Handbook of Short-term Psychotherapy

A Rationale for Dynamic Short-term Therapy

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A Rationale for Dynamic Short-term Therapy

Short-term therapy generally has three goals: (1) modifying or removing the symptom complaint for which help is being sought, which is the immediate objective, (2) producing some corrective influence on the inpidual's general adjustment, and (3) initiating essential alterations in the personality structure. With properly conducted treatment we may anticipate substantial or complete symptom relief as well as some modification for the better of behavioral coping. However, we may scarcely have broken ground on the third goal of personality reconstruction. We may hope, nevertheless, that the experience of treatment will have set into motion a process following therapy that over a long-term period will result in true character permutations. That such changes do occur has been demonstrated in follow-up studies of patients who have received appropriate professional help over a brief span. Though not anticipated, significant and lasting changes in the self-image and the quality of interpersonal relationships have been noted.

When we review the many systems of short-term therapy that address themselves to the goal of personality reconstruction, we find that the majority acknowledge the operation of unconscious conflict, along with the conditioning of faulty habit responses, as a source of the neurotic process. In dynamic forms of therapy a prime objective is helping the patient acquire greater knowledge of oneself including one's hidden motives. A question is whether the kind of treatment being employed can lend itself to the achievement of this objective.

Categories of Short-term Therapy

Throughout the literature one finds a tendency to subpide short-term therapy into three distinctive categories: (1) crisis 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

family habit patterns, and to rectify behavioral deficits. To attain these objectives, a variety of eclectic techniques are 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 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.

Some 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. The second, more ambitious, goal-directed forms of crisis intervention are often seen operating in outpatient clinics and private practice. If the assigned number of sessions have 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 his 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 him. The only 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 is up against. By studying how the patient utilizes the relationship with him, the therapist 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 his training, the therapist believes himself 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.

Universality of Dynamic Principles

The subpisions of short-term treatment that have been described—namely, crisis intervention, supportive-educational short-term therapy, and dynamic short-term therapy—are artificial. In practice their boundaries become diffuse. Because patients respond selectively to different techniques, effective therapists in all three categories of treatment will vary their interventions according to the immediate problems and needs of their patients. Moreover, because all operate within the matrix of a relationship that develops between patients and therapists, underlying personality problems and conflicts will surface during therapy and yield vitally significant dynamic material for examination. What the therapist does with the material the patient brings up during interviews can affect the outcome of treatment. *Indeed the techniques and interventions used by the therapist to influence the patient's symptoms may be less important than the fantasies and behavioral responses they evoke in the patient.* For example,

some manifestations reflect projections of past fears and desires in relation to early authority figures. These, if undetected or disregarded, may effectively block therapeutic progress. Such transference resistances are extremely common and are probably the chief reason for failures in therapy. Frequently they are apparent only in nonverbal behavior, dreams, fantasies, and insidious acting-out away from the therapist's office. *This is why a dynamic approach, during which the reactions of patients to the therapist and to the pervading techniques, constantly assessed and taken into consideration, can prove useful in all forms of short-term therapy*. While the interview focus may be on symptoms, environmental distortions, and other complaint factors, the real therapeutic work will be organized around personality reactions and conflicts mobilized by the maneuvers of the therapist.

A man with emphysema who came to therapy requesting hypnosis to eliminate his smoking habit was exposed to my usual induction method. A technique that I customarily employ is to ask the patient to lift his left index finger when he experiences certain things that I suggest to him, for example, a fantasying of certain scenes. At the suggestion that he picture himself walking along the street and that he lift his left finger (which I touched) as soon as the image came to him, the patient instead lifted his right finger. He also resisted suggestions that his left arm would become so stiff and heavy that he could not move it. On the contrary, he spontaneously waved his arm in the air. On termination of the induction, I humorously pointed out these facts and speculated that his negating of my suggestions was probably an expression of oppositional tendencies. Said I, smiling, "Could you be an oppositional character who won't allow himself to be pushed around?" His immediate response was to laugh heartily and to say that people considered him a "stubborn cuss." It required no great effort to connect his oppositional behavior with a childhood pattern of asserting himself with his parents and older siblings by displaying negativism and sometimes violence to avoid what he considered being dominated and crushed. I commented that I certainly was not his parent, but that he might react to me and to what I was doing for him as if I was somebody who wanted to dominate and crush him. He could easily block himself by such an attitude from benefiting from treatment. My statement seemed like a revelation to him. He speculated that this was probably why his previous psychotherapeutic effort with another therapist had failed. He never could understand why he would have flashes of anger toward the therapist and would sometimes mumble to himself after he left the therapist's office, "I won't let that son- of-a-bitch brainwash me." He felt so ashamed of these reactions that he had concealed them from his therapist, who failed to pick up the

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transference resistance. By anticipating his transference reaction, I was able to secure his cooperation and to achieve a good result in treatment.

Had I not utilized hypnosis but just an ordinary interviewing technique or behavior therapy, the patient would undoubtedly have revealed his oppositional tendencies *were I to look for them*—if not in his behavior, then in dreams and other representations. The principle that I am trying to illustrate is that the therapeutic tactics employed, while aimed at relieving the immediate crisis situation or symptomatic upset, will usually set into motion customary resistances and defensive operations that may then be closely examined and worked through, if possible, as a means of inculcating essential insights. In other words, even though the methods may be nonanalytic, the patient's reactions to them and to the therapist become an important exploratory focus, if no more than to deal with obstructive transference and other barriers to change. Personality modifications eventually may evolve from this as a serendipitous pidend, one that may continue in a propitious environment for an indefinite time and ultimately become a permanent change.

It would seem prudent, obviously, in view of the great demand for services from the relatively small cadre of available trained therapists, that, at the start, at least, short-term therapy should practically be geared toward goals of optimal functioning. Hopefully, however, even a brief exposure to therapy will uncover fundamental personality conflicts, which the therapist, if he deems the patient prepared to scrutinize them, may carefully bring to the patient's attention with the object of inviting reconstructive change should the patient truly desire to move ahead in his development.

We must not expect to accomplish miracles with dynamic short-term procedures, even when executed with perfection. At the end of the formal brief treatment period we usually observe some alteration of the patient's symptoms, an alleviation of suffering, and a certain degree of behavioral correction. If we have diligently searched for them, we will have recognized fundamental character problems that are likely to create difficulties in the future, and during the treatment we may have been able to start the patient on a productive path toward altering self-defeating personality patterns. Unfortunately, the latter objective is avoided by some therapists. In my opinion, in most cases, this is because the therapist writes it off as unattainable and hence does not apply himself to its accomplishment. To repeat, we cannot expect too radical a personality reorganization within the limited

treatment period. The most to be hoped for is the initiation of sufficient self-understanding to challenge some values and defenses and to encourage experimentation with new and more constructive ways of relating to others and to the self. In this way a chain reaction may be set off, continuing for months and even years after the treatment period, that will hopefully lead ultimately to extensive personality change. That such far-reaching results are achievable in an impressive number of patients is the finding among many therapists who have applied themselves to a dynamic approach in a disciplined way. They attained success because they found and worked on a specific important focus during the treatment.

Dealing with Unconscious Determinants

In patients with intact personalities a few well-conducted sessions, however superficial they may seem, may suffice to bring about an amelioration of symptoms, and no further treatment will be needed. However, there are many patients whose problems are more deeply entrenched who will require *for even mere symptom relief* some resolution of personality conflicts that are incessantly generating trouble for them. Even learning better modes of problem solving requires some insight into internal forces that govern behavior.

It is precisely because the most disturbing sources of turmoil so often lie beyond awareness that efforts in many patients applied exclusively toward environmental manipulation, persuasion, suggestion, reassurance, reeducation, or reconditioning so often are only partially successful. This is not to depreciate the effectiveness of supportive and educational measures, for in suitable patients, apart from bringing about necessary relief from suffering, a certain degree of personality change may occur through their implementation. Unfortunately, lasting characterologic alterations are rare. The chances are that if we really hope to succeed in bringing about explicit personality change, assuming that this is our goal, we will have to clarify and manage inner conflicts that are beyond the periphery of awareness in an effort to promote greater self-understanding. The question in short-term therapy is whether this can be done briefly in a specific case and, if so, how best it can be done.

Traditionally, the method most often employed in dealing with unconscious conflict is long-term psychoanalysis. A good deal of misunderstanding, however, still exists about psychoanalysis, some of which stems from its misapplication to areas in which its competence as a therapeutic procedure may be

challenged. Such misdirection has tended to shred its authenticity. Freud's enduring legacy lies in his penetrating insights into human behavior. These include the concept of the unconscious, the trenchant nature of behavior, the indelible imprint of childhood experience on character structure, the consanguinity of abnormal mental symptoms and normal mental processes, the significance of anxiety, the structure of symbolism, the nature of dreams, and the importance of transference and resistance. These innovations have become firmly incorporated into psychiatric and psychological thinking and have inspired practically all current systems of psychotherapy. They are intrinsic to our contemporary ideas about dynamically based short-term psychotherapy.

Psychoanalysis in its long-term classical form has not proven itself to be a practical form of therapy in the majority of cases seeking help—not only because it is expensive and drags on for years, but also, even where finances and a willingness to participate in a prolonged therapeutic relationship are present, only a small number of patients are suitable candidates for the technique. Identifying who might satisfactorily respond is difficult. Roughly, persons who are not too sick and not too immature, a so-called "normal-neurotic" group, qualify. These constitute only a small fraction of the vast army of people who cluster around clinics and practitioners' offices seeking help for a wide variety of problems.

Attempts to find other means than classical analysis to expose underlying sources of problems continue to this very day. Blocking such attempts are obstructions to surfacing of the unconscious and the stranglehold that hidden needs and defenses have on one's values and behavior. Because such unconscious ingredients are frozen into the character structure, efforts to demonstrate their unreasonableness are resisted with a desperate tenacity.

Are we then doomed in helping people reach reconstructive personality transformations? It is fallacious to conclude that a seriously defective childhood imposes a life sentence on everyone. Growth is possible at all stages of an inpidual's life, corrective emotional experiences being sponsored by constructive life events, particularly meaningful interpersonal relationships. Where an inpidual has lived through a crisis and has resolved it successfully, he may also be rewarded with new and better personality responses that can serve him well in handling future stressful situations.

The idea that the unconscious is forever concealed unless uprooted by formal psychoanalytic

therapy is no longer accepted by disciples of modern cognitive approaches who contend that an inpidual is not a helpless pawn of his unconscious. Rather the inpidual exercises a certain degree of command over inner conflicts, constantly striving to make them conscious so he can gain mastery over them. To an extent, he is even capable of exercising decisions about which aspects of his unconscious to reveal, titrating their exposure against his tolerance of anxiety. As he works through his anxiety, he becomes increasingly aware of segments of himself that have been concealed and hence have evaded detection and control. Countering this, of course, are resistances that may obstruct such attempts at self-healing.

The virtue of the cognitive approach is the philosophy it espouses to the effect that techniques other than formal analysis can be immensely helpful in resolving resistance to the opening up of crucial areas for exploration and ultimately lead to self-understanding. Left to one's own resources, the average inpidual may not have sufficient motivation, the fortitude to struggle with the anxiety inevitable to the handling of repudiated aspects of the psyche, and the willingness to abandon the material and subversive gains accruing to neurotic indulgence. On the other hand, the inpidual who turns to a carefully designed approach executed by a skilled empathic therapist will learn to deal with resistances to self-understanding and support experimentation with more reality-oriented patterns.

How self-understanding helps to bring deeper problems to the surface and to encourage healthier adaptation is not entirely clear. Roy Schafer (1973) expresses it this way: "It is impressive that, as these changes take place in the patient's conception of himself, often by dint of and with the accompaniment of much suffering, he begins to feel better and to function better. His symptoms diminish in scope and persistence; his mood improves; his social and sexual relationships are enhanced. It seems that it can be a gain just to be able to recognize one's neurotic misery." Whatever the involved mechanisms, the inpidual's sense of mastery is helped.

Since the goal of self-understanding requires the uncovering of at least some unconscious determinants, the manner of their exposure and the timing are especially important in short-term therapy. Generally, the first few sessions will reveal data from the historical material (and particularly the present behavioral patterns of the patient) that offer clues regarding the operative dynamics. Usually it is unwise to present the patient with such clues, no matter how significant they may seem, until he himself expresses awareness of what is going on. Even then any interpretations must be cautiously

offered in the form of tentative presentations (Wolberg, 1977, pp. 589-590). The relationship of expressed conflictual material to the present complaint factor is vitally important if such a relationship can be demonstrated.

A mild-mannered, soft-spoken patient came to my office with the complaint of migraine headaches. As he walked into the room, he tipped over a chair and then profusely apologized while ashes from his cigarette spilled over the carpet. During the interview I got the impression from his posture, the set of his jaw, and slashing movements of his hands that his fawning, obsequious manner was a cover for an inner boiling pot of anger. In my mind I made a connection between his smoldering rage and his migraine. I also speculated that he was not aware of the extent of his anger and how he repressed it. To have confronted him with my hypothesis would probably have ended our relationship before it began. Instead, I bided my time until I had more evidence to confirm my impression while working on establishing a closer relationship.

At the fourth session the patient spoke of needing some extensive dental work because he ground his teeth during his sleep. This reinforced my idea that his anger, under control usually, was strong enough to break through in sleep. Repetitive use of such phrases as “The man is all chewed up,” “It kills me to think of how people take advantage of welfare,” “I slaughtered him at tennis,” and so on, enabled me to say, “I wonder if you hold back on your anger when you have a right to be upset?” I then repeated some incidents that he had revealed to me in which he had felt taken advantage of but had failed to assert his rights. This led to an expostulation of indignation at the state of the world and the nefariousness of people who needed to “Jew you down.” His next association was that Freud was a Jew and Freud was a psychoanalyst who was currently being criticized in articles he had read. “Is there,” I asked him, “anything I as a psychoanalytic psychotherapist am doing that upsets you or makes you angry?” “Why,” he replied astonished, “should I be?” “Well,” I retorted, “are you?” The patient then laughed and in an embarrassed way talked about his resentment at the fee I charged, at the punctiliousness of my appointment times, and at the fact that I had given him an ending date when he was sure he could not get well in so short a period. The trouble, he insisted, with most doctors was that they were too busy to devote themselves to any single patient. This was the case also with some parents, including his own parents, who had spent little time with him.

Without apologizing for my actions or acting indignant, I encouraged him to tell me more about how he felt, implying that I approved of his frankness and his right to feel what he felt. As I anticipated, he backtracked, apologizing for his boldness and rudeness. This reaction, I replied, was in service of his guilt, a habitual pattern to keep his anger under control. “But,” he retorted, “I really do like doctors and Jews. And there is some Jewish blood in my family.”

Opening up some transference feelings served to help our relationship; and to support his ability to criticize his family more frankly for some of the ways he was handled as a child. A noticeable change occurred in the frequency of his migraine attacks, and at our termination date he expressed great satisfaction with the benefits he had received from therapy both in relieving his headaches and giving him a greater sense of freedom.

Conclusion

All persons, irrespective of the degree of emotional illness have a potential for improvement and growth, both spontaneously through constructive life experiences and, more expeditiously, when treated with appropriate psychotherapy. For radical and enduring amendments in the personality structure some cognitive alteration is essential. Without such change, improved habit and behavioral patterns are apt to be short-lived. During therapy far-reaching improvements may be approached by exploring and working through basic conflicts, especially those revealed in the transference. Where transference is not apparent in the therapeutic situation, it may often be detected in distortions in the inpidual’s relationship with other people as well as in the dreams, fantasies, and acting-out tendencies. Irrespective of the techniques that are being employed, (e.g., nondirective interviewing, active anxiety- provoking confrontation, analytic interpretation, behavior therapy, Gestalt approaches, etc.), the patient will respond to these techniques with a wide range of habitual characterologic reactions and resistances. These, utilized as a productive focus on which to concentrate during therapy, may help penetrate defenses and initiate new ways of thinking, feeling, and behaving. Apart from the fact that time in treatment is usually too short to permit the development of too intensive transference reactions that reach a point of a transference neurosis, it is actually not essential for the patient to evolve and work through a transference neurosis to achieve extensive reconstructive change. Indeed, the effect of too great an intensification of transference may be to increase resistance to therapy and to prolong treatment.

Where a relationship is found between the patient's presenting symptoms and complaints, prevailing character patterns, and their origins in early life experiences, the process of reconstructive change is expedited. Such change may continue the remainder of the inpidual's life, particularly where the patient's environment supports the change and he continues self- observation and experimenting with productive new patterns.