THE TECHNIQUE OF PSYCHOTHERAPY

SHORT-TERM PSYCHOTHERAPY

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Short-Term Psychotherapy

Most of the psychotherapeutic treatments given in this country are short-term by the patients' choice. At the Postgraduate Center for Mental Health, one of the largest outpatient clinics in the United States, for example, patients are seen for psychoanalytically oriented psychotherapy with no limit set for the number of sessions to be given. Patients terminate treatment when they have decided they need no more help. Under these circumstances, the average number of sessions given comes to 17, and this is accompanied by an improvement rate of over 80 percent. Even though the Center is a psychoanalytic training unit, and patients are encouraged to remain in long-term therapy, only 15 percent are deemed suitable candidates for protracted treatment focused on reconstructive goals.

Follow-up studies on patients who have improved with short-term therapy have shown that the majority retain their gains and that some continue to progress by themselves once the start has been made during formal treatment. This does not mean that they would not have improved even more with long-term therapy. It merely indicates that short-term therapy is an important cost-effective approach for many psychiatric problems. It also has been shown by the nation's pioneer health maintenance

organization to reduce utilization of medical resources. Yet there are still many therapists who are reluctant to accept the value of short-term approaches. Hoyt (1985) has listed the following reasons for this reluctance: (1) the belief that "more is better" and that long-term methods are more penetrative and thorough, (2) the idea that one should not contaminate the " pure gold" of analysis with baser metals of a supportive nature, (3) the therapist's predetermined notion that long-term therapy is indicated in spite of the patient's wishes, (4) the belief that short-term therapy involves an overwhelming investment of work and energy, (5) the subtle economic factor of maintaining a steady rather than fluctuating source of income, (6) countertransference and undue therapist reactions to termination.

A number of studies have appeared that bear out that short-term therapy is a most efficient means of bringing about at least symptomatic improvement or cure. More than 25 years ago, this was proven by an experimental program of Group Health Insurance, Inc., in which 1200 participating psychiatrists treated a large sample of patients suffering from a wide spectrum of emotional problems (Avnet, 1962). At the end of the limited treatment period a 76 percent cure or improvement rate was scored. Follow-up investigation 2.5 years later recorded 81 percent of patients as having achieved recovery or improvement (Avnet, 1965). On the basis of these studies, it was grossly predicted that four of five patients receiving brief forms of treatment would report or feel some kind of improvement, even with

current treatment methods executed by long-term oriented therapists.

That depth changes are also possible has been reported by psychoanalytically trained psychotherapists who present evidence that far-reaching and lasting changes may occur even with a limited number of dynamically oriented sessions (Sifneos, 1967, 1972; Davanloo, 1978; Malan, 1964a, 1976; Mann, 1973; Wolberg, 1980). This contention has understandably been subject to challenge. Personality distortions have a long history. They involve habit patterns and conditionings dating to childhood that have become so entrenched that they resist dislodging in a brief period. Repetitively they force the inpidual into difficulties with oneself and others, and they may persist even after years of therapy with an experienced psychoanalyst have revealed their source, traced their nefarious workings through developmental epochs, and painstakingly explored their present-day consequences. We can hardly expect that the relatively few sessions available for short-term therapy can effectuate the alchemy of extensive reorganization not possible with prolonged treatment. Reconditioning any established habit requires time; and time is of the essence in molding personality change if change is at all possible. *But experience persuades that this time need not be spent in all cases in continuous psychotherapy* . Removing some misconceptions about one's illness and one's background may dislodge the cornerstone, crumble the foundations, and eventually collapse some of the neurotic superstructure. This development may not be apparent until years

have passed following a short-term treatment effort. Obviously, this bounty cannot always be realized. We may hypothesize that the more experienced, highly trained, and flexible the therapist, the more likely it is to occur. Yet the environment in which the inpidual functions will undoubtedly also have a determining effect on any reconstructive changes that will evolve, since the milieu may sponsor and encourage or vitiate and crush healthy personality growth. But without having had the benefit of therapy, however brief it may have been, even the most propitious environment will have registered little improvement, save for exceptional cases.

There are patients who by themselves have already worked through a considerable bulk of their problems and who need the mere stimulation of a few sessions with a proficient therapist to enable them to proceed to astonishing development. Such an extensive pidend may not come about, nor should they be expected with many patients in short-term treatment, even where the therapist is sufficiently endowed by personality, training, and experience to do good psychotherapy.

Reasonable anticipations of what short-term treatment should accomplish in the average person are (1) relief of symptoms, (2) restoration to the optimal level of functioning that existed prior to the present illness, and (3) an understanding of some of the forces that initiated the immediate upset. When dynamic short-term therapy has been employed, we may, in addition,

hope for (1) recognition of some pervasive personality problems that prevent a better life adjustment, (2) at least partial cognizance of their origin in past experiences and childhood conditionings, (3) recognition of the relationship between prevailing personality problems and the current illness, and (4) an identification of remediable measures that can be applied to environmental difficulties and perhaps to aspects of personality distortions as a whole. If treatment is managed well, patients will be given an opportunity to move beyond restoring their customary emotional balances. Should they possess sufficient motivation to propel them toward further development, should neurotic secondary gain elements be minimal, and should their environment be sufficiently accommodating to sponsor their continued movement, deeper alterations may occur. We may accept any reconstructive change as a welcome blessing if it comes, but, should it not, we must be satisfied that the patients have derived something worthwhile, even though goal limited, out of their sparse sessions. If therapy is interrupted at the peak of the improvement curve, before the idealized relationship projections dissolve in the acid substratum of transference and resistance, and before dependency has had an opportunity to establish a permanent beachhead in the relationship, the rate of improvement can be substantial.[1]

SELECTION OF CASES

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 at least a minor degree of personality reconstruction.

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 feelings 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 re-educative

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, therapists alert themselves 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, or for sundry other reasons cannot be done. They often possess the desire and capacity of 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 hypoanalysis. 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 followup.

Patients are generally considered unsuited for dynamic short-term psychotherapy if they are not motivated to search for sources of their problems, are unable to withstand the frustration of receiving immediate symptomatic relief, cannot establish a close interpersonal relationship, do not have the ability or ego strength to tolerate anxiety consequent to the challenging and yielding of neurotic patterns of behavior, are not sufficiently " psychologically minded" to be able to reflect on reasons for their maladjustment, or resort habitually to the abuse of tranquilizers, alcohol, or drugs as a way of dealing with tension.

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 the supportive help of an empathic counselor. Milieu therapy, rehabilitation procedures, and social or group approaches may be useful.

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 to operate 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 alterations.

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 hypochondrical 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. Continued 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 working relationship.

In addition to adults 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.

ESSENTIAL COMPROMISES IN SHORT-TERM THERAPY

Apart from the fact that acceptance of abbreviated goals may be necessary in short-term therapy, a number of other compromises may be essential. Prominent among these are (1) the employment of greater activity than in longer term treatment, (2) the flexible practice of differential therapeutics, (3) the overcoming of prejudices related to the " depth" of therapy, (4) avoiding denigration of short-term as compared with long-term approaches, and (5) utilization of interrupted rather than continuous treatments.

Encouragement of Therapist Activity

Anathema to short-term therapy is passivity in the therapist. Where time is of no object, the therapist can settle back comfortably and let the patient pick his or her way through the lush jungles of the psyche. To apply the same tactics in the few sessions that are available in short-term therapy will usually bring meager rewards. Treatment failures are often the product of lack of proper activity. It is for this reason that the conventional non-

directive, detached attitude is unwise, as are free association and the use of the couch. Focused interviewing in the sitting up position is almost mandatory.

There are some therapists, of course, whose personalities support a passive role. Such practitioners may still be able to make an effort at involving themselves more actively, assuming as their objective a rapid assay of the central problem, dealing with its most obvious aspects. If one concentrates one's fire, one will be able to hit the target with greater certainty. At least the therapist will prevent the patient from steering the course of treatment into unproductive channels.

In short-term therapy, one cannot afford the luxury as in prolonged treatment of permitting the patient to wallow in resistance until he or she somehow muddles through. Resistance will, of course, occur, but it must be dealt with rapidly through an active frontal attack before it paralyzes progress.

One of the most difficult things to teach students aspiring to become short-term therapists is that activity in the relationship, with an involvement of oneself as a real person, and open expressions of interest, sympathy, and encouragement, are permissible. Somehow passivity has become synonymous with doing good psychotherapy with the result that at the end of

the prescribed sessions the patient is no further advanced toward resolution of the problem than when therapy first started. Often therapists are not aware of how uninvolved they are until observed working behind a one-way mirror or through videotaping and their passivity is pointed out to them by a supervisor. Whether they can do anything about their impassiveness is another matter, but, in my experience, encouragement to express a more open interest, to engage oneself more vigorously in the interview, to give one's facial expressions a free release, to offer advice where needed, and to make interpretations when necessary may vitalize the therapeutic situation sufficiently to convince that a stoic bearing, a blankness of countenance, and an unresourceful adherence to a phlegmatic role are not necessarily the " scientific" way of doing therapy. This does not mean that therapists will have to revolutionize their personalities in order to do short-term therapy. Inpiduals are constituted differently. Some therapists by nature are quiet and reserved; forcefulness is not within their behavioral range. But they will still be able to exercise the essential activity through a communicative and reassuring relationship. Activity means being interested in the patient and immediate life problems; it does not mean being controlling of the patient. Neither does it give the therapist license to cuddle the patient, make the patient's decisions and otherwise rob the patient of the responsibility of doing things for himself or herself.

Use of Differential Therapeutics

Insofar as the use of a differential therapeutics is concerned (see page 552) psychoanalytically trained therapists are particularly fearful of therapeutic contaminants. Mindful of the long struggle for acceptance of analytic covenants, they are reluctant to take what they consider to be a backward step by dignifying nonanalytic techniques. In this attitude they attempt to delay Freud's prediction that it eventually may be necessary to blend the " gold" of psychoanalysis with the " copper" of other therapies.

Short-term therapy requires a combination of procedures from psychiatric, psychoanalytic, psychological, and sociological fields. Sometimes utilized in the same patient are psychotherapeutic techniques, casework, drugs, hypnosis, group therapy, psychodrama, and desensitization and reconditioning procedures. This fusion of methods, in which there are extracted from the different approached tactics of proven merit, promise the most productive results. To implement such an eclectic regimen, a degree of flexibility is required that enables the therapist to step outside the bounds of training biases and to experiment with methods from fields other than habitual ones.

Here we run headlong into prejudices about what will happen to a personally cherished system of psychotherapy if one introduces into it foreign elements. It may reassure therapists to keep reminding themselves that there is nothing sacred about any of our present day modes of doing

psychotherapy. They all work in some cases and fail in others. We actually owe it to our patients, as well as to ourselves to experiment with as many techniques as we can in order to learn which of these will be effective and which do not yield good results. Certain rigidities in the therapist will interfere with the proper experimentation. Eclecticism does not sanction wild therapy. It presupposes a scrupulous empirical attitude, assaying the values of the different methods for the great variety of conditions that challenge the therapist in daily practice.

Overcoming Prejudices About Depth

Important also is the overcoming of prejudices about " depth." Before a therapist is capable of doing effective short-term therapy he or she will need to abandon value judgments about " superficial" versus " deep" therapy. There is a tendency on the part of psychotherapists to put varying significances on levels of depth as they apply to the content of the therapeutic interviews. Material that relates to the past, from the dredgings of the unconscious, and from transferential interactions become emblazoned with special virtue. All else is labeled " superficial" from which little may be expected insofar as real personality change is concerned. Such notions are the product of a misuse of psychoanalytic wisdom that purports that the only true road to cure is through the alleys of the unconscious. This in spite of the fact that clinical experience persuades that the pulgence of unconscious content

carries no guarantee that a patient will get well.

Psychotherapy is no mining operation that depends for its yield exclusively on excavated psychic ore. It is human interaction that embraces a variety of dimensions, psychological and social, verbal and nonverbal. Some of these elements are so complex that we can scarcely express them in words. How can we, for example, describe such things as " faith," " hope," " trust," " acquisition of insight," "meaning," " restoration of mastery," " self-realization," and " development of capacity to love." These are aspects of therapy fluctuating within the matrix of change. In the architecture of personality building, no one tissue or girder stands alone. They are all interrelated. Revelation of the unconscious blends into the total therapeutic Gestalt. It does not constitute it.

Even though in short-term therapy we can only deal with the immediate and manifest, we may ultimately influence the total personality in depth, including the unconscious. Human warmth and feeling, experienced by a patient in one session with an empathic therapist, may achieve more profound alterations than years with a probing, detached therapist intent on wearing out resistance. This does not mean that one should be neglectful of the unconscious. Within a short span of therapy, repressed psychic aspects may still be elicited and handled.

Correcting Misconceptions About Time in Therapy

Rectification of prejudices about the superiority of long-term over short-term therapy is another must. It may be argued that if a few sessions can potentially induce corrective change, would not prolonged treatment do the job even more effectively, enabling the inpidual to apply to current life situation the kinds of discipline that sponsor a healthy perspective? There is no question that an extended time period permits the therapist to handle resistance that some patients mobilize toward the giving up of their neuroses. There is no question, too, that some patients, for instance, those that are masochistically inclined, gain a subversive gratification out of their neurotic misery and are loathe to yield it too readily. Here the therapist functions as a sentinel, alerting the patient to the presence and particular manifestations of resistance. Such patients would probably do better in prolonged treatment if we could avoid the trap of dependency and could successfully deal with transference elements that unleashed tend to enmesh the patient in the tangled folds of the past.

On the other hand, we may overemphasize the need for long-term treatment in many patients. We may assume that all persons possess healthy and resilient elements in their personality, which given half a chance, will burgeon forth. A brief period of treatment may be all that is required to set into motion a process of growth.

The question of the superiority of longterm over short-term therapy is therefore a rhetorical one. Experience persuades that some patients get nowhere with long-term therapy and do remarkably well with short-term approaches. There are others in whom short-term treatment does not succeed in denting the surface of their problem and who require a prolonged period of therapy before the slightest penetration is made. As has been pointed out the problem of selection of cases is as poignant a one as is the utilization of proper techniques. It is doubtful that we can always define syndromes that best will respond to either approach. Factors other than symptomatology and diagnosis determine how the patient will progress. Nor is it possible to delineate precisely special tactics that can expedite treatment in all cases. What works with one therapist and patient may not work with others. Each therapist will need to experiment with methods best suited to inpidual style and personality.

At the present stage of our knowledge, long-term treatment is not always an indulgence. If the patient is so constituted as to be able to take advantage of explorations into the psyche, and if the therapist is equipped to work on a depth level, extended therapy may be a rewarding adventure. Without question the “working through” of psychological blocks, and the resolution of the manifold facades and obstructions the mind concocts to defeat itself, can in some persons best be accomplished in a prolonged professional relationship. Here the therapist concentratedly and continuously

observes the patient, dealing with resistances as they develop, and bringing the patient to an awareness of the basic conflicts that power defensive operations. Given the proper patient with a personality problem of longstanding, who possesses an adequate motivation for change, with an ego structure sufficiently plastic, an environment that is malleable, a social milieu that will accept the patient's new found freedoms, who can afford luxuries of time and finances, and who relates constructively in a treatment experience with a well-trained psychotherapist, long-term therapy will offer the best opportunity for the most extensive personality change.

Moreover, there are certain chronic conditions that respond to no other instrumentality than continuous psychotherapy, no matter how assiduously the therapist is applied toward releasing forces of health within the patient. The situation is akin to diabetes in which the patient survives solely because he or she receives life-giving insulin. In certain problems, dependency is so deep-rooted that the patient can exist only in the medium of a protective relationship in which the patient can receive dosages of support. The patient appears to thrive in therapy and seemingly may be utilizing insights toward a better integration. But this improvement is illusory; the patient constantly needs to maintain a life-line to the helping authority to whom he or she clings with a desperation that defies all efforts at treatment termination. Such patients obviously will not do well with short-term methods, although long-term approaches may be inadequate also.

From the foregoing one may get the impression that long-term therapy is the preferred treatment where the patient has a severe personality disorder. This is not always the case. There are some risks in employing prolonged treatment in many patients. Dependent inpiduals who have been managing to get along on their own, albeit on a tenuous independency level, may become more and more helpless, and importune for increasing demonstrations of support with an exaggeration rather than a relief of their symptoms. Inpiduals with fragile ego structures will tend to develop frightening transference reactions in prolonged treatment, or they may go to pieces in the process of releasing repressions.

Patients who have been found to respond best to short-term therapy are those who possess a resilient repertoire of coping mechanisms, and who, prior to their immediate upset, were functioning with some degree of satisfaction. It is essential here to qualify the finding that acute problems are best suited for short-term approaches. Our frame of reference is the conventional body of techniques that we utilize today. There is no reason to assume that with the refinement of our methodology even severe personality difficulties may not be significantly improved on a short-term basis. This author has personally observed chronic cases treated with short-term methods, including obsessive-compulsive neurosis and borderline schizophrenia, and has noted many gratifying results. Indeed, had I believed that these patients should continue in extended therapy, I am certain that

some would have marooned themselves in permanent treatment waters that would have swamped their tiny surviving islands of independence.

The best strategy, in this author's opinion, is to assume that every patient, irrespective of diagnosis, will respond to short-term treatment unless proven refractory to it. If the therapist approaches each patient with the idea of doing as much as reasonably possible within the span of up to 20 treatment sessions, the patient will be given an opportunity to take advantage of short-term treatment to the limit of potential. If this expediency fails, a resort to prolonged therapy may be taken.

Use of Interrupted Treatments

Realization that therapy is not a close-ended matter with permanent beginning, middle, and end phases has introduced a new model for the delivery of services. This is oriented around the principle that termination of psychotherapy with a successful outcome does not necessarily immunize the inpidual against future emotional illness. Conditions outside the inpidual related to career, status, economic stability, marital situation, and social milieu, as well as within the person, e.g., increased vulnerabilities associated with aging, value change, and physical well-being may impose stresses beyond habitual adaptive capacities. Returning for treatment on a short-term basis may be as important for many people as visiting their personal

physicians throughout their life for unexpected ailments that periodically develop. The idea that one can discharge a patient and never see the patient again is an erroneous one and should not be encouraged. This means that all therapy is relevant to a time frame, and that patients are seen as " evolving, receptive to and needing different interventions at different times" (Bennett, 1983).

CATEGORIES OF SHORT-TERM THERAPY

A number of attempts have been made to subpide short-term therapy into a number of distinctive categories. In general intervention, (2) supportive-educational short-term therapy, and (3) dynamic short-term therapy. The goals of crisis intervention usually differ from those in the other brief methods. Here, after from 1 to 6 sessions, an attempt is made to restore habitual balances in the existing life situation. Supportive educational approaches, such as behavior therapy, constitute forms of intervention that are undertaken, along with educational indoctrination, to relieve or remove symptoms, to alter faulty habit patterns, and to rectify behavioral deficits. To attain these objectives, a variety of eclectic techniques is implemented, depending on the idiosyncratic needs of the patient and the skills and methodological preferences of the therapist. The number of sessions varies, ranging from 6 to 25. In some cases less than six sessions may be ample, and occasionally even one session has proven productive (Rockwell & Pinkerton,

1982; Bloom, 1981). In dynamic short-term therapy the thrust is toward achieving or at least starting a process of personality reconstruction. Sessions here may extend to 40 or more.

In crisis intervention, sessions may have to be prolonged, psychotropic medications may have to be employed, family members may have to be actively involved, and a multidisciplinary treatment team may have to be available at times. Less urgent forms of crisis intervention that are being practiced are indistinguishable from the kind of counseling commonly done in social agencies. The focus is on mobilizing positive forces in the inpidual to cope with the crisis situation, to resolve remediable environmental difficulties as rapidly as possible, utilizing if necessary appropriate resources in the community, and to take whatever steps are essential to forestall future crises of a similar or related nature. No attempt is made at diagnosis or psychodynamic formulation. Other kinds of crisis intervention attempt provisionally to detect underlying intrapsychic issues and past formative experiences and to relate these to current problems. More extensive goals than mere emotional stabilization are sought.

The " social-counseling" forms of crisis intervention are generally employed in walk-in clinics and crisis centers where large numbers of clients apply for help and where there is a need to avoid getting involved too intimately with clients who might get locked into a dependent relationship.

Visits are as frequent as can be arranged and are necessary during the first 4 to 6 weeks. The family is often involved in some of the interviews, and home visits may have to be made. The interview focus is on the present situational difficulty and often is concerned with the most adaptive ways of coping with immediate pressing problems. Vigorous educational measures are sometimes exploited to activate the patient. The employment of supportive measures and the use of other helping inpiduals and agencies is encouraged.

More ambitious, goal-directed forms of crisis intervention are often seen operating in outpatient clinics and private practice. If the assigned number of sessions has been exhausted and the patient still requires more help, referral to a clinic or private therapist or continued treatment with the same therapist is considered.

Brief supportive-educational approaches have sponsored a variety of techniques, such as traditional interviewing, behavior therapy, relaxation, hypnosis, biofeedback, somatic therapy, Gestalt therapy, sex therapy, group therapy, etc., singly or in combination. The number of sessions will vary according to the inpidual therapist, who usually anchors the decision on how long it takes to control symptoms and enhance adaptation.

The philosophy that enjoins therapists to employ dynamic short-term treatment is the conviction that many of the derivatives of present behaviors

are rooted in needs, conflicts, and defenses that reach into the past, often as far back as early childhood. Some of the most offensive of these components are unconscious, and while they obtrude themselves in officious and often destructive ways, they are usually rationalized and shielded with a tenacity that is frustrating both to the victim and to those around. The preferred way, according to prevailing theories, that one can bring these mischief makers under control is to propel them into consciousness so that the patient realizes what he or she is up against. By studying how the patient utilizes the relationship with the therapist, the latter has an opportunity to detect how these buried aberrations operate, projected as they are into the treatment situation. Dreams, fantasies, verbal associations, nonverbal behavior, and transference manifestations are considered appropriate media for exploration because they embody unconscious needs and conflicts in a symbolic form. By training, therapists believe themselves capable of decoding these symbols. Since important unconscious determinants shape one's everyday behavior, the therapist tries to establish a connection between the patient's present personality in operation, such as temperament, moods, morals, and manners, with early past experiences and conditionings in order to help the patient acquire some insight into how problems originated.

METHODOLOGY

A variety of short-term therapeutic methods have been proposed by

different therapists (Barten, 1969, 1971; Bellak, 1968; Bellak & Small, 1965; Castelnuovo-Tedesco, 1971; Davanloo, 1978; Gottschalk et al, 1967; Harris, MR, et al, 1971; Levene et al, 1972; Malan, 1964, 1976; Mann, J, 1973; Patterson, V, et al, 1971; Sifneos, 1967; 1972; Wolberg, LR, 1980). There obviously are differences among therapists in the way that short-term therapy is implemented—for example, the focal areas chosen for attention and exploration, the relative emphasis on current as compared to past issues, the attention paid to transference, the way resistance is handled, the depth of probing, the dealing with unconscious material that surfaces, the precise manner of interpretation, the degree of activity, the amount of advice giving, the kinds of interventions and adjunctive devices employed, and the prescribed number of sessions. Moreover, all therapists have to deal with their own personalities, prejudices, theoretical biases, and skills, all of which will influence the way they work. In spite of such differences, there are certain basic principles that have evolved from the experiences of a wide assortment of therapists working with perse patient populations that have produced good results. The practitioner may find he or she can adapt at least some of these principles to his or her own style of operation even though continuing to employ methods that have proven themselves to be effective and are not exactly in accord with what other professionals do. While many of the suggestions as to technique discussed in previous chapters are applicable, in the pages that follow 20 techniques are suggested as a general guide for

short-term therapy.

The important operations consist of (1) establishing a rapid positive working relationship (therapeutic alliance), (2) dealing with initial resistances, (3) gathering historical data, (4) selecting a focus for therapy, (5) defining precipitating events, (6) evolving a working hypothesis, (7) making a tentative diagnosis, (8) conveying the need for the patient's active participation in the therapeutic process, (9) making a verbal contract, (10) utilizing appropriate techniques in an active and flexible manner, (11) studying the reactions and defenses of the patient to the techniques being employed, (12) relating present-day patterns to patterns that have operated throughout the patient's life, (13) watching for transference reactions, (14) examining possible countertransference feelings, (15) alerting oneself to resistances, (16) assigning homework, (17) accenting the termination date, (18) terminating therapy, (19) assigning continuing self-help activities, and (20) arranging for further treatment if necessary.

These operations explained below, may be utilized in toto or in part by therapists who can adapt them to their styles of working.

Establish as Rapidly as Possible a Positive Working Relationship (Therapeutic Alliance)

An atmosphere of warmth, understanding, and acceptance is basic to

achieving a positive working relationship with a patient. Empathy particularly is an indispensable personality quality that helps to solidify a good therapeutic alliance.

Generally, at the initial interview, the patient is greeted courteously by name, the therapist introducing oneself as in this excerpt:

> *Th.* How do you do, Mr. Roberts. I am Dr. Wolberg. Won't you sit down over there (*pointing to a chair*), and w e 'll talk things over and I'll see what I can do to help you (*patient gets seated*).
>
> *Pt.* Thank you, doctor, (*pause*)

A detached deadpan professional attitude is particularly fatal. It may, by eliciting powerful feelings of rejection, provoke protective defensive maneuvers that neutralize efforts toward establishing a working relationship.

It is difficult, of course, to delineate exact rules about how a therapeutic alliance may be established rapidly. Each therapist will utilize himself or herself to achieve this end in terms of own techniques and capacities in rapport. Some therapists possess an extraordinary ability even during the first session, as the patient describes the problem and associated feelings, of putting the patient at ease, of mobilizing faith in the effectiveness of methods that will be utilized, and of subduing the patient's doubts and concerns. A confident enthusiastic manner and a conviction of one's ability to help somehow communicates itself nonverbally to the patient. Therapist

enthusiasm is an important ingredient in treatment.

The following suggestions may prove helpful.

Verbalize What The Patient May Be Feeling

Putting into words for the patient what he or she must be feeling but is unable to conceptualize is one of the most effective means of establishing contact. “Reading between the lines” of what the patient is talking about will yield interesting clues. Such simple statements as, “ You must be very unhappy and upset about what has happened to you” or “ I can understand how unhappy and upset you must be under the circumstances” present the therapist as an empathic person.

Encourage The Patient That The Situation Is Not Hopeless

It is sometimes apparent that, despite presenting oneself for help, the patient is convinced that he or she is hopeless and that little will actually be accomplished from therapy. The therapist who suspects this may say “You probably feel that your situation is hopeless because you have already tried various things that haven’t been effective. But there *are* things that can be done, that *you can do* about your situation and I shall guide you toward making an effort.” Empathizing with the patient may be important: “ Putting myself in your position, I can see that you must be very unhappy and upset

about what is happening to you."

Sometimes it is useful to define the patient's role in developing and sustaining the problem in a nonaccusing way: 'You probably felt you had no other alternative than to do what you did." "What you are doing now seems reasonable to you, but there may be other ways that could create fewer problems for you." While no promise is made of a cure, the therapist must convey an attitude of conviction and faith in what is being done.

> *Pt.* I feel hopeless about getting well. Do you think I can get over this trouble of mine?
>
> *Th.* Do you really have a desire to get over this trouble? If you really do, this is nine-tenths of the battle. You will want to apply yourself to the job of getting well. I will point out some things you can do, and if you work at them yourself, I see no reason why you can't get better.

Where the patient becomes self-deprecatory and masochistic, the positive aspects of reactions may be stressed. For example, should the patient say that he or she is constantly furious, one might reply, "This indicates that you are capable of feeling strongly about things." If the patient claims detachment and does not feel anything, the answer may be, "This is a sign you are trying to protect yourself from hurting." Comments such as these are intended to be protective in order to preserve the relationship with the therapist. Later when it becomes apparent that the relationship is sufficiently solid, the therapist's comments may be more provocative and challenging.

The patient's defenses being threatened, anxiety may be mobilized, but the patient will be sustained by the therapeutic alliance and will begin to utilize it rather than run away from it.

Deal With Initial Resistances

Among the resistances commonly encountered at the first session are lack of motivation and disappointment that the therapist does not fulfill a stereotype. The therapist's age, race, nationality, sex, appearance, professional discipline, and religion may, as emphasized in previous chapters, not correspond with the patient's ideas of someone in whom he or she wants to confide.

> *Th.* I notice that it is difficult for you to tell me about your problem.
>
> *Pt.* (Obviously in discomfort) I don't know what to say. I expected that I would see an older person. Have you had much experience with cases like me?
>
> *Th*. What concerns you is a fear that I don't have as much experience as you believe is necessary and that an older person would do a better job. I can understand how you feel, and you may do better with an older person. However, supposing you tell me about your problem and then if you wish I will refer you to the best older therapist who can treat the kind of condition you have.

This tactic of accepting the resistance and inviting the patient to tell you more about himself or herself, as stated before, can be applied to other stereotypes besides age. In a well-conducted interview the therapist will

reveal as an empathic understanding person, and the patient will want to continue with him or her in therapy.

Another common form of resistance occurs in the person with a psychosomatic problem who has been referred for psychotherapy and who is not at all convinced that a psychological problem exists. In such cases the therapist may proceed as in this excerpt.

Pt. Dr. Jones sent me here. I have a problem with stomachaches a long time and have been seeing doctors for it for a long time.

Th. As you know, I am a psychiatrist. What makes you feel your problem is psychological?

Pt. I don't think it is, but Dr. Jones says it might be, and he sent me here.

Th. Do you think it is?

Pt. No, I can't see how this pain comes from my head.

Th. Well, it might be organic, but with someone who has suffered as long as you have the pain will cause a good deal of tension and upset. [*To insist on the idea that the problem is psychological would be a poor tactic. First the therapist may be wrong, and the condition may be organic though undetectable by present day tests and examinations. Second, the patient may need to retain the notion of the symptom's organicity and even to be able to experience attenuated pain from time to time as a defense against overwhelming anxiety or, in certain serious conditions, psychosis.*]

Pt. It sure does.

Th. And the tension and depression prevent the stomach from healing. Tension interferes with healing of even true physical problems. Now when you

reduce tension, it helps the healing. It might help you even if your problem is organic.

Pt. I hope so.

Th. So what we can do is try to figure out what problems you have that are causing tension, and also lift the tension. This should help your pain.

Pt. I would like that. I get tense in my job with the people I work. Some of them are crumbs. [*Patient goes on talking, opening up pockets of anxiety*.]

The object is to accept the physical condition as it is and not label it psychological for the time being. Actually, as has been indicated, it may be an essential adaptational symptom, the patient needing it to maintain an equilibrium. Dealing with areas of tension usually will help relieve the symptom, and as psychotherapy takes hold, it may make it unnecessary to use the symptom to preserve psychological homeostasis.

Motivational lack may obstruct therapy in other situations, as when a patient does not come to treatment on his or her own accord but is sent or brought by relatives or concerned parties. Additional examples are children or adolescents with behavior problems, people who are addicted (drug, alcohol, food, gambling), and people receiving pensions for physical disabilities. More on handling lack of motivation is detailed elsewhere (p 573).

Gather Historical Material and Other Data

Through " sympathetic listening" the patient is allowed to tell the story with as little interruption as possible, the therapist interpolating questions and comments that indicate a compassionate understanding of the patient's situation. It is hoped that the data gathered in the initial interview permits a tentative diagnosis and a notion of the etiology and possibly the psychodynamics. Should the patient fail to bring up important immediate concerns and problems, the therapist can ask direct questions. Why has the patient come to treatment at this time? What has been done about the problem to date? Has the patient arrived at any idea as to what is causing the difficulty? What does the patient expect or what would he or she like to get from therapy?

It is often advantageous to follow an outline (see Ch. 24) in order to do as complete a history or behavioral analysis as possible during the first session or two. This may necessitate interrupting the patient after the therapist is convinced that he or she has sufficient helpful data about any one topic.

Among the questions to be explored are the following:

1. Have there been previous upsets that resemble the present one?

2. Were the precipitating events of previous upsets in any way similar to the recent ones?

3. What measures aggravated the previous upsets and which alleviated the symptoms?

4. Apart from the most important problem for which help is sought, what other symptoms are being experienced (such as tension, anxiety, depression, physical symptoms, sexual problems, phobias, obsessions, insomnia, excessive drinking?

5. What tranquilizers, energizers, hypnotics, and other medications are being taken?

Statistical data are rapidly recorded (age, education, occupation, marital status, how long married, and children if any). What was (and is) the patient's mother like? The father? Any problems with brothers or sisters? Were there any problems experienced as a child (at home, at school, with health, in relationships with other children)? Any problems in sexual development, career choice, occupational adjustment? Can the patient remember any dreams, especially nightmarish and repetitive dreams? Were there previous psychological or psychiatric treatments?

To obtain further data, the patient may be exposed to the Rorschach cards, getting a few responses to these unstructured materials without scoring. This is optional, of course. The therapist does not have to be a clinical psychologist to do this, but he or she should have read some material on the Rorschach. The patient may also be given a sheet of paper and a pencil and be

asked to draw a picture of a man and a woman. Some therapists prefer showing the patient rapidly the Thematic Apperception Cards. What distortions appear in the patient's responses and drawings? Can one correlate these with what is happening symptomatically? These tests are no substitutes for essential psychological tests where needed, which can best be done by an experienced clinical psychologist. But they can fulfill a useful purpose in picking up gross defects in the thinking process, borderline or schizophrenic potentialities, paranoidal tendencies, depressive manifestations, and so on. No more than 10 or 15 minutes should be utilized for this purpose.

An example of how Rorschach cards can help reveal underlying impulses not brought out by regular interviewing methods is illustrated in a severely depressed man with a controlled, obsessional character whose passitivity and inability to express aggression resulted in others taking advantage of him at work and in his marriage. When questioned about feelings of hostility or aggression, he denied these with some pride. The following were his responses to the Rorschach Cards.

1. Two things flying at each other.

2. Something sailing into something.

3. Two figures pulling something apart; two adults pulling two infants apart.

4. Animals' fur spread out. X-ray (*drops card*)

5. Flying insect, surgical instrument forceps.

6. Animal or insect split and flattened out.

7. X-ray fluoroscope of embryo, adolescents looking at each other with their hair whipping up in the wind.

8. Two animals climbing a tree, one on each side; female organs in all of these cards.

9. Fountain that goes up and spilling blood.

10. Underwater scene, fish swimming, crabs. Inside of a woman's body.

The conflicts related to aggression and being torn apart so apparent in the responses became a principal therapeutic focus and brought forth his repressed anger at his mother.

Select the Symptoms, Behavioral Difficulties, or Conflicts that You Feel are Most Amenable for Improvement

The selection with the patient of an important problem area or a disturbing symptom on which to work is for the purpose of avoiding excursions into regions that, while perhaps challenging, will dilute a meaningful effort. Thus, when you have decided on what to concentrate,

inquire of the patient if in his or her opinion these are what he or she would like to eliminate or change. Agreement is important that this chosen area is significant to the patient and worthy of concentrated attention. A patient who complains that the selection is too limited should be assured that it is best to move one step at a time. Controlling a simple situation or alleviating a symptom will help strengthen the personality, and permit more extensive progress.

Thus the focal difficulty around which therapy is organized may be depression, anxiety, tension, or somatic manifestations of tension. It may be a situational precipitating factor or a crisis that has imposed itself. It may be a disturbing pattern or some learned aberration. It may be a pervasive difficulty in relating or in functioning. Or it may be a conflict of which the patient is aware or only partially aware. Once agreement is reached on the area of focus, the therapist may succinctly sum up what is to be done.

> *Th*. Now that we have decided to focus on the problem [designate] that upsets you, what we will do is try to understand what it is all about, how it started, what it means, why it continues. Then we'll establish a plan to do something about it.

Example 1. A symptomatic focus

> *Th*. I get the impression that what bothers you most is tension and anxiety that makes it hard for you to get along. Is it your feeling that we should work toward eliminating these?

Pt. Yes. Yes, if I could get rid of feeling so upset, I would be more happy. I'm so irritable and jumpy about everything.

Example 2. A focus on a precipitating event

Th. What you are complaining most about is a sense of hopelessness and depression. If we focused on these and worked toward eliminating them, would you agree?

Pt. I should say so, but I would also like to see how I could improve my marriage. It's been going downhill fast. The last fight I had with my husband was the limit.

Th. Well, suppose we take up the problems you are having with your husband and see how these are connected with your symptoms.

Pt. I would like that, doctor.

Example 3. A dynamic focus

Whenever possible the therapist should attempt to link the patient's symptoms and complaints to underlying factors, the connections with which the patient may be only dimly aware. Carefully phrased interpretations will be required. It may not be possible to detect basic conflicts, only secondary or derivative conflicts being apparent. Moreover, the patient may not have given the therapist all the facts due to resistance, guilt, or anxiety. Or facts may be defensively distorted. It is often helpful (with the permission of the patient) to interview, if possible, the spouse or another inpidual with whom the patient is related after the first or second interview. The supplementary data

obtained may completely change the initial hypothetical assumptions gleaned from the material exclusively revealed by the patient.

Nevertheless, some invaluable observations may be made from the historical data and interview material that will lend themselves to interpretation for defining a focus. Thus a patient presenting great inferiority problems and repetitive difficulties in work situations with supervisors, who as a child fought bitterly with an older sibling, was told the following: " It is possible that your present anxiety while related to how you get along with your boss touches off troubles you've carried around with you for a long time. You told me you always felt inferior to your brother. In many cases this sense of inferiority continues to bother a person in relation to new substitutive older brothers. It wouldn't be mysterious if this were happening to you. What do you think?" This comment started off a productive series of reminiscences regarding his experiences with his brother, a focus on which resulted in considerable understanding and betterment of his current relationships.

More fundamental nuclear conflicts may be revealed in later sessions (for example, in the above patient an almost classical oedipal conflict existed), especially when transference and resistance manifest themselves.

Considering the short span of a session it would be most propitious to concern our selves exclusively with issues related to a dynamic theme. It is

obviously impossible to do this when so many urgent reality issues impose themselves during the allotted time. The duty of the therapist is to sift out issues that truly must be discussed (one cannot concentrate on early love objects when the patient's house is burning down) separating them from issues utilized for defensive resistance or indulgence of transference gratifications. Nevertheless, where our goal is personality reconstruction we must utilize every session to best advantage even when pressing reality matters require attention. What the therapist readies himself or herself to do is to listen to the patient's legitimate immediate concerns and establish a bridge to dynamic issues in order to show how a basic theme weaves itself through every aspect of the patient's existence including the immediate reality situation and the relationship with the therapist.

Undoubtedly the relationship with the therapist offers the best focus from the standpoint of understanding personality distortions and their maladaptive consequences. In long-term approaches treatment may be considered incomplete unless adequate consideration is given to transference and countertransference issues. In short-term therapy the press of time and the need to deal with the immediate stressful concerns of the patient may tend to push this focus onto the back burner. At the end of the assigned limited number of sessions, transference phenomena may have received hardly any attention. This is all the more reason for sensitizing oneself to any relationship happenings that offer an opportunity for exploration. When such

happenings do occur, or when the therapist discerns transferential distortions from dreams and acting-out, proper interpretation may make a deep imprint on the patient. Even in sessions limited to five or ten treatment hours, when one hits upon some transferential propitious happenings and explored them later on, the discussion is often considered by the patient a high point in therapy. Obviously, we can expect no miracles from such a brief interchange, but if the patient's resistance is not too great, it can have an important influence.

Define the Precipitating Events

It is essential that we identify clearly the precipitating factors that led to the patient's present upset or why the patient came to treatment at this time.

> *Th*. It seems as if you were managing to get along without trouble until your daughter told you about the affair she is having with this married man. Do you believe this started you off on the downslide?
>
> *Pt*. Doctor, I can't tell you the shock this was to me. Janie was such an ideal child and never was a bit of a problem. And then this thing happened. She's completely changed, and 1 can't understand it.

Sometimes the events are obscured or denied because the patient has an investment in sustaining situational irritants even while seeking to escape from their effects. Involvement in an unsatisfactory relationship with a disturbed or rejecting person from whom the patient cannot extricate is an

example. It may be necessary to encourage continuing conversation about a suspected precipitant, asking pointed questions in the effort to help the patient see the relationship between symptoms and what may have considered unrelated noxious events. Should the patient fail to make the connections, the therapist may spell these out, asking pertinent questions that may help the patient grasp the association.

Evolve a Working Hypothesis

After the first session the therapist should have gathered enough data from the present and past history, from any dreams that are revealed, and from the general attitude and behavior of the patient to put together some formulation about what is going on. This is presented to the patient in simple language, employing concepts with which the patient has some familiarity. This formulation should never be couched in dismal terms to avoid alarming the patient. Rather a concise, restrained, optimistic picture may be painted making this contingent on the patient's cooperation with the therapeutic plan. Aspects of the hypothesis should ideally bracket the immediate precipitating agencies with what has gone on before in the life history and, if possible, how the patient's personality structure has influenced the way the patient has reacted to the precipitating events.

A woman experiencing a severe anxiety attack revealed the

precipitating incident of discovering her husband's marital infidelity. As she discussed this, she disclosed the painful episode of her father's abandoning her mother for another woman.

Th. Is it possible that you are afraid your husband will do to you what your father did to your mother?

Pt. (*breaking down in tears*) Oh, it's so terrible I sometimes think I can't stand it.

Th. Stand his leaving you or the fact that he had an affair?

Pt. If it could end right now, I mean if he would stop, it (*pause*).

Th. You would forget what had happened?

Pt. (*pause*) Yes— Yes.

Th. How you handle yourself will determine what happens. You can see that your present upset is probably linked with what happened in your home when you were a child. Would you tell me about your love life with your husband?

The focus on therapy was thereafter concerned with the quality of her relationship with her husband. There were evidences that the patient herself promoted what inwardly she believed was an inevitable abandonment.

The therapist in making a tentative thrust at what is behind a problem should present formulations in simple terms that the patient can understand. The explanation should not be so dogmatic, however, as to preclude a revision of the hypothesis at a later date, should further elicited material

demand this. The patient may be asked how he or she feels about what the therapist has said. If the patient is hazy about the content, the confusion is explored and clarification continued.

For example, a patient with migraine is presented with the hypothesis that anger is what is creating the symptom. The patient then makes a connection with past resentments and the denial defenses that were erected, which apparently are still operative in the present.

> *Th*. Your headaches are a great problem obviously since they block you in your work. Our aim is to help reduce or eliminate them. From what you tell me, they started way back probably in your childhood. They are apparently connected with certain emotions. For example, upset feelings and tensions are often a basis for headaches, but there may be other things too, like resentments. What we will do is explore what goes on in your emotions to see what connections we can come up with. Often resentments one has in the present are the result of situations similar to troubles a person had in childhood.
>
> *Pt.* I had great pains and trouble fighting for my rights when I was small—a bossy mother and father who didn't care. I guess I finally gave up.
>
> *Th*. Did you give up trying to adjust at home or work?
>
> *Pt.* Not exactly. But fighting never gets anywheres. People just don't listen.

Make a Tentative Diagnosis

Despite the fact that our current nosological systems leave much to be desired, it may be necessary to fit the patient into some diagnostic scheme if

for no other reason than to satisfy institutional regulations and insurance requirements. There is a temptation, of course, to coordinate diagnosis with accepted labels for which reimbursement will be made. This is unfortunate since it tends to limit flexibility and to invalidate utilizing case records for purposes of statistical research. Even though clinical diagnosis bears little relationship to preferred therapeutic techniques in some syndromes, in other syndromes it may be helpful toward instituting a rational program.

Convey the Need for the Patient's Active Participation in the Therapeutic Process

Many patients, accustomed to dealing with medical doctors, expect the therapist to prescribe a formula or give advice that will operate automatically to palliate the problem. An explanation of what will be expected of the patient is in order.

> *Th*. There is no magic about getting well. The way we can best accomplish our goals is to work together as a partnership team. I want you to tell me all the important things that are going on with you and I will try to help you understand them. What we want to do is to develop new, healthier patterns. My job is to see what is blocking you from achieving this objective by pointing out some things that have and are still blocking you. Your job is to act to put into practice new patterns we decide are necessary, you telling me about your experiences and feelings. Psychotherapy is like learning a new language. The learner is the one who must practice the language. If the teacher did all the talking, the student would never be able to carry on a conversation. So remember you are going to have to carry the ball, with my help of course.

Make a Verbal Contract With The Patient

There should be an agreement regarding the frequency of appointments, the number of sessions, and the termination date.

Example 1. Where Limitation of the Number of Sessions is Deemed Necessary in Advance

Th. We are going to have a total of 12 sessions. In that time we should have made an impact on your anxiety and depression. Now, let's consult the calendar. We will terminate therapy on October 9, and I'll mark it down here. Can you also make a note of it?

Pt. Will 12 sessions be enough?

Th. Yes. The least it could do is to get you on the road to really working out the problem.

Pt. What happens if I'm not better?

Th. You are an intelligent person and there is no reason why you shouldn't be better in that time.

Should the therapist dally and compromise confidence in the patient's capacity to get well, the patient may in advance cancel the termination in his or her own mind to an indeterminate future one.

Example 2. When the Termination Date is Left Open

Th. It is hard to estimate how many sessions we will require. I like to keep them below 20. So let us begin on the basis of twice a week.

Pt. Anything you say, doctor. If more are necessary, OK.

Th. It is really best to keep the number of sessions as low as possible to avoid getting dependent on them. So w e 'll play it by ear.

Pt. That's fine.

The appointment times may then be set and the fee discussed.

Utilize Whatever Techniques are Best Suited to Help the Patient with Immediate Problems

After the initial interview, techniques that are acceptable to the patient, and that are within the training range and competence of the therapist, are implemented, bearing in mind the need for activity and flexibility. The techniques may include supportive, educational, and psychoanalytically oriented interventions and a host of adjunctive devices, such as psychotropic drugs, hypnosis, biofeedback, behavioral and group approaches, and so on, in whatever combinations are necessary to satisfy the patient's immediate and future needs. An explanation may be given the patient about what will be done.

Th. At the start, I believe it would be helpful to reduce your tension. This should be beneficial to you in many ways. One of the best ways of doing this is by teaching you some relaxing exercises. What I would like to do for you is to make a relaxing casette tape. Do you have a casette tape recorder?

Pt. No, I haven't.

Th. You can buy one quite inexpensively. How do you feel about this?

Pt. It sounds great.

Th. OK. Of course, there are other things we will do, but this should help us get off to a good start.

Many therapists practicing dynamic short-term therapy ask their patients to reveal any dreams that occur during therapy. Some patients insist that they rarely or never dream or if they do, that they do not remember their dreams.

Th. It is important to mention any dreams that come to you.

Pt. I can't get hold of them. They slip away.

Th. One thing you can do is, when you retire, tell yourself you will remember your dreams.

Pt. What if I can't remember?

Th. Keep a pad of paper and a pencil near the head of your bed. When you awaken ask yourself if you dreamt. Then write the dream down. Also, if you wake up during the night.

In some patients brief group therapy may be decided on. This is an active, goal oriented ahistorical, current-life approach, with emphasis on decision making and patient responsibility with modeling, feedback, and stress on behavioral practice (Imber et al. 1979; Marcovitz & Smith, 1983).

Study the Patient's Reaction and Defense Patterns

The utilization of any technique or stratagem will set into motion reactions and defenses that are grist for the therapeutic mill. The patient will display a range of patterns that the therapist can study. This will permit a dramatic demonstration of the patient's defenses and resistances in actual operation rather than as theories. The patient's dreams and fantasies will often reveal more than actions or verbalizations, and the patient should continually be encouraged to talk about these. The skill of the therapist in working with and interpreting the patient's singular patterns will determine whether these will be integrated or will generate further resistance. Generally, a compassionate, tentative type of interpretation is best, sprinkling it if possible with a casual light humorous attitude. A patient who wanted hypnosis to control smoking appeared restless during induction:

Th. I noticed that when I asked you to lean back in the chair and try relaxing to my suggestions, you were quite uneasy and kept on opening your eyes. What were you thinking about?

Pt. (*emotionally*) My heart started beating. I was afraid I couldn't do it. What you'd think of me. That I'd fail. I guess I'm afraid of doctors. My husband is trying to get me to see a gynecologist.

Th. But you kept opening your eyes.

Pt. (*pause*) You know, doctor, I'm afraid of losing control, of what might come out. I guess I don't trust anybody.

Th. Afraid of what would happen here, of what I might do if you shut your eyes?

(*smiling*)

Pt. (*laughing*) I guess so. Silly. But the thought came to me about something sexual.

While the Focus at ail Times is on the Present, be Sensitive to How Present Patterns Have Roots in the Past

Examination in dynamic short-term therapy of how the patient was reared and the relationship with parents and siblings is particularly revealing. An attempt is made to note established patterns that have operated throughout the patient's life of which the current stress situation is an immediate manifestation. This data is for the therapist's own consumption and should not be too exhaustive, since the patient if encouraged to explore the past may go on endlessly, and there is no time for this. At a propitious moment, when the patient appears to have some awareness of connections of the past with the present, a proper interpretation may be made. At that time a relationship may be cited among genetic determinants, the existing personality patterns, and the symptoms and complaints for which therapy was originally sought.

Watch for Transference Reactions

The immediate reaching for help encourages projection onto the therapist of positive feelings and attitudes related to an idealized authority figure. These should not be interpreted or in any way discouraged since they

act in the interest of alleviating tension and supporting the placebo element. On the other hand, a *negative* transference reaction should be dealt with rapidly and sympathetically since it will interfere with the therapeutic alliance.

Th. [*noting the patient's hesitant speech*] You seem to be upset about something.

Pt. Why, should I be upset?

Th. You might be if I did something you didn't like.

Pt. (*pause*) No—I'm afraid, just afraid I'm not doing what I should. I've been here six times and I still have that panicky feeling from time to time. Do other patients do better?

Th. You seem to be comparing yourself to my other patients.

Pt. I—I—I guess so. The young man that came before me. He seems so self-confident and cheerful. I guess I felt inferior, that you would find fault with me.

Th. Do you think I like him better than I do you?

Pt. Well, wouldn't you, if he was doing better than I was?

Th. That's interesting. Tell me more.

Pt. I've been that way. My parents, I felt, preferred my older brother. He always came in on top. They were proud of his accomplishments in school.

Th. So in a way you feel I should be acting like your parents.

Pt. I can't help feeling that way.

Th. Don't you think this is a pattern that is really self-defeating? We ought to explore this more.

Pt. (*emotionally*) Well, I really thought today you were going to send me to another doctor because you were sick of me.

Th. Actually, the thought never occurred to me to do that. But I'm glad you brought this matter out because we will be able to explore some of your innermost fears about how people feel about you.

Examine Possible Countertransference Feelings

If you notice persistent irritability, boredom, anger, extraordinary interest in or attraction to any patient, ask yourself whether such feelings and attitudes do not call for self-examination. Their continuance will almost certainly lead to interference with a good working relationship. For example, a therapist is treating an unstable middle-aged female patient whom he regards as a plumpish, sloppy biddy who sticks her nose into other people's affairs. He tries to maintain an impartial therapeutic stance, but periodically he finds himself scolding her and feeling annoyed and enraged. He is always relieved as the session hour comes to an end. He recognizes that his reactions are countertherapeutic, and he asks himself if they are really justified. The image of his own mother then comes to his mind, and he realizes that he had many of the same feelings of exasperation, displeasure, and disgust with his own parent. Recognizing that he may be transferring in part some of these attitudes to his patient whose physical appearance and manner remind him of

his mother, he is better able to maintain objectivity. Should self analysis, however, fail to halt his animosity, he may decide to send the patient to another therapist.

Countertransference may also be a sensitive instrument in dynamic psychotherapy toward understanding of projections from the patient of aspects of inner conflict of which the patient may be incompletely aware.

Constantly Look for Resistances That Threaten to Block Progress

Obstructions to successful therapeutic sessions are nurtured by misconceptions about therapy, lack of motivation, needs to maintain certain benefits that accrue from one's illness, and a host of other sources, conscious and unconscious. Where resistances are too stubborn to budge readily or where they operate with little awareness that they exist, the few sessions assigned to short-term therapy may not suffice to resolve them. One way of dealing with resistances once they are recognized is to bring them out openly in a noncondemning manner. This can be done by stating that the patient may hold on to them as defenses, but if this is so, he or she must suffer the consequences. A frank discussion of why the resistances have value for the patient and their effects on treatment is in order. Another technique is to anticipate resistances from the patient's past modes of adaptation, dreams, and the like, presenting the patient with the possibility of their appearance

and what could be done about them should they appear. The therapist should watch for minimum appearances of resistance, however minor they may be, that will serve as psychological obstructions. Merely bringing these to the attention of the patient may help dissipate them.

Pt. I didn't want to come here. Last time I had a terribly severe headache. I felt dizzy in the head, (pause)

Th. I wonder why. Did anything happen here that upset you; did I do anything to upset you?

Pt. No, it's funny but it's something I can't understand. I want to come here, and I don't. It's like I'm afraid.

Th. Afraid?

Pt. (*Pause; patient flushes*.) I can't understand it. People are always trying to change me. As far back as I can remember, at home, at school.

Th. And you resent their trying to change you.

Pt. Yes. I feel they can't leave me alone.

Th. Perhaps you feel I'm trying to change you.

Pt. (*angrily*) Aren't you?

Th. Only if you want to change. In what way do you want to change, if at all?

Pt. I want to get rid of my headaches, and stomachaches, and all the rest of my aches.

Th. But you don't want to change to do this.

Pt. Well, doctor, this isn't true. I want to change the way/want to.

Th. Are you sure the way you want to change will help you get rid of your symptoms?

Pt. But that's why I'm coming here so you will tell me.

Th. But you resent my making suggestions to you because somehow you put me in the class of everybody else who you believe wants to take your independence away. And then you show resistance to what I am trying to do.

Pt. (*laughs*) Isn't that silly, I really do trust you.

Th. Then supposing when you begin to feel you are being dominated you tell me, so we can talk it out. I really want to help you and not dominate you.

Pt. Thank you, doctor, I do feel better.

In brief therapy with patients who possess a reasonably strong ego, confrontation and management of the patient's untoward reactions to challenges may be dramatically effective. Managing the patient's reactions will call for a high degree of stamina, sensitivity, and flexibility on the part of the therapist, an ability to cope with outbursts of anger and other disturbing reactions, and knowledge of how to give reassurance without retracting one's interpretations. However, because judgments about what is happening are made on fragmentary data, it is apt to create justifiable anger and resistance where a therapist is wrong about an appraisal of the problem. This is less the case in long-term therapy where the therapist has a firmer relationship with

the patient and is more certain about the dynamics.

Give the Patient Homework

Involve the patient with an assignment to work on how the symptoms are related to happenings in the patient's environment, to attitudes, to fallacies in thinking, to disturbed interpersonal relationships, or to conflicts within oneself. Even a bit of insight may be a saving grace. As soon as feasible, moreover, ask the patient to review his or her idea of the evolution of the problem and what the patient can do to control or regulate the circumstances that reinforce the problem or alleviate the symptoms. Practice schedules may be agreed on toward opposing the situations or tendencies that require control. The patient may be enjoined to keep a log regarding incidents that exaggerate the difficulties and what the patient has done to avoid or resolve such incidents. The patient may also be given some cues regarding how one may work on oneself to reverse some basic destructive personality patterns through such measures as acquiring more understanding and insight, rewarding oneself for positive actions, self-hypnosis, and so on. These tactics may be pursued both during therapy and following therapy by oneself.

For example, the following suggestion was made to a patient who came to therapy for help to abate migraine attacks:

Th. What may help you is understanding what triggers off your headaches and

makes them worse. Supposing you keep a diary and jot down the frequency of your headaches. Every time you get a headache write down the day and time. Even more important, write down the events that immediately preceded the onset of the headache or the feelings or thoughts you had that brought it on. If a headache is stopped by anything that has happened, or by anything you think about or figure out, write that down, and bring your diary when you come here so we can talk about what has happened.

Suggestions on homework assignments may be found in Chapter 53.

Keep Accenting the Termination Date if One was Given the Patient

In preparing the patient for termination of therapy, the calendar may be referred to prior to the last three sessions and the patient reminded of the date. In some patients this will activate separation anxiety and negative transference. Such responses will necessitate active interpretation of the patient's past dependency and fears of autonomy. Evidences of past reactions to separation may help the patient acquire an understanding of the underpinnings of present reactions. The therapist should expect a recrudescence of the patient's symptoms as a defense against being on one's own and as an appeal for continuing treatment. These manifestations are dealt with by further interpretation. *Do not promise* to continue therapy even if the patient predicts failure.

Pt. I know w e 're supposed to have only one more session. But I get scared not having you around.

Th. One of our aims is to make you stronger so you won't need a crutch. You know

enough about yourself now to take some steps on your own. This is part of getting well. So I want you to give yourself a chance.

Many patients will resent termination of therapy after the designated number of sessions have ended. At the middle point of therapy, therefore, the therapist may bring up this possibility. The therapist should search for incidents in the past where separations have created untoward reactions in the patient. Inpiduals who were separated from their parents at an early age, who had school phobias produced by inability to break ties with the mother, and who are excessively dependent are particularly vulnerable and apt to respond to termination with anxiety, fear, anger, and depression. The termination process here may constitute a prime focus in therapy and a means of enhancing inpiduation.

Th. We have five more sessions, as you know, and then we will terminate.

Pt. I realize it, but I always have trouble breaking away. My wife calls me a holder-oner.

Th. Yes, that's exactly what we want to avoid, the dependency. You are likely to resent ending treatment for that reason. What do you think?

Pt. (*laughing*) I'll try not to.

Th. Well, keep thinking about it and if you have any bad reactions let's talk about it. It's important not to make treatment a way of life. By the end of the five sessions, you should be able to carry on.

Pt. But supposing I don't make it?

Th. There you go, see, anticipating failure. This is a gesture to hold on.

Pt. Well, doctor, I know you are right. I'll keep working on it.

Terminate Therapy on the Agreed-upon Date

While some therapists do not consider it wise to invite the patient who has progressed satisfactorily to return, others find it a helpful and reassuring aid for most patients to do so at the final session. I generally tell the patient to write to me sometime to let me know things are coming along. In the event problems develop that one cannot manage by oneself, the patient should call for an appointment. Rarely is this invitation abused and if the patient does return the difficulty can be rapidly handled, eventuating in reinforcement of one's understanding.

> *Th*. This is, as you know, our last session. I want you now to try things out on your own. Keep practicing the things I taught you—the relaxation exercises [where these have been used], the figuring out what brings on your symptoms and takes them away, and so forth. You should continue to get better. But setbacks may occur from time to time. Don't let that upset you. That's normal and you'll get over the setback. In fact, it may help you figure out better what your symptoms are all about. Now, if in the future you find you need a little more help, don't hesitate to call me and I'll try to arrange an appointment.

Actually relatively few patients will take advantage of this invitation, but they will feel reassured to go out on their own knowing they will not be abandoned. Should they return for an appointment, only a few sessions will

be needed to bring the patient to an equilibrium and to help learn about what produced the relapse.

Stress the Need for Continuing Work on Oneself

The matter of continuing work on oneself after termination is very much underutilized. Patients will generally return to an environment that continues to sponsor maladaptive reactions. The patient will need some constant reminder that old neurotic patterns latently await revival and that one must alert oneself to signals of their awakening. In my practice I have found that making a relaxing tape (a technique detailed on p. 1019) sprinkled with positive suggestions of an ego-building nature serves the interest of continued growth. In the event the patient has done well with homework during the active therapy period, the same processes may continue. Institution of a proper philosophical outlook may also be in order prior to discharge. Such attitudes may be encouraged as the need to isolate the past from the present, the realization that a certain amount of tension and anxiety are normal, the need to adjust to handicaps and realistic irremediable conditions, the urgency to work at correcting remediable elements in one's environment, the recognition of the forces that trigger one's problems and the importance of rectifying these, and the wisdom of stopping regretting the past and of avoiding anticipating disaster in the future. It must be recognized that while the immediate accomplishments of short-term therapy may be modest,

the continued application of the methods the patient has learned during therapy will help bring about more substantial changes.

Arrange for Further Treatment if Necessary

The question may be asked regarding what to do with the patient who at termination shows little or no improvement. Certain patients will require long-term therapy. In this reference there are some patients who will need help for a prolonged period of time; some require only an occasional contact the remainder of their lives. The contact does not have to be intensive or frequent. Persons with an extreme dependency character disorder, borderline cases, and schizophrenics often do well with short visits (15 to 20 minutes) every 2 weeks or longer. The idea that a supportive person is available may be all that the patient demands to keep him or her in homeostasis. Introducing the patient into a group may also be helpful, multiple transferences diluting the hostile transference that so often occurs in inpidual therapy. A social group may even suffice to provide the patient with some means of a human relationship. Some patients will need referral to another therapist who specializes in a different technique, for example, to someone who does biofeedback, behavioral therapy, hypnosis, psychopharmacology, or another modality.

Th. Now, we have completed the number of sessions we agreed on. How do you feel about matters now?

Pt. Better, doctor, but not well. I still have my insomnia and feel discouraged and depressed.

Th. That should get better as time goes on. I should like to have you continue with me in a group.

Pt. You mean with other people? I've heard of it. It scares me, but I'd like to do it. Where the patient is to be referred to another therapist, he or she may be told:

Th. You have gotten a certain amount of help in coming here, but the kind of problems you have will be helped more by a specialist who deals with such problems. I have someone in mind for you who I believe will be able to help you. If you agree, I shall telephone him to make sure he has time for you.

Pt. I'd like that. Who is the doctor?

Th. Dr ._____ If he hasn't time, I'll get someone else.

CRISIS INTERVENTION

Every inpidual alive is a potential candidate for a breakdown in the adaptive equilibrium if the stressful pressures are sufficiently severe. A crisis may precipitate around any incident that overwhelms one's coping capacities. The crisis stimulus itself bears little relationship to the intensity of the victim's reaction. Some persons can tolerate with equanimity tremendous hardships and adversity. Others will show a catastrophic response to what seems like a minor mishap. A specifically important event, like abandonment by a love object, can touch off an explosive reaction in one who would respond much less drastically to bombings, hurricanes, cataclysmic floods,

shipwreck, disastrous reverses of economic fortune, and major accidents. The two important variables are, first, the *meaning* to the inpidual of the calamity and, second, the *flexibility of one's defenses,* that is, the prevailing ego strength.

The immediate response to a situation that is interpreted as cataclysmic, such as the sudden death of a loved one, a violent accident, or an irretrievable shattering of security, is a dazed shock reaction. As if to safeguard oneself, a peculiar denial mechanism intervenes accompanied by numbness and detachment. This defensive maneuver, however, does not prevent the intrusion of upsetting fantasies or frightening nightmares from breaking through-periodically. When this happens, denial and detachment may again intervene to reestablish a tenuous equilibrium, only to be followed by a repetition of fearsome ruminations. It is as if the inpidual is both denying and then trying somehow to acquire understanding and to resolve anxiety and guilt. Various reactions to and defenses against anxiety may precipitate self-accusations, aggression, phobias, and excessive indulgence in alcohol or tranquilizers. Moreover, dormant past conflicts may be aroused, marshalling neurotic symptomatic and distorted characterologic displays. At the core of this confounding cycle of denial and twisted repetitive remembering is, first, the mind's attempt to protect itself by repressing what had happened and, second, to heal itself by reprocessing and working through the traumatic experience in order to reconcile it with the present reality situation. In an inpidual with good ego strength this struggle usually terminates in a

successful resolution of the crisis event. Thus, following a crisis situation, most people are capable after a period of 4 to 6 weeks of picking up the pieces, putting themselves together, and resuming their lives along lines similar to before. People who come to a clinic or to a private practitioner are those who have failed to achieve resolution of stressful life events.

In some of these less fortunate inpiduals the outcome is dubious, eventuating in prolonged and even permanent crippling of functioning. To shorten the struggle and to bolster success in those who otherwise would be destined to a failing adaptation, psychotherapy offers the inpidual an excellent opportunity to deal constructively with the crisis.

In the psychotherapeutic treatment of crisis situations (crisis therapy) the goal is rapid emotional relief—and not basic personality modification. This does not mean that we neglect opportunities to effectuate personality change. Since such alterations will require time to provide for resolution of inner conflicts and the reshuffling of the intrapsychic structure, the most we can hope for is to bring the patient to some *awareness* of how underlying problems are related to the immediate crisis. It is gratifying how some patients will grasp the significance of this association and in the post-therapy period work toward a betterment of fundamental characterologic distortions. Obviously, where more than the usual six session limit of crisis-oriented therapy can be offered, the greater will be the possibility of demonstrating

the operative dynamics. Yet where the patient possesses a motivation for change—and the existing crisis often stimulates such a motivation—even six sessions may register a significant impact on the psychological status quo.

Crisis Therapy

Selection of techniques in crisis therapy are geared to four variables (Wolberg, 1972). The first variable we must consider relates to *catastrophic symptoms that require immediate handling.* The most common emergencies are severe depressions with strong suicidal tendencies, acute psychotic upsets with aggressive or bizarre behavior, intense anxiety and panic states, excited hysterical reactions, and drug and alcoholic intoxications. Occasionally, symptoms are sufficiently severe to constitute a portentous threat to the inpidual or others, under which circumstances it is essential to consider immediate hospitalization. Conferences with responsible relatives or friends will then be essential in order to make provision for the most adequate resource. Fortunately, this contingency is not now employed as frequently as before because of modern somatic therapy. Consultations with a psychiatrist skilled in the administration of somatic treatments will, of course, be in order. Electroconvulsive therapy may be necessary to interrupt suicidal depression or excitement. Acute psychotic attacks usually yield to a regimen of the neuroleptics in the medium of a supportive and sympathetic relationship. It may require almost superhuman forbearance to listen

attentively to the patient's concerns, with minimal expressions of censure or incredulity for delusional or hallucinatory content. Panic reactions in the patient require not only fortitude on the part of the therapist, but also the ability to communicate compassion blended with hope. In an emergency room in a hospital it may be difficult to provide the quiet objective atmosphere that is needed, but an attentive sympathetic doctor or nurse can do much to reassure the patient. Later, frequent visits, even daily, do much to reassure a frightened patient who feels himself or herself to be out of control.

Less catastrophic symptoms are handled in accordance with the prevailing emotional state. Thus during the first stages of denial and detachment, techniques of confrontation and active interpretation of resistances may help to get the patient talking. Where there is extreme repression, hypnotic probing and narcoanalysis may be useful. On the other hand, where the patient is flooded by anxiety, tension, guilt, and ruminations concerning the stressful events, attempts are made to reestablish controls through relaxation methods (like meditation, autogenic training, relaxing hypnotherapy, and biofeedback), or by pharmacological tranquilization (diazepam, Xanax), or by rest, persions (like social activities, hobbies, and occupational therapy), or by behavioral desensitization and reassurance.

Once troublesome symptoms are brought under reasonable restraint, attention can be focused on the second important variable in the crisis

reaction, *the nature of the precipitating agency .* This is usually in the form of some environmental episode that threatens the inpidual's security or damages the self-esteem. A developmental crisis, broken love affair, rejection by or death of a love object, violent marital discord, persisting delinquent behavior and drug consumption by important family members, transportation or industrial and other accidents, development of an incapacitating or life-threatening illness, calamitous financial reverses, and many other provocative events may be the triggers that set off a crisis. It is rare that the external precipitants that the patient holds responsible for the present troubles are entirely or even most importantly the cause.

Indeed, the therapist will usually find that the patient participates actively in initiating and sustaining many of the environmental misfortunes that presumably are to blame. Yet respectful listening and questioning will give the therapist data regarding the character structure of the patient, the need for upsetting involvements, projective tendencies, and the legitimate hardships to which the patient is inescapably exposed. An assay of the existing and potential inner strengths in relation to the unavoidable stresses that must be endured and identification of remediable problem areas will enable the therapist better to focus the therapeutic efforts. Crucial is some kind of cognitive reprocessing that is most effectively accomplished by interpretation. The object is to help the patient find a different meaning for the upsetting events ad to evolve more adequate ways of coping.

The third variable, *the impact on the patient of the family system,* is especially important in children and adolescents as well as in those living in a closely knit family system. The impact of the family may not be immediately apparent, but a crisis frequently indicates a collapsing family system, the end result of which is a breakdown in the identified patient's capacities for adaptation. Crisis theory assumes that the family is the basic unit and that an emotional illness in any family member connotes a disruption in the family homeostasis. Such a disruption is not altogether bad because through it opportunities are opened up for change with potential benefit to each member. Traditional psychotherapy attempts to treat the inpidual patient and often relieves the family of responsibility for what is going on with the patient. Crisis theory, on the other hand, insists that change must involve more than the patient. The most frequently used modality, consequently, is family therapy, the object of which is the harnessing and expansion of the constructive elements in the family situation. The therapist does not attempt to halt the crisis by reassurance but rather to utilize the crisis as an instrument of change. During a crisis a family in distress may be willing to let a therapist enter into the picture, recognizing that it cannot by itself cope with the existing emergency. The boundaries are at the start fluid enough so that new consolidations become possible. The family system prior to the crisis and after the crisis usually seals off all points of entry. During the crisis, before new and perhaps even more destructive decisions have been made, a point is

reached where we may introduce some new perspectives. This point may exist for only a short period of time; therefore it is vital that there be no delay in rendering service.

Thus a crisis will permit intervention that would not be acceptable before nor subsequent to the crisis explosion. One deterrent frequently is the family's insistence on hospitalization, no longer being able to cope with the identified patient's upsetting behavior. Alternatives to hospitalization will present themselves to an astute therapist who establishes contact with the family. Some of the operative dynamics may become startlingly apparent by listening to the interchanges of the patient and the family.

The most important responsibility of the therapist is to get the family to understand what is going on with the patient in the existing setting and to determine why the crisis has occurred now. There is a understandable history to the crisis and a variety of solutions may have been tried. The therapist may be curious as to why these measures were attempted and why they failed, or at least why they have not succeeded sufficiently. The family should be involved in solutions to be utilized and should have an idea as to the reasons for this. Assignment of tasks for each member is an excellent method of getting people to work together and such assignments may be quite arbitrary ones. The important thing is to get every member involved in some way. This will bring out certain resistances which may have to be negotiated. Trades

may be made with the object of securing better cooperation. Since crisis intervention is a short-term process, it should be made clear that visits are limited. This is to avoid dependencies and resentments about termination.

The fourth variable is often the crucial factor in having initiated the crisis situation and consists of *unresolved and demanding childhood needs, defenses and conflicts* that obtrude themselves on adult adjustment, and compulsively dragoon the patient into activities that are bound to end in disaster. These would seem to invite explorations that a therapist, trained in dynamic psychotherapeutic methodology, may be able to implement. The ability to relate the patient's outmoded and neurotic modes of behaving, and the circumstances of their development in early conditionings, as well as the recognition of how personality difficulties have brought about the crisis, would be highly desirable probably constituting the difference between merely palliating the present problem and providing some permanent solution for it. Since the goals of crisis intervention are limited, however, to re-establishing the precrisis equilibrium, and the time allotted to therapy is circumscribed to the mere achievement of this goal, one may not be able to do much more than to merely point out the areas for further work and exploration. Because crisis therapy is goal limited, there is a tendency to veer away from insight therapies organized around psychodynamic models toward more active behavioral-learning techniques, which are directed at reinforcing appropriate and discouraging maladaptive behavior. The effort

has been directed toward the treatment of couples, of entire families, and of groups of nonrelated people as primary therapeutic instruments. The basic therapeutic thrust is, as has been mentioned, on such practical areas as the immediate disturbing environmental situation and the patient's disruptive symptoms, employing a combination of active procedures like drug therapy and milieu therapy. The few sessions devoted to treatment in crisis intervention certainly prevent any extensive concern with the operations of unconscious conflict. Yet a great deal of data may be obtained by talking to the patient and by studying the interactions of the family, both in family therapy and through the observations of a psychiatric nurse, caseworker, or psychiatric team who visit the home. Such data will be helpful in crisis therapy planning or in a continuing therapeutic program.

In organizing a continuing program the therapist must recognize, without minimizing the value of depth approaches, that not all persons, assuming that they can afford long-term therapy, are sufficiently well motivated, introspective, and possessed by qualities of sufficient ego strength to permit the use of other than expedient, workable, and goal-limited methods aimed at crisis resolution and symptom relief.

Techniques in Crisis Intervention

The following is a summation of practical points to pursue in the

practice of crisis intervention.

1. *See the patient within 24 hours of the calling for help* even if it means canceling an appointment. A crisis in the life of an inpidual is apt to motivate one to seek help from some outside agency that otherwise would be avoided. Should such aid be immediately unavailable, one may in desperation exploit spurious measures and defenses that abate the crisis but compromise an optimal adjustment. More insidiously, the incentive for therapy will vanish with resolution of the emergency. The therapist should, therefore, make every effort to see a person in crisis preferably on the very day that help is requested.

2. At the initial interview *alert yourself to patients at high risk for suicide*. These are (a) persons who have a previous history of attempting suicide, (b) endogenous depression (history of cyclic attacks, early morning awakening, loss of appetite, retardation, loss of energy or sex drive), (c) young drug abusers, (d) alcoholic female patients, (e) middle-aged men recently widowed, porced, or separated, (f) elderly isolated persons.

3. *Handle immediately any depression in the above patients*. Avoid hospitalization if possible except in deep depressions where attempts at suicide have been made recently or the past or are seriously threatened now. Electroconvulsive therapy is best for dangerous depressions. Institute antidepressant medications (Tofranil, Elavil, Sinequan) in adequate dosage where there is no immediate risk.

4. *Evaluate the stress situation*. Does it seem sufficiently adequate to account for the present crisis? What is the family situation, and how is it related to the patient's upset? What were past modes of dealing with crises, and how successful were they?

5. *Evaluate the existing support systems available to the patient* that you can utilize in the therapeutic plan. How solid and reliable are certain members of the family? What community resources are available? What are the strengths of the family with whom the patient will live?

6. *Estimate the patient's ego resources*. What ego resources does the patient have to depend on, estimated by successes and achievements in the past? Positive coping capacities are of greater importance than the prevailing pathology.

7. *Help the patient to an awareness of the factors involved in the reaction to the crisis*. The patient's interpersonal relations should be reviewed in the hope of understanding and re-evaluating attitudes and patterns that get the patient into difficulty.

8. *Provide thoughtful, empathic listening and supportive reassurance*. These are essential to enhance the working relationship and to restore hope. The therapist must communicate awareness of the patient's difficulties. The patient should be helped to realize what problems are stress related and that with guidance one can learn to cope with or resolve.

9. *Utilize tranquilizers only where anxiety is so great that the patient cannot make decisions*. When the patient is so concerned

with fighting off anxiety that there is no cooperation with the treatment plan, prescribe an anxiolytic (diazepam, Xanax). This is a temporary expedient only. In the event a schizophrenic patient must continue to live with hostile or disturbed parents who fail to respond to or refuse exposure to family therapy, prescribe a neuroleptic medication and establish a way to see that medications are taken regularly.

10. *Deal with the immediate present and avoid probing of the past*. Our chief concern is the here and now. What is the patient's present life situation? Is trouble impending? The focus is on any immediate disruptive situation responsible for the crisis as well as on the corrective measures to be exploited. Historical material is considered only if it is directly linked to the current problem.

11. *Avoid exploring for dynamic factors*. Time in therapy is too short for this. Therapy must be reality oriented, geared toward problem solving. The goal is restoration of the precrisis stability. But if dynamic factors like transference produce resistance to therapy or to the therapist, deal rapidly with the resistances in order to dissipate them. Where dynamic material is " thrown" at the therapist, utilize it in treatment planning.

12. *Aim for increasing self-reliance and finding alternative constructive solutions for problems*. It is essential that the patient anticipate future sources of stress, learning how to cope with these by strengthening adaptive skills and eliminating habits and patterns that can lead to trouble.

13. *Always involve the family or significant others in the treatment plan*. A crisis represents both an inpidual and a family system collapse, and family therapy is helpful to alter the family system. A family member or significant friend should be assigned to supervise drug intake where prescribed and to share responsibility in depressed patients.

14. *Group therapy can also be helpful* both as a therapy in itself and as an adjunct to inpidual sessions. Contact with peers who are working through their difficulties is reassuring and educational. Some therapists consider short-term group therapy superior to inpidual therapy for crises.

15. *Terminate therapy within six sessions if possible and in extreme circumstances no later than 3 months after treatment has started to avoid dependency*. The patient is assured of further help in the future if required.

16. *Where the patient needs and is motivated for further help for purposes of greater personality development after the precrisis equilibrium has been restored, institute or refer for dynamically oriented short-term therapy*. In most cases, however, further therapy is not sought and may not be needed. Mastery of a stressful life experience through crisis intervention itself may be followed by new learnings and at least some personality growth.

SUPPORTIVE, BEHAVIORAL AND EDUCATIONAL APPROACHES IN SHORT TERM THERAPY

By far the most common measures utilized in short-term therapy are supportive, behavioral, and educational approaches that aim at symptom relief and problem solving. These are employed without compromising the possibility that some reconstructive personality alterations may serendipitously germinate over time. The therapist assiduously avoids probing for unconscious conflicts or developmental difficulties in childhood, or issues of transference and resistance except where they interfere with the conduct of therapy. A focus on problems in the here-and-now is agreed on by patient and therapist, and the number of sessions may be set in advance. These usually are limited to from 6 to 10, but may sometimes be extended to 25 sessions. Upon agreement the therapist actively pursues the focus with selective inattention to and refusal to be perted by peripheral aspects no matter how important they may seem. The theme is " get in fast and get out fast." This usually precludes dealing with extensive dynamic factors. In the few sessions that constitute the treatment plan, all that may be reasonably expected is resolution of a current problem situation and restoration of the patient to a previous optimal level of functioning.

The fact that we have so many different techniques for the same emotional problem can be confusing. What may help is a system approach that considers behavior an integrate of coordinated inpidual systems that are tied together like links in a chain. I have tried to illustrate this in Table 57-1, which can help in the selection of a therapeutic focus and preferred treatment

modality. Because of time restrictions one will want to select the one method or combination of methods that is most applicable to the prevailing difficulty. Thus if the patient complains about fatiguability, loss of appetite and weight, listlessness, diminished libido, and insomnia, and it becomes apparent that he or she is suffering from a depressive disorder, one may consider organizing the therapeutic thrust around the biochemical link and supplying an antidepressant medication. This would not preclude working with other links in the behavioral chain if these are implicated. If the patient suffers from a great deal of tension with gastrointestinal irritability and bouts of high blood pressure, the therapist may want to manage the somatic link with relaxation therapy or biofeedback while searching for coordinate etiological factors. A conditioned phobic complaint, e.g., fear of entering elevators or other enclosed spaces, would invite a working with the conditioning link through behavioral approaches such as in vivo desensitization. While recognizing that personality factors associated with intrapsychic conflict are probably present, one would have to bypass the intrapsychic link unless such factors constituted the primary complaint, or if personality problems were operating as resistance to symptom-oriented interventions. In the latter case dynamic therapy would be considered. Should the patient have a severe marital problem one would deal with the interpersonal link through couple therapy. In the event stress could not be eliminated because of intolerable environmental circumstances, the therapist would focus on situational

difficulties, and institute the proper therapy associated with the social link. If the assessment of the problem points to the philosophic link because of noxious attitudes and belief systems (which can be as pathogenic as virulent viruses and bacteria), one would attempt to detoxify thinking patterns through cognitive therapy. Unless this is done, disturbed cognitions can poison relationships with people and vitiate the self-image.

Table 57.1 Therapeutic Focus, Goals, and Selection of Modality

(A) COMPLIANT FACTOR (target symptoms)	(B) SYNDROMES	(C) AREAS OF PATHOLOGY	(D) GOALS	(E) THERAPEUTIC FOCUS (implicated links)	A
Depression Hyperactivity Hallucinations Severe anxiety Panic attacks Impulsivity and inattention Binge eating Obsessions and compulsions Phobias	1. Major depression 2. Bipolar disorder a. depressed b. manic 3. Atypical depression 4. Schizophrenic disorder 5. Schizophreniform disorder 6. Generalized anxiety disorder 7. Panic disorder 8. Attention deficit disorder 9. Bulimia 10. Obsessive-compulsive disorder 11. Agoraphobia	Neuro-transmitter system	Restoring balance in neuro-transmitter system	Biochemical link	Bio
Poor emotional and impulse control;	Organic brain syndrome Organic mental	Neuronal masses of brain	Resolving affective and autonomic	Neuro-physiological link	Ne tox

incoordination; personality change; tension; defective information processing; paranoid attitudes; neurological impairments; delirium; amnesia; dementia	disorder (primary degenerative dementia; multi-infarct dementia) Substance-induced intoxications (alcohol, amphetamine, barbiturate, cannabis, cocaine, opioid, PCP, other)		dysregulations Removal of abused toxic substances		
Physical complaints of various organ systems (e.g. severe pain; headache; indigestion; backache; hypertension; colitis, etc.)	Organic physical disease	Implicated organ systems	Relieving or resolving organic and functional pathology	Somatic link	Me Psy
Conditioned behavioral disturbances and poor adjustment following an identifiable psycho-social stressor Depression; jitteriness; conduct disorder (truancy; vandalism; reckless driving; fighting) work or academic failure; phobic avoidance	Adjustment disorder (with depressed mood; with various emotional features; with disturbances of conduct; with academic or work inhibitions; with withdrawal; with atypical features) Phobic disorders	Conditioned anxieties	Reconditioning anxiety responses	Conditioning link	Lea
Anxiety; panic attacks; obsessions; compulsions; depression; somatic symptoms; sensory and	Panic disorder Generalized anxiety disorder Obsessive-compulsive disorder Dissociative disorder	Unconscious conflicts	Recognition, understanding and resolution of conflicts	Intrapsychic link	Psy the

motor disturbances; fugue states; multiple personality; depersonalization; sexual deviations, sexual dysfunctions; phobias	Psychosexual disorder Agoraphobia Simple phobia Social phobia Posttraumatic stress disorder				
Disturbed relationships with people (paranoidal, oppositional, hostile, defensive, stubborn, power driven, hypersensitive, eccentric, seclusive, aggressive, indifferent, excitable, irrational, overactive, exhibitionistic, exploitative, self-centered, impulsive, explosive, manipulative) Antisocial behavior Academic problems Occupational problems Marital problems Family problems Substance abuse and dependence	Personality disorder (paranoic, schizoid, schizotypal, histrionic, narcissistic, antisocial, borderline, avoidant, dependent, compulsive, passive-aggressive, atypical) Substance abuse/dependence (alcohol, barbiturates, other hypnotics, opioids cocaine, amphetamine, PCP, hallucinogens, cannabis, tobacco) Identity disorder Adjustment disorders	Interpersonal-relationships Developmental arrest (impaired separation-inpiduation)	Personality maturation Improved relationships with authority and peers Enhanced self-esteem Improved identity	Developmental interpersonal link	De the Psy the Rol Gro Soc psy Sel Obj the Sys
Situational problems (e.g. education, health, housing, neighborhood, finances, cultural	Phase of life problem Environmental problem Occupational problem	Environmental stress	Rectification of or adaptation to environmental stress	Social link	Soc An Ecc Pol

differences, pollution, international tensions)	Adjustment problem				
Distorted values and standards Maladaptive belief systems	Multiform adaptational difficulties	Cognitive distortions	Re-education Cognitive restructuring	Philosophical-spiritual link	Phi The Me

Target symptoms (A) characteristic of different syndromes (B) may often be expediently resolved by dealing directly with specific responsible areas of pathology (C). Goals in therapy here (D) are directed at such distortions. Looking at behavior as a chain of interrelated systems (biochemical, neurophysiological, somatic, conditioned, intrapsychic, developmental-interpersonal, social-environmental, philosophic-spiritual) a suitable focus is on the implicated links of this chain (E). Distinctive fields of interest (F) and special theories related to each link inspire a number of therapeutic modalities (G) that may be preferred approaches in certain syndromes even though through feedback interventions bracketed to other links may also be effective.

We can console ourselves in a minor way. No matter what technique is employed, if the therapist is skilled in its use, has faith in its validity, and communicates this faith to the patient, and if the patient accepts the technique and absorbs this faith, he or she will be influenced in some positive way. The therapist anticipates that in resolving a difficulty related to one disturbed link in the behavioral chain, this will influence by feedback other links. Thus, if neuroleptics are prescribed for a schizophrenic patient with a disturbing thinking disorder, the impact on the biochemistry will register itself positively in varying degrees on the patient's neurophysiology, general behavior, intrapsychic mechanisms, interpersonal relations, social attitudes, and perhaps even one's philosophical outlook. Applying behavior therapy to a phobia will in its correction influence other aspects from the biochemical

factors to spiritual essences. Modifying disturbed interpersonal relations through group or interpersonal therapy, correcting environmental difficulties through therapeutic counseling, and altering belief systems through cognitive therapy will have an effect throughout the behavioral continuum. This global response, however, does not in the least absolve therapists from trying to select the best method within their range of skills that is most attuned both to the patient's immediate concerns and unique learning aptitudes.

Be this as it may, there are some general principles that are applicable to most patients. First, one starts therapy by allowing the patient to unburden verbally, to tell his or her story uninterruptedly, interpolating comments to indicate understanding and empathy and to keep the patient focused on important content. Second, the therapist helps the patient arrive at some preliminary understandings of what the difficulty is all about. Third, a method is selected that is targeted on the link that is creating greatest difficulty for that patient biochemical, physiological, behavioral, interpersonal, social or philosophic. Fourth, as therapy progresses the therapist tries to show the patient how he or she is not an innocent bystander and that the patient, in a major or minor way may be involved in bringing trouble on him or herself. Fifth, the therapist deals with any resistances that the patient develops that block an understanding of the problem and the productive use of the techniques employed. Sixth, the therapist tries to acquaint the patient with some of the disturbed attitudes carried around by the patient that can create

trouble for him or her in the future, how they developed, how they operate now, and how they may show up after he or she leaves therapy. Seventh, the patient is given homework that is aimed at strengthening oneself enough so that problems may be minimized or prevented from occurring later on. Within this broad framework there are, of course, wide differences on how therapists with varying theoretical orientations will operate. By and large, however, psychotherapists with adequate training should anticipate satisfactory results with the great majority of their patients utilizing this format.

Employing whatever techniques or group of techniques are indicated by the needs of the patient and that are within the scope of one's training and experience, the therapist may be able to achieve the goals agreed on in a rapid and effective way. Where the therapist has become aware of the underlying dynamics, it may be necessary to mention at least some salient aspects and to enjoin the patient to work on these by oneself after treatment has ended. On the other hand, the therapist may not be able to achieve desired goals unless interfering dynamic influences that function as resistance are dealt with during the treatment period because the patient is blocked by such resistance toward making progress.

Dealing with Environmental Factors

In practically every emotional problem an improvement in well-being motivates the inpidual to alter circumstances of living. This comes about as the patient recognizes that he or she does not have to exist under conditions of stress and deprivation. Demoralized by the inner turmoil, the patient may have hopelessly accepted a bad environmental plight as inevitable. In desperation surcease may be sought through involvement in situations that offer asylum, but the patient then gets into predicaments that turn out to be a greater blight than boon. The patient may even masochistically arrange matters so that he or she can suffer as if to pay penance for pervasive guilt feelings. Over and over we observe the phenomenon of people, distraught with inner conflict, deliberately attempting to give this objectivity by immersing themselves in outside vexations that consume their attention and concern.

In the course of therapy, it is essential to help the patient break the grip of forces that are hurtful or depriving by identifying them and pointing out their effects. Unless the patient has a basic understanding of the role he or she plays in supporting difficulties of which the patient bitterly complains, wresting from one jam will only result in arranging for another in a very short time.

Generally, it is better for the patient to figure out for oneself what can be done to straighten out his or her life. However, active suggestions may have to

be given if the patient cannot devise a plan of action alone, and, toward this end, the therapist may suggest available resources that can aid the patient in this particular need. For instance, a patient who has withdrawn from activities may be encouraged to participate in sports, hobbies, and social recreations, the therapist guiding the patient to groups where such persions may be found. The patient's economic situation may have to be supplemented through opportune expediencies to supply funds for medical and dental care. A husband, wife or child may be ill, and the pressures on the patient will require alleviation through referral to appropriate clinics or agencies. Better housing may be essential to remedy overcrowding or to remove the patient from neighborhoods where there is exposure to prejudice, threats to life, and crime. A handicapped child may require assignment to a special rehabilitative clinic. A child failing at school may need psychological testing. An aging parent with nothing else to do to occupy his or her time may rule a household with an iron fist and be responsible for an impending break-up of a family. Appropriate outlets may have to be found to consume the oldster's energies. Adoption of a child may be the best solution for a childless couple who are anxious to rear a boy or girl. A patient who has moved from another town may feel alone and estranged and need information about recreational and social facilities in the community. These and countless other situations may require handling in the course of short-term psychotherapy.

The therapist, may, of course, be as puzzled as the patient regarding

how to fill an existing need. He or she may not know the suitable resources. The chances are, however, that resources do exist if a proper search is launched. A voluntary family agency, or the family agency of the religious faith of the patient, may be able to act as the initial information source, as may a Council of Social Agencies, Welfare Council, Community Council, local or State health or welfare department or children's agency like a Children's Aid Society. Public health nurses and social workers are often cognizant of immediate instrumentalities in the community, and it may be appropriate to call in a social worker to work adjunctively with the therapist as a consultant.

Perhaps the most pressing problems will concern the patient's relationships with members of the immediate family. Pathological interactions of the various family members are the rule, and the patient may be imprisoned by the family role. Indeed, the patient may not be the person in the family who needs the most help; he or she may be the scapegoat or the member with the weakest defenses. Active assistance may have to be given the patient in resolving family crises. For example, a woman sought help for depressive spells accompanied by sporadic lower abdominal spasms. Although she rationalized her reasons for it, it soon became apparent that she resented deeply a situation that she had brought upon herself. Her sister's son who was getting a Master's degree at college needed his thesis typed. The patient casually offered to help and soon found herself working steadily against a deadline, typing several drafts of a two hundred page manuscript.

This she did without compensation and with only minimal appreciation from her sister and nephew. Yet the patient felt obligated to continue since she had promised to complete the thesis. Periodically she would abandon her typewriter when her abdominal cramps became too severe; but her guilt feelings soon drove her back to work. Encouraged by the therapist's appraisal of the unfairness of the situation, the patient was able to discuss with her nephew, with reasonable calmness, her inability to complete his manuscript. This precipitated a crisis with her sister who credited the patient's defection to ill-will. After several sessions were focused on the role she had always played with her exploitative sister, the patient was able to handle her guilt feeling sufficiently to desist from retreating from her stand. A temporary break with her sister was terminated by the latter who apologetically sought to restore the relationship which assumed a much more wholesome tenor.

It may at times be necessary to see other family members to enlist their cooperation. Patients rarely object to this. For instance, a patient though married was being victimized by an over-concerned and dominating mother who visited her daily and assumed control over the patient's household. It was obvious that the patient's protests masked a desire to maintain a dependent relationship with her mother. She refused to get into a fight with her mother or to offend her by requesting that she stay away. She claimed that her mother never would understand her protest to be left alone; her mother was the one person concerned over the patient's depression and

helplessness. This was why she commandeered the role of housekeeper in her daughter's home. The patient was urged to discuss with mother her need to become more independent and to take over increasing responsibility. It was pointed out that some of her depression and helplessness were products of her refusal to accept a mature status. The more she depended on her mother, the more inadequate she felt. This situation sponsored a retreat from self-reliance. It was important to urge her mother to stay away from her apartment. I then suggested to the patient that I have a talk with the mother. The presumed purpose as far as the mother was concerned was to get as much historical data as possible. Her parent readily acquiesced and the interview centered around the patient's great sensitivity as a child and her lack of confidence in herself. Feeling myself to be in rapport with the woman, I pointed out to her how urgent it was to help her daughter grow up. I suggested that it might be difficult to resist her daughter's pleas for help, but that it was vital that she do so in order to stimulate her daughter's independent growth. Nor should she come to her child's rescue when the latter made mistakes. It was important for her daughter to make her own decisions and to take the consequences of her blunders. As a matter of fact the more mistakes she made, the more she would learn. The mother agreed to assist me in helping her daughter, and her cooperation in restricting visits to weekly intervals, as a guest not as a housekeeper, was a principal factor in my being able to bring the patient to a much more self-confident adjustment.

Psychotherapy may have to be prescribed for one or more members of the patient's family in order to alter a family constellation that is creating difficulties for all. In our search for pathology we are apt to overlook the fact that every family unit contains healthy elements which if released can aid each of its constituent members. Instead of or in addition to inpidual therapy family therapy may best be employed. If family therapy is decided on, sessions may be held with as many of the family group as possible. Each person must be made to see how he or she is deprived and depriving, punished and punishing, and exploited and exploiting. Even a few sessions with this intimate group may serve to release feelings and attitudes that may rejuggle the family equation sufficiently to permit the emergence of healthy trends.

Managing Dependency

Most persons in trouble at the start of therapy feel helpless and want to lean on an idealized parental agency. Being permitted to do so relieves their fear and lessens their anxiety. Whether the therapist realizes it or not he or she will be a target for the patient's dependency yearnings, no matter if one tries to be detached and passive, or actively supportive, reassuring or persuasive. Gratification of dependency needs is hoped to be a temporary measure that is ideally followed by developing independence as mastery is restored. This is accompanied by such signs as a decrease in sensitivity,

diminished tendencies to over-react to stimuli, a greater ability to handle criticism, a channeling off into more constructive channels of rage, a better management of feelings of rejection, an avoidance of destructive competition, a reduction of personal over-ambitiousness, and a correction of distorted ideas about one's world. There are no miracles regarding such developments. They come about as the patient is helped to overcome the symptoms, to solve problems, and to evaluate more rationally an immediate environmental situation that will then enable the patient to make better and less neurotic decisions. Basic personality patterns may not undergo alteration although methods of living around them may be handled more easily. Over time the therapist may hopefully discern some reconstructive changes if the patient has some awareness of underlying personality distortions and has motivation to change these. Engaging in additional dynamic therapy may expedite these changes.

DYNAMIC SHORT-TERM PSYCHOTHERAPY

Where the therapist has decided to deal with the intrapsychic link in the behavioral chain with the object of reconstructive personality change, one would have to consider that patterns of behavior will generally follow a sequence of conditionings that date back to childhood. Many of the patterns have become firmly fixed, operate automatically, and, while the circumstances that initiated them no longer exist, and the memory traces are

firmly embedded in the unconscious, they continue to display themselves often to the dismay of the inpidual and the consternation of those around him or her. Thus, where defiance in childhood was a prerequisite to expressing assertiveness in relation to overly restrictive and moralistic parents, defiant, recalcitrant, aggressive, or hostile outbursts may be essential before assertiveness can be released. Where self-worth was measured in terms of vanquishing a sibling or parent and proving oneself better than these adversaries, compulsive competitive activities may preoccupy the inpidual to an extraordinary degree. Where sexual feelings were mobilized by parental provocations, strokings, spankings, enemas, observation of adult sexual activities, or precocious stimulation in varied kinds of sex play, engagement in similar activities, or the exploitation of phantasies about such activities, may be requirements for the release of sexual feeling. These impulses may become organized into perversions. Recrudescence into adult life of unusual behavior is often explicable on the basis of the linkage of adult needs with outmoded anachronistic patterns. Such behavior is usually rationalized when it is manifestly out of keeping with the reality situation.

The inpidual is, more or less, at the mercy of personality distortions, since the experiences that produced them are sealed off from awareness by repression and are thus not easily available to conscious deliberation or control. The patient is driven by needs, drives and defenses that clash with the demands of society on the one hand and with personal values on the

other.

Since the patient carries the burdens of conflict, which impose extraordinary pressures, he or she will be prone to overreact to stressful circumstances in the environment, particularly when these create insecurity or undermine self-esteem. If one's coping mechanisms falter, one may become overwhelmed by a catastrophic sense of helplessness and by shattering of feelings of mastery. This contingency may bring the frightening experience of anxiety with which one will have to deal with whatever mechanisms of defense can be mustered. Often these revive early defenses, which at one time were employed in childhood, but which are now worthless, since though temporarily allaying anxiety, they foster complications that further tend to disorganize the inpidual in dealings with life.

One must not underestimate the importance of promptings developed in childhood that have been relegated by repression to the dubious oblivion of the unconscious. These underpinnings of personality—the drives and defenses of childhood—assert themselves throughout the life of the inpidual.

Thus a man, undermined by an overprotective mother who crushed his autonomy and emerging feelings of masculinity, may have sufficient ego strength to rise as an adult above his devalued self-image, by pushing himself into positions of power and achieving monetary success. To all outward

appearances he may appear masterful, strong, and accomplished. Yet his feeble inner promptings to make himself dependent register themselves in passive impulses with homosexual phantasies. He will drive himself into compromising relationships with men, promoting fierce competitiveness, needs for identification with their strength, paranoidal outbursts and perhaps desires for sexual contact when under the influence of alcohol. Understandably, the inpidual will function under a great hardship being in almost constant conflict, with little awareness of what is going on inside of himself.

Essentially the process of therapy that is rooted in the dynamic theoretical model consists of utilizing the relationship situation with the therapist as a means of helping the patient to gain an understanding of himself in regard to how his current reactions and interpersonal involvements are related to formative experiences in his past. An attempt is made to bring him to an awareness of unconscious needs, drives and value systems, as well as their origin, significance and contemporary manifestations through special techniques introduced by Freud, such as exploration of dreams. The resistances to unveiling these repressed ingredients are dealt with by interpretation. In the course of working with the patient, the therapist will observe the development of attitudes toward him that reflect early disturbed feelings toward authority (transference). Repeated in the medium of the therapeutic relationship ultimately will be some important

incidents that resemble traumatic experiences with past authorities.

It goes without saying that the therapist must have the education, understanding and the personality stability to cope with the patient's projections in order to help the patient gain an awareness of his unconscious maneuvers. The therapist may tend to become frustrated by some patients. He or she may feel enervated by the acting out, demandingness, hostility, critical attitudes, and unreasonableness of the patient who will watch carefully for the therapist's reactions. Should the therapist respond in ways similar to actions of the parents, the therapeutic process will tend to stop. Actually, the patient will probably engineer the situation so that certain traumatizing experiences can be reenacted with the therapist. If the therapist acts in a therapeutically positive manner the contrast to the past actions of the parents helps the patient gain a different conception of what rational authority is like. The hope is that eventually the patient will, because of new understanding, begin to relate to the therapist in a way different from the habitual responses to authority. Thus, the patient will utilize the therapeutic situation as a vehicle for the evolution of constructive attitudes towards oneself and others. New capacities as a person will develop, as will lessened severity of conscience, greater assertiveness and independence, and an ability to express basic drives in relation to the standards of a group.

The particular way of working will depend on the experience and skill of

the therapist. One cannot, as a rule, due to lack of time, employ the time-honored devices of free-association, passivity, and anonymity. Nor should the couch be the preferred position. Transference reactions are dealt with rapidly with the objective of avoiding a transference neurosis. While the latter may release the deepest conflicts, there is no time available for the essential working through. If a transference neurosis develops without intention, this must be dissipated as soon as possible because of its interference with therapy. Resistance is managed by active interpretations.

To help the patient gain a better understanding of inner drives, the therapist utilizes focused interviewing, structures a broad picture of the existing dynamics, and encourages the patient to fill in the details through concentrated self-observation. If the therapist knows how to employ them, dreams can be advantageously utilized. For example, a patient in the early part of therapy experienced an unaccountable recrudescence of symptoms that discouraged him greatly. Productions were relatively sterile, and, since there was currently no concentration on depth material, and no explanation for the relapse on the basis of unusual environmental difficulties, I assumed that he was resisting talking about matters that bothered him. He denied having any particular feelings toward me, but, when I specifically inquired about dreams, he recalled the following:

> " I'm in a room where there is a performance going on, like a theatre. But I'm not paying attention to it. A quite heavy, unattractive, chunky man is

there carrying a large gun, like a machine gun. This man—he and I are emotionally involved, but there is no connotation of physical sex. He gets up and leaves, and I follow. He said he was told by his doctor that day—I don't know how he put it—that he had a heart attack. He began to cry. It meant the end of everything between us. Life was not absolutely desolate for me. He was losing everything, but I was detached and unconcerned. The heart attack meant I would be free of him. Then later in the night I had a second dream involving you. A law suit is going on, something like a trial. You are the lawyer. You are cross examining people. I am disappointed in your performance, the way you handle the cross examination—jumping around, no logic. (*Patient laughs*) You make a reference to making money. I feel let down. All you want is to make money—calculating." The portion of the session that follows brings out what was bothering the patient—a transference response in which he was equating me with his inadequate greedy father from whom he desired escape.

Dr. You must have had some feelings about me that upset you. (*Pause. Patient laughs*)

Pt. That day you took off on ethics. I felt you were taking off on something I had no desire to talk about. Also when I talked about the law suit I had contemplated and the lawyer handling the case, (*The patient was involved in a minor civil suit*) you said: " You act precipitously." I felt you misunderstood me because I don't act precipitiously. I nullify action by indecision. You spoke strongly.

Dr. Yes.

Pt. I guess I seek perfection from you, like I do from my girl friend. When you make a grammatical error, I dwell on it all day.

Dr. You seem to have a need for a powerful, accepting, perfect person in whom you can put your trust, and you get infuriated when that person shows any weakness. (*Interpreting the patient's feeling as a response to not finding the idealized authority figure.*)

Pt. I see that, but this doesn't have to be that way.

Dr. Why do you think it is that way?

Pt. I don't know, (*pause*)

Dr. What about your ever having had a perfect person around? Have you?

Pt. Jesus, no. I wish I had. My father was cruel and weak. I couldn't depend on him. He left my mother and me. I felt helpless and dependent on my mother. (*The patient's father had abandoned his mother when the patient was a boy.*)

Dr. Maybe you hoped that a strong man would come into your life some day?

Pt. I always wanted one. Even now I get excited when I see such a person.

Dr. Perhaps you felt I was going to be such a person? (*Patient laughs*.)

Pt. This is a false outlook on life. I'm not in bondage. I'm not a slave. This is all a lot of crap.

Dr. What about bondage to me? In the dream you escape when the man claims to be sick.

Pt. I do feel I need you, but seeing you puts me in bondage. But I don't dare let myself feel angry toward you. Only toward my girl friend.

Dr. Perhaps that's why you had a return of your symptoms. The feelings of being trapped with me, in a dependency, with an inadequate father figure at that. (Interpreting the patient's symptoms as a product of conflict.)

Pt. Yes, yes, I am sure of it.

It is quite possible that the patient may have been able to work through his transference without the use of dreams. However, I felt that handling his dream short-circuited this process.

There is no substitute for experience in doing dynamic short-term therapy. The seasoned therapist will be able to attune himself or herself sensitively to what is going on, gauging the manner of making an interpretation, and moving from challenge to support in response to the immediate reactions of the patient. It is difficult to outline specific rules that apply to every case since no two therapists will develop the same relationships with any one patient. And a patient will play different roles with different therapists, depending upon where in his or her characterologic scheme the patient happens to fit the therapist. Almost anything can happen in a therapeutic situation, but if the therapist is flexible, sensitive, and empathic mindful of the basic processes of psychotherapy, and aware of existing neurotic impulses as they are mobilized in a relationship with the patient, one should be able to bring the average patient to some understanding of basic problems within the span of a short-term approach. In long-term therapy, sooner or later, the patient's symptoms, the current precipitating factor, the immediate conflicts activated in the present disorder, the underlying personality structure, deeply repressed conflicts originating in childhood, the relationship with parental agencies, and the defensive mechanisms will slowly become defined and correlated. The working through process proceeds on all levels of the psychic organization, and no aspect of personality or environment is usually considered unimportant in the painstaking investigative design.

In dynamic short-term therapy, we cannot afford the leisurely pace that so extensive a proceeding requires. It is essential to focus on areas that will yield the highest pidends. Generally these deal with problems of immediate concern to the patient. While aspects that trouble the patient topically may not actually be the most important elements of the disorder, they do engulf the attention. Skill as a therapist is revealed in the ability to establish bridges from the immediate complaints to more basic personality difficulties. Only when a continuity has been affirmed between the immediate stresses and the conflictual reservoirs within the personality, will the patient be able to proceed working on more substantial issues. Focusing on what the patient considers to be mere corollaries to the pain, before having shown the patient that they are actually the responsible mischief makers, will usually turn out to be an unproductive exercise. It would be as if in a business faced with bankruptcy we were to advise delay in regulating office expenditures in favor of studying the economic picture of the world at large. The perturbations of management could scarcely be allayed with remote objectives when what immediately occupies them is the anxiety of meeting the weekly payroll. Were one to consider the day-to-day survival needs, and tangentially relate current operations to more comprehensive, and ultimately more important, general business factors, greater cooperation would be secured.

The particular problem area to be attacked at first in dynamic short-term therapy is, therefore, more or less of the patient's own choosing. Often

this deals with the *precipitating stress situation* an exploration of which may alleviate tension and serve to restore the inpidual to an adaptive balance. Here an attempt is negotiated to identify the immediate trouble source, and to relate it to the patient's subjective distress. An endeavor is made at working through, at least partially, of the difficulties liberated by the stress situation. These, derivatives of enduring and fixed underlying core conflicts, are handled as autonomous sources of anxiety. Historical material is considered only when it is bracketed to the current problems. Not only may the patient be brought back to emotional homeostasis rapidly, particularly when seen immediately after the stress situation has set in, but inroads may be made on deeper conflicts.

A bright young man of eighteen applied for therapy on the basis that he was about to fail his last year of high school. What worried him was that he would not receive a certificate and could, therefore, not enter college. His parents were no less disturbed than the patient at his impending educational debacle. While his first three years of high school work had yielded passable grades, these were far below his potential as revealed by an intelligence test. What was even more provoking was that in his college entrance examinations he had scored lowest in his class. He had also been unable to secure a passing grade in his midterm examinations. Embarrassed and manifestly upset, he expressed a futile attitude during the initial interview about better ability to study. What kept happening to him was that his mind wandered. When he

forced himself to read his assignments, he could not retain what he read. The prospect of repeating his last year at school was a severe blow to his pride. He envisaged accepting a position as a general helper at a local gasoline service station.

No comment was made to discourage him from stopping school. Instead my retort dealt with the wisdom of adjusting one's career to one's intellectual capacity. If it were true that he was unable to keep up with his class because of his inferior mental ability, it might be very appropriate to accept a less ambitious career status. Why burden oneself with impossibilities? The patient then spent the remainder of the session trying to convince me that his intelligence quotient was in the upper ten percentile. This was most extraordinary, I admitted. Perhaps there were emotional reasons why he had to fail.

During the next few sessions we feverishly explored his fears of competitiveness, his desire to remain the favorite child in his family, his dependency on his mother, his impulse to frustrate and punish his father for pushing him to satisfy a personal selfish ambitiousness, and his dread to leave home and to pursue an independent life. The meaning of his need to fail soon crystallized in his mind. He realized that it required an effort to avoid educational success, that he was actually trying to fail in order to retain the pleasures of irresponsible childhood.

No moral judgments were expressed as to the virtues of these aims. If he really wanted to be a child, if he desired to hurt himself in order to get back at his parents, if he had the wish to retreat from being as good as any of his colleagues, this was within his rights as a person. However, he had to realize that he was doing this to himself. Angrily he protested that such was not at all the case. He was convinced that his parents did not want him to grow up; they lamented losing their older children when they went to college. They wanted him to be dependent. Why then should he go along with their designs and nefarious intentions; why should he be the " fall guy"? The rage he vented at his parents was followed shortly by a recognition of his own dependency desires and his fear of growing up. As we explored this he discovered that there was a clearing of his mind and a greater dedication to his studies. His successful final examinations were a fitting climax to his fifteen sessions of therapy. Letters that I received from the patient from an out-of-town college, and a follow-up visit one year later, revealed measures of personality growth hardly consistent with the relatively short period that he stayed in treatment.

Another early focus in therapy is on *distressing symptoms.* The patient is only too eager to talk about these. Their exploration may lead to a discovery of provocative anxieties and conflicts that initiate and sustain them. The importance of giving some meaning to disturbing or mysterious complaints cannot be overemphasized. So long as a symptom remains unidentified, it is like an autonomous and frightening foreign body. To label it, to explain its

significance, gives the inpidual a measure of control helping one to restore one's sense of mastery. This enables one to function better, since, in finding out some reasons for the symptoms, one can utilize one's energies to correct their source.

Generally, the presenting symptom is explored thoroughly in the context of the question: "How is the symptom related to the inpidual's personality structure as a whole?" For example, a man comes to therapy undermined by uncontrollable bouts of anxiety. The history reveals that the first attack followed a quarrel with his wife. From the character of his relationship with his mother, his Rorschach responses, and his dreams it is apparent that he basically is a dependent inpidual who is relating disagreeably to his wife. The symptom of anxiety is explicable on the basis of his releasing hostility toward the parental substitute and fearing abandonment and counterhostility. Our focus shifts then from his symptom to his personality structure in operation.

Other areas of focus may present themselves, for instance transference and resistance manifestations which, when they appear, will occupy the therapist's attention to the exclusion of any other concern. But here, too, when such reactions arise, they should be integrated with the general theme of the patient's personality functioning.

All persons possess blind spots in understanding of themselves. Many of these are due to gaps in education; some are distortions promoted by parents and friends; some are perversions of factual data; some are misrepresentations initiated and sustained by misguided education. During therapy some of these falsifications will require greater clarification. In assuming a role geared toward clarification, the therapist disclaims being an oracle of wisdom, but that there are some facts of which he or she is confident. If the therapist is not sure of the stand, ideas may be offered with some reasonable reservations, since it may turn out that they are wrong.

In short-term therapy, the interpretation of unconscious motives prior to their eruption into awareness is generally avoided. This is because the therapist may not in a brief contact feel sure of one's ground, and because one does not wish to stir up powerful resistances that will negate the therapeutic efforts. Interpretations deal with immediately discernable feelings and personality reactions. However, it is sometimes possible for an extremely experienced psychoanalytically trained therapist, who has established good rapport with a patient, to interpret in depth, albeit in a reassuring way. It may be possible also to utilize confrontation, which in some cases may be very productive with a dramatic impact on the patient. For example, a young man in a state of anxiety with uncomfortable somatic accompaniments reveals great fear of standing next to strong looking men in the subway. His dreams repetitively picture him fleeing from men with destructive weapons. The

therapist, on the basis of his experience, and his intuitive feelings about the patient's problem, concludes that the patient is concerned about homosexual impulses. The therapist has, in the first few interviews, won the confidence of the patient. He decides to interpret the patient's inner conflict. The following is from a recording of the interview:

Dr. You know it is very common for a person who has lost confidence in himself to assume he isn't masculine. The next thing that happens is that he gets frightened of being beat up, hurt, attacked and even sexually assaulted by strong men. He begins to feel that he is more feminine than masculine. The next thing he begins to assume is that he is homosexual and this scares the devil out of him. (*pause*.)

Pt. Yes, yes. Isn't he? I mean how does one know?

Dr. I get the impression this is something that is bothering you.

Pt. I get caught in this terrible fear. I feel I'm not a man and that I'll do something terrible.

Dr. You mean like letting yourself get involved sexually with a man?

Pt. Not exactly, but when I have a few drinks, I find myself looking at the men with muscles and it scares the hell out of me. *Dr*. When you have a few drinks, you might get sexually aroused. This is not uncommon. But what makes you think you are a homosexual?

Pt. I know I'm attracted to women and I enjoy being with women. But I constantly compare myself to other men and I come out the low man on the totem pole.

Dr. So the problem is your position in relation to other men, and your feelings about yourself. This seems to me to be your real problem. You've probably had a low opinion of yourself as far back as you can remember. What do you

feel about what I have said?

Pt. (*Obviously flustered*) I . . . I . . . I think you're right (*blushes*). (*In this interchange the patient has been given an opportunity to face his inner phantasies and to give them another interpretation than that he is a hopeless homosexual. The emotional relief to the patient was manifest even in one interview*.)

Unless the therapist is on firm ground psychodynamically, and has developed a good working relationship, probings in depth are apt to pose a hazard. They may create great anxiety, or they may provoke resentment and resistance. The best rule is to preserve a good relationship with the patient by testing the patient's reactions to a few interpretations in depth that are presented in a casual and tentative manner.

A patient with an obsessive fear of being hurt, injured and cut, and thus of coming to an untimely death, had so gentle and obsequious a manner with people that I was convinced he was concealing profoundly destructive tendencies. On one occasion when he was discussing his fear of death, I said: " A problem like yours may be touched off by a number of things. I had one patient who imagined himself to be a killer. This scared him so that he had to push the idea out of his mind. Instead he substituted fears of being hurt or killed. This happens over and over again. Whether or not the same thing is happening to you, I don't know. But if so there may be reasons for it. In the case of the man I treated, he confused being assertive with being aggressive and murderous."

This initiated an exploration into the patient's childhood. There was little question that he had felt overprotected and thwarted in various ways, particularly in exploratory activities. Quarreling, fighting and even disagreeing with others were considered to be evil and " against God's will." My indirect interpretation was accepted and utilized. Where an interpretation is premature or wrong, or where the patient's ego resources are unable to sustain its implications, one may on the other hand, react badly. The therapist then will have to retrieve the situation, working toward the reestablishment of a positive relationship.

The interpretation of a transference reaction is especially helpful when correct. An adolescent boy treated his visits with me as a casual incident in his routine, refusing to talk about himself and waiting for me to do something dramatic to remove his facial tic. At one visit I remarked, "You just won't say anything about yourself and your feelings. I get the impression that you don't trust me." The patient's reaction was a startled one. He blushingly revealed that he was embarrassed at his thoughts. He never was able to be frank with his family. Whenever he pulged any secrets to his brothers or his parents, they were immediately revealed to the whole family to his great embarrassment. When I retorted that there must be something about coming to see me that made him feel sheepish, he admitted wanting to ask me for some " sex books" to explain masturbation and sex. Perhaps, I replied, he felt I might get the idea he wanted to stimulate himself pornographically with this

literature. He blushed furiously at this, whereupon I reassured him that there was nothing to be ashamed of, that a strong sexual interest at his age was normal, and that I certainly would reveal nothing about our conversations to his parents. After all, what we talked about was between ourselves. This maneuver had the effect of releasing a flood of memories of incidents in which his confidence had been betrayed. Our sessions thereafter took a new direction with the patient participating actively. I repeatedly assured him that his parents or family would never know about the content of our talks.

In some cases, it may be expedient to present the patient with a general outline of personality development, particularly what happens with delayed separation inpiduation, inviting the patient to see which elements apply to him or her. I have found that this is occasionally helpful where insufficient time is available in therapy to pinpoint the precise pathology. Patients are usually enthusiastic at first at having received some clarification, and they may even acknowledge that segments of the presented outline relate to themselves. They then seem to lose the significance of what has been revealed to them. However, much later on follow-up many have brought up pertinent details of the outline and have confided that it stimulated thinking about themselves.

For instance, a man whose depression was set off by his losing face at work when a younger colleague was advanced ahead of him, came to therapy

in an extremely discouraged state and with little motivation to inquire into his patterns of adjustment. Deep resentments were apparent from the violent responses to the Rorschach cards, and from his dreams, which centered around destruction and killing. When I commented that it would be natural for him to feel angry under the circumstances, he countered with the remark that he had written advancement off years ago, that he bore no resentment toward his victorious colleague, and that he was resigned to getting the " short end of the stick." From childhood on he was the underdog in the family, and he was accustomed to this role. Apparently, I retorted, he was not as resigned as he imagined himself to be, otherwise he would not have reacted to the present situation with such despair. Maybe he had not written himself off as a permanent underdog. Then I sketched an outline that followed along lines that I have used on other patients with minor variations. This deals with derivative conflicts much closer to awareness than the nuclear conflicts from which they come that are too deeply repressed to be available in the short period devoted to therapy. The following is from an audio tape that I made with the patient's consent:

> " I believe I have a fair idea of what is going on with you, but I'd like to start from the beginning. I should like to give you a picture of what happens to the average person in the growing up process. From this picture you may be able to see where you fit and what has happened to you. You see, a child at birth comes into the world helpless and dependent. He or she needs a great deal of affection, care, and stimulation. The child also needs to receive the proper discipline to protect him or her. In this medium of loving and understanding care and discipline, where one is given an

opportunity to grow, to develop, to explore, and to express oneself, independence gradually increases and dependence gradually decreases, so that at adulthood there is a healthy balance between factors of dependence and independence. Let us say they are equally balanced in the average adult; a certain amount of dependence being quite normal, but not so much that it cripples the person. Normally the dependence level may temporarily go up when a person gets sick, or insecure, and independence will temporarily recede. But this shift is only within a narrow range. However, as a result of bad or depriving experiences in childhood, and from your history this seems to have happened to you to some extent (*the patient's father, a salesman was away a go o d deal of the time and his older brother brutally intimidated him.*), the dependence level never goes down sufficiently and the independence level stays low. Now what happens when a person in adult life has excessive dependency and a low level of independence? Mind you, you may not show all the things that I shall point out to you, but try to figure out which of these do apply to you. "Now most people with strong feelings of dependence will attempt to find persons who are stronger than they are, who can do for them what they feel they cannot do for themselves. It is almost as if they are searching for idealized parents, not the same kind of parents they had, but much better ones. What does this do to the inpidual? First, usually he becomes disappointed in the people he picks out as idealized parental figures, because they never come up to his expectations. He feels cheated. For instance, if a man weds a woman who he expects will be a kind, giving, protective, mother figure, he will become infuriated when she fails him on any count. Second, he finds that when he does relate himself to a person onto whom he projects parental qualities, he begins to feel helpless within himself; he feels trapped; he has a desire to escape from the relationship. Third, the feeling of being dependent, makes him feel passive like a child. This is often associated in his mind with being non-masculine; it creates fears of his becoming homosexual and relating himself passively to other men. This role, in our culture, is more acceptable to women, but they too fear excessive passivity, and they may, in relation to mother figures, feel as if they are breast-seeking and homosexual.

" So here he has a dependency motor that is constantly operating, making him forage around for a parental image who will inevitably disappoint

him. (*At this point, the patient interrupted and described how disappointed he was in his wife, how ineffective she was, how unable she p roved herself to be in taking care of him. We discussed this for a minute and then I continued*.) In addition to the dependency motor, the person has a second motor running, a resentment motor, which operates constantly on the basis that he is either trapped in dependency, or cannot find an idealized parental figure, or because he feels or acts passive and helpless. This resentment promotes tremendous guilt feelings. After all, in our culture one is not supposed to hate. But the hate feelings sometimes do trickle out in spite of this, and on special occasions they gush out, like when the person drinks a little too much. (*The patient laughs here and says this is exactly what happens to him*.) If the hate feelings do come out, the person may get frightened on the basis that he is losing control. The very idea of hating may be so upsetting to him that he pushes this impulse out of his mind, with resulting tension, depression, physical symptoms of various kinds, and self-hate. The hate impulse having been blocked is turned back on the self. This is what we call masochism, the wearing of a hair shirt, the constant self-punishment as a result of the feedback of resentment. The resentment machine goes on a good deal of the time running alongside the dependency motor.

" As if this weren't enough, a third motor gets going along with the other two. High dependence means low independence. A person with low feelings of independence suffers terribly because he does not feel sufficient unto himself; he does not feel competent. He feels nonmasculine, passive, helpless, dependent. It is hard to live with such feelings, so he tries to compensate by being overly aggressive, overly competitive, and overly masculine. This may create much trouble for the person because he may try to make up for his feelings of loss of masculinity. He may have phantasies of becoming a strong, handsome, overly active sexual male, and, when he sees such a figure, he wants to identify with him. This may create in him desires for and fears of homosexuality which may terrify him because he does not really want to be homosexual. Interestingly, in women a low independence level is compensated for by her competing with men, wanting to be like a man, acting like a man, and resenting being a woman. Homosexual impulses and fears also may emerge as a result of repudiation of femininity.

"A consequence of low feelings of independence is a devalued self-image with starts the fourth motor going. The person begins to despise himself, to feel he is weak, ugly and contemptible. He will pick out any personal evidence for this that he can find, like stature, complexion, physiognomy, and so on. If he happens to have a slight handicap, like a physical deformity or a small penis, he will focus on this as evidence that he is irretrievably damaged. Feelings of self-devaluation give rise to a host of compensatory drives, like being perfectionistic, overly ambitious and power driven. So long as one can do things perfectly and operate without flaw, he will respect himself. Or, if he is bright enough, and his environment favorable, he may boost himself into a successful position of power, operate like a strong authority and gather around himself a group of sycophants who will worship him as the idealized authority, whom in turn the inpidual may resent and envy while accepting their plaudits. He will feel exploited by those who elevate him to the position of a high priest. "Why," he may ask himself, " can't I find somebody strong I can depend on?" What he seeks actually is a dependent relationship, but this role entails such conflict for him that he goes into fierce competitiveness with any authority on whom he might want to be dependent. (*The patient nods and keeps saying " Yes, yes."*)

" So here we have our dependency operating first; second, resentment, aggression, guilt, and masochism; third, drives for independence; and, fourth, self-devaluation and maneuvers to overcome this through such techniques as perfectionism, over-ambitiousness and power strivings, in phantasy or in reality.

"To complicate matters some of these drives get sexualized. In dependency, for instance, when one relates to a person the way a child or infant relates to a parent, there may be experienced a powerful suffusion of good feeling which may bubble over into sexual feeling. There is probably a great deal of sexuality in all infants in a very diffuse form, precursors of adult sexuality. And when a person reverts emotionally back to the dependency of infancy, he may re-experience diffuse sexual feelings toward the parental figure. If a man relates dependently to a woman, he may sustain toward her a kind of incestuous feeling. The sexuality will be not as an adult to an adult, but as an infant to a mother, and the feelings for

her may be accompanied by tremendous guilt, fear, and perhaps an inability to function sexually. If the parental figure happens to be a man instead of a woman, the person may still relate to him like toward a mother, and emerging sexual feelings will stimulate fears of homosexuality. (*If the patient is a woman with sexual problems, the parallel situation of a female child with a parental substitute may be brought up: A woman may repeat her emotions of childhood when she sought to be loved and protected by a mother. In body closeness she may experience a desire to fondle and be fondled, which will stir up sexual feelings and homosexual fears*.) In sexualizing drives for independence and aggressiveness, one may identify with and seek out powerful masculine figures with whom to fraternize and affiliate. This may again whip up homosexual impulses. Where aggressive-sadistic and self-punitive masochistic impulses exist, these may, for complicated reasons, also be fused with sexual impulses, masochism becoming a condition for sexual release. So here we have the dependence motor, and the resentment-aggression-guilt-masochism motor, and the independence motor, and the self-devaluation motor, with the various compensations and sexualizations. We have a very busy person on our hands. *(At this point the patient revealed that he had become impotent with his wife and had experienced homosexual feelings and fears which were upsetting him because they were so foreign to his morals. What I said was making sense to him*.)

" In the face of all this trouble, how do some people gain peace? By a fifth motor, that of detachment. Detachment is a defense one may try to use as a way of escaping life's messy problems. Here one withdraws from relationships, isolates himself, runs away from things. By removing himself from people, the inpidual tries to heal himself. But this does not usually work because after a while a person gets terrified by his isolation and inability to feel. People cannot function without people. They may succeed for a short time, but then they realize they are drifting away from things; they are depriving themselves of life's prime satisfactions. Compulsively, then, the detached person may try to reenter the living atmosphere by becoming gregarious. He may, in desperation, push himself into a dependency situation with a parental figure as a way out of his dilemma. And this will start the whole neurotic cycle all over again.

" You can see that the person keeps getting caught in a web from which there is no escape. So long as he has enough fuel available to feed his various motors and keep them running, he can go on for a period. But if opportunities are not available to him to satisfy his different drives, and if he cannot readily switch from one to the other, he may become excessively tense and upset. If his tension builds up too much, or if he experiences great trouble in his life situation, or if his self-esteem gets crushed for any reason, he may develop a catastrophic feeling of helplessness and expectations of being hurt. (*The patient here excitedly blurted out that he felt so shamed by his defeat at work that he wanted to atom bomb the world. He became angry and weak and frightened. He wanted to get away from everything and everyone. Yet he felt so helpless he wanted to be taken care of like a child. He then felt hopeless and depressed. I commented that his motors had been thrown out of gear by the incident a t work and this had precipitated excessive tension and anxiety*.)

"When tension gets too great, and there seems to be no hope, anxiety may hit. And the person will build up defenses to cope with his anxiety, some of which may succeed and some may not. For instance, excessive drinking may be one way of managing anxiety. Fears, compulsions, physical symptoms are other ways. These defenses often do not work. Some, like phobias, may complicate the person's life and make it more difficult than before. Even though ways are sought to deal with anxiety, these prove to be self-defeating.

" Now we are not sure yet how this general outline applies to you. I am sure some of it does, as you yourself have commented. Some of it may not. What I want you to do is to think about it, observe yourself in your actions and relations to people and see where you fit. While knowing where you fit will not stop the motors from running, at least we will have some idea as to with what we are dealing. Then we'll better be able to figure out a plan concerning what to do ."

Self-observation should be encouraged and this will help the "working-through" process without which insight can have little effect. It is important

then even though a patient can spend limited time in treatment that he or she gain some awareness of the source of the problems. This ideally should establish the complaint factor as a parcel of a much broader design, and should point to the fact that self-defeating patterns are operating that are outcroppings of elements rooted in past experiences. Once the patient gets the idea that these troubles are not fortuitous, but are events related to definite causes—perhaps carryovers of childish needs and fears—he or she will be more apt to utilize energies toward resolving difficulties rather than expending them in useless resentment and self-recriminations. Insight may operate primarily as a placebo force at first, but if it enables the inpidual to relate significant forces in development to day-to-day contemporary functioning, this may enable the patient to establish inhibitory controls, and even to structure life along more meaningful and productive lines.

Because the degree of insight that can be inculcated in the patient in a short period of therapy is understandably limited, some therapists circumscribe the area of inquiry. Sifneos, for example, organizes interpretations around oedipal problems, Mann around issues of development, others around separation and grief. Whatever the focus, resistances will tend to sabotage self-understanding. Though the patient may seek to get rid of anxiety and disturbing symptoms, though possessing incentives to be assertive and independent, though wishing to be fulfilled happily and creatively, he or she is a prisoner of one's conditionings that tend

compulsively and confoundingly to repeat. Moreover, there are virtues derived from a perpetuation of neurotic drives: symptoms do tend to give the patient temporary protection from anxiety; secondary gains operate that supply the inpidual with spurious pidends for the illness; normality poses dangers more disagreeable than being well. To work through resistances toward complete understanding, and to put insight into practice with corrective personality change, is a prolonged procedure that will have to go on outside of therapy, perhaps the remainder of the inpidual's life.

What will be needed is a form of discipline to approach the task of self-understanding toward liberation from destructive patterns. In order to get well the patient will have to acquire the strength to renounce patterns that have personal values. Even though awareness is gained into the need to renounce certain ways of behaving, the patient may prefer to hang onto a preferred though neurotic way of life despite the inevitability of suffering. The patient may also become resentful to the therapist for not reconciling irreconcilable objectives of achieving the fruits of victory without bothering to till the soil and plant the seed, and of retaining neurotic patterns while avoiding the accompanying pain.

For example, a female patient seeks love from men at the same time that she is extremely competitive with them. To outdo and outshine them has intense values for her. When she fails to vanquish them, she becomes

infuriated; when they stop short of giving her the proper affection, she goes into despair. Her lack of insight into her ambivalence toward men is startling in view of the fact that she is capable of advising her friends in *their* affairs of the heart. From her history it is suspected that her problem stems in part from her competitiveness with an older brother against whom she was pitted by her mother, who herself was in rivalry with her passive husband. Yet the patient loved and admired her brother. What bothers the patient is that she can never hold onto a strong male; only weak and passive men seek her out, for whom she has only contempt.

Within six sessions of therapy the patient became aware of her two antagonistic drives, to give affection and to defeat men. An inkling of her strong competitiveness with men also filtered through. She acknowledged how contradictory her motives were, but this had no effect whatsoever on her behavior. Indeed, she became embittered with and repudiated my suggestion that until a change occurred in her rivalrous attitudes toward men, she could not expect that they would respond to her, nor would she be able to realize the love she desired. She countered with the statement that she was looking for a man with " guts" who could fight back and make her feel like a woman.

Ordinarily, one would anticipate that a problem of this severity could be resolved only in prolonged treatment, preferably with the setting-up and working-through of a transference neurosis. For many reasons long-term

therapy was not feasible, and after eighteen sessions treatment was terminated with symptomatic relief, but with no alteration of her patterns with men. What I enjoined her to do was to practice principles of self-observation, which I encourage in all patients who have a desire to achieve more than symptomatic change. Follow-up visits over a 10-year period have revealed deep and continuing changes with a successful marriage to a man she respects with whom she has enjoyed raising two children.

Post-Therapy Self-Observation

Among the areas around which post-therapy self-observation is organized are the following:

1. *Relating outbursts of tension, anxiety and symptom exaggeration to provocative incidents in the environment and to insecurities within the self*. The patient may be told: "Whenever you get upset, tense or anxious, or whenever your symptoms get disturbing, ask yourself: 'What is going on? What has upset me?' Keep working at it, thinking about matters until you make a connection between your symptoms and what has provoked them." If the patient has gotten clues about the operative dynamics from the treatment experience, he or she will be in a position to pinpoint many of the current upsets. Even if the assigned determinants are not entirely complete, the fact that the patient attempts to identify the sources of trouble will help to overcome helplessness and to alleviate much tension.

2. *Observing circumstances that boost or lower feelings about oneself*. The patient is instructed to watch for incidents and situations that boost morale or that are deflating to the ego relating these, if possible, to operations of inherent personality assets and liabilities. For instance, when first forming a relationship with a person, a feeling of peace and contentment may follow on the assumption that the relationship will magically resolve problems. A realization may then dawn that such inordinate expectation can sponsor a parade of troubles since it is based on neurotic dependency. If, on the other hand, the patient experiences greater self-esteem in doing something constructive through personal efforts, the resulting feeling of independence and self-growth may encourage further efforts in this direction.

3. *Observing one's relationship with people*. The patient is encouraged to ask oneself: "What tensions do I get with people? What kind of people do I like or dislike? Are these tensions with all people or only with certain kinds of people? What do people do to upset me and in what ways to I get upset? What do I do to upset them or to upset myself when I am with them? What do I do and what do they do that tends to make me angry? What problems do I have with my parents, my mate, my children, my boss, associates at work, authorities, people in general?" Whatever clues are gathered about habitual reaction patterns will serve to consolidate an understanding of one's general personality operations.

4. *Observing daydreams or dreams during sleep*. The patient may be reminded, if during therapy he or she has learned that

dreams have a meaning, that one may be able to get some valuable data about oneself from phantasies or dreams. The patient may be instructed: “Make a note of any daydreams or night dreams especially those that repeat themselves. Try to remember them and to figure out what they mean.” How valuable this exercise may be is illustrated by the case of a young man with fears about his masculinity who developed stomach pains the evening of a blind date that forced him to cancel his appointment. Unable to understand why his pains disappeared immediately after the cancellation, he asked himself to remember any dreams that night. The dream he recalled was this: “ My father had his arm around my mother and kept me from her. I felt guilty.” He was so enthusiastic that he had made a connection between the incident of the blind date and his oedipal problem that he telephoned me to say he was going to challenge his putting women into the role of his mother by seeing his date through another evening. This he was able to do. Obviously not all patients will be able to utilize their dreams in self-observational practices.

5. *Observing resistances to putting one's insights into action*. The patient is advised that every time understanding is applied to the challenging of a neurotic pattern, this will tend to strengthen one. “You will eventually get to a point where you will be able to block destructive or self-defeating actions before they get you into trouble. But expect some resistance, tension and fear. When you stall in doing what you are supposed to do, ask yourself why? What are you afraid of? Then deliberately challenge your fear and see if you can

overcome it."

By a studied application of the above principles of self-observation, the patient may be able to achieve considerable personality growth after treatment has stopped. Gradually one may become aware of patterns that have to be revised before interpersonal horizons can be expanded. Understandably, this process is slow. First, the inpidual realizes that symptoms do not occur at random, but rather are related to life situations and relationships with people which stir up tensions, hostilities, and anxieties. This leads to a questioning of the types of relationships that are habitually being established. It may seem incredible to the patient that other ways of behaving are possible. Even partial acceptance of this premise may spur an inquiry into origins of existing attitudes toward people and toward oneself, A continuity may be established between present personality traits and past conditionings. The " blueprint" of the personality that was tentatively sketched while in treatment becomes more solidly outlined, and essential revisions in it are made. The patient sees more clearly the conditions under which early fears and conflicts originated to paralyze functioning. In the course of this investigation one may recover memories long forgotten, or may revive feelings associated with early recollections that have been repressed. There is an increasing facility to master the anxiety associated with the past. He or she begins to doubt that life need be a repetition of past happenings and becomes increasingly convinced that it is unnecessary to inject past attitudes

into present situations. Tenuously, against resistance, the patient tests new responses, which in their reward help gradually to extinguish old reactions. Throughout this reconstructive process, the old patterns keep coming back, particularly when the inpidual feels insecure or self-esteem becomes undermined. The recognition that one is trying to regress as a security measure assists in reversing the retreat. More and more one expresses a claim to a new life, the right to be more self-expressive. The ego expands; the conscience gets less tyrannical; inner promptings find a more healthy release; relationships with people undergo a change for the better.

There is, of course, no guarantee that these productive developments will take place in all cases. Nor can any estimate be made as to how long a period change will require after therapy has ended. But persistence in the practice of self-observation, and active challenging of neurotic patterns, are prime means of achieving reconstructive results. Where the patient has been taught self-relaxation or self-hypnosis, one may advantageously employ these techniques to catalyze self-observation.

Notes

1 Some of the material in this chapter has been utilized and adapted, with the permission of the publishers from my books: Handbook of Short-Term Psychotherapy. New York, Thieme-Stratton, 1980; and Short-Term Psychotherapy, New York, Grune & Stratton, 1965.