Handbook of Short-term Psychotherapy

Criteria of Selection

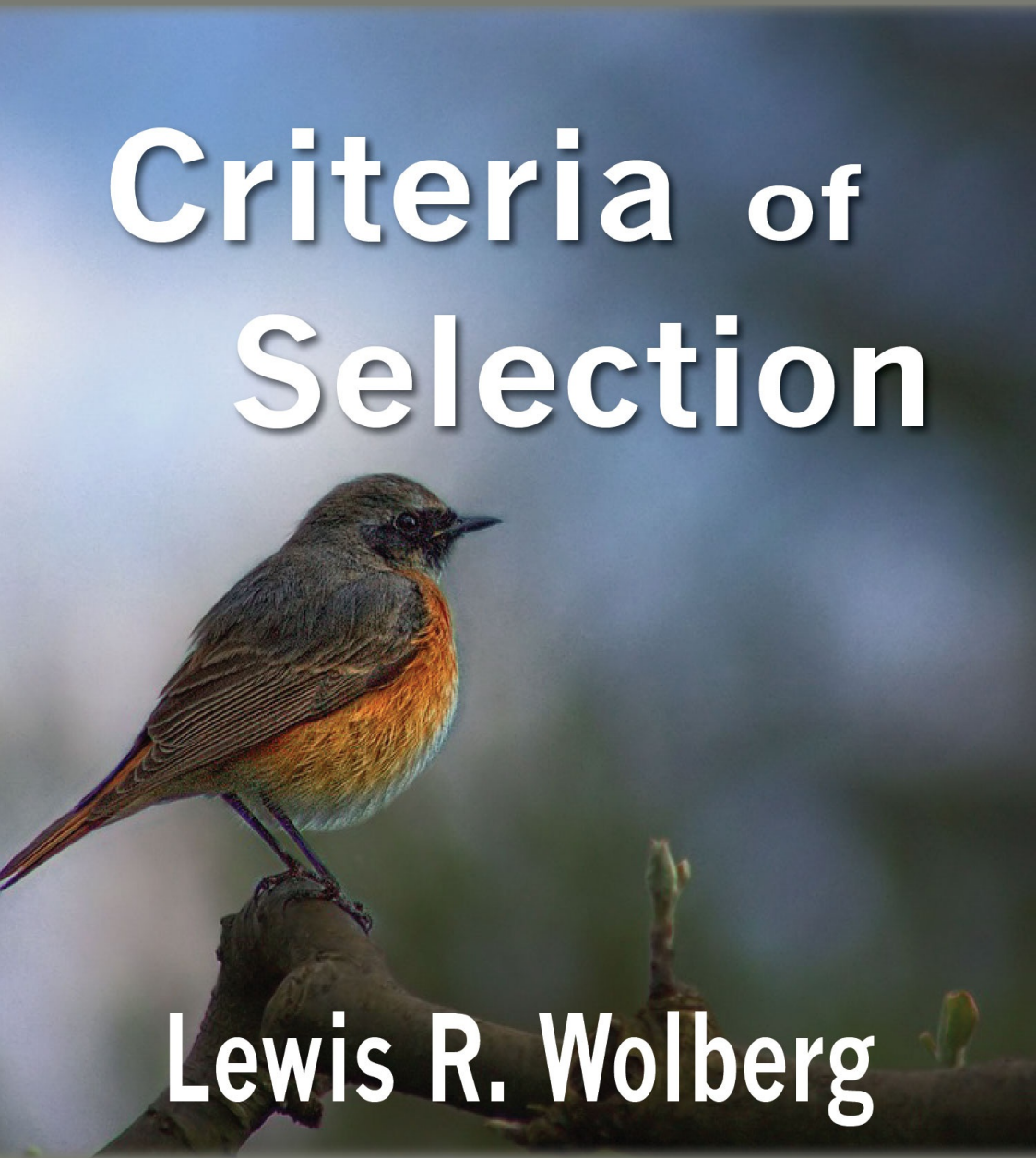

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Table of Contents

Criteria of Selection

While the best patients are undoubtedly those who are adequately motivated for therapy, intellectually capable of grasping immediate interpretations, proficient in working on an important focus in therapy, not too dependent, have had at least one good relationship in the past, and are immediately able to interact well with the therapist, they generally constitute only a small percentage of the population who apply to a clinic or private practitioner for treatment. The challenge is whether patients not so bountifully blessed with therapeutically positive qualities can be treated adequately on a short-term basis with some chance of improving their general modes of problem solving and perhaps of achieving a minor degree of personality reconstruction.

Patient Classification

In practice one may distinguish at least five classes of patients who seek help. We have categorized them as Class 1 through 5. In general, Classes 1 to 3 require only short-term therapy. Classes 4 and 5 will need management for a longer period after an initial short-term regimen of therapy.

Class 1 Patients

Until the onset of the current difficulty Class 1 patients have made a good or tolerable adjustment. The goal in therapy is to return them to their habitual level of functioning. Among such patients are those whose stability has been temporarily shattered by a catastrophic life event or crisis (death of a loved one, porce, severe accident, serious physical illness, financial disaster, or other calamity). Some inpiduals may have been burdened with extensive conflicts as far back as childhood but up to the present illness have been able to marshal sufficient defenses to make a reasonable adaptation. The imposition of the crisis has destroyed their capacities for coping and has produced a temporary regression and eruption of neurotic mechanisms. The object in therapy for these patients is essentially supportive in the form of *crisis intervention* with the goal of reestablishing the previous equilibrium. Reconstructive effects while not expected are a welcome pidend. Generally, no more than six sessions are necessary.

An example of a Class 1 patient is a satisfactorily adjusted woman of 50 years of age who drove a friend's automobile with an expired license and in the process had a severe accident, killing the driver of the car with which she collided and severely injuring two passengers in her own car, which was damaged beyond repair. She herself sustained a concussion and an injured arm and was moved by ambulance to a hospital, where she remained for a week. Charged with driving violations, sued by the owner of the car she borrowed and by the two injured passengers, she developed a dazed, depressed reaction and then periods of severe dizziness. Therapy here consisted of a good deal of support, reassurance, and help in finding a good lawyer, who counseled her successfully through her entangled legal complications.

Sometimes a crisis opens up closed traumatic chapters in one's life. In such cases it may be possible to link past incidents, feelings, and conflicts with the present upsetting circumstances enabling the patient to clarify anxieties and hopefully to influence deeper strata of personality. In the case above, for example, the patient recalled an incident in her childhood when while wheeling her young brother in a carriage, she accidentally upset it, causing a gash in her sibling that required suturing. Shamed, scolded, and spanked, the frightened child harbored the event that powered fear and guilt within herself. The intensity of her feeling surprised her, and their discharge during therapy fostered an assumption of a more objective attitude toward both the past and the immediate crisis event. It may not be possible in all cases, but an astute and empathic therapist may be able to help the patient make important connections between the past and present.

Class 2 Patients

The chief problem for Class 2 patients is not a critical situation that has obtruded itself into their lives, but rather maladaptive patterns of behavior and/or disturbing symptoms. The object here is symptom cure or relief, modification of destructive habits, and evolvement of more adaptive behavioral configurations. Multiform techniques are employed for 8 to 20 sessions following eclectic *supportive-educational* models under the rubric of many terms, such as short-term behavioral therapy, short-term reeducative therapy, and so forth.

A phobia to air travel exemplifies the complaints of a class 2 patient. This was a great handicap for

Miss J since job advancement necessitated visits to remote areas. The origin of the patient's anxiety lay in the last flight that she had taken 8 years previously. A disturbance in one of the engines reported to the passengers by the pilot necessitated a return to the point of origin. Since that time Miss J had not dared enter a plane. Therapy consisted of behavioral systematic desensitization, which in eight sessions resulted in a cure of the symptom.

In utilizing the various eclectic techniques the therapist alerts himself to past patterns that act as a paradigm for the present symptom complex, as well as to manifestations of resistance and transference. In a certain number of cases the patient may be helped to overcome resistances through resolution of provocative inner conflicts and in this way achieve results beyond the profits of symptom relief.

Class 3 Patients

Those in whom both symptoms and behavioral difficulties are connected with deep- seated intrapsychic problems that take the form of personality disturbances and inappropriate coping mechanisms make up the Class 3 classification. Such patients have functioned at least marginally up to the time of their breakdown, which was perhaps initiated by an immediate precipitating factor. Most of these patients seek help to alleviate their distress or to solve a crisis. Some come specifically to achieve greater personality development. On evaluation either they are deemed unsuitable for long-term treatment, or extensive therapy is believed to be unnecessary. They often possess the desire and capacity to work toward acquiring self-understanding.

The goal for Class 3 patients is personality reconstruction along with symptomatic and behavioral improvement. Techniques are usually psychoanalytically oriented, involving interviewing, confrontation, dream and transference interpretations, and occasionally the use of adjunctive techniques like hypnosis. Some therapists confine the term *dynamic short-term therapy* to this class of patients and often employ a careful selection process to eliminate patients whom they feel would not work too well with their techniques (Buda, 1972; Davanloo, 1978, Malan, 1963; Sifneos, 1972; Ursano & Dressier, 1974).

An example of a Class 3 patient is a young mother who brought her son in for consultation because

he was getting such low marks in the final year of high school that the chances of his getting into college were minimal. Moreover, he firmly announced his unwillingness to go to college, insisting on finding a job after graduation so that he could buy an automobile and pursue his two hobbies: baseball and girls. During the interview with the boy it was obvious that he had motivation neither for further college education nor for any kind of therapeutic help. It was apparent too that his stubborn refusal to study and to go on to higher learning was a way of fighting off the domination of his mother and stepfather. Accordingly, the mother was advised to stop nagging the boy to continue his schooling. Instead she was urged to permit him to experiment with finding a job so that he could learn the value of a dollar and to discover for himself the kinds of positions he could get with so little education.

The next day the mother telephoned and reported that she had followed the doctor's instructions. However, she asked for an appointment for herself since she was overly tense and suffered from bad backaches that her orthopedist claimed were due to "nerves." What she wanted was to learn self-hypnosis, which her doctor claimed would help her relax. Abiding by her request, she was taught self-hypnosis—not only for relaxation purposes, but also to determine the sources of her tension. Through interviewing aided by induced imagery during hypnosis, she was able to recognize how angry she was at me for not satisfying her desire to force her son to go to college. Images of attacking her father, who frustrated and dominated her, soon brought out her violent rage. She realized then that her obsequious behavior toward her husband was a cover for her hostility. Acting on this insight, she was soon able to express her anger and to discuss her reactions with her husband and the reasons for her rages. This opened up channels of communication with a dramatic resolution of her symptoms and an improvement in her feelings about herself and her attitudes toward people, confirmed by a 5-year follow-up.

Class 4 Patients

Patients of the Class 4 category are those whose problems even an effective therapist may be unable to mediate in a brief span and who will require more prolonged management after the initial short-term period of formal therapy has disclosed what interventions would best be indicated. The word "management" should be stressed because not all long-term modalities need be, and often are not, best aimed at intrapsychic alterations. Among inpiduals who appear to require help over an extended span are those whose problems are so severe and deep-rooted that all therapy can do for them is to keep them

in reasonable reality functioning, which they could not achieve without a prolonged therapeutic resource.

Class 4 patients include the following:

1. Inpiduals with chronic psychotic reactions and psychoses in remission who require some supervisory inpidual or group with whom contact is regularly made over sufficiently spaced intervals to provide some kind of human relationship, however tenuous this may be, to oversee essential psychotropic drug intake, to regulate the milieu, and to subdue the perils of psychotic processes when these are periodically released. Such patients do not usually require formal prolonged psychotherapy or regular sessions with a psychotherapist; they could do as well, or better, with a paraprofessional counselor. Milieu therapy, rehabilitation procedures, and social or group approaches may be helpful.

2. Persons with serious character problems with tendencies toward alcoholism and drug addiction who require regular guidance, surveillance, group approaches, and rehabilitative services over an indefinite period.

3. Inpiduals with uncontrollable tendencies toward acting-out who need controls from without to restrain them from expressing impulses that will get them into difficulties. Examples are those who are occasionally dominated by dangerous perversions, desires for violence, lust for criminal activities, masochistic needs to hurt themselves, accident proneness, self-defeating gambling, and other corruptions. Many such persons recognize that they need curbs on their uncontrollable wayward desires.

4. Persons so traumatized and fixated in their development that they have never overcome infantile and childish needs and defenses that contravene a mature adaptation. For instance, there may be a constant entrapment in relationships with surrogate parental figures, which usually evolve for both subjects and hosts into a sado-masochistic purgatory. Yet such persons cannot function without a dependency prop, and the therapist offers himself as a more objective and nonpunitive parental agency. Some of these patients may need a dependency support the remainder of their lives.

   Many of the patients in this category fall into devastating frustrating dependency relationships during therapy or alternatives to therapy from which they cannot or will not extricate themselves. Realizing the dangers of this contingency, we can, however, plan our strategy accordingly, for example, by providing supportive props outside of the treatment situation if support is needed. Nor need we abandon reconstructive objectives, once we make proper allowances for possible regressive interludes. In

follow-up contacts, I was pleased to find, there had been change after 5, 10, and in some cases 15 years in patients who I believed had little chance to achieve personality change.

5. Persons with persistent and uncontrollable anxiety reactions powered (a) by unconscious conflicts of long standing with existing defenses so fragile that the patient is unable to cope with ordinary demands of life or (b) by a noxious and irremediable environment from which the patient cannot escape.

6. Borderline patients balanced precariously on a razor edge of rationality.

7. Intractable obsessive-compulsive persons whose reactions serve as defenses against psychosis.

8. Paranoidal personalities who require an incorruptible authority for reality testing.

9. Inpiduals with severe long-standing psychosomatic and hypochondriacal conditions, such as ulcerative colitis, or chronic pain syndromes that have resisted ministrations from medical, psychological, and other helping resources. Often these symptoms are manifestations of defenses against psychotic disintegration.

10. People presenting with depressive disorders who are in danger of attempting suicide and require careful regulation of antidepressive medications or electroconvulsive therapy followed by psychotherapy until the risk of a relapse is over.

Class 5 Patients

In Class 5 we place those inpiduals who seek and require extensive reconstructive personality changes and have the finances, time, forbearance, and ego strength to tolerate long-term psychoanalysis or psychoanalytically oriented psychotherapy. In addition, they have had the good fortune of finding a well-trained, experienced, and mature analyst who is capable of dealing with dependent transference and other resistances as well as with one's personal countertransferences. Patients who can benefit more from long-term reconstructive therapy than from dynamically oriented short-term therapy are often burdened by interfering external conditions that may be so strong, or by the press of inner neurotic needs so intense, that they cannot proceed on their own toward treatment objectives after the short-term therapeutic period has ended. Continuing monitoring by a therapist is essential to prevent a relapse. In certain cases the characterologic detachment is so great that the patient is unable to establish close and trusting contact with a therapist in a brief period, and a considerable bulk of time during the short-term

sessions may be occupied with establishing a work relationship.

A special group of patients requiring long-term therapy are highly disturbed children and adolescents who have been stunted in the process of personality development and who require a continuing relationship with a therapist who functions as a guiding, educational, benevolent parental figure.

Long-term patients in Classes 4 and 5 usually constitute less than one-quarter of the patient load carried by the average psychotherapist. The bulk of one's practice will generally be composed of patients who may adequately be managed by short-term methods.

Conclusion

If we are pragmatically disposed to treat as many patients as possible for economic or other reasons, we may say that all patients irrespective of diagnosis, and severity and chronicity of problems are potential candidates for short-term therapy. Should any patients fail to respond to abbreviated methods, we can always continue treatment, having acquired invaluable information during the short-term effort as to what interventions would best be indicated for their problems. Even where the yardstick of cost effectiveness is not paramount, the majority of inpiduals who seek help for emotional problems can with efficient short-term methods achieve satisfactory results and may even go on by themselves, with the learnings they have acquired, to attain some degree of personality growth. A few may require an additional visit or two from time to time to resolve some problems that they are unable to handle by themselves. They thus will have been able through a practical brief therapeutic approach to have been spared the expense, inconvenience, and in some cases the dangers of long-term therapy.