Handbook of Short-term Psychotherapy

A General Outline of Short-term Therapy

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A General Outline of Short-term Therapy

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 can adapt at least some of these principles to his own style of operation even though he continues to employ methods that have proven themselves to be effective with his patients and are not exactly in accord with what other professionals do. In the pages that follow 20 techniques are suggested as a general guide for short-term therapy.

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

An atmosphere of warmth, understanding, and acceptance is basic to achieving as 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 himself 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 we'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 uniquely toward this end in terms of his own techniques and capacities for rapport. Some therapists possess an extraordinary ability even during the first session, as the patient describes his problem and associated feelings, of putting the patient at ease, of mobilizing his 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 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 his situation is not hopeless

It is sometimes apparent that, despite presenting himself for help, the patient is convinced that he is hopeless and that little will actually be accomplished from therapy. Where the therapist suspects this, he 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 his 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 he is doing.

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 his reactions may be stressed. For example, should he say he is constantly furious, one might reply, "This indicates that you are capable of feeling strongly about things." If he says he detaches 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 he 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 not correspond with the patient's ideas of someone in whom he 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 can be applied to other stereotypes besides age. In a well-conducted interview the therapist will reveal himself or herself 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 his 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 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. Case 1 in Chapter 6 illustrates the management of a nonmotivated adolescent. More on handling lack of motivation is detailed elsewhere (Wolberg, 1977, pp. 458-470).

Gather Historical Material and Other Data

Through “sympathetic listening” the patient is allowed to tell his story with as little interruption as possible, the therapist interpolating questions and comments that indicate a compassionate understanding of the patient’s situation. The data gathered in the initial interview should hopefully permit a tentative diagnosis and a notion of the etiology and possibly the psychodynamics. Should the patient not bring the matter up, he may be asked what he considers his most important problem to be? Why has he come to treatment at this time? What has he done about the problem to date? Has he himself arrived at any idea as to what is causing his difficulty? What does he expect or what would he like to get from therapy?

It is often advantageous to follow an outline[1] 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 has obtained 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 passivity 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 opinion these are what he would like to eliminate or change. Agreement is important that this chosen area is significant to the patient and worthy of concentrated attention. If the patient complains that the selection is too limited, he is 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 in the first interview, 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 all kinds of new 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.

As has been indicated, 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.

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 I can't understand it.

Sometimes the events are obscured or denied because the patient has an investment in sustaining situational irritants even while he seeks to escape from their effects. Involvement in an unsatisfactory relationship with a disturbed or rejecting person from which the patient cannot extricate himself 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 his symptoms and what

he 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 that he 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 out 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 the dynamics of a problem should present it 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 feels about what the therapist has said. If he is hazy about the content, his confusion is explored and clarification continued.

For example, a patient with migraine is presented with the hypothesis that anger is what is creating his symptom. The patient then makes a connection with past resentments and the denial defenses that he 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 (Wolberg, 1977, pp. 6, 62-63, 410-418).

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 his confidence in the patient's capacity to get well, the patient may in advance cancel the termination in his own mind in favor of 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 we'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

Following 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 cassette tape. Do you have a cassette 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.

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 you 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 his actions or verbalizations, and he 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 all Times is on the Present, be Sensitive to How Present Patterns Have Roots in the Past

Examining how the patient was reared and the relationship with parents and siblings is particularly revealing. An attempt is made to establish 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 his past with his present, a proper interpretation may

be made. At that time a relationship may be cited between 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.

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 if he desires hold on to them as defenses, but if this is so, he must suffer the consequences. A frank discussion of why the resistances have value for the patient and their effects on his 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 rapidly

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 *I* 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.

Give the Patient Homework

Involve the patient with an assignment to work on how his symptoms are related to happenings in his environment, to attitudes, to fallacies in thinking, to disturbed interpersonal relationships, or to conflicts within himself.

Even a bit of insight may be a saving grace. As soon as feasible, moreover, ask the patient to review his idea of the evolution of his problem and what he can do to control or regulate the circumstances that reinforce the problem or alleviate his 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 his difficulties and what the patient has done to avoid or resolve such incidents. The patient may also be given some cues regarding how he may work on himself to reverse some basic destructive personality patterns through such measures as acquiring more understanding and insight, rewarding himself 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.

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 his 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 we’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 (which is not too common in my experience) 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 underestimated. Patients will usually 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 he must alert himself to signals of their awakening. In my practice I have found that making a relaxing tape (a technique detailed in Chapter 15) 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 off 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 his 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 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, or behavioral therapy, 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 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.

Conclusion

Twenty operations are recommended for an effective dynamically oriented short-term therapy program. They 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 may be utilized in toto or in part by therapists who can adapt them to their styles of working. Irrespective of theoretical persuasion, there are a number of areas of general agreement among different professionals practicing short-term therapy:

1. *Time*. The most frequently designated number of sessions range from 3 to 6 for crisis intervention, from 6 to 12 for supportive-educational approaches, and from 12 to 20 for more extensive psychotherapy along dynamic lines. These may be crowded into a span of a few weeks, or they may be distributed over a number of months. Some therapists prefer to see their patients on a once-a-week basis; others find twice a week the optimal frequency. In some cases 40 to 50 sessions are still considered acceptable for short-term coverage. Time limits are often set in advance with the patient.

2. *Selection of cases*. Ali types of problems of acute and chronic duration are considered suitable. Even patients with serious psychopathology are candidates. Some therapists who confine themselves to dynamic short-term therapy believe selection of appropriate patients is mandatory.

3. *Goals*. Reconstructive changes are deemed not only desirable but also obtainable in suitable patients, especially with the use of dynamic approaches, provided there exists proper motivation and concurrence of reconstructive objectives on the parts of patient and therapist.

4. *Degree of therapist activity*. A relatively high degree of activity is generally preferred.

5. *Focus of therapy*. A restriction of focus to a zone agreed on by patient and therapist is important, if not essential. If a nuclear conflict is identifiable and the patient does not defensively avoid it too much, its consideration as a focus is desirable in dynamically oriented approaches. Considered significant are transference phenomena, which in some systems may occupy a position of central importance.

6. *Techniques*. The full range of eclectic supportive, educational, and reconstructive techniques are used including, in dynamic approaches, traditional analytic techniques of transference analysis, interpretation of resistance, dream and fantasy exploration, and the relating of transference to genetic determinants.

[1] Further details on history taking and convenient appropriate forms may be found in Wolberg, 1977, pp. 401—409,1176-1178.