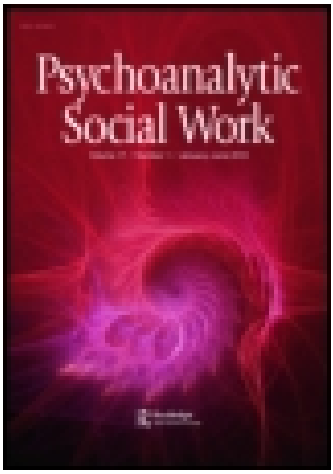

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Sändor Ferenczi

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Sándor Ferenczi: Forerunner of Modern Short-Term Psychotherapy

Carol Tosone

ABSTRACT. This essay will explore the early contributions of Sándor Ferenczi and their relationship to current psychodynamic perspectives on short-term treatment. Ferenczi's development of the "active technique" and his later collaboration with Otto Rank influenced the works of Alexander and French, and the later writings of Malan, Davanloo, Sifneos, and Mann. Ferenczi's emphasis on here-and-now transference interpretations and the importance of the patient's emotional experience in treatment have proven to be enduring contributions to contemporary psychoanalytic practice. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-342-9678. E-mail address: getinfo@haworth.com]*

INTRODUCTION

Short-term psychoanalytic psychotherapy is receiving renewed attention in the United States, largely due to economic pressure to provide cost-effective treatment to all segments of the population. In an effort to reduce costs, the government, insurance companies, and managed care organizations have become regulators in the therapeutic enterprise. Many managed care firms, for example,

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permit their patients only 20 out-patient psychotherapy sessions each year. Psychotherapists are encouraged to treat patients in as few sessions as possible; those who comply are often rewarded with a greater number of referrals, while those who do not are likely to get fewer. In fact, clinicians who request additional sessions beyond the 20 may be removed from the managed care list of mental health providers, thus reducing the size and scope of their practices. In essence, managed care determines which modes of therapy are deemed effective and viable.

Given the current managed care mental health climate, it is not surprising that therapists are considering models of time-limited treatment. Many psychotherapists and psychoanalysts adopt these models reluctantly, but realize that they must prepare themselves for actual treatment opportunities and trends. Of the plethora of psychoanalytically informed short-term models available to them, clinicians frequently choose the works of Malan (1963, 1976, 1979), Mann (1973), Davanloo (1978, 1980), and Sifneos (1987). These writers are generally regarded as the major contributors to the field of modern short-term psychotherapy, and as such they acknowledge that their respective works are derived from basic psychoanalytic principles established by Freud and his followers.

HISTORICAL ROOTS OF MODERN SHORT-TERM PSYCHOTHERAPY

The origin of modern short-term treatment can be traced back to the early writings of Freud and Breuer. In *Studies on Hysteria* (1895), Freud describes his work with Miss Lucy R., a woman who suffered from chronic rhinitis, olfactory hallucinations, depression, and fatigue. After being seen by Freud approximately once a week for nine weeks she was cured of her olfactory hallucinations. This time frame is consistent with brief psychotherapy today. In the early years of psychoanalysis, Freud treated other cases which were of even shorter duration. Katharina was seen on only one occasion, as was the composer Gustav Mahler who was reportedly cured of his impotency after a four-hour stroll with Freud (Jones, 1955).

While many of these early cases were successful, Freud's primary focus was on the development of psychoanalysis as a science

(Jones, 1957). The actual length of psychoanalysis was a secondary concern, and as psychoanalytic theory grew in complexity, so did many of the analyses which Freud conducted. Malan (1963) observed that the increasing length of psychoanalysis corresponded to the burgeoning interest in interpretation and working through of the transference, and in the decreasing emphasis on symptom relief as the primary focus of treatment. The technical shift from the cathartic method to that of free association also contributed to the lengthening of the psychoanalytic process.

Freud did not indicate to his patients that treatment would be brief, nor did he, as a rule, advocate setting any time limit (the case of the Wolfman is a notable exception). In fact, toward the end of his career, Freud (1937) concluded that "psychoanalytic therapy . . . is a lengthy business" (p. 373). In *Analysis Terminable and Interminable*, Freud is critical of his earlier work with the Wolfman. He viewed the setting of time limits as a "black-mailing device" and cautioned analysts to use this technique judiciously. Prophetically, Freud is also critical of Otto Rank for accelerating psychoanalysis "to suit the rush of American life" (p. 374).

Throughout most of his career Freud responded negatively to any attempts to shorten the length of treatment, particularly those of Ferenczi and Rank (1925). Freud regarded their efforts as threats to the integrity of the psychoanalytic community. In discussing the various factors involved in Freud's rejection of their work, Flegenheimer (1992) notes that Freud had to first establish psychoanalysis as a legitimate and effective mode of treatment, before he could consider modifications on the time frame and other parameters.

FERENCZI: PIONEER OF SHORT-TERM TREATMENT

Sándor Ferenczi, a close friend and collaborator of Freud, is generally regarded as the first analyst to explore modifications in technique aimed at shortening the length of psychoanalysis (Eisenstein, 1980; Marmor, 1980). He became concerned about the steady movement toward longer treatment periods and the concomitant passivity of the analyst, and strove to reverse these trends. As a valued member of Freud's inner circle, Ferenczi sought to create a shorter and more effective form of treatment, without abandoning

the basic psychoanalytic principles and design. While his experiments eventually led to a rift with Freud, many of Ferenczi's innovations have provided the foundation for the development of modern brief treatment models, such as those of Malan, Mann, Davanloo and Sifneos. Proponents of short-term psychotherapy regard him as the most original thinker among the early analysts (Bauer & Kobos, 1987).

These practitioners draw upon Ferenczi's work with the "active technique." The therapist's active stance forms the cornerstone of all modern types of short-term psychotherapy. Ferenczi (1920/1926) first introduced his ideas about shortening the length of psychoanalysis at the Sixth International Congress of Psychoanalysis in September 1920, at which time the response of his colleagues was mixed, with some being critical, some receptive, and others misunderstanding the *crux* of his argument.

Ferenczi (1920) begins his paper, *The Further Development of an Active Therapy in Psycho-Analysis,* by describing his innovation as an "old acquaintance," one which stems from Freud's earlier work and which is inherent in the psychoanalytic process itself. Interpretation, he points out, is an active interference with the patient's psychic activity, so that thoughts are altered in a particular direction and result in the appearance of new ideas. Had it not been for the analyst's interpretive activity, these ideas might have remained unconscious due to resistance. Ferenczi alerts colleagues to the power of their interpretive interventions in actively influencing their patients' thoughts and behaviors.

Ferenczi (1919, 1920, 1924) also draws attention to the limitations of free association, noting that some patients may employ the fundamental rule of association as resistance. In discussing the abuses of free association, Ferenczi (1919) observes that obsessional neurotics, for example, may relate only senseless associations in an effort to defeat the analyst with his own weapon. Ferenczi (1920) maintains that for some patients, the analyst's activity is to prescribe the performance of some behaviors and the cessation of others. He reports that this type of activity has been successfully employed in the treatment of phobic patients. In these instances, patients were directed to carry out the avoided activities, thereby making them active participants in the treatment process. Since these interven-

tions occurred in the context of a psychoanalytically informed treatment, Ferenczi contended that they did not alter Freud's method in any essential way.

In fact, Ferenczi refers to statements Freud made in his *Address to the Congress at Budapest* in 1918 as providing the basis for his active technique. In this address, Freud suggested the use of active measures in certain cases of phobias and obsessional neurosis to advance the patient's therapy (Lorand, 1966). Theoretically speaking, Ferenczi asserted that this particular use of the active method is justified because it provokes the patient's acting out and the manifestation of affect, leading to the return of the repressed. Ferenczi's goal in using this method was to more rapidly remove the patient's resistance, thereby shortening the length of the analysis.

Active therapy necessitates considerable clinical acumen and Ferenczi cautions beginning analysts not to overvalue such tactics for therapeutic progress. According to Ferenczi, active measures should be applied only after the patient proves unresponsive to more conventional techniques. Once the resistance is overcome, the analyst should resume a more traditional stance. Techniques such as "injunction" and "prohibition" are helpful in the treatment of phobias, but should be used sparingly and only as a supplement to the "real analysis." Parenthetically, Ferenczi's descriptions of these techniques as well as those of the "relaxation exercises" described in his 1925 paper, *Contra-indications to the "Active" Psychoanalytic Technique*, have clear similarities to later brief behavioral therapies for anxiety and obsessional disorders.

The ideas outlined in Ferenczi's (1920) paper, as well as his collaborative efforts with Rank (to be discussed shortly) evoked harsh judgments from the established psychoanalytic community. In an effort to both clarify and revise his position on active therapy, Ferenczi (1925) delivered a paper at the Ninth International Psycho-Analytic Congress at Bad Homburg which outlined contraindications to use of the active technique. In this paper, he emphasizes the importance of timing. Since the technique influences the development of the transference, Ferenczi felt it should be avoided at the beginning and applied only when a solid working alliance has been established, preferably toward the end of treatment.

Ferenczi (1925) also reversed his views of the setting of a time

limit as a useful active measure, stating that this procedure is called for in only rare circumstances. He also declared that it was Rank and not he who was the originator of this idea. In this way, Ferenczi sought to regain the favor of his colleagues and to distance himself from Rank who, by believing that birth trauma was central to neurosis, departed from the main tenet of psychoanalytic theory, the Oedipus complex (Jones, 1957; Stanton, 1991; Aron & Harris, 1993).

THE COLLABORATION OF FERENCZI AND RANK

When Ferenczi and Rank published their monograph, *The Development of Psychoanalysis* in 1925, they outlined a broader role for active therapy than Ferenczi had described in his earlier papers. At the time their collaborative efforts met with skepticism and scorn, but today their work is praised as the precursor to modern brief treatment (Bauer & Kobos, 1987; Crits-Christoph & Barber, 1991; Flegenheimer, 1992). Ferenczi and Rank introduced several ideas which became central to the practice of short-term dynamic psychotherapy and which anticipated the work of Alexander and French (1946).

Ferenczi and Rank were troubled by the increasing length of psychoanalytic treatment. They focused their endeavors on the refinement of psychoanalytic technique, rather than on the development of theory. Without refuting the importance of genetic reconstruction, they placed greater emphasis on present life events and reactions, particularly those pertaining to the treatment situation. Referring to Freud's technical paper *Remembering, Repeating and Working Through* (1914), Ferenczi and Rank challenged the idea that remembering was the principle aim of psychoanalysis and that repetition was an indication of resistance. Rather, they proposed that the repetition compulsion was not only unavoidable but essential for cure to occur. In their conceptualization of treatment, the patient first reproduces the early conflict and trauma in the relationship with the analyst as a substitute for remembering. In this phase of treatment, it is the "activity" of the analyst to promote this actual reliving of the patient's early relationships in the affectively charged treatment situation. This is necessary before insight, interpretation,

and reconstruction can meaningfully occur. Ferenczi and Rank viewed reconstruction as an intellectual process which did not necessarily lead to an affective response in the patient. For them, the quality of the patient's emotional experience with the analyst was the key factor bringing about psychic change. Ferenczi and Rank held that "the final goal of psycho-analysis is to substitute, by means of technique, affective factors of experience for intellectual processes" (1925, p. 62). Therefore, they recommended that the analyst be active and intensify the emotional experience of the patient. As would be reiterated later by Davanloo (1980) and others, insight without affect serves as a major source of resistance and can increase intellectual defenses.

Ferenczi and Rank maintained that patients could accept the reality of the unconscious only after experiencing something analogous to it in the therapeutic situation; that is, unconscious wishes and affects need to be revived and worked through in the present therapeutic relationship in order for reconstruction to be effective. The unconscious material reproduced in relation to the analyst is gradually transformed into actual remembering. In this way, Ferenczi and Rank have assigned the leading role in psychoanalytic technique to repetition instead of remembering. The analyst's "activity" then becomes one of fostering the patient's insight and early memories. Ferenczi and Rank argue that "it is really the insight gained from understanding the repetition compulsion which first makes the results of 'active therapy' comprehensible and gives the theoretical reason for its necessity" (1925, p. 5).

The work of Ferenczi and Rank centered on the importance of the therapeutic relationship as a vehicle to examine the patient's patterns of reactions and interactions with others, especially in the here and now. The goal was to provide a more positive outcome than had occurred in childhood. Their monograph foreshadowed the later writing of Strachey (1934), Gill (1979, 1982) and others who emphasize the curative effect of transference interpretations. Briefly, Strachey, for example, considered transference interpretations to be the most effective because the giver of the interpretation is at one and the same time the object towards which the id impulse is directed. The impulse is interpreted at the active moment by an analyst who, unlike the original object, does not respond defensively

to the patient. De-emphasizing genetic insight, the analyst focuses instead on the emotional immediacy and relevance of the patient's reactions to the therapeutic relationship. Strachey refers to this as a "mutative interpretation" due to its ability to produce structural changes in the mind.

Similarly, Gill (1979, 1982) focuses on the interpersonal nature of psychoanalysis in his discussion of "here and now" interpretations. According to Gill, interpretations should take into account how the interaction with the therapist makes the transference plausible to the patient. The here and now experience of the therapist-patient dyad is a fundamental aspect of the treatment process and one which requires considerable interpretive attention. Gill (1979) acknowledged that both patient and analyst are motivated to avoid these "potentially disturbing interactions" (p. 266) which may account for the failure of some analysts to deal adequately with the transference.

Ferenczi and Rank (1925) emphasized the here and now relationship with the analyst as a way to explore and modify the patient's interpersonal conflicts. They suggested that analysis of the "living out" tendencies in the therapeutic situation might be sufficient without focusing on historical sources in childhood. Their approach, involving the setting of a time limit to accelerate the analytic process, was in sharp contrast to the prevailing classical technique which used the transference as a springboard to comprehend and reconstruct the repressed sources of psychic conflict. The classical approach also did not emphasize the length of treatment.

Karl Abraham, founder of the Berlin Institute and Society, was particularly critical of "active therapy" and Ferenczi's collaborative work with Rank. Abraham believed that these works departed from classical psychoanalytic technique. Ferenczi, in turn, accused Abraham and The Berlin School of sacrificing clinical performance in favor of theory development. At the time, the Berlin Institute and Society served as the center of the international psychoanalytic movement (Grotjahn, 1966; Stanton, 1991). Ferenczi and Rank implied that the classical approach was effective in promoting self-understanding, but it had the concomitant potential to strengthen intellectual defenses. Psychoanalysis, they suggested was entering a

new phase of "emotional experience" which would replace the emphasis on intellectual insight.

THE INFLUENCE OF FERENCZI AND RANK ON ALEXANDER AND FRENCH

While the work of Ferenczi and Rank (1925) was considered controversial in the established psychoanalytic community, Franz Alexander and Thomas French (1946) recognized its value to the development of psychoanalytic therapy. In particular, Alexander notes that Ferenczi and Rank were pioneers in recognizing that positive therapeutic results could be achieved through the corrective experience of the transference relationship. Alexander believed that Ferenczi and Rank's work did not receive the recognition it deserved because of their method of enforced termination. Setting a termination date for treatment, Alexander argued, was not successful for the majority of cases. However, Alexander held that this "one faulty technical generalization" (1946, p. 23) should not detract from Ferenczi and Rank's overall contribution to the development of psychoanalytic procedure.

When Alexander and French published *Psychoanalytic Therapy: Principles and Applications* in 1946, they regarded their work as a "continuation and realization of ideas first proposed by Ferenczi and Rank" (p. 23). Alexander and French, in collaboration with nine other contributors who shared their vision, called for analysts to be more flexible in their application of psychoanalytic principles by adapting their methods to the specific needs of each patient. These methods involved such practices as suggestion, advising relatives, direct guidance, face-to-face interviews, and less frequent contacts. While Alexander and French and their collaborators argued that these are psychoanalytic methods because they are informed by psychodynamic principles, critics (E.J., 1946; Greenacre, 1954) believed that these techniques were not part of real analysis. In fact, E.J. (1946) noted that the word "unconscious" was not mentioned at any point in the text.

As outlined by Alexander and French, the corrective emotional experience involves the reliving of early conflicts and trauma in the transference relationship, but this time under more favorable

circumstances than had occurred earlier. The experience is effective because the analyst's attitude to the transference behavior of the patient is different from that of the parent in the original conflict. In this way, the analyst attempts to counteract the harmful influence of the parents incurred during the patient's childhood. As articulated in a later paper by Alexander (1954), "the same type of conflict is exposed to an adult ego and not to the infantile weak ego. In other words, a stronger ego is exposed to a weaker conflict" (p. 690). Alexander and French reiterated Ferenczi's point that treatment should be conducted on as high an emotional level as the patient's ego could tolerate without losing the capacity for insight.

Alexander (1954) recognized that the concept of the corrective emotional experience was not new, but was implicit in the psychoanalytic theory of treatment. Providing a corrective experience, Alexander contends, also involves manipulation of the transference to best meet the goals and needs of each patient. Alexander offers the example of his first patient, the spoiled son of a wealthy and indulgent merchant, with whom Alexander set a modest fee based on the son's own income. When external circumstances changed so that Alexander could have increased the patient's fee, he deferred doing so. The patient did not express gratitude. Instead, he asked for a referral to another analyst. The patient stated that Alexander reminded him too much of his father. By not increasing his fee, the patient experienced Alexander as a permissive and indulgent father with whom he could experience only anger and guilt. The patient had withdrawn from his father and now was responding similarly with his analyst.

Upon reflection, Alexander was able to realize that his countertransferential reaction was similar to that of the patient's father, thus contributing to the treatment impasse. Alexander referred the patient to a more experienced colleague who set an appropriate fee and whose demeanor was more distant. It was this seasoned analyst who provided a corrective emotional experience by not responding as a doting father. While the patient experienced the new analyst as a stern and demanding father, he later reported that he had benefitted greatly from the second treatment.

According to Alexander, this case illustrates the value of a corrective experience made possible by the later therapeutic encounter.

The patient needed to live through a new father-son relationship in order for this experience to become an integral part of his emotional life. The analyst discerned the type of transference the patient intended and provided a more suitable experience. He did not succumb to the role induced by the patient. In other examples, the analyst served as a guide by offering advice. Patients were primarily seen face-to-face in direct conversation with the analyst. Free association did not appear to play a prominent role. Dependency on the analyst was discouraged by the use of weekly sessions or time-limited treatment. In this way, the handling of the transference was decidedly different from that of classical analysis.

In contrasting the two approaches to the transference, Greenacre (1954) noted that psychoanalysis accepts and promotes the full transference relationship, with its contents explored and selectively interpreted. She also provided the rationale for specific psychoanalytic methods: Analytic sessions were spaced sufficiently close together to sustain the continuity of the therapeutic relationship; that is, the analysand usually undergoes five or six sessions per week. Scheduled sessions insure a rhythm and continuity to the therapeutic work. Use of the couch advances a relaxed state, a condition in which the patient can more readily free associate. Greenacre believed that the reduced treatment time espoused by Alexander and French could increase the risk of inadequate analysis of the negative transference. She also maintained that silent periods were sometimes indications of a patient's difficulty with erotic or aggressive feelings and infrequent sessions would hinder their expression and analysis.

Greenacre was critical of the concept of the corrective experience, referring to it as "little more than the old-fashioned habit training with especially strong suggestive influencing" (1954, p. 676). While psychoanalysis proper relies on the "working through" process, she noted that the corrective emotional experience involves the "working out" process. Greenacre describes this latter process as one of bringing into reality, under the direction of the analyst, new behavior patterns. She continues:

> The aim in the "working through" is a loosening of the neurotic tendencies at their source, since deepest emotional

> tensions are invested in the specific experiences; while in the "working out," counteracting, neutralizing or freshly coating experiences are relied upon to coerce the emotions into new patterns without paying too much specific attention to the old. One is a method of detailed analysis; the other of survey, and forward propulsion with the aid of the strong suggestion of personal attachment which will, however, presumably and paradoxically be without increased dependency. (Greenacre, 1954 p. 66)

Alexander (1954) holds a different view of dependency in the transference experience. Instead of signifying a deep penetration into the unconscious sources of the patient's neurosis, Alexander argued that such an experience could indicate a regressive evasion from oedipal level conflict. He offered the example of the "couch diver," a patient who readily indulged his dependency on the analyst as a necessary part of treatment. In this instance, the patient's oedipal rivalry with the analyst was more difficult to mobilize. The chronologically earliest material, the patient's dependency needs, was not necessarily the deeper or more repressed material. In fact, it served as resistance to the emergence of feelings of oedipal competition with the analyst. By reducing the frequency of therapeutic contact, Alexander believed that the patient's dependency needs were intensely brought into consciousness. Alexander also believed that transference interpretations were more effective when the dependent gratifications of the transference relationship were curtailed. Alexander noted that this technique was similar to Ferenczi's active technique of not permitting the automatic gratification of unconscious impulses.

Alexander also adopted Ferenczi's (1919) approach to countertransference, viewing it as a useful way to understand the patient's unconscious material. Alexander viewed the concept of the blank screen analyst as an abstraction, noting that each analyst brings his or her unique interpersonal patterns to the treatment situation. These patterns may become problematic when the transference neurosis has developed and the analyst feels placed in a role by the patient. In the previously mentioned case of the wealthy merchant's son, Alexander noted that the second analyst applied the "principle

of the contrast." That is, he maintained a nonvaluative and helpful stance, but within the context of an interpersonal climate opposite to that which occurred in the original situation.

Greenacre, adhering to a more classical approach, would caution the analyst to stay with the work of analyzing and not be lured to serve in the roles of model, guide, or one of the patient's choosing. She emphasized that the analyst's nonparticipation in a personal sense creates a "tilted" emotional relationship in which the revival of past conflicts can be more readily seen and interpreted, particularly when the situation is not contaminated with information about the analyst's background.

As exemplified by Greenacre's comments on the corrective emotional experience and on the transference-countertransference matrix, many in the established psychoanalytic community continued to view the application of these techniques as undermining the fundamental principles of psychoanalysis. Thus, the work of Alexander and his collaborators met with similar controversy as did that of Ferenczi and Rank some years earlier, particularly Ferenczi's development of active therapy.

FERENCZI'S CONTROVERSIAL APPLICATIONS OF THE ACTIVE TECHNIQUE

When Ferenczi introduced the concept of active therapy, it was initially quite conservative. The role of the analyst was limited to that of a "friendly observer and adviser." He adamantly maintained that any wishes on the part of the patient to receive "signs of positive counter-transference must remain unfulfilled," (1925, p. 225). As active therapy became more extreme, it led to his communicating loving feelings to patients, both in words and actions. Physical contact between him and his patients came to involve kissing, hugging, and non-erotic caressing.

Ferenczi (1930) referred to these techniques as "relaxation" and "neocatharsis." He justified their use by maintaining that interpretation alone was insufficient for certain patients; treatment sometimes requires that the analyst serve in the role of surrogate parent to compensate for past parental failures. These patients needed to be "adopted" to experience a normal nursery for the first time

in their lives. In this way, Ferenczi (1930, 1931) tried to make less of a distinction between the treatment of adults and the treatment of children. His concern with the injured child inside the adult patient clearly foreshadowed the "inner child" therapy, as did his then unprecedented view that some patients need to experience aspects of the therapist's countertransference love.

Although Ferenczi intended for his "principle of indulgence" to operate side by side with Freud's principle of abstinence, the early psychoanalytic societies were not ready to consider these technical innovations. Freud himself reacted quite strongly, admonishing "God the Father Ferenczi" in his now famous letter to Ferenczi about the dangers of neocatharsis (Jones, 1957). Ferenczi subsequently stopped using this technique, but by the time of his death in 1933, he had lost much of his influence in the analytic establishment. As a consequence of the controversy, many of his important contributions to the current practice of brief therapy were lost (Flegenheimer, 1992).

FERENCZI'S IMPACT ON THE PRACTICE OF MODERN SHORT-TERM THERAPY

Ferenczi's work was far ahead of its time. Certain techniques constituting the therapist's heightened activity level are now established as brief therapy principles and are evident throughout all phases of treatment, from assessment to termination. Davanloo (1978, 1980) and Sifneos (1987), in particular, focus their activity on the persistent challenging of defenses and on anxiety-provoking conflicts respectively. Their models require highly confrontational techniques aimed at stimulating emotions. Together with Malan (1963, 1976, 1979), these authors maintain an active transference approach and seek to bring together the affective and cognitive elements of treatment. The interactive process between patient and analyst is reciprocal and emotionally charged. Mann (1973) adheres to the active analytic position, but he also revives Ferenczi and Rank's concept of enforced termination. He believes that the setting of limits forces a patient to face reality and to give up unrealistic transference expectations.

As practiced by these major proponents of modern short-term

therapy, the active transference approach involves increased verbal interaction between the patient and therapist. As Bauer and Kobos (1987) observe, a verbally active therapist is not compatible with a free-associating patient. In psychoanalysis, the therapist maintains a stance of evenly hovering attention and there are few interruptions into the patient's associations. In short-term therapy, the patient's associations are often directed by the therapist to explore specific material relevant to the focus and goals of treatment. For example, if a patient became more defensive when discussing a certain topic, Davanloo would forcefully challenge the patient's resistance. His approach often raises strong affect in the patient, particularly anger. By contrast, a practitioner of long-term psychoanalytic psychotherapy or psychoanalysis would tend to observe the pattern and development of resistance before confronting the patient.

Short-term therapists adhere to a focus on the core conflict and do not permit the patient to digress defensively from this central concern. As a result, the therapist is often confronting, clarifying, and interpreting defenses, thereby increasing the emotional intensity of the session. Since the treatment focus tends to involve issues which are expressed and explored in the therapeutic dyad, the level of emotional involvement is high for the therapist as well.

With the prevailing trend from one-person to two-person psychology, practitioners of short-term therapy generally acknowledge the interpersonal nature of therapy. The therapist is not viewed as a "blank screen" but rather as a coparticipant whose behavior shapes the transference. This approach is consistent with Ferenczi's insights on countertransference as a way to understand the patient's experience. Countertransference themes in short-term treatment often involve guilt and problems tolerating separation and loss. Shafer (1986) notes that brief treatment thwarts the therapists' reparative need to completely heal the patient, as well as the need to be omniscient and omnipotent. Unlike long-term therapy, Mann (1986) observes that in short-term psychotherapy, therapists do not receive narcissistic gratification in having patients depend on them.

Brief Focal Psychotherapy, established by Malan, emphasizes another aspect of Ferenczi's work, namely concentrating the therapist's effort on analyzing the point at which trauma occurred. Malan, like Ferenczi, did not feel it was necessary to analyze every

feature of the patient's mental life. Dealing with selective aspects of the patient's conflict is described in the other models as well. In his practice of Time-Limited Psychotherapy, for instance, Mann focuses on the central issue of the patient's chronically endured pain. Malan and Davanloo focus on the triangle of conflict (wish, anxiety, and defense) and the triangle of insight (therapist, current relationship, and parent or past figure). Lastly, Sifneos' Short-Term Anxiety Provoking Psychotherapy concentrates on the patient's "circumscribed chief complaint."

The careful selection of patients is also common to the majority of short-term practice models. Given the high level of emotional intensity, patients must be able to benefit from this experience. It is therefore not surprising that these practitioners choose patients who are highly motivated, capable of insight, and able to establish a collaborative relationship with the therapist. These ego resources are necessary to help the patient throughout the arduous and painful treatment process.

Modern short-term therapy is characterized by a high level of commitment on the part of both the patient and therapist. This can also be seen in much of Ferenczi's work. Short-term therapists have had to continually defend their techniques as having been founded on core psychoanalytic principles. They have worked hard to dispel the myth that short-term therapy is superficial and dictated solely by factors extraneous to the patient's interest. Patients often turn to brief treatment as a last resort after other therapies have failed, as did Ferenczi's patients who came from all parts of the world with the hope of being cured.

CONCLUSION

Sándor Ferenczi, a psychoanalytic pioneer and practitioner, suggested changes in psychoanalytic technique which would shorten the length of psychoanalysis. His introduction of "active therapy" involved increased activity from both the patient and analyst as a means to facilitate the exploration of unconscious material. The psychoanalyst prescribed the performance or cessation of certain behaviors, thus instituting active measures which made the patient a full participant in the psychoanalytic process.

Interpretation, Ferenczi contended, was an active intervention which interrupted the patient's psychic activity, leading to the uncovering of repressed thoughts and ideas. In collaboration with Rank, Ferenczi underscored the importance of here-and-now transference interpretations and emphasized the emotional experiences of the patient in the transference, rather than the sole intellectual recovery of memories. Ferenczi noted that intellectual discovery without affect can serve as resistance.

Ferenczi's central ideas on active psychoanalytic treatment and interpretation are the cornerstone of modern dynamic short-term treatment. His ideas have been lauded and incorporated into the works of modern short-term therapists, such as Davanloo, Mann, and Sifneos. Ferenczi's emphasis on the importance of present life events in psychoanalytic treatment is currently receiving much attention in the psychotherapeutic community. This can be seen in the emphasis on the treatment of Axis I disorders and symptomatology, as well as the process of maintaining a process in most models of short-term treatment.

Sándor Ferenczi's incessant drive to improve psychoanalytic methodology has provided inspiration to modern short-term therapists. While Davanloo and others have had the benefit of years of development in research, theory, and technique, it was Ferenczi who pioneered these efforts and who served as a role model. His courage and experimental spirit embody the essence of psychoanalytic inquiry, and have, in my estimation, earned him the title of "Forerunner of Modern Short-Term Psychotherapy."

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