

This book will be the gold standard for guides to brief psychodynamic psychotherapy, authored by a leading master dynamic therapist and teacher. It presents Levenson's latest version of time-limited dynamic psychotherapy (TLDP), a theoretically integrative treatment with contemporary psychodynamic theory as a conceptual foundation. Levenson writes in a succinct and lucid style, which makes her ideas readily accessible to trainees as well as to experienced practitioners who want to enhance their conduct of therapy. The application of clinical theory to case formulation and therapeutic intervention strategies is brilliantly articulated. The author's talent for describing clinical material in a way that vividly brings to life the therapeutic interaction is displayed in the illustrative case presented in Chapter 5. Other distinctive features of this book are the exceptionally thorough history of brief dynamic therapy, the thorough review of research on TLDP, and a closing section where Levenson offers her thoughts on what should be future developments in the field of brief dynamic therapy.

—**Jeffrey L. Binder, PhD, ABPP**, Clinical Professor, Vanderbilt University Department of Psychiatry and Behavioral Sciences, Nashville, TN; Fellow, American Psychological Association and Georgia Psychological Association

If you would like to learn about brief dynamic therapy from a master clinician, teacher, and trainer, this is the book for you.

—**Jacqueline B. Persons, PhD**, Director of the Oakland Cognitive Behavior Therapy Center, Oakland, CA; Clinical Professor, Department of Psychology, University of California at Berkeley

This concise information-packed volume convincingly demonstrates the special value of time-limited dynamic psychotherapy (TLDP) in the panoply of current brief therapies. In updating her classic book on this topic, Levenson expertly shows how TLDP incorporates modern attachment theory, cultural sensitivity, assimilative therapy integration, and cost-benefit in providing a combined insight-oriented and experiential therapy suitable for a surprisingly wide spectrum of patients. In addition, its illustrative clinical cases can't help but fascinate, instruct, and inspire all mental health clinicians!

—**Stanley B. Messer, PhD**, Distinguished Professor Emeritus and former Dean, Graduate School of Applied and Professional Psychology, Rutgers University, Piscataway, NJ

Dr. Levenson has seamlessly updated the previous edition, making it fresh and timely, while retaining her unique style of clear, practical, integrative writing, liberally sprinkled with humor. This book is saturated with the knowledge and wisdom gleaned from her stellar career as an expert teacher and master therapist. I highly recommend this book for beginning and experienced psychotherapists alike.

—**Richard D. Lane, MD, PhD**, Professor of Psychiatry, Psychology and Neuroscience, University of Arizona, Tucson

I have closely followed Hanna Levenson's work for many years and always learn from her. Her experiential focus brings psychodynamic work to life, and her integrative mindset opens pathways to innovation and to a broader repertoire of possibilities for therapeutic intervention. I highly recommend.

—**Paul L. Wachtel, PhD**, Distinguished Professor, doctoral program in clinical psychology, City College of New York, NY

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What Is Brief Therapy?

What is brief therapy often depends on the shifting definition of “brief.” For instance, in 1979, when I began my first real job in clinical psychology in the psychiatry department of the San Francisco Veterans Affairs (VA) Medical Center, the concept of “brevity” played little part in the center’s outpatient practice. At the time, the outpatient psychiatry department was being flooded with Vietnam War veterans seeking help. The clinicians, who were used to seeing their patients for extended periods (sometimes decades), were getting burned out as more and more patients were being added to their caseloads. I had been hired to start a program to train third-year psychiatry residents and psychology predoctoral interns in brief therapy. In my employment interview with the then director of the outpatient service, he let it be known that although it seemed that briefer forms of intervention might be warranted, they “would never work at the

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Brief Dynamic Therapy, Third Edition, by H. Levenson

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VA because the veterans thought of the VA as home.” Not an auspicious way to start a new position!

The model of training I used back then involved an upper limit of 20 sessions, in part because the trainees’ rotation at the site was 6 months long and in part because the training protocol would then mirror the time-limited nature of the therapy. The trainees were assigned to work with one patient,¹ video recording each session and sharing parts of it during a group consultation, which ran concurrently for 21 weeks. In addition, there was a weekly seminar designed to cover topics relevant to where the trainees were in the trajectory of their therapies (e.g., intake, establishing an alliance, termination issues).

I stayed at the VA for 20 years, heading up what came to be known as the VA Brief Therapy Program. During that time, several hundred trainees (and some staff) completed the program. When I retired from the VA, I was still using the same 20-session model. However, the length of most of the treatments provided by my colleagues located in other VA psychiatry inpatient and outpatient services had become increasingly shorter for the same financial (“cost-effective”) reasons that caused therapies to become briefer in the private sector. As time went on, my colleagues often referred complex cases to the Brief Therapy Program, knowing that those patients would be seen for a longer period of time in the “brief” program than elsewhere. The moral of the story is that often what is considered brief is, to some extent, in the eyes of the beholder (and reflected in the zeitgeist).

To underscore the point further, when I was an intern at a training site with a reputation for psychoanalytically oriented, long-term therapy, I did a rotation in brief dynamic psychotherapy.² After a couple of sessions, I had to inform my brief therapy patient that I would only be able to see her for

¹I wish to mention my use of the word *patient* throughout this book instead of *client*. As Shedler (2006) pointed out, “In truth, both words are problematic, but patient seems to me the lesser of evils” (p. 10). The Latin root of patient is “one who is suffering,” and it seems to me that the work of the therapist is to alleviate suffering and restore robustness. However, I do not wish to imply a hierarchical power relationship where “doctors” perform procedures on passive patients. Nonetheless, if the term *patient* has a negative connotation for you, please replace it in your mind with whatever term you prefer.

²This does not mean, however, that these therapists felt competent to do brief therapy. In fact, Levenson and Davidovitz (2000) found that half the psychologists doing therapies planned to be brief never had any coursework in the subject. And those psychodynamic therapists doing short-term work were less skilled and trained in it than their colleagues from other orientations.

3 months. I practiced telling her the short-term nature of the therapy over and over so that my voice would not betray the guilt I felt in not giving her “enough.” When I finally worked up the courage to tell her, she exclaimed, “Is it really going to take that long?”

EVERYONE DOES BRIEF THERAPY

If you are a practicing therapist or studying to be one, I know you are probably doing brief therapy. In a national survey of almost 4,000 mental health professionals, Levenson and Davidovitz (2000) found that almost 90% of psychologists do some form of therapy that is designed to be time limited and focused, and psychodynamically oriented therapists conduct one-quarter of all the planned brief therapy in the United States.³ In addition, everyone does unplanned brief therapies because most patients choose to stay in therapy a brief amount of time, whether or not the therapist has other ideas. In a recent study with a sample size of 710 patients from a university counseling center, Hansen and colleagues (2024) found a mode of two sessions, with 90% discontinuing treatment by the 10th session. Swift and Greenberg (2012), in a meta-analysis of over 650 studies, found an almost 20% dropout rate, and another study (Baier et al., 2020) found 20% to 50% dropouts even in highly effective treatments. Muran and colleagues (2009) commented that current dropout levels are comparable to those found “even in highly effective treatments over 50 years ago” (p. 234). Budman and Gurman (1988) termed these premature terminations *brief therapies by default* (compared with *brief therapies by design*). We tend to forget that long before third-party payers began setting limits on treatment, patients themselves did.⁴

³Of course, these data do not explain why patients drop out of therapy. A recent study by Hansen and colleagues (2024) found that the number one reason patients left treatment “prematurely” was that they felt their problems were solved. Swift and colleagues (2009) discussed theoretical issues and empirical findings regarding the definition of “premature termination.” For example, who is considered a “dropout” may be based on not completing a specified number of sessions, therapist judgment, or leaving therapy before one has attained clinical improvement. These authors found a dropout rate of 77% when they used the criterion of patients discontinuing treatment before achieving clinically significant change.

⁴Nonetheless, researchers (e.g., Ciharova et al., 2024; Schleider et al., 2021) have found that the session frequency, rather than length, increases treatment effects.

Most people who come for therapy are in emotional pain, and they want to have this pain alleviated as soon as possible. They are not fascinated by their psyches, nor do they seek mental health perfectionism. Sometimes, patients experience their needs for immediate relief at variance with their therapists' goals for "problem resolution." Often, too, patients feel adrift in open-ended therapies where they are uncertain what the goals are or how the process will benefit them. "Where are we going?" "What are we doing?" "Am I making progress?" are frequently asked questions.

Having said this, I need to make an important point about how brief therapy can be. "Since the advent of psychotherapy, one of the most common questions has been, 'how much psychotherapy is enough'" (Cameron, 2006, p. 147). When we speak of brief dynamic psychotherapy, contemporary models stay within a 20-or-fewer session range (Farber, 2020), although historically, brief dynamic models could range upward to 40 sessions (Koss & Shiang, 1994; Shapiro et al., 1994). I make a distinction between brief dynamic therapy and what has been called ultra brief therapy or managed care therapy. In examining a national database of more than 6,000 patients, Hansen and colleagues (2002) found that the average number of sessions patients received through managed care organizations or employee assistance programs was less than five! With the greater demand for therapy, it is probably quite likely that this number is even smaller today. For example, in 2022, thousands of mental health workers went on strike to demand that America's largest nonprofit health maintenance organization shorten the waiting time for therapy and elongate the therapy length (Anguiano, 2022). As stated by Levenson and Burg (2000) in their discussion of training psychologists in the era of managed care, the empirical basis of such ultra brief therapies is minimal. Farber (2020), among others, noted that "if psychotherapy is too brief, its benefits may be attenuated" (p. 409). Therefore, the reader should keep in mind that when I am talking about brief dynamic therapy, I am referring to therapy that relies on the development of a meaningful therapeutic relationship. However, brief dynamic therapy is about much more than just limited time. It is neither condensed long-term therapy nor what you do when you cannot do "real" (i.e., long-term) therapy. The following section explicates the parameters that are core to brief dynamic therapies.

QUALITIES THAT DEFINE BRIEF DYNAMIC PSYCHOTHERAPY

Are there essential characteristics that brief dynamic psychotherapies have in common and that also distinguish them from more open-ended or longer-term models? A number of years ago, I (Levenson & Butler, 1994) did a content analysis of as many publications as I could find addressing this topic. A review of more recent articles, chapters, and books on the topic for this edition resulted in the same fundamental qualities.⁵ Some of these qualities are mentioned repeatedly in the literature and, therefore, appear essential in defining brief dynamic psychotherapy; others are less frequently reported and seem more peripheral. These characteristics might be conceptualized as a consensual, operational definition of short-term dynamic psychotherapy. There are two main categories of these characteristics: those qualities pertaining to the brief features per se and those germane to the psychodynamic aspects.⁶

Modifications to Make Therapy Briefer

Limited Therapeutic Focus and Goals

The chief factor distinguishing brief from long-term dynamic psychotherapy is its circumscribed focus. Even before mentioning the concept of time, writers agree that “articulating a clinical focus or foci is a hallmark characteristic of all brief psychotherapy approaches” (Messer & Warren, 1995, p. 126). Therapists need a central theme, topic, or problem to guide the work when time is limited. Yogi Berra, former catcher for the New York Yankees known for his idiosyncratic use of the English language, captured the essence of this quality: “If you don’t know where you’re going, you will wind up somewhere else.”

⁵Although there is literature on brief dynamic therapy as applied to groups and couples, my focus in this book is chiefly on individual psychotherapy.

⁶However, Binder (2004) challenged whether these qualities are unique to time-limited approaches, arguing that they are characteristic of good psychotherapy in general, regardless of length. Although I agree with Binder that a well-delivered brief dynamic psychotherapy is good, sound therapy, it is helpful to note that brief dynamic approaches are likely to delineate more limited treatment foci and more specific goals than their longer term counterparts.

Joseph Weiss (1993) wrote about this definition in his book on how psychotherapy works:

When I was a student at the San Francisco Psychoanalytic Institute, a prominent teacher advised me to avoid formulating the patient's problems, especially at the beginning of treatment. He assumed that in general it is possible to formulate a case only after a prolonged period of exploration, and so that if the therapist develops hypotheses about the patient too early, he risks the premature closure of his mind. *I now believe that this advice is wrong* [emphasis added]. (p. 70)

Binder (2004; Binder & Betan, 2012, 2022), in his excellent books outlining the competencies of the brief dynamic psychotherapist, perceptively delineated two different therapeutic skills related to focusing. The first is the ability to discern what will constitute the focus of the work, and the second is how to track and maintain this focus throughout the therapy.

Related to, but distinct from, therapeutic focus is the concept of limited goals. The aim of brief dynamic psychotherapy is not to “cure” once and for all. Rather, the therapy should provide an opportunity to foster changes in behavior, thinking, and feeling, permitting more adaptive coping, improved interpersonal relationships, and a better sense of one's self. Brief dynamic therapy is seen as an opportunity to begin a process of change that (hopefully) continues long after the therapy is over. Clearly, both therapist and patient need to accept limits.

Time Limits and Time Management

Naturally, the amount of time is the obvious variable that defines an approach as short term, brief, or time limited. The issue of time is the second most frequently mentioned brief therapy criterion. Most modern brief dynamic approaches set 12 to 20 sessions as the upper limit of brief therapy (Farber, 2020). Originally, the limiting or rationing of time was used conceptually to accelerate the therapeutic work, either by raising the patient's awareness of the existential issues of finite time and mortality (e.g., Mann, 1973) or by encouraging therapist activity and adherence to a focus (e.g., Horowitz & Marmar, 1984). Today, the limit of time is driven

more by research findings indicating change can occur more quickly than previously thought and the pragmatics of financial costs of lengthy psychotherapies (Maljanen et al., 2016).

Although it is most customary for psychodynamically oriented short-term therapists to use the traditional weekly 50-minute “hour,” many experiment with the frequency, duration, and number of sessions. Brief dynamic therapists have felt that limiting the length of the therapy encourages individuation, autonomy, and positive expectations. Also, there is some intriguing evidence that providing time limits might encourage those patients who otherwise might terminate “prematurely” in an open-ended format to stay in therapy longer (Hansen et al., 2024; Hilsenroth et al., 2001).

Recently, brief dynamic therapists are moving away from conceptualizing therapy merely in terms of a specific amount of time and are, instead, addressing ways to make every session count regardless of the length of treatment. These models are categorized as time attentive or time efficient, where “brevity” is more of an attitude in the therapist’s mind that affects the work (Fraser, 2018). Also, brief therapists are comfortable with rendering help for short periods throughout the patient’s life cycle. For example, I have been in practice long enough to have seen some patients for three or four different brief therapies at various stages in their lives.

The issue of time for brief therapy holds promise and caution. In the best of situations, we are learning that more treatment is not necessarily better (Schleider et al., 2021) and that higher session frequency, rather than length per se, can be effective and efficient (Ciharova et al., 2024; Tiemens et al., 2019). In the worst of situations, there may be no therapeutic rationale for the number of sessions patients receive—such decisions being driven solely by the financial bottom line (Levenson & Burg, 2000).

Selection Criteria

The importance of selection criteria is controversial in the brief dynamic psychotherapy field. Early in the history of psychoanalysis, as psychoanalytic treatments became progressively longer, Freud (1953) put forth the possibility that treatment might be shortened, but only for psychologically healthier patients. Thus, early practitioners of brief dynamic therapy

emphasized rigorous patient selection (e.g., choosing those who were psychologically minded, highly motivated, and of above average intelligence). Current short-term therapists tend to take a more process-oriented and pragmatic approach and judge if lengthening the therapy is warranted as the work progresses.

Therapist Activity

Brief dynamic psychotherapy requires the therapist to be an active participant in the process. However, activity is needed only to the extent necessary to maintain the focus, foster a positive alliance, and make progress within a certain amount of time. When learning brief therapy techniques, many clinicians become confused, thinking that therapist activity means outright direction. It more appropriately entails the therapist's willingness to guide the work with awareness of the aforementioned aspects of focus and time while being sensitive to the patient's presentation and the context of the clinical material.⁷ Thus, therapist activity can range from supportive interventions (e.g., reassurance, strengthening of adaptive defenses) to more exploratory ones (e.g., interpretation, confrontation), depending on factors (e.g., strength of the therapeutic alliance) emerging in the session, as well as patient characteristics and preferences (e.g., psychological health, quality of interpersonal relationships).

Therapeutic Alliance

The strength of the therapeutic alliance, especially from the patient's perspective, has long been shown to be one of the major factors predicting outcome (Crits-Christoph & Gibbons, 2021; Zilcha-Mano et al., 2014). Although various researchers define the alliance somewhat differently, it is generally thought of as comprising the emotional bond between therapist and patient and an agreement on the goals and means to accomplish

⁷I like Wachtel's (2023) term "suggestive dialogue" (p. 222) because it acknowledges the subtle directiveness of the therapist while contextualizing it as occurring within a conversation in which the therapist and patient feel free to share their perspectives equally.

those goals. The quality of the alliance early in therapy has been shown to predict patient dropout and the amount of “work” done in sessions (e.g., Prusinski, 2024). Heinonen and colleagues (2014) found that therapists who had an engaging and encouraging relational style fostered working alliances, especially in short-term therapies. Perlman and colleagues’ (2020) research is an excellent example of how therapists can learn to cultivate such facilitative interpersonal skills through deliberate practice. Analyzing over 100 research studies, Levitt et al. (2016) found that strong alliances promote clients’ openness, self-compassion, and internalization of the therapist as a validating object—all of which promote the safety needed to explore challenging issues. Although forming a positive alliance as quickly as possible is important in all therapies, it is critical in brief therapy, where the therapist might not get many opportunities to repair ruptures in the therapeutic relationship (Muran et al., 2009).

Rapid Assessment and Prompt Intervention

The therapist’s ability to formulate the patient’s case and begin intervening quickly is also imperative. When I was an intern at the aforementioned setting famous for its long-term, psychoanalytically oriented training program, we spent approximately 3 months getting a full history and developing an understanding of the patient’s dynamics before accepting the patient for treatment. Today, those 3 months could constitute the total time frame allotted for an entire therapy.

Termination

The brief therapist must be willing to terminate with patients in a considered manner. Because the therapy is short term, termination is woven into the fabric of the work from the beginning. If the ending of a brief dynamic therapy is handled poorly, previous good therapeutic work can be undone. Training in this final phase of treatment is of the utmost importance. However, it has been my experience that many trainees (even those almost finished with their professional education) have never seen the beginning, middle, and planned ending of one case!

Optimism

In their book on models of brief psychodynamic therapy, Messer and Warren (1995) considered how the psychoanalytic vision of human reality is more “tragic” (with people seen as trapped and suffering), whereas briefer approaches are characterized by a more “comic” outlook. “The brief therapist approaches therapy in a more optimistic spirit, believing that worthwhile change is achievable within the set time limit” (p. 42).

My colleagues and I have compared the attitudes of short-term to long-term therapists (Bolter et al., 1990) and found that the brief practitioners are more likely to believe that psychological change occurs outside of therapy and that setting time limits intensifies the therapeutic work. In another study, Levenson and Bolter (1988) examined the values and attitudes of psychiatry residents and psychology interns before and after a 6-month training in time-limited dynamic psychotherapy and found that post-training, students were more willing to use brief therapy, more positive about achieving significant insight, more expectant that the benefits would be long lasting, and less likely to think that extensive “working through” is necessary. Also, they were more willing to be active and believe that patients would continue to change after the therapy was over. Similarly, experienced therapists became more positive and optimistic toward brief therapy following a daylong workshop (Neff et al., 1996).

Contract

The final major difference between shorter and longer term dynamic therapies concerns setting up a therapeutic contract. This contract is “neither legalistic nor necessarily written” (Hobbs, 2006, p. 120). The degree of specificity of such a contract varies, but there is an understanding at the outset of the therapy that the work will be limited in time and/or focused in scope.

Modifications of Psychoanalytic Concepts and Techniques

Brief dynamic therapy relies on major psychoanalytic and psychodynamic concepts, such as the importance of affect, past experiences (especially interpersonal ones from childhood), unconscious (or implicit or procedural)

mental phenomena, transference–countertransference, the mind in conflict, defensive processes, and recurrent themes of behavior, thoughts, and feelings (Blagys & Hilsenroth, 2000; Shedler, 2022). However, post-modern, brief dynamic therapists eschew highly inferential psychoanalytic concepts and those that have no empirical support (e.g., Oedipus complex, psychosexual stages of development).

Also, the brief dynamic therapist will more likely emphasize the patient's strengths and resources in dealing with real-life issues rather than fostering regression and fantasy. Therefore, psychoanalytic methods such as free association or lying on the couch are not used. Another major modification of the psychoanalytic technique is that there is more emphasis on the here and now of the patient's life than the there and then of childhood. For many modern brief therapists, interpretation (especially transference interpretation) plays a less central role, and insight, though still important, is not considered the curative mechanism.⁸

Not only are traditional psychoanalytic interventions modified, but techniques from other theoretical approaches such as process experiential therapy and cognitive behavior therapy may also be incorporated (Abbass, 2015; Fosha, 2000; Levenson, 2020; McCullough & Magill, 2009; Safran & Muran, 2000). In brief dynamic treatments, the understanding of patients in terms of psychodynamic theory is decoupled from the exclusive use of dynamic techniques. Brief dynamic therapists may be thinking psychodynamically, but most feel free to use a variety of intervention strategies from other theoretical orientations.

While I have presented some general characteristics that distinguish short-term from long-term models and brief dynamic therapy from other brief therapies, there is no single approach called brief dynamic psychotherapy. As becomes obvious in the following chapters, quite an array of approaches fit within this rubric. To make brief dynamic therapy concepts come alive for the reader and not get watered down in generalities, I refer to

⁸However, the definition of what constitutes “insight” is quite complex. The reader is referred to a book edited by Louis Castonguay and Clara Hill (2007) on insight in psychotherapy from various perspectives.

a particular brief dynamic therapy—time-limited dynamic psychotherapy (TLDP)—throughout the text to illustrate ways of formulating and intervening in a timely manner. I use TLDP to introduce the reader to the applicability of brief dynamic approaches for today’s practicing clinician. TLDP is a model with which I am quite familiar from clinical (Levenson, 1995, 2003, 2020; Levenson et al., 2020; Levenson & Strupp, 2007), training (Levenson & Burg, 2000; Levenson & Evans, 2000; Levenson et al., 2023; Levenson & Strupp, 1999), and applied perspectives (Levenson & Bein, 1993; Levenson & Davidovitz, 2000; Levenson & Overstreet, 1993). It is an integrative short-term approach that interweaves major principles of time-sensitive clinical work. I hope it will capture the breadth and depth of what brief dynamic psychotherapy can offer.