Brief and Emergency Psychotherapy

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Some Basic Propositions

Psychotherapy is basically a simple process of learning, unlearning, and relearning, based upon 1) a sound theory of the psychology of personality, 2) a set of hypotheses concerned with the development of psychopathology, and 3) an interrelated series of propositions concerned with optimal restructuring. Using a general theory of psychology and a general theory of psychopathology, the therapist attempts to help the patient to restructure his past apperceptions from maladaptive ones to more adaptive ones (1).

For psychoanalysts, the guiding propositions in trying to understand a contemporary personality and its adaptive problems center on the attempt to establish *continuity* between childhood and adulthood, between waking and sleeping thought, and between normal life and pathology. The entire attempt to understand a personality and the problems in its functioning is predicated upon establishing these continuities, finding common denominators in the acquisition of apperceptive distortions, and helping the patient attain better configurations.

Now, all this sounds basically simple and, indeed, it is a simple process. Complications arise from the fact that the adult patient, especially, has had years of accumulation of apperceptive distortions. These apperceptive distortions interact with each other so that they form configurations which are a Gestalt, a new configuration which needs to be analyzed, i.e., broken down into its previous components. Furthermore, aside from the basic complexity of the personality, the burdens of psychotherapy lie in the fact that much of pathological learning has started early, has been often repeated, and has some primary as well as secondary gains for the patient, which he may be reluctant to give up.

Therefore, psychoanalysis and psychotherapy are usually of necessity drawn-out, long-lasting procedures of many years' duration. The many cults and faddish quick-help methods, such as scientology, dienetics, EST, primal scream, or a variety of encounter groups, are unlikely to bring about fundamental changes. The learning and relearning they provide usually rely on the immediate effects of catharsis and on a kind of "permission" to ease the superego and permit narcissistic behavior and, to some extent, acting-out. These "therapies" provide, at best, some short-lived relief.

It is understandable, therefore, that for a long time brief psychotherapy, in general, was held in low esteem, especially by psychoanalysts and other dynamically trained therapists. The theoreticians cried of reductionism, and the practitioners thought of it as merely supportive, or as comparable to providing emotional band-aids.

Brief psychoanalytically conceived psychotherapy, however, has genuine merit. It can, indeed, bring about some dynamic and structural changes, often in as few as five or six sessions. To do this, it has to be extremely carefully conceptualized and all interventions have to be carefully planned for optimal effect. Brief therapy can be effective because it is predicated upon very close conceptualization of what ails the patient. The idea is to understand everything, if possible, and then to do only the very little bit that will make a difference. A very old story which demonstrates this point: A general's car broke down and army mechanics were called to fix it. When they were unable to repair the car, they turned for help to an old village smith. The smith took a look at the car, rattled it a little and then banged it sharply. Immediately, the car started up. The general asked, "What do I owe you?" The village smith replied, "A hundred bucks." "A hundred bucks for one bang?" said the general. "No," replied the smith, "One buck for the bang, ninety-nine for knowing *where* to bang." That's the way I see brief and emergency psychotherapy. As a modality, I see *brief therapy relating to traditional long-term therapy the way a short story relates to a novel!*

The process of brief therapy is aided by the fact that most major psychopathological conditions can be understood in terms of a basic set of hypotheses, as I point out below. What varies in the individual patient's psychopathology is the relative importance and role that one or another factor plays, for instance, in a depression. This determines the rank order of therapeutic attention paid to each variable. This conception is not asking more of the psychotherapeutic operation than one would of any medical or surgical intervention. One can expect that a surgeon approaching potential gall bladder surgery has a good grasp of the general propositions involved in the anatomy, physiology and pathology of the gall bladder and its surrounding structures, and has a notion about the sequence of his interventions; he will modify the operation only as the individual circumstances demand.

Similarly, I expect that a psychotherapist dealing with depression is aware of the fact that six, seven or eight factors may play a dominant role: 1) problems of *self-esteem;* 2) *aggression* in the presence of 3) a *severe superego* manifesting itself mostly as intra-aggression; 4) a feeling of *loss* —of love, of a love object, or part of oneself; 5) a feeling of *disappointment,* which Edith Jacobson (3) has also related to a feeling of having been deceived; 6) instead of the narrower concept of *orality,* I like to speak of *stimulus hunger* and the fact that the depressed personality tends to be more dependent on positive input than other people;[2] 7) the depressed personality, in a broader sense, is more dependent specifically on *narcissistic* nutrients; 8) the outstanding defense mechanism in depression is usually *denial.*

Though these are the main factors in all depressions, they play a varying role in each depression. For instance, sometimes problems of self-esteem may play the primary role, and insult to the self-esteem is the primary factor in precipitating the current depression. In other cases, a feeling of disappointment or deception may have triggered aggression which, in the presence of the severe superego, leads to intra-aggression and not only depression but potential suicide.

In the brief psychotherapy of depression, it is important to listen for the presence and role of these factors in the individual patient, and to see the historical common denominators between the precipitating situation and historical circumstances. By vigorously working through the relevant factors with the appropriate methods of intervention and sequence of methods of intervention, depression, in my experience, lends itself very well to brief psychotherapy most of the time.

As they do for depression, certain general propositions hold true for the victim of any violence, be it mugging, rape or a violent accident. A history of past experiences with violence will be crucial or, more broadly, the specific personality structure will be crucial. The new event will, to a large extent, be interpreted in terms of the preexisting experience and personality structure. Someone who already has a great fear of passivity will respond differently from someone who has little. The particular experience that brings the patient to us has to be brought into relation to earlier insults to his or her integrity, such as violence inflicted by older siblings, a parent, or others. The specific features of the assault have to be brought into relation to specific preexisting personality problems, be they fears of castration, a problem of poorly defined self-boundaries, or other factors. Presumably, the impact of the contemporary crisis has its particular effect in terms of those preexisting problems and produces in the patient a feeling of depersonalization, guilt or panic, depending on the circumstances.

Therefore, in all instances, treatment consists of helping the patient understand his symptomatology as an attempt to adapt to his contemporary problem in terms of the past. This is often a maladaptive anachronism, and we offer the patient better problem-solving. It is, indeed, possible that the patient will acquire new strength, and reconstitute with a better capacity for tolerating certain stresses than he or she had prior to his particular emergency. In a broader sense, one could say that the brief psychotherapy permits a working-through of an old problem and leads potentially to a better form of dealing with it

than existed premorbidly. In that sense, brief psychotherapy can not only be effective for an existing problem, but may also lead to truly better general integration. Elsewhere, we have described a great number of problems and conditions which can be clearly conceptualized and the treatment of which can then follow a broad outline (2). This should not lead one to adhere to a rigid program as if it were a train schedule. It should be considered as a perspective with which to approach a patient and his problems heuristically. One must remain flexible for finding the best possible fit or be ready for a complete change of hypothesis should circumstances call for it. In that way, the psychotherapist is not in a different situation than the microbiologist who looks through the microscope with a certain knowledge of cell structure and certain expectations which help him see what is there. Without having such a preconceived notion of what to look for under the microscope, however, one would hardly be able to see anything.

Based on such conceptions, I believe it is possible to listen carefully to a detailed history in the first session, to formulate a general treatment plan in terms of the general dynamics and structure of the condition, and to make an individual plan for the *areas of intervention* and *methods of intervention* suitable for the particular patient. By areas of intervention I mean: in a depression, I may choose to address myself in one patient to the loss of self-esteem and only after that to his aggression, intra-aggression and severe superego. In another patient, I may primarily address myself to his severe superego and the intra-aggression, and turn only later to orality and the feeling of deception and other factors. The method of intervention may be interpreting or any others on the list further below.

Methods of Intervention

1) *Interpretation*—While this is the classical method of intervention in dynamic psychotherapy, it is by no means the only one.

2) *Catharsis* certainly has its role to play even if it plays an exaggerated one in such faddist therapies as primal scream and others. The mistake is simply to believe that catharsis alone will have a therapeutic effect, when the fact is that it is one form of intervention which, by itself, is probably never enough.

3) *Mediate Catharsis* is a term which I like to use when I express emotionally charged propositions for the patient. For instance, with a depressed patient with a severe superego and a good deal of aggression, I may say, "Certainly if the foreman had done that to me, I would have kicked him." In this instance, I am expressing sentiments for the patient which might be too strong for his sensitive superego but, by virtue of my saying them, I take the superego responsibility for them. I hope that I also convey to the patient that if an authority such as I, the therapist, can permit himself such an aggressive thought, that it may not be so unacceptable. Identification and introjection of the therapist as a more benign part of the superego then play an important role in this part of the therapeutic process. Other forms of indirect or mediate catharsis: "Of course, a conscientious person like yourself would not permit himself to think so, let alone to do it, but somebody else might certainly feel like killing the son-of-a-bitch." By this statement, I give the patient a double message: 1) I reassure him that he would never lose such control and that, as a matter of fact, he is a person of strict conscience and 2) I convey the idea that in this instance, such aggressive sentiments are not inappropriate.

4) *Reality Testing* is the more necessary the more disturbed a patient is, and the greater the need for the therapist to play the role of an auxiliary reality tester, interpreting the patient's distortions of reality, and functioning as an auxiliary ego for him.

5) *Drive Repression* may play a role if we have a patient who feels that he ought to be able to do as the Jones' do, i.e., with regard to promiscuity, but has reacted with a panic in such a situation. I will flatly say—for instance, to an adolescent girl who feels she has to engage in a certain amount of promiscuity in

order to have social standing in her high school—that she simply should not. I will then help her to accept that she does not have to be promiscuous in order to be accepted by her peers. By this means, I hope to actually take a burden off her mind—or, at least, to arrange for a pause in which she can reconstitute.

By selective inattention, one may sometimes discourage some forms of behavior and encourage others, in effect bringing about selective repression in the patient. It must be kept in mind, however, that repression has a normal role to play in daily functioning and that insufficient repression is, of course, as least as much a problem as is excessive repression.

6) *Sensitization to Signals* is concerned with making the patient aware that certain behavior on his part, be it acting out or panic, occurs when there is a specific dynamic constellation. It may not involve anything more sophisticated than pointing out to a patient that she always has a flare-up with her husband in the two or three days preceding her period.

7) *Education* might involve acquainting the patient with the facts about sodium retention and irritability and advising her to reduce her salt intake, etc. I might possibly prescribe a mild sedative for the two or three premenstrual days to help avoid a serious marital conflict.

8) *Intellectualization* plays a greater role in brief therapy than in traditional longer term therapies. At times, I use it to increase the therapeutic alliance. At other times, it is useful—for instance, with a very panicky patient—to give him at least the feeling of intellectually understanding his symptom—and with this, at least some control over what otherwise seems to him totally disruptive and ego-alien behavior.

9) *Support* in terms of the therapist's accepting certain feelings expressed by the patient, be they aggression, sexuality or greed, makes it easier for him to bear anxiety. Making reassuring statements has its role to play at certain times in therapy, but it can never be all that is called for, if one expects to provide

something more than just ad hoc help.

10) *Conjoint Sessions and Family Network Therapy* are special techniques which I cannot go into here, except to say that I use them in connection with brief therapy in a very specific way. I try to conceptualize very clearly what I want to accomplish in a joint session, and then arrange for it to accomplish circumscribed goals. In other words, it becomes one of the overall planned forms of intervention, if the joint session seems to be the most economical and most appropriate method, and I feel that it is likely to lead to the best learning or unlearning experience for the patient.

11) *Psychoactive Drugs. See Enabling Conditions*

The Therapeutic Process and the Therapeutic Relationship

Since I see all psychotherapy as a form of unlearning, learning, and relearning, by insight, conditioning, and identification-internalization, it is part of my conception of the therapeutic relationship that it should provide and create optimal circumstances for unlearning, learning, and relearning. This methodology, of course, affects the therapeutic relationship as defined within the terms of the 1) *transference/countertransference relationship,* 2) *the therapeutic alliance,* and 3) *the therapeutic contract.* I would like to discuss these propositions within the framework of brief psychotherapy as a chronological process.

The First Session

In the first session, I expect a great deal of work to be accomplished. Of this, the establishment of the three aspects of the therapeutic relationship is but one of the tasks.

1) Transference/countertransference relationship

To be sure, in the broad meaning of the term transference relationship, the patient already comes programmed with certain apperceptive distortions derived from the past, which he ascribes to the as yet unknown therapist, e.g., by dreaming the preceding night of going to the dentist. Certainly, more personal transference/countertransference relations form as soon as the patient and therapist meet in the waiting room.

As an integral part of establishing a relationship in the first session, 1 expect to hear from the patient as *complete a history as possible,* an exhaustive account of the patient's current problems, their onset and the life situation in which they arose. I consider the history-taking reasonably complete only if I can see the person now sitting opposite me at various stages of his development in the concrete settings of the places he lived in and their general cultural, ethnic and geographic aspects, and can reasonably well relate his current chief complaint and the dynamic situation surrounding its onset in terms of this past history. In inquiring about precipitating events, I also ask specifically why the patient happens to be here *today.* I include in my questions almost routinely one concerning any dream the patient might have had the night before the appointment, thus hoping to get an idea of the preformed transference expectations.

In the course of the history-taking, a significant interpersonal relationship is established, including positive or negative countertransference features—more or less of a rescue fantasy on my part, including cognitive closure and possible critical feelings. For the patient, the intensive interest in his history is often a form of narcissistic gratification. It conveys the genuine interest of the interviewer and thus contributes to the establishment of a positive transference.

At the end of the first session, I review the salient features of the history and the complaint or problem which brought the patient into therapy. I try to point out some common denominators that one can easily perceive between the history and the current problem, and the relationship of these factors to me as

therapist as expressed by the patient.

I consider it important to give the patient at least an intellectual understanding of what his problem might be, thus decreasing his feeling of helplessness and giving him the feeling that whatever ails him can at least be understood and that *I can understand it.* This further contributes to the development of an interpersonal relationship between the patient and myself.

In order to get a meaningful history, I am not inactive in eliciting it; I let the patient talk only as long as I feel the information is immediately relevant and then redirect the interview. It is part of my hypothesis concerning very close conceptualization that I formulate some general notion of what the dynamics and structure might be like and attempt to follow up these heuristic hunches. I remain, I hope, flexible for altering my notions as other data come in.

With the careful history-taking and my review of the salient features, I create an atmosphere of *compassionate empathy.* This has luckily remained entirely genuine because of my seeing life somewhat in terms of a Greek drama, all of us being, to some extent, helpless victims of circumstances to which we adapt in various ways. I perceive my job as helping the patient to achieve a little better adaptation than he had achieved before.

I also *create some feeling of hope predicated upon my understanding of the patient's problems,* mixing it with realistic limitations as formulated in the statements concerning the therapeutic alliance and the therapeutic contract.

To be sure, part of the therapeutic relationship involves appropriate *identification of positive and negative transference,* as in psychoanalysis or analytic psychotherapy, but this must be adapted to the needs of brief therapy: This is, in essence, a matter of style, where clear and often concrete formulation plays an especially important role.

2) The therapeutic alliance

I introduce the therapeutic alliance with a specific formula: *"The rational and intelligent part of you needs to sit together with the irrational unconscious part of you that causes you problems."* I may briefly explain the nature of the *therapeutic process* as I see it, in the first or second session, to increase this alliance. I briefly convey some basic ideas: The *first* idea is that we can understand behavior if we understand that there is *continuity between childhood and adulthood,* between *waking and sleeping thought,* and between *normal and pathological behavior*. I illustrate this fact with an example or two from the patient's account. Dreams, of course, are especially valuable for this purpose because they show the relationship between the day residue, the dream, and past history, and possibly something about the transference relationship.

My *second* main explanation of the therapeutic process involves an account of the acquisition of dynamics and structure via apperception and apperceptive distortions and role identification. I will compare the experiential process to the laying down of thousands and thousands of transparencies, e.g., of mother feeding, of mother cleaning, of mother punishing, fused with pictures of other significant people in the patient's life, and suggest that his contemporary apperception of various figures is structured to a greater or lesser degree by the Gestalten acquired in the past.

I may at times use a Thematic Apperception Test (TAT) picture and strive to demonstrate this phenomenon, especially since I tend to use the TATs sometimes as a device for aiding communication, interpretation and insight in the process of brief psychotherapy; this is likely to happen in the second session or the third session. The procedure is, of course, that I ask the patient to tell me a story about what is going on in the TAT picture, what led up to it and what the outcome will be; then I point out common denominators in his responses, highly specific features of his story as compared to some others that I can relate, or some specific features, such as his not seeing the gun or the pregnancy, etc.

I explain to the patient that the success of the therapy depends to a large

extent on the *ability of part of him to work in alliance with me.* So as not to make patients feel overburdened, I may add that their main job is just to talk and that it is mostly my job to lead the way or to facilitate the rest of the process of understanding. Many people are, of course, not accustomed to the dissociative process that is involved in good analytic reporting and giving what I call an *"internal travelogue."* I frequently convey the idea by relating the story of a delinquent who was being prepared by a social worker for a consultation with me. When she asked him if he knew what a psychiatrist was, he said, "Yeah, that's the guy who makes you squeal on yourself." I explain to patients that what is expected is that they squeal on themselves—in a sense, tell things that they observe about themselves. If this is difficult, I have them give a concrete account of their day and then ask them what they thought at different points. I speak of starting with an *"external* travelogue" and turn next to an *"internal* travelogue." I also have a standard set of questions that help patients report and contribute their part to the therapeutic alliance. I may inquire as to what they were thinking while engaged in any number of semi-automatic tasks such as driving, shaving, or putting on make-up. I may ask patients what the last thought was that they had before falling asleep, and what they first thought of upon waking up.

In this respect, I hold myself responsible for *facilitating the therapeutic process,* which does not necessarily mean only making it go. To the contrary, I consider regulating the flow of the interview one of my crucial tasks, analogous to giving gas and putting on the brakes when driving a car. Selective inattention to some material, dilution by a little more general talking, or, on the other hand, silence and interpretation of defenses, are some of the main instruments I can employ to control the therapeutic process as my part of the therapeutic alliance.

3) The therapeutic contract

During the first session, in addition to taking an extensive history and establishing the basics of the transference relationship and the therapeutic alliance, the therapist begins the formulation of the therapeutic contract. As in so

many other respects, the therapeutic contract in brief psychotherapy is much more clear-cut and specifically stated than it is in longer forms of psychotherapy. I explain to the patients that I hope that we will be able to deal with their problems in five sessions, each of them lasting approximately 50 minutes, and that I shall want to hear from them about a month after the fifth session, by telephone, letter or in person, telling me how they are faring. I add that I have reason to believe that five sessions may well be sufficient and successful, but if it should turn out that they are not enough, it will be part of my responsibility to see that the patient gets whatever further therapy is necessary either by myself, or, if that is impossible, by somebody else. I add to this that if I need to transfer the patient to someone else, that second person will be seeing the patient through therapy and that I will personally introduce the patient to the therapist and, with his permission, sit in on the first session, and, incidentally, give a brief account to the other therapist in the patient's presence. Of course, I also mention that if there should be a real reason for contacting me before the month is up following the fifth session, then the patient should by all means do so. However, in order to interfere with the *secondary gain of continued transference feelings and dependence*, I add here that it is best to give the treatment process a chance; I quite genuinely believe that often the treatment process opens up some painful areas which are only partially healed by the time the actual therapy stops. I convey to the patient that it is best to permit the therapeutic process to come to its own conclusion spontaneously and that it is best for the patient to try to give the treatment results a chance to solidify rather than for him to call me the first time anything disturbing is experienced, possibly just because he feels abandoned. I thus try to convey—*as part of the contract*—that I will continue to be interested and do whatever is necessary, while I try at the same time to create a situation in which the patient feels motivated to attempt to achieve optimal results in the five sessions—in essence, by my conveying the idea that the *good patient* gives up secondary gains and passivity. Clearly, this is a situation which behavior therapists would consider, appropriately, a matter of reward for giving up some secondary gains.

In essence, this covers the establishment of the three aspects of the therapeutic process in the first session of therapy.

Second Session

In the *second session* we explore further, get better closure and reexamine the basis for choosing areas and methods of intervention (2).

I attempt to strengthen the positive therapeutic relationship—both transference and alliance—and interpret negative transferences, watching for disappointment and negative transference in myself as well as for excessive zeal. If possible, I ask the patient at the beginning of the second session what he thought about after he left the first session. I often refer to the "esprit d' escalier": As one walks down the stairs, one thinks of things that one might have said and of things one might have replied.

Furthermore, as a matter of routine, I ask the patient what he dreamt the night after the first appointment and what he dreamt the previous night, and I especially look for clues concerning the therapeutic relationship. I get a high yield of dreams because even after the patient tells me he didn't have one, I ask whether he at least recalls some feeling, or some word or picture, and thereupon the patient will very often report an entire dream.

Aside from other therapeutic operations, I attempt to modify the superego, the ego ideal and introject by lending myself as modifier. I may tell anecdotes about myself or offer opinions, contrary to the most customary procedure in psychoanalysis or prolonged psychotherapy. I use vivid concrete stories to convey certain ideas with colorful imagery, best delivered in an understated way. For example, to attempt to make some narcissistic behavior ego-alien, I might tell the story of Rothschild and a poor bum who told him the heartbreaking story of his life. As tears roll down Rothschild's cheeks and he finally reaches for the bell to summon the butler, the poor bum's hopes soar. When the butler appears,

Rothschild turns to him and says, “Throw the bum out; he’s breaking my heart.” Or I may illustrate self-harming behavior by telling the story of the guy who stands in front of his burning house laughing uproariously. His neighbor comes over and says, “Hey, Joe, are you crazy? Your house is burning. How come you’re laughing?” He says, “Oh, that’s okay, the bed bugs are finally getting it!”

I consider it part of the technique of brief psychotherapy to have a suitable style likely to facilitate optimal learning.

Third and Fourth Sessions

In the third and fourth sessions, more of the same methodology continues. From the third session on I start referring to the *impending separation* by mentioning to the patient that there will be only two more sessions. I often predict—in order to be wrong—that in response to this expected separation the patient might even feel worse next time and that this might be due to a fear of separation and a fear of abandonment. Again, I will try to make this acceptable by talking about the fact that so many people call a doctor late at night, though they had some complaint most of the day, because suddenly they become afraid that next morning might be too late or that they may not be able to get hold of the doctor.

Fifth Session

In the fifth session, I review with the patient what we have learned, and address myself to loose ends. Very often we learn of some new aspects, despite all attempts to conceptualize in advance. All work, however, is especially directed towards aspects of the therapeutic alliance and the transference and towards the reaffirmation of the contract as stated before.

I aim to terminate with a positive relationship. As mentioned earlier, I also ask the patient to get in touch with me a month later and let me know how he is faring. This is accompanied by the statement that, of course, if the patient should

have difficulties before that time, he should by all means contact me. At the same time, however, I caution the patient that the wish not to be abandoned may make one call more readily than may be necessary. There is some benefit in trying to go it alone rather than be dependent. The patient is again reassured that if it turns out that further therapy is necessary, it will be carried on either by myself or by someone else, whom I will introduce to the patient.

Enabling Conditions

At times, one may have to provide enabling conditions within which the psychotherapeutic relationship can take place. *Psychotropic drugs* may play a chief role in this. I have previously written (2) of the various roles drugs may play for clinical reasons, for metapsychological considerations, and, at times, for physiological reasons. By *clinical reasons,* I mean that if a patient is so crippled by agoraphobia that he cannot come to my office when no one is available to come with him, I am likely to prescribe enough medication to decrease the anxiety so that the patient can at least come to the session without a companion. Among the *metapsychological reasons,* I consider the prescription of chlorpromazine if I feel that impulse control needs to be improved in order to enable one to perform the psychotherapeutic intervention. This holds true for some psychotics. With them, at times, *environmental intervention* in the life situation is necessary: If the patient's sole contact with reality is via a TV set and that TV set breaks down, I consider it essential to see to it that his TV set is fixed promptly.

Returning to drugs specifically: I like to think of them as enabling conditions for psychotherapy, very similar to the role anesthesia plays for the surgeon. Sometimes they make interventions bearable and create the field within which one can intervene psychotherapeutically. One may stop the drugs as soon as they are not necessary to carry on the psychodynamic intervention.

Naturally, the role of drug giving has to be considered dynamically and especially in terms of the transference role, but generally they play a role in

regulating the therapeutic process in psychotherapy and psychoanalysis. For psychotics, this has been described best by Ostow (5).

Some Administrative Aspects of Brief Therapy

I believe brief therapy to be useful in all settings—in private practice as well as in clinics and social agencies. A measure of improvement can be produced in acute conditions of all kinds, even chronic psychosis. Naturally, longer therapies are indicated for complex restructuring of personalities.

In public clinics, Leighton's admonition, "Action on behalf of one must be within the framework of calculations for the many" (4, p. 110), is very appropriate. I cannot accept the fact that many clinics and agencies have a year-long waiting list because only a few patients are seen in long-term therapy. Upon inspection, this therapy often turns out to be of poor quality because of insufficient conceptualization of the process or simply lack of therapeutic skill.

I urge the adoption of brief psychotherapy as the *intake procedure of choice.* If used properly, this method avoids waiting lists with their ensuing chronicity of pathology, and leaves enough time for well-thought-out longer therapies when they are indicated.

With regard to the *indications* for brief therapy: Instead of selecting patients or diagnostic categories, *I rather select the treatment goals.* In that framework, brief therapy can be useful for virtually any patient for primary, secondary and tertiary prevention. In the latter instance, for example, I have found it very useful in the treatment of acute exacerbations of chronic psychotics. In such cases, it may make the difference between someone needing to be hospitalized, or being able to remain in the community.

Brief Therapy as the Intake Method of Choice

There are at least two basic forms of intake for brief therapy as the method

of choice:

1) A Clinic Director sees all patients at intake, and then turns them over to a staff member who is both available and particularly likely to do well with a given patient.

2) Whichever staff member is free takes the next patient and continues therapy.

Both methods have advantages and disadvantages. In the first method, one advantage is that the presumably most experienced person does the initial assessing. Also, if the therapist chosen for the patient should become ill, go on vacation or leave the position, the chief (director) can serve automatically as auxiliary therapist to see the patient through, having already met the patient and formed some relationship.

The disadvantage of this method is, of course, the discontinuity: The first relationship is formed with the clinic head and then another one with the actual therapist. To minimize the problem of the transfer, I suggest that, at the end of the intake, the director actually call in the person he has in mind to see the patient through and, in the presence of the patient, run through the salient features of the chief complaint, history, and whatever understanding of the problem has been arrived at. At the end of his presentation, the therapist would then ask some questions of the patient and the clinic director. Thus, a dialogue is started between patient and therapist, which ends with the setting of a date for the next session.

The second method, where whoever does the intake sees the patient through, has the advantage of direct continuity. Whatever supervision is indicated can be obtained in the usual way, by reviewing the case with a senior at any given time.

The disadvantage to this method is that there is no selection process concerning the most suitable therapist for a given patient. No one else is directly

familiar with the patient in case the actual therapist is not available. Above all, there may be an administrative as well as a technical disadvantage: Many clinics are organized with one M.D. as the bead, most of the other therapists being psychologists or social workers. If the patient is not first screened by the M.D. in charge, there may be a greater chance of overlooking a medical condition which might play a primary or secondary role in the patient's complaints. In many instances, medical screening may also be a legal requirement. Furthermore, if the medical director has at least brief intake acquaintance with the patient, he has a sounder basis for prescribing psychotropic medication if it is called for later on, rather than if he does so only on the basis of secondhand information.

One rationale for brief therapy, which I see as five-session therapy (with a sixth session as a follow-up a month later) is the fact that statistics from outpatient clinics suggest that most patients break off treatment after five sessions. Generally, people are not attuned to the idea of long- range psychotherapy. Among other things, they are accustomed to the medical model of usually rather prompt and brief treatment. In view of this fact, it is better to tailor-make therapy for the number of sessions the majority of patients are actually likely to appear, rather than to plan long-range therapy, which is too frequently prematurely interrupted.

Another basis for such time-limited therapy is the fact that this temporal goal setting, as part of the contract, seems to work well. It increases motivation, forces the therapist to conceptualize clearly, and avoids the secondary gain of passivity and dependence. Also, brief therapy can be offered to many more patients than can long-term therapy, and it can be made available very promptly, without the long waiting lists which cause pernicious chronicity. Moreover, it may indeed free therapy time for that percentage of patients who turn out to need longer therapy and are both willing and able to engage in it.

Conclusions

Brief psychotherapy (when used in emergencies it becomes emergency therapy) is a form of therapy with a status of its own. When it is predicated upon a comprehensive theory of personality, psychopathology and therapy such as psychoanalysis, it can be effective for unlearning and relearning because of the careful conceptualization of the dynamics and the process of therapy itself. The aim is to understand "everything" and to select carefully the few interventions which are likely to be crucially effective. The therapeutic relationship, carefully defined, and planfully utilized, plays an important role. Brief therapy is probably the intake method of choice, at least for clinics. It offers reasonable help to the largest number of those in need.

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Notes

1 The author is greatly indebted to Helen Siegel, M.A., for her editorial assistance.

2 In speaking of the depressed personality, I have compared it often to the poikylotherm in distinction to the homoiotherm. In the latter, there is something like an emotional thermostat built into the psychic structure in the form of positive introjects which provide a certain measure of love and self-approval, almost independent of external circumstances. This is similar to the warm-blooded animal which maintains its body temperature to a considerable extent even if the temperature outside is higher or lower, in distinction to the cold-blooded or poikylotherm.

APPENDIX:
SAMPLE INTERVIEW

Following is a transcript of an initial interview, which may serve to illustrate some of my basic principles and methods. The interviewee is a 30-year-old Vietnam veteran amputee who was interviewed before an audience of 400 people, as part of a seminar on brief therapy. These circumstances limited some avenues of inquiry. All possible identifying characteristics have been deleted and the interview was videotaped with the patient's permission.

Dr. Bellak: Would you be kind enough and tell me what brought you here in the first place?

Patient: My marriage... Me and my wife separated due to problems of mine where I became passive to the point where if she wanted to do something, I just agreed with her to avoid arguments. When I was in Vietnam I had got blown up by a mine. And I did a lot of things in Vietnam that I don't really like myself for. And I've just become a mental pacifist because I'm afraid that if I do get mad, of what I would do, because in Vietnam I had killed at times due to various strenuous circumstances behind it, like having several of my comrades blown away. Being put in a position where I had killed...had done things that fell between being justifiable just to stay alive and what is not. And I got to a point where I developed a resistance in myself to the point where I would not love, would not hate. And it just got to...got to the point where I just could not live in that atmosphere. I had to let out some of the hate or some of the fear. Because I held myself to a point where I did not love. You can't love without hating.

Dr. Bellak: OK. That gives me a bit of an idea. It's my job to ask you questions and try to understand as much as possible. Under the circumstances, if there is something that you don't want to go into, that's your privilege.

All right, you gave me a bit of a general background. Exactly when did you come here. Do you remember the date?

Patient: December 10.

Dr. Bellak: December 10. What was the final push that got you here?

Patient: The final push was that I had been separated from my wife since July before I came here, and from July to December my nerves had gotten to the point where I drank quite a bit. And I'd be sitting at the bar and my hands would be shaking to the point where I couldn't control them. I'd crush a glass just trying to hold them steady. My nerves ... I was afraid of violence. I was having blackouts. My nerves were catching up with me.

Dr. Bellak: And what would you say made you that nervous? Between July and December especially?

Patient: Not knowing whether I could live with me.

Dr. Bellak: That's too fancy.

Patient: I was trying to make myself not love or hate. Totally blocked it all out. I got to a point where I had no emotions. Didn't feel.

Dr. Bellak: Where did you live at the time?

Patient: I had an apartment in Wallingford.

Dr. Bellak: Did you live by yourself?

Patient: I lived by myself.

Dr. Bellak: Still, there must have been something extra. Something that make you come in here one day in December, after being upset all that while.

Patient: My wife had come in here before and basically she talked me into coming, with the idea that they could give me some better answers.

Dr. Bellak: But was there something extra special that made you come in December and not in July?

Patient: I had got to the point where I had left…when I felt that I could finance it myself… Then by December, I had found out that I could not rationalize some of the things I did by myself. When I was married, I had made myself think that they were rational.

Dr. Bellak: Like?

Patient: Dealing with Nam. I was in several positions where we'd been hit. I worked on what we called hunter-killer teams in Vietnam. You went out with one other man. I went on five missions. Two missions I came back by myself. Lost two men…friends of mine.

Dr. Bellak: So that was still really on your mind.

Patient: This was why I felt ... I had gotten to the point where I was afraid to love anybody, for the fear of losing them. In Nam, we got attached to each other very quick. All the guys I worked with. All the guys that worked with me. I knew things about them that I didn't know about my own brother, and they knew things about me. And after losing so many people, I just refused to get close to anybody… afraid to be close for fear of losing them.

Dr. Bellak: OK. Did you live all by yourself or did you see friends? From the time you and your wife separated. ...

Patient: Matter of fact, from the time I was strictly by myself. For the first three or four months.

Dr. Bellak: When did you actually come back from Vietnam?

Patient: I've been back a few years…from 1971.

Dr. Bellak: 1971. And the difficulties with your wife developed then?

Patient: I wasn't married at the time.

Dr. Bellak: Oh, I see.

Patient: I was from New Year's Eve till June 28th in the hospital. Just getting back together… about six months…had one leg cut off…that a mine blew off….I basically got back or got home and my wife and parents had already sort of set up the wedding arrangements. I didn't know about it.

Dr. Bellak: But you knew the girl, I hope.

Patient: Yeah, I knew the girl. (*Laughs*)

Dr. Bellak: OK. (*Laughs)* I was thinking of some Japanese friends of mine where the mother selects the girl.

Patient: I went from 210 pounds down to 105 pounds, during a period of being in the hospital.

Dr. Bellak: In the hospital?

Patient: And there wasn't too much arguing. I didn't really want to fight or argue with anybody anymore. And I still basically stayed that way.

Dr. Bellak: They arranged it and you accepted it? Is that what you're telling me?

Patient: Yeah, we were good friends and we knew each other and had dated. Well, really only about a month before I went into the Army, but I would have postponed it awhile. Two or three months.

Dr. Bellak: Do I hear between the lines that if you had not been in your particular shape that you might not have agreed to the marriage?

Patient: More than likely, because when I was in the hospital I didn't even ask about it and they were talking about it then. They waited a year…she waited ... we waited ... to give me time to adjust to life and its problems.

Dr. Bellak: OK, so you agreed to go along with it, though. But what were your misgivings? What were your doubts?

Patient: Well, much of my life I had been very athletic. I ran track the first year I was in the Army. I had run cross-country. I didn't know if I could accept not running, not being able to go out and play. Basically, the thought of work ... I could probably work as well as anybody, but I didn't know if I could do the other things in my life that always seemed to be so important to me.

Dr. Bellak: How did that affect the matter of whether you would or would not get married?

Patient: I basically didn't know if I wanted anybody else to support me that way and I wasn't sure

that I even wanted to be that way.

Dr. Bellak: And then how did the marriage go?

Patient: Well, basically until the day I left, my wife felt that we had a great marriage. I usually agreed to whatever she wanted to do. I really didn't want to argue for fear of being mad because I was afraid of what I might do if I got mad. I just gave in and let her have her way. But it eventually just got to the point where I started hating myself even more because I gave in to things that I really didn't want to do, really didn't like.

Dr. Bellak: Could you give me some examples?

Patient: Well, like she was Catholic and I was Baptist. She never insisted that I go to Church, but she always wanted me to and I, basically, the times I did go…not really, I guess you'd say, under duress…but I really didn't want to go….But I got tired of saying no.

Dr. Bellak: Other things? How about the conflict between you two?

Patient: Well, basically, I liked to horseback ride and I liked athletic things. I still do. I like to water-ski and boat ride and every time I tried to get something that we could do together, she was always afraid of it. Like just horses. I bought two horses and she rode it about a hundred yards and stopped and she got thrown off it and she never would get back on it. It aggravated me that she would not try to do the things that we could do together. I just got to the point where I thought about what I wanted to do and just did it by myself.

Dr. Bellak: And towards the end, in July, what was the main point of the differences?

Patient: I had…we had drawn up blueprints for a house we were building and every time I would get through with them, she decided that she wanted to change things a little and we sent them back to the drawing board five times. And I started to agree with her, just not to argue and basically it wasn't the way I would have liked. I know about houses because I used to build them.

Dr. Bellak: Is that your field? What do you do?

Patient: A carpenter. I build furniture.

Dr. Bellak: That's what you still do?

Patient: As a hobby. I'm basically military retired.

Dr. Bellak: OK, what would you say ails you most right now?

Patient: (Long pause) Now I can never get to the point where I like me.

Dr. Bellak: OK, let's look into that. What is it, if you had to make a list, that makes you dislike yourself the most especially?

Patient: I'm very closed . . . I've just gotten passive. (*Starts to cry)* You know, that's not my way

normally. Normally I speak out, right? I'm very straightforward.

Dr. Bellak: So you dislike yourself for that. Having given in.

Patient: It got to the point where I didn't like me for giving in all the time.

Dr. Bellak: OK, what else? Is that what *still* bothers you? Do you think about it?

Patient: Yeah.

Dr. Bellak: Today?

Patient: Yeah.

Dr. Bellak: Yesterday?

Patient: Yeah…Well, we didn't talk yesterday.

Dr. Bellak: Are you and your wife still on talking terms?

Patient: We're still on talking terms. I keep my kids on the weekend.

Dr. Bellak: But what of the things that you dislike about yourself kept running through your mind?

Patient: I guess part of it is the fear of me. Not being able to control me.

Dr. Bellak: And then what would you do?

Patient: Rather than be around people where I would be put into a position where I would be afraid that I would…I'd rather be by myself.

Dr. Bellak: I can understand that. But—and I know this is painful for you—but could you try and spell out specifically what you are afraid of? Of doing?

Patient: Disintegrating. Just accidentally becoming mad.

Dr. Bellak: And *then* what would you do?

Patient: Killing somebody out of instinct rather than ...

Dr. Bellak: How? How?

Patient: With my hands.

Dr. Bellak: How?

Patient: There are several methods that the Army taught us.

Dr. Bellak: Which ones did you think of using?

Patient: There are certain areas. Like the person's Adam's apple. Taking your two hands and breaking off the windpipe. And several methods of crushing a man's ribcage and breaking his back. Hands over his neck, pull back. I had caught myself twice going for a man's throat when I had got angry.

Dr. Bellak: We want to understand. Could you be a little more graphic?

Patient: OK, the first time I was in a bar. Somebody else had come in *(sighs)* ... he was a homosexual and made a proposition to me. And I got mad. If there weren't two guys in there that were friends of mine, and stopped me, I would have killed him.

Dr. Bellak: How, in this case?

Patient: Well, I had grabbed him by his throat and had him up against the wall. I had my hands around his throat *(voice cracks),* and I was trying to….And the other one. I had come into the bar and a man and another woman there were arguing and I just went for him. I tried to kill him. I had him by the inside of his throat rather than the outside… and this scared me to the point where I refused to get mad. That happened in the first year after coming back from the hospital. I got to the point where I just did not go out and socialize with people at all. I just basically stayed home.

Dr. Bellak: And has it become better now?

Patient: I have more control now. Of my feelings. I can take and block everything out. But also by blocking out, it leaves me in a situation where I have to fight myself.

Dr. Bellak: Well, you described that very clearly—that empty feeling that is left after you have tried to push away both love and hate. You made that very clear. Do you have friends at this point?

Patient: I have about four people that I trust enough to call a friend.

Dr. Bellak: Guys?

Patient: Three are male, one's a female.

Dr. Bellak: What did you dream last night?

Patient: I don't remember if I had a dream. I only dreamed twice since I came back from Vietnam.

Dr. Bellak: Do you want to tell me those? Anytime that you feel too uncomfortable…

Patient: One was four years ago when me and my wife separated for awhile. I guess it was the day after I had taken her back to Pittsburgh and left her with her parents. I took the train back. That night…when I was in Nam I had gotten hit several times while I was sleeping and I had gotten into the habit of sleeping with a gun.

Dr. Bellak: By "hit" you mean attacked?

Patient: Yeah, while we were asleep. And I started dreaming about the day I was hit in Vietnam. For

some reason, something made a noise in the house and I rolled out of bed and fired six times, blew six holes.

Dr. Bellak: In the dream?

Patient: No, really. And that was what scared me. I had rolled out of the bed. We were sleeping on cots in Vietnam and I always had an M16 there and here I had a .38 and when we got hit, I would roll out of the bed and start shooting. Before I really realized I was not still in Vietnam, I had rolled out of the bed and fired the gun six times till I flicked the trigger. And I blew six holes in the side door of my house. Luckily there was nobody there.

Dr. Bellak: OK, that was the night after you left your wife off with her parents in Pittsburgh.

Patient: Four years ago.

Dr. Bellak: And any others?

Patient: I had one while I was still in the hospital. Well, I had several of them that reoccurred as the same dream. It was the day we were hit, going through the minefield. The day I was hit I had 20 men on patrol ... 20 men…seven of them were killed… and 12 of us came back amputees. Mutilated. One leg…both legs…both legs and arms. And the dream was about the same thing. About all the pain.

Dr. Bellak: Do you recall any dreams from your childhood?

Patient: When I was real young—about being attacked by a big gorilla. A bunch of gorillas.

Dr. Bellak: Gorillas?

Patient: Being attacked by a bunch of gorillas. I think I had a habit of watching a lot of Tarzan movies. That dream really stuck with me.

Dr. Bellak: OK, that tells me a little bit. You certainly have had a rough time. I just know a little bit about it. I'm still a consultant to West Point and I was during Vietnam so I saw quite a few people coming back and during World War II, I just had enough of a taste of it myself to know what you're talking about. Nothing quite that drastic.

Would you be kind enough and give me a very brief capsule of your life history?

Patient: I was born in 1948. I'm 30 years old. I lived in Philadelphia about until the time that I got drafted in the service.

Dr. Bellak: Your family?

Patient: I have an older brother, and an older sister, and a younger sister.

Dr. Bellak: How much older is your brother?

Patient: My brother is two years older than I am. My sister is six years older than I am, and my

younger sister is six years younger than I am.

Dr. Bellak: And your parents? What kind of people are your parents?

Patient: They're basically, from anybody else's standpoint of view, very pleasant, easygoing people. Which my father is in reality. My mother likes to put on one face for everyone else and she really likes to bitch a lot.

Dr. Bellak: And what was her relation to you?

Patient: At times we had, or I had…problems growing up, where I had gotten into trouble doing certain things in school.

Dr. Bellak: Two terms that I don't understand. Problems growing up and getting into difficulties in school. What does that mean?

Patient: In school, I had always been passive, but twice I had gotten into trouble for fights.

Dr. Bellak: Passive meaning what?

Patient: Easygoing. I didn't like to fight, didn't want to fight. Didn't want to argue. Didn't want to be a bully. Didn't—I tried to get along with people.

Dr. Bellak: I'll remind you of that later, OK? But twice you got into fights?

Patient: And both times I felt that I was basically justified and then I was expelled from school.

Dr. Bellak: Did you hurt the guys?

Patient: Not so that they had to go to the hospital. Just two black eyes, that's all.

Dr. Bellak: OK *(Laughs).* What was the worst thing your mother ever did to you?

Patient: That fight—that time I felt I was justified in getting into that fight, when I got home my father agreed with me, but yet my mother gave me a whipping for it.

Dr. Bellak: How did she whip you?

Patient: With a belt.

Dr. Bellak: How old were you at the time?

Patient: The first time probably 13. The second time about 15.

Dr. Bellak: You were a pretty big guy.

Patient: Basically, it wasn't that she could hurt me by the whipping. Just so that she could hurt me inside. I leaned on her chair for her to do it. She didn't…

Dr. Bellak: She didn't what?

Patient: She didn't just whip me standing there. I basically ...

Dr. Bellak: So you sort of agreed to it.

Patient: Yeah…

Dr. Bellak: Was it with your pants? You wore your pants?

Patient: Without my pants.

Dr. Bellak: If you would describe—if you would apply three descriptive words to your father, what would you pick?

Patient: (Silence)

Dr. Bellak: The first ones that come to your mind. Don't make it too hard.

Patient: Passive, in terms of my mother. In comparison. Strong. Outgoing in terms of everybody else.

Dr. Bellak: What does he do?

Patient: He's retired now.

Dr. Bellak: What did he do?

Patient: We had a grocery store in Pittsburgh. Then when we moved to Philly, he and my brother opened a construction company, which I worked with.

Dr. Bellak: And your mother? If you would describe her? You already said she was bitchy. What else?

Patient: Two-faced. She was one way outside to everybody else and another way inside. Incredible! She expected everyone to live one way and she wanted to live another way.

Dr. Bellak: You got through high school?

Patient: Yes.

Dr. Bellak: And then what did you do between that and the Army?

Patient: The time between high school and the time I was drafted…Well, I left home about six months before I graduated high school. The reason I left was that I had a fight with my father and he slapped me. That was the first time that he had beaten me up in five or six years. And I left because I was afraid that I was going to hit him back. I wanted to hit him back…but I loved him. (*Starts to cry*) I loved him but I wanted to hit him. That's the reason I left.

Dr. Bellak: Why did he hit you?

Patient: We had that grocery store down there. We worked there together in the mornings. He had this habit of thinking that people were supermen. He'd tell you ten things that he wanted you to do, come back in five minutes, and think of two more things for you to do.

Dr. Bellak: I get the picture.

Patient: I think I was about 17. One day in the store I just finally told him that I couldn't take it anymore, that I only had two hands and not four hands. And that's the first time I think I ever talked back to him. And he slapped me.

Dr. Bellak: So that was a good time to get into the Army?

Patient: I worked for a year and a half for an oil company, after high school and then I got drafted.

Dr. Bellak: Let's just think over some of the things that you've been saying.

Patient: Well, basically, what I didn't like about the way I was living was that I had gotten totally passive.

Dr. Bellak: If I can interrupt, if I may, I really didn't ask you enough about your wife. Would you just give me a very brief capsule. What kind of a woman is she?

Patient: My wife is 28, attractive. She has a different notion of what love is.

Dr. Bellak: What's her background? Let's stick to simple things.

Patients: Her background? After she got out of high school, she worked in a bank.

Dr. Bellak: What kind of family?

Patient: Her father is German, mother is Italian. And a lot of our problems stem from them because they never showed any love of any kind to her. They totally refuse—they ignore that sex exists. According to them, they don't know how kids are born, they just hatched them. She did not understand that. Her parents would never kiss in public or kiss openly or show any affection of any kind. Totally closed, cold, no feeling.

Dr. Bellak: If you were to describe how her parents are different from each other, what would you say?

Patient: Her father basically dominating, overbearing. Very tight with money. To the point where I know there were times when I have seen her younger brothers and sisters ask him for money, like a quarter to get a coke or something, he would never let anybody see what he had, he'd turn around and hide it and just take out a quarter.

Dr. Bellak: And her mother?

Patient: Her mother is like the father, basically.

Dr. Bellak: And your wife? If you could describe her briefly?

Patient: When we first got married, she was not basically aggressive. She was not aggressive in any way. She was afraid of any kind of sex. She really didn't know how to show affection. Just blocks it away.

Dr. Bellak: And did sex remain a problem?

Patient: Yes.

Dr. Bellak: Ordinarily, I would go into it, but I don't think we need to under the circumstances.

But, now that you've rounded that out, did you mention children?

Patient: Yes, I have two girls.

Dr. Bellak: How old?

Patient: Five and almost two.

Dr. Bellak: How do you get along?

Patient: (Sighs) Both girls and me get along very well. I keep them every weekend—Friday and Saturday.

Dr. Bellak: OK, let's go back to what you think we might have learned from what you have told me so far. After all, my job is, among other things, to be of help you.

Patient: (Silence).

Dr. Bellak: Well, let me make it a little bit easier. After all, I have a bit more perspective. It's easier for someone standing away. Also, I'm supposed to know something about it. Let's see if we can agree on some things. Look, what you complain about most and what brought you here is a fear that your anger might get out of hand and that you might do violence. And you have some very good reasons for it. Vietnam was a terrible experience. A couple of times it almost got out of hand and you had some very disturbing dreams, one of being hit and another in which you actually shot your .38.

Patient: Yeah, and in the other dream—well they were the same dream but it was when I was in the hospital.

Dr. Bellak: OK. Now, well curiously enough, when you told me your earlier history, particularly with school, you started off by saying that most of the time you were passive. Then a couple of times you beat up guys pretty badly. Your whole concern now, and about the marriage, was that you were being too passive. Feeling a great deal of anger, and the more you sat on it because you were afraid that it might get out of hand, the more you felt relief. As a kid, you had dreams of a gorilla going after you. And it scared you.

Patient: Yeah, terribly!

Dr. Bellak: In a way, I see a little similarity between that anxiety dream of somebody big, like a gorilla, doing you violence and the dreams of being hit, being attacked.

Patient: Basically, they're both about being attacked.

Dr. Bellak: That's right.

Patient: They're both forms of being attacked. One by an animal and the other by a man.

Dr. Bellak: Yes. Whom did the gorilla look like, incidentally, in the dream? The first thing that comes to your mind.

Patient: A big ape.

Dr. Bellak: Is it anybody you know?

Patient: No.

Dr. Bellak: All right. (Laughs).

Patient: Just looked like a big furry gorilla.

Dr. Bellak: So there is a certain continuity. While Vietnam undoubtedly made things worse…

Patient: The fear of being attacked. The thought of it.

Dr. Bellak: And also, the whole axis turns around aggression, passivity. In school, you say that you were passive most of the time, which is a curious way of putting it. Not everybody would put it that way. And that continues through your marriage, the closest relationship you have. You started out by saying, if I remember correctly, that when your parents arranged it, you were passive about it and agreed to the arrangement. When you described your wife, you said that she was not aggressive. That seems to be very much on your mind. You mentioned that she was not aggressive and then that she got to be and bugged you with the constant changes about the blueprints and different things. But at any rate, the point I want to make is that to be aggressive or to be passive seems to be a thread that runs through your mind very readily. It's practically the main axis. Now, then, what did you tell me about your parents that might have a bearing on that?

Patients: Only that my father was passive with my mother.

Dr. Bellak: What effect might that have had on you? On your personality?

Patient: It made me where I almost did the same thing with my wife. Like the way my parents continuously argued.

Dr. Bellak: If I put it in my vulgar way, I would say that you might have said to yourself as a kid. "I'll be goddamed if I'm going to be a patsy to a woman the way my father has been." Is that right?

Patient: And I wound up doing the same thing. Either that, or I let myself get to the point of doing the same thing.

Dr. Bellak: Either that, or at least it felt that way to you.

Patient: Right.

Dr. Bellak: What conclusions would you draw?

Patient: That I'm afraid of being like my father. Afraid of being pushed.

Dr. Bellak: OK, could I push that just a bit? That you're afraid of being passive. One of the guys who got to you particularly was a homosexual in the bar.

Patient: Yeah. But I was only 21 at the time. I had never had relations with another man. Never wanted to. Never….

Dr. Bellak: So, if I may stretch things a little by implication—the idea that he would think that you would be in any way interested in something not masculine got you sore. That's the point I want to make for right now. And how do you think we could fit in that other time that you nearly got at the guy's Adam's apple?

Patient: That was over a man striking a woman. I was brought up never to do that.

Dr. Bellak: Well, aside from the fact that . . . psychologically, what do you think it might be? Look, you saw somebody attacked. When you and I see a car accident on the highway, what do we do?

Patient: Stop and see if we can help.

Dr. Bellak: But if there is already an ambulance and a cop car there, what do we do anyhow?

Patient: Stop and see if anybody was hurt.

Dr. Bellak: Yes, but usually everyone slows down a bit because you feel that "Gee, this could happen to me. Maybe I shouldn't drive so fast." One identifies, as we psychiatrists say, with the other person. Could there have been something in that, when you saw the guy hit the woman?

Patient: Other than the actual fact?

Dr. Bellak: Well, I could be wrong, but what I wonder about in such a case, if one doesn't identify with the underdog. You don't want to see her hit, because you feel, "Damn, I don't want to be hit."

Patient: I don't want to be hurt, but I don't want to hurt anyone either.

Dr. Bellak: OK, let's see if we can agree on a couple of things. One is that Vietnam was a terrible experience. It might do all sorts of things to anybody's…

Patient: (*interrupts*) People have to do a lot of things that they shouldn't have to do.

Dr. Bellak: I know, but this might just have made more of an impression on *your* personality because

you had already been concerned with a fear of being attacked, as witnessed in the dreams about the gorilla, a recurrent dream in your childhood. You felt that you had to stand up against your mother, about whom you had understandably mixed feelings. Mixed feelings. You bent over the chair and let her whip you, but at the same time you must have been full of a hell of a rage.

Patient: Anger, because I didn't understand why. I felt that I was justified in what I did.

Dr. Bellak: Well, among other things ... So that you came with that pattern. Vietnam made it worse. Then you had the feeling that you let yourself be shoved into a marriage. You started out with a bit of a grudge and misgivings that you had let yourself be shoved. And then, very promptly, saw yourself in a situation and a relationship that seemed too much like the one you saw between your father and mother.

What does it add up to? If you and I would just change chairs mentally and you were the psychiatrist, what would you think of all the things you have heard today?

Patient: As far as the marriage?

Dr. Bellak: No, as far as understanding what is going on with you.

Patient: What's going on with me?

Dr. Bellak: Yes, and what we might do about it.

Patient: (Silence)

Dr. Bellak: Well, in view of the fact that we see that some of the same problems that trouble you now and troubled you in your marriage existed in some form in your youth, in your earlier life, what do you think you and your therapist might work on?

Patient: Getting me to the point that I can, basically, release enough of myself to feel.

Dr. Bellak: How do you propose to do that?

Patient: The only way I can do it is to learn not to be afraid of reaching out and of being hurt.

Dr. Bellak: Is there another way? Obviously, what ails you now has its origins in childhood. Getting to understand the fact that many of the things that happened to you as a kid make Vietnam much more difficult for you to absorb and digest and to deal with now—and they still have an effect on you today, the things that happened to you as a child. The better you can understand to a certain extent how you either overemphasize or even distort some of the things that happen to you now because you were already primed in childhood— the gorillas and all that—the less you are going to feel that rage. I think that rage has been there since childhood, and got an extra shove from all the things in Vietnam. I don't know if you could have married any woman…

Patient: At that point.

Dr. Bellak: At any time, and not come with the same set of expectations. "I better watch out that she

is not a battle-axe who shoves me around." Because that is what you were accustomed to. So, the more you work on that, on understanding your current feelings in terms of your early past, with Vietnam just thrown in psychologically for good measure, the better able you will be to handle the tensions that you have, which just seem to be all along a matter of passivity, aggression—really, apparently, the axis around which your life revolves. Some people have that problem even without Vietnam if one has had that childhood. That's one thing. The more you can go into that, the better.

Would you like to hear my guess about who the gorilla was in the dream? I bet you can make a pretty good guess. Can you tell me? The first person who comes to your mind.

Patient: My mother.

Dr. Bellak: Oh, sure. And I bet if we could *go* into the dream in enough detail, we could find things that would identify her. And I think that she is even sometimes identified in your mind with some of the Vietnamese.[3] Well, it gets a bit complex. But those are some of the things that you two can continue to go into. Meanwhile, I'm sure you use whatever athletics you can to get rid of some of the tension. I think that's a very good short range measure. Like punching a bag.

You're right-handed, I take it.

Patient: Yes.

Dr. Bellak: Never were left-handed?[4]

Patient: No.

Dr. Bellak: Well, I think that's probably as much as we can go into now I feel, having seen problems similar to yours before, that there is a good deal of hope that the two of you—you and your therapist—can really work this out.

You know, there's not anyone so tough that he doesn't have some passivity. I don't care how tough the guy is.

Patient: Basically, I'm not afraid of being passive. The problem is that usually I get too passive.

Dr. Bellak: Well, in part I guess you had to because with your mother…and then that made you feel like nothing and you had to get really angry. So, if you two can work it out so that you neither feel too passive nor the need to feel too aggressive, I think that things should work out very well.

Thank you very much again. I really appreciate that you were willing to discuss things.

Patient: Thank you very much.

REFERENCE

1. Bellak, L. Adult psychiatric states with MBD and their ego function assessment. In L. Bellak (Ed.),

Psychiatric Aspects of Minimal Drain Dysfunction in Adults. New York: Grune & Stratton, 1979.

Notes

3 The ideal concise interpretation I should have made here is: "I think all you did was to replace the *gorillas* with *guerillas*."

4 This was just a brief notion that the patient's problems with impulse control might be related to any aspect of minimal brain dysfunction. I discuss this more fully in another book (1).