 years. She had one daughter in her 20s, who was no longer living at home. Ruth worked as a high school teacher. She had ended her marriage of 12 years at the age of 36 because she felt her husband was controlling, emotionally abusive, and generally unable or unwilling to be responsive to her emotional needs. Since her divorce, she had

had a series of short-term affairs with men, which typically would end because of her dissatisfaction with her partners. She tended to become involved with men she looked down on. She reported that she was afraid of pursuing men whom she was more interested in, for fear of being rejected. She maintained that, in the past, she had found it difficult to acknowledge to herself that she really wanted an enduring, intimate relationship and that she had depended on her physical attractiveness in order to seduce men into casual relationships that had boosted her self-esteem. As she grew older, however, she became concerned that her appearance was deteriorating and that she would have difficulty continuing to attract men; she became increasingly concerned about the possibility of spending the rest of her life alone. A second presenting problem revolved around her feelings of being "disempowered" and of not being treated respectfully by colleagues at work.

Although I initially felt very sympathetic toward her, a pattern developed fairly rapidly in which I had difficulty maintaining a sense of emotional engagement with her and found myself biding time until the sessions ended. I became aware of a tendency on her part to tell long stories with considerable obsessional detail, and to do so in an unemotional, droning fashion that left me feeling distant and unengaged. In addition, I found that she seldom paused as if to welcome my input or feedback. Thus, she seemed to be delivering an unending monologue, in which my presence was barely acknowledged. Although I would often begin sessions with a renewed intention of taking an interest in her, I typically ended up feeling bored and vaguely irritated. Periodically she would touch on painful emotional memories and become tearful. To my consternation, however, I found that, rather than my feeling empathic toward her at such times, my feeling of detachment would continue.

In an attempt to understand what was being enacted between us, I began to metacommunicate about my emotional disengagement. I hoped to clarify potential links between my experience, her characteristic style of presentation, and the intrapsychic processes linked to it. She seemed responsive to my feedback and indicated that on various occasions she had received feedback of a similar kind from others in her life and that she was eager to come to understand how her own inner struggles and characteristic way of coping with them might be contributing to this dynamic. Over time, our understanding of the configuration's being enacted in our relationship became fleshed out to some extent. She was able to articulate an underlying fear of

abandonment that led her to defend against vulnerable feelings by controlling her style of presentation. She was also able to articulate a semiconscious perception of my disengagement and a tendency to intensify her deadening monologue as a way of dealing with feelings evoked by this perception. Although, on one hand, I felt encouraged by her openness to exploring what was going on between us, I had an intuition that something did not feel quite right—perhaps an element of compliance in her response to me and a vague sense of myself perhaps beginning to play the sadistic role in a sadomasochistic enactment. At different points I shared with her my sense that she seemed all too ready to work with whatever I presented. At one level, she seemed to take this observation in and work with it, but, at another level, it felt as if even this response had an element of compliance.

An important shift took place in session 19, which she began by telling me about how she had experienced a minor comment of mine at the end of the previous session as extremely validating. During the previous session she talked about a situation at work in which she was feeling chastised and infantilized by her superior and felt powerless to change the situation. Since we were at the end of the session, I had remarked something to the effect of, "This seems like something important to talk about. There are some important issues here."

When I asked Ruth what she had found helpful about my comment, she remarked that it had reassured her that I didn't think she was petty or that she had set up the problem situation at work herself. At the same time, she began to wonder out loud why she had such a lack of confidence that my little comment at the end of the session was so important to her. When I responded that I had been wondering about the same thing, she spontaneously connected her response to times in the past when I had commented on my feelings of being disengaged from her, and she had responded by attempting to work with my observations. At this point, she began to shift the topic, and I encouraged her to explore what had occurred internally at the moment prior to the shift. She responded: "What came to mind is, 'Well, that's probably good because I'm a good patient,' and then I just think of saying, 'Well, now I want to be a bad patient. Like now I don't want to be nice.'" Then she went into a story about a friend of hers who had been in therapy and had one day knocked her therapist's books off the shelf in anger. In the rest of the session we began to explore the way in which her tendency to comply in an attempt to be a "good girl" (in her words) was a theme that cut across many situations for her.

In the following session, she began, for the first time, to complain more directly about what she felt she was not getting from me in treatment. Whereas the previous session felt like a preliminary, playing with the possibility of acknowledging her dissatisfaction, in this session, her frustration, anger, and disappointment felt more tangible. She began the session by indicating that she was aware that the treatment was more than half-way through—she asked for my evaluation of how things were going so far and for a plan for the rest of the treatment. With my encouragement, she was eventually able to tell me that she needed more emotional engagement from me and that she did not want to try to be a more interesting person in order to keep my interest. This description, of course, misses the subtle nuances of the interplay between us as she moved toward increased articulation of her dissatisfaction with aspects of my conduct toward her and toward assertion of her desire for more emotional engagement and support from me. In contrast to the previous session, there were times in this session when I felt strongly chastised and pressured to provide her with something that I was not sure I was able to provide. At the same time, her ability to express her need for more emotional engagement helped me to empathize more fully with her experience of not feeling accepted and validated by me. In this and subsequent sessions she was also able to contact sad and painful feelings of being hurt by my failure to accept and prize her as she wished me to. Witnessing the emergence of these feelings led to a subtle but irrevocable shift in my perception of her. Although there continued to be periods during which her characteristic, emotionally flat, droning style of speaking continued, I found myself more engaged during these times than I had been in the past. It was as if I were now unable to experience this aspect of her without simultaneously seeing her as a whole person with hopes, dreams, and frustrated yearnings.

The experience of challenging me and seeing that our relationship was able to survive enabled her subsequently to bring her feelings of despair and the underlying vulnerable and dependent feelings into the relationship. She began the following session by saying that, although she had left the previous session "all fired up" and ready to make changes in her life, she found herself sinking back into an apathetic inertia. She then made a passing allusion to feeling that she needed someone to help her out of her inertia. When I asked her if she felt as though she needed help from me right now, she began to cry slightly and to speak about her feelings of disappointment and loss

in life in general. I was aware of feeling somewhat touched by her tears, but also somewhat distanced, as if I were not being allowed fully into her experience. My sense is that a number of factors were contributing to my feeling of distance, including her shift to a general focus rather than the here-and-now of our relationship, a strangled quality to her voice, and the fact that she was looking down in that moment. Her downward glance was particularly salient for me, and I mentioned it to her and asked her if she was aware of it. She acknowledged that she was aware and that she felt that she wanted to push her feelings back inside, because she felt she was being self-pitying. Further exploration led her to articulate a fear of "blubbering and not even being able to talk," her anticipation of consequent embarrassment, and a desire to be by herself. At this point I conveyed to her my sense of being "kept outside" and my remark led to an exploration of the way in which she was pulling away from me in her pain and sadness. This helped her to articulate a fear of being abandoned by me, accompanied by deep and heartfelt sobbing. There followed a tearful exploration of how she had spent so much of her life depriving herself of real contact and support from people because of her difficulty in acknowledging to herself how deeply she wanted to be nurtured and cared for. She then expressed her relief at being able to share her painful feelings and longings with me, mixed with sadness and feelings of loss in the acknowledgment of having spent so many years without receiving the contact and support she needed.

In subsequent sessions we explored her fears and sadness about imminent abandonment by me, as well as her anger. Since the sessions were videotaped for research purposes, I am able to excerpt some of the dialogue between us around these issues. She began session 23 by talking about her fears of abandonment in general.

Patient: I have this fear of being abandoned and disappointed. And so I guess I just shut down and cut people out of my life.

Therapist: In the back of my mind I'm thinking that we only have six or seven more sessions, and so I'm wondering about this whole issue of opening up and being abandoned in this context.

P: Well, it does make me sort of scared when I start thinking about the ending. And I guess that's true of me in general. I guess I'm reluctant to really involve myself deeply in relationships . . . but the desire is still there.

T: Uh-huh . . . I have a sense of a real yearning inside of you. [Patient begins to cry and then stops herself.] What's happening for you?

P: Well, it starts to hurt, and then I think, intellectually, "It's so inappropriate for me to be upset about therapy ending."

T: It doesn't seem inappropriate to me. We've worked together for a while now and really started to develop a relationship, and my sense is that you're beginning to open up and trust. And we're ending soon . . . and that's got to be painful.

P: Well, and I guess part of it is the finiteness of it. I leave with whatever feelings I have, and for you, it's like, "Good. That was a tough one. That's over." And then you go on with something else.

We began to discuss the inequity of the situation and her anger at me. She also spontaneously drew a parallel between the asymmetry of our investment in the relationship and a general tendency for the men she felt deeply about to not reciprocate the depth of her feelings.

In the following session, the theme of inequity emerged once again. Ruth returned to the concern that I would be glad when things were over, because I found her frustrating and difficult to work with. While it was true that I had felt frustrated, bored, and disengaged from Ruth, especially in the earlier part of the treatment, I was now experiencing our sessions as vitally alive and engaging. I had a growing feeling of empathy for her dilemma; I felt deeply moved by her pain and very much understood her feelings of anger toward me. I struggled with the question of whether or not I should say anything to her about the change in my feelings toward her. I tentatively resolved not to say anything, trusting that she would be able to experience the change in my feelings toward her at an affective level and fearing that verbal reassurances would be experienced as hollow. She then spontaneously told me that she did not want me to tell her whether she was right about my feelings, because, if I denied what she claimed, she might not believe me, and, if I did not she would be upset.

Further exploration helped her to flesh out her concerns about my feelings toward her and to articulate her desire that I really care about her. Putting this yearning into words led to more sadness, but also to a feeling of satisfaction about her ability to take the risk of revealing her desires. The session ended with Ruth returning to her feelings of hurt and anger about the fact that I had not volunteered to meet

beyond the preestablished termination session. I empathized with her feelings and told her that I believed it was legitimate for her to feel both hurt and angry with me.

She began session 28 by talking about her difficulty trusting that men are interested in her or care about her, unless they go overboard in their attempts to woo her. When they did do this, however, she said she had a tendency to lose *herself*. She maintained that given this pattern, she felt good that she was starting to feel okay about our relationship, despite my not having actively reassured her. She told a story about a recent encounter with a male friend, in which she had difficulty trusting that he would be there for her, despite evidence to the contrary.

T: It sounds as though normally there's a real lack of faith that relationships will work out.

P: Yeah [appears touched by this comment]. That really captures something important. Normally I tend to devalue relationships when I don't get much active reassurance from people. And I guess there's a risk of my doing that to some extent with our relationship, because you're not proposing that we extend our meetings.

T: What I'm thinking is that you really need and deserve somebody to be there for you on an ongoing basis, and I'm wondering if you can still find anything of value in our relationship despite the fact that I'm not going to be there for you in the future in the way you deserve.

P: [beginning to cry slightly] I'm thinking about it, and I think it's okay. I don't feel abandoned by you. I'm sad, I think, because I'm so aware in this moment of the way my lack of faith in people and fear of abandonment have acted as obstacles to my getting into a good relationship. And I'm thinking about my daughter as well . . . how her lack of faith in relationships gets in the way. I know this is a bit of a digression, but I guess I'm identifying with her. . . . This is an important place to come to. And I thought I wasn't going to cry today [said with a slightly jocular tone followed by a short period of silence]. I feel like thanking you. And then saying goodbye [said quickly in a jocular tone].

T: This feels like an awkward moment?

P: Yeah. It feels a little difficult staying with the feeling of contact with you.

T: So some of what's going on is that, along with the pain, you feel a sense of connection with me and of gratitude. That's what's uncomfortable.

P: Yeah. Any sort of closeness. It's almost like I have to cut that feeling. I think one time we talked about how I start to feel suffocated when I feel intimate [during a previous session we had begun to explore such feelings when they emerged during a moment of intimacy between us, and this had led to some associated childhood memories].

T: Can you say anymore about this feeling of suffocation?

P: I guess it's something about the welling up of all these emotions. There's some part of me that always wants to push it down. I don't know what would happen if I didn't. I don't know if it's about being exposed or being out of control. I don't know. But I want to contain it. It's bigger than the both of us [laughing, then pause]. I don't know what love really is. I think I have it with my daughter . . . but even that . . . it's not direct. The direct expression of feelings is very hard.

T: Uh-huh. I was wondering when you said, "It's bigger than the both of us." I know you were laughing, but it sounded interesting.

P: Well, when you ask what am I afraid of . . . I'm afraid that feelings . . . they're consuming. . . . I think I've been in an environment where feelings were so measured . . . It's almost like a family image that comes to me . . . where things aren't stopped, where they're not repressed . . . where they're bountiful. I think my natural exuberance as a child was prohibited. But it's just that letting things tumble out of you in an unrestrained way and letting yourself *be* doesn't mean that horrible things are going to tumble out.

T: But it sounds as if the fear is that it's all consuming and that you don't really know where it's going to lead, in a way.

P: Yes.

T: And maybe that's what you mean when you say, "It's bigger than the both of us."

P: Yes.

T: Because there's a kind of uncharted territory in a way.

P: Yeah.

T: For me as well. I feel a sense of contact with you right now . . . a sense of connection and intimacy, and there's a sense that the feelings are not something I have control of.

P: Yeah. I think that's it. "You've got to keep those reins on." But the idea of it is such a wonderful image for me.

T: Well I was struck by your words before, "A family image." "Bountiful." There's a real sense of richness there.

P: Yeah.

The final two sessions were devoted to summing up and consolidation. Ruth's feeling was that the seed of a new way of being in relationships was beginning to grow in her. She was able to acknowledge her sadness about separating from me and her anxiety about the future, as well as a growing optimism and belief that things could be different in her life. Things had not changed dramatically at work, nor had she gotten into a new relationship with a man. But she felt a subtle sense of beginning to feel more empowered in general, and more hopeful about the possibility that things would be different for her in intimate relationships. Various strands in our work were never completely tied together, and certain issues were touched on but not explored in depth. For example, we never developed a real understanding of the origin and meaning of her feelings of suffocation in moments of intimacy, and some of her feelings toward me (e.g., sexual feelings) were touched on or alluded to but not explored in depth. This lack of closure is typical in BRT, and learning to live with this type of ambiguity is one of the important lessons for patients and therapists alike. This lack of complete closure is true in any therapy, but working within a short-term time frame heightens this issue and forces therapists to struggle with their grandiose ambitions and come to terms with their own lack of understanding and control.

Discussion

In summary, it seems that the first stage in the treatment process entailed my becoming embedded in a relational configuration with Ruth in which her particular way of managing vulnerable feelings and maintaining a safe distance in our relationship contributed to my feelings of boredom, disengagement, and frustration. My attempts to

disembed from this configuration through countertransference disclosure activated a new cycle of the enactment in which her compliance became intensified or at least more salient. My attempt to metacommunicate about this cycle resulted in further compliance, although it may have helped to prepare the ground for her to begin to break out of her compliant stance in subsequent sessions.

When she finally did begin to assert herself in relation to me, my ability to survive her aggression without retaliating played a critical role in helping her bring her resentment and dissatisfaction more fully into the relationship. It was at this point that Ruth's awareness of the brief-therapy time frame played a pivotal role in accelerating her ability to acknowledge and express her feelings of dissatisfaction with the treatment and her anger and hurt about my failure to care about her in the way that she desired. This failure of mine was expressed both in my feelings of irritation, frustration, and boredom with her and in my unwillingness to extend the length of the treatment.

Would it have been more therapeutic for me to contain my negative feeling towards her and attempt to provide a holding environment? This question seems particularly relevant given that she did find my countertransference disclosure quite hurtful. I cannot rule out the possibility that if I had been able to manage my feelings internally and provide more of a holding environment, she would have found it helpful. On the other hand, Ruth was particularly sensitive to subtle signs of rejection, and I am not confident that I could have provided her with the type of authentic caring she needed without first acknowledging what she no doubt perceived implicitly about my attitude (see Bass, 1996). I believe that in doing so I gave her an opportunity to respond with her legitimate feelings of anger and hurt, and this opportunity, in turn, helped me to appreciate her dilemma and to move through my own countertransference feelings and out of my egocentric stance.

A second question that arises is, would it have been more beneficial for me to extend the time limit once I began to understand how meaningful and important doing so would have been for her as a tangible act of caring on my part? I believe that extending the treatment could have been helpful to her and that she could potentially have learned a lesson she was not able to learn from short-term therapy—that it is possible to depend, over an extended period of time, on another person who is able and willing to be there to the best of his or her ability through bad and good times. In other words, long-

term treatment might have brought about the type of change in her internal object relations that would be impossible to effect in short-term treatment. On the other hand, I believe that the time-limited nature of our work together helped her to experience the legitimacy of her needs, in the face of an imperfect world and in a relationship with a therapist whom she experienced as good enough, despite my failure to be there for the long term.

A related question is if my unwillingness to extend the time limit constituted a type of retraumatization for her. Is it possible that my terminating at a point when she was just beginning to open up and trust was experienced as yet another abandonment in her life? While I cannot completely rule out this possibility, I believe that critical to determining whether or not the termination in short-term treatment is traumatizing is the therapist's ability to process, in a nondefensive way, the full range of conflicting feelings that emerge (both the patient's and his or her own). This is what I struggled to do with Ruth. While working on this article, I reviewed the videotapes of our final sessions together, and many of my feelings came back to me: warmth, caring, sadness, regret, excitement, hope, and some guilt as well. I did not communicate any of these feelings to her explicitly during our work together, but I think that she sensed them and that this intuition played an important role in her being able ultimately to experience our relationship as helpful rather than traumatic. I believe that it is particularly important for therapists not to hide behind theoretical justifications for the time frame, but rather to work to understand the unique meaning for them of terminating with each specific patient, in the same way that they help their patients explore the meaning of termination. In this way, the time limit can become a catalyst for understanding and true meeting rather than a barrier.

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