Handbook of Short-term Psychotherapy

Choosing a Dynamic Focus

Presenting Interpretations

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C. Presenting Interpretations

The most effective focus is one that deals with a basic repetitive conflict, the manifest form of which is being expressed through the immediate complaint factor. As an example, consider a crisis situation involving a wife, the mother of two small children, who insists on a porce because of continuing disenchantment with her marriage. The porce decision appears to be the terminal eruption of years of disappointment in her husband's failure to live up to her ideal of what a man should be like. After we cut through endless complaints, it became apparent that the standard against which she measures her husband is her father, whom she worships as the epitome of success and masculinity. This idealization actually has little basis in fact, being the remnant of an unresolved oedipal conflict. Be this as it may, it has thwarted her ability to make a proper adjustment to her marriage, and now with the decision of a porce the integrity of her family is being threatened. She comes to therapy at the urging of her lawyer who realizes that she is too upset at present to make reasonable decisions.

A therapist who minimizes the importance of dynamic conflicts may attempt to achieve the goal of crisis resolution by invoking logic or appeals to common sense. He may suggest ways of patching things up, insisting that for the sake of the children a father, however inadequate, is better than no father. He may, upon consulting with the husband, point out various compromises the husband can make, and after the wife has verbally disgorged a good deal of her hostility in the therapeutic session, she may be willing to cancel her porce plans and settle for half a loaf rather than none. The reconciliation is executed through a suppression of her hostility, which finds an outlet through sexual frigidity and various physical symptoms. On the other hand, should the therapist recognize the core conflict that is motivating her idea of porce, there is a chance that the patient may be helped to an awareness of her merciless involvement with her father and the destructive unreasonableness of her fantasies of what an ideal marriage is like. She may then allow herself to examine the real virtues of her husband and the true advantages of her existing marriage.

A dynamic focus should, therefore, be prospected in the course of exploring the immediate complaint factor. Such a focus is often arrived at intuitively (Binder, 1977). The more empathic, skilled, and experienced the therapist, the more likely he will be to explore the actual operative dynamics. However, no matter how firmly convinced he is in his immediate assumptions, he realizes that these are being predicated on incomplete data. He knows that his patient may deliberately withhold important information, or though the patient may recognize certain conflicts she is still oblivious to their significance or completely unaware of their existence. Whatever tentative theories come to the therapist's mind, he will continue to check and to revise them as further information unfolds. Interviews with relatives and friends are extremely valuable since they may open facets of problems not evident in the conversations with the patient. Moreover, once the patient during the first encounter has pulged data, later interviews will help uncover rationalizations, projections, and distortions that will force the therapist to revise his thesis and concentrate on a different focus from the one that originally seemed so obvious.

No matter how astute the therapist has been in exposing a truly momentous focus, the patient's reactions will determine whether the exposure turns out to be fruitful or not. For example, even though an underlying problem is causing havoc in a person's life and is responsible for the crisis that brings the person to therapy, this does not imply that the patient will elect to do anything about it. Its emotional meaning may be so important to the patient, the subversive pleasures and secondary gains so great, that suffering and misery are easily accepted as conditions for the indulgence of destructive drives even where the patient has full insight into the problem, recognizes its genetic roots, and realizes the complications that inevitably indemnify the indulgence. I recall one patient whose yearning for revenge on a younger sibling produced a repetitive series of competitive encounters with surrogate figures toward whom retaliatory hostilities and violence brought forth punishment by employees, colleagues, and friends. A series of abuses culminated in a disastrous incident in which a physical assault on a fellow employee resulted in the patient's discharge from a promising executive position. This happening was so widely publicized in the industry that the patient was unable to secure another job. During therapy the patient was confronted with the meaning of his behavior and particularly his revenge and masochistic motives; he readily recognized and accepted their validity. This did not in the least deter his acting out on any occasion when he could vent his rage on a sibling figure. At the end of our brief treatment period,

it was recommended that he go into long-term therapy, which he bluntly refused to do. He seemed reconciled to pursue a damaging course for the momentary joy that followed an outburst of aggression.

Experience with the addictions provide ample evidence of the futility of focusing on the dynamics of a dangerous and what appears on the surface to be a disagreeable way of behaving. But, that some patients disregard logic does not nullify the need to persist in making careful interpretations in the hope of eventually eroding resistance to the voice of reason.

We may expect that a patient in need of help will communicate sufficiently to supply essential material from which a focus may be extrapolated. Understandably, there will be differences in emphasis among therapists, even among those who have received similar theoretical grounding. The available material is usually sufficiently rich to enable therapists to empathize with aspects that synchronize with their needs, intuitions, ideas, and biases.

Since all people share certain conflicts that are basic in our culture, some of these can constitute the dynamic focus around which interpretations are made. Thus manifestations of the struggle over separation-inpiduation following the ideas of Mann (1973), persistence of oedipal fantasies as exemplified in the work of Sifneos (1972), and residues of psychic masochism such as described by Lewin (1970) are some of the core conflicts that may be explored and interpreted. Sensitizing oneself to indications of such conflicts as they come through in the patient's communications, the therapist may repeatedly confront the patient with evidence of how he is being victimized by the operations of specific inner saboteurs. There is scarcely a person in whom one may not, if one searches assiduously enough, find indications of incomplete separation-inpiduation, fragments of the oedipal struggle, and surges of guilt and masochism. It is essential, however, to show how these are intimately connected with the anxieties, needs, and defenses of each patient and how they ultimately have brought about the symptoms and behavioral difficulties for which the patient seeks help.

Lest we overemphasize the power of insight in bringing about change, we must stress that to a large extent the choice of a focus will depend on the therapist's seeing the presenting problem of the patient through the lens of his theoretical convictions. A Freudian, Jungian, Adlerian, Kleinian, Horneyite, Sullivanian, Existentialist, or behavior therapist will focus on different aspects and will organize a

treatment plan in accordance with personal ideologies. While the focus, because of this, will vary, there is considerable evidence that how the focus is implemented and the quality of the relationship with the patient are at least as important factors in the cure, if not more so, than the prescience of the therapist and the insightful bone of dynamic wisdom he gives the patient to chew on. That implantations of insight sometimes do alter the balance between the repressed and repressive forces cannot be disputed. How much the benefits are due to this factor and how much are the product of the placebo effect of insight, however, is difficult to say. Where a therapist is firmly convinced of the validity of the focus he has chosen and he convinces his patient that neurotic demons within can be controlled through accepting and acting upon the "insights" presented, tension and anxiety may be sufficiently lifted to relieve symptoms and to promote productive adaptation. Even spurious insights if accepted may in this way serve a useful purpose. Without question, nevertheless, the closer one comes in approximating some of the sources of the patient's current troubles, the greater the likelihood that significant benefits will follow.

In this respect for some years I have employed a scheme that I have found valuable in working with patients. This consists of studying what resistences arise during the implementation of the techniques that I happen to be employing at the time. The resistances will yield data on the existing dynamic conflicts, the most obstructive of which is then chosen as a focus.

Experience with large numbers of patients convinces that three common developmental problems initiate emotional difficulties and create resistance to psychotherapy—first, high levels of dependency (the product of inadequate separation-inpiduation), second, a hypertrophied sadistic conscience, and, third, devaluated self-esteem. Coexisting and reinforcing each other, they create needs to fasten onto and to distrust authority, to torment and punish oneself masochistically, and to wallow in a swamp of hopeless feelings of inferiority and ineffectuality. They frequently sabotage a therapist's most skilled treatment interventions, and, when they manifest themselves, unless dealt with deliberately and firmly, the treatment process will usually reach an unhappy end. Dedicated as he may be to their resolution, the most the therapist may be able to do is to point out evidences of operation of these saboteurs, to delineate their origin in early life experience, to indicate their destructive impact on the achievement of reasonable adaptive goals, to warn that they may make a shambles out of the present treatment effort, and to encourage the patient to recognize his personal responsibility in perpetuating their operation. The tenacious hold they can have on a patient is illustrated by this fragment of an interview.

The patient, a writer, 42 years of age, who made a skimpy living as an editor in a publishing house came to therapy for depression and for help in working on a novel that had defied completion for years. Anger, guilt, shame and a host of other emotions bubbled over whenever he compared himself with his more successful colleagues. He was in a customarily frustrated, despondent mood when he complained:

Pt. I just can't get my ass moving on anything. I sit down and my mind goes blank. Staring at a blank piece of paper for hours, I finally give up.

Th. This must be terribly frustrating to you.

Pt. (*angrily*) Frustrating is a mild word, doctor. I can kill myself for being such a shit.

Th. You really think you are a shit?

Th. Frankly, Fred, I'm not even going to try. But you must have had some hope for yourself, otherwise you never would have come here.

Pt. I figured you could get me out of this, but I know it's no use. I've always been a tail ender.

Th. (*confronting the patient*) You know, I get the impression that you've got an investment in holding on to the impression you are a shit. What do you think you get out of this?

Pt. Nothing, absolutely nothing. Why should I need this?

Th. You tell me. [*In his upbringing the patient was exposed to a rejecting father who demanded perfection from his son. The father was never satisfied with the even better than average marks his son obtained at school and compared him unfavorably with boys in the neighborhood who were prominent in athletics and received commendations for their school work. It seemed to me that the paternal introject was operating in the patient long after he left home, carrying on the same belittling activities that had plagued his existence when he was growing up.*]

Pt. (*pause*) There is no reason. (*pause*)

Th. You know I get the impression that you are doing the same job on yourself now that your father did on you when you were a boy. It's like you've got him in your head. [*In the first part of the session the patient had talked about the unreasonableness of his father and his own inability to please his father.*]

Pt. I am sure I do, but knowing this doesn't help.

Th. Could it be that if you make yourself helpless somebody will come along and help you out? [*I was convinced the patient was trying to foster a dependent relationship with me, one in which I would carry him to success that defied his own efforts.*]

Pt. You mean, you?

Th. Isn't that what you said at the beginning, that you came to me to get you out of this thing? You see if I let you get dependent on me it wouldn't really solve your problem. What I want to do is help you help yourself. This will

strengthen you.

Pt. But if I can't help myself, what then?

Th. From what I see there isn't any reason why you can't get out of this thing—this self-sabotage. (*The patient responds with a dubious expression on his face and then quickly tries to change the subject.*)

In the conduct of brief treatment one may not have to deal with the underlying conflicts such *as those above as long as the patient is moving along and making progress. It is only when therapy is bogged down that sources of resistance must be uncovered*. These as has been indicated, are usually rooted in the immature needs and defenses of dependent, masochistic, self-devaluating promptings. At some point an explanation of where such promptings originated and how they are now operating will have to be given the patient. This explanation may at first fall on deaf ears, but as the therapist consistently demonstrates their existence from the patient's reactions and patterns, the patient may eventually grasp their significance. The desire to make oneself dependent and the destructiveness of this impulse, the connection of suffering and symptoms with a pervasive desire for punishment, the masochistic need to appease a sadistic conscience that derives from a bad parental introject, the operation of a devalued self-image, with the subversive gains that accrue from victimizing oneself, must be repeated at every opportunity, confronting the patient with questions as to why he needs to continue to sponsor such activities.

Sometimes a general outline of dynamics (such as are detailed in Chapter 9) may be offered the patient with the object of either stirring up some anxiety or resistance or of providing the patient with an interpretation that fosters a better understanding of himself. While the delineated drives and defenses are probably typical in our culture of both "normal" and neurotic inpiduals, the specific modes of operation and the kinds of symptoms and maladjustments that exist are unique for each inpidual. Every person has a thumb, but patterns of thumbprints are all different. The therapist, employing a blueprint such as Figure 10-1, may try to fit each patient's problems into it and then choose for focus whatever aspects are most important at the moment. For example, the patient may during a session complain of a severe headache and thereafter proceed to beat himself masochistically, blaming himself for being weak and ineffectual. The therapist should then search to see how this trend affiliates itself with guilt feelings and what immediate situation inspired such feelings. The therapist may discover that what is behind the guilt is anger in the patient at his wife for not living up to his expectations in executing her household

duties. Further probing may reveal anger at the therapist for not doing more for the patient. Such transference manifestations may enable the therapist to make a connection with the patient's mother toward whom there has existed since childhood a good deal of anger for her neglect and rejection. This will open up a discussion of the patient's excessive dependency needs and the inescapable hostility, low independence, and devalued self-esteem that dependency brings about. An association may be established between the patient's hostility turned inward and the migraine headaches for which therapy was sought in the first place. The therapist should in this way take advantage of every opportunity to show the patient the interrelationship between his various drives, traits,' and symptoms, keeping in mind that while a certain trend may encompass the patient's chief concern at the moment, it never occurs in isolation. It is related intimately to other intrapsychic forces even though the connection may not be immediately clear.

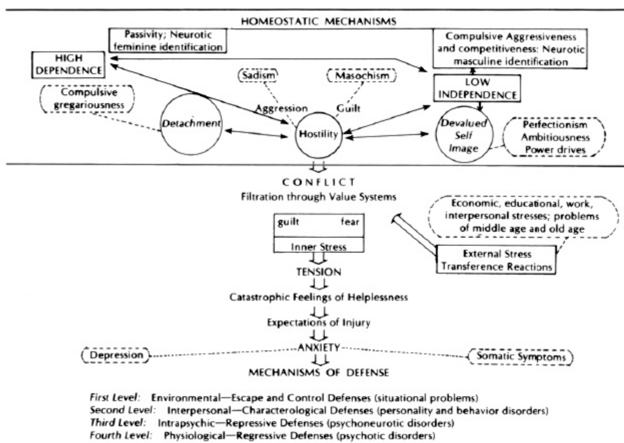

FIG. 10-1.
Outline of Personality Operations

An individual can make a reasonable adjustment for a long time even with a vulnerable character structure. His personality motors, defective as they may have been, still operate harmoniously; various balances and counterbalances maintain the psychological equilibrium. Then because of the imposition of an external crisis situation or because of stresses associated with inner needs and external demands, anxiety, depression, phobias, and other symptoms appear. The patient may consider that his adjustment

prior to the presence of some precipitating factor was satisfactory if not ideal, with no awareness of how his tenuous personality interactions have been sponsoring various symptoms and ultimately had produced his breakdown. He is very much like a man with back pain who credits his “sciatica” to one incident of lifting a weight that was too heavy, oblivious of the fact that for months or years he has, through faulty posture and lack of exercise, been accumulating weak and strained muscles.

Thus a patient whose self-image is being sustained by a defense of perfectionism, for as far back as he can remember, will have to perform flawlessly even in tiny and most inconsequential areas of achievement. To perform less than perfect is tantamount with failure and signals inferiority and a shattered identity. The merciless demands he makes on himself may actually be impossible of fulfillment. At a certain point when he cannot face up to demands in some truly important situation, his failure will act like a spark in an explosive mixture. The eventuating symptoms that finally bring him into treatment are depression and insomnia. It will require little acumen for a therapist to spot the perfectionistic trends around which the patient fashions his existence. But to argue him out of his perfectionism and to counter the barrage of rationalizations evolved over a lifetime are difficult, if not impossible, tasks. We may, nevertheless, attempt to work with cognitive therapy and select perfectionism as a focus, pointing out the distortions in logic that govern the patient’s thinking process. Not all therapists have the skill and stamina to do this, nor do we yet have sufficient data to testify to the efficacy of this approach in most cases.

What would seem indicated is to review with the patient the full implications of his perfectionism, its relationship to his defective self-image, the sources of self-devaluation in incomplete separation-inpiduation, the operations of masochism, and so forth. Obviously, the therapist must have evidence to justify these connections, but even though he presents an outline to the patient of possibilities and stimulates the patient to make connections for himself, he may be able to penetrate some of the patient’s defenses. Giving the patient some idea about personality development may, as I have indicated, be occasionally helpful, especially where insufficient time is available in therapy to pinpoint the precise pathology. Patients are usually enthusiastic at first at having received some clarification, and they may even acknowledge that segments of the presented outline relate to themselves. They then seem to lose the significance of what has been revealed to them. However, in my experience later on in follow-up, many have brought up pertinent details of the outline and have confided that it stimulated thinking

about themselves. Thus in the case of Roger described in the last chapter, I gave him the following general interpretation:

Th. I believe I have a fair idea of what is going on with you, but I'd like to start from the beginning. I should like to give you a picture of what happens to the average person in the growing-up process. From this picture you may be able to understand where you fit and what has happened to you. You see, a child at birth comes into the world helpless and dependent. He needs a great deal of affection, care, and stimulation. He also needs to receive the proper discipline to protect him. In this medium of loving and understanding care and discipline, where he is given an opportunity to grow, to develop, to explore, and to express himself, his independence gradually increases and his dependence gradually decreases, so that at adulthood there is a healthy balance between factors of dependence and independence. Let us say they are equally balanced in the average adult; a certain amount of dependence being quite normal, but not so much that it cripples the person. Normally the dependence level may temporarily go up when a person gets sick or insecure, and his independence will temporarily recede. But this shift is only within a narrow range. However, as a result of bad or depriving experiences in childhood, and from your history, this seems to have happened to you to some extent [*the patient's father a salesman was away a good deal of the time and his older brother brutally intimidated him*], the dependence level never goes down sufficiently and the independence level stays low. Now what happens when a person in adult life has excessive dependency and a low level of independence? Mind you, you may not show all of the things that I shall point out to you, but try to figure out which of these do apply to you.

Now, most people with strong feelings of dependence will attempt to find persons who are stronger than they are, who can do for them what they feel they cannot do for themselves. It is almost as if they are searching for idealized parents, not the same kind of parents they had, but much better ones. What does this do to the inpidual? First, usually he becomes disappointed in the people he picks out as idealized parental figures because they never come up to his expectations. He feels cheated. For instance, if a man weds a woman who he expects will be a kind, giving, protective, mother figure, he will become infuriated when she fails him on any count. Second, he finds that when he does relate himself to a person onto whom he projects parental qualities, he begins to feel helpless within himself, he feels trapped, he has a desire to escape from the relationship. Third, the feeling of being dependent, makes him feel passive like a child. This is often associated in his mind with being nonmasculine; it creates fears of his becoming homosexual and relating himself passively to other men. This role, in our culture, is more acceptable to women, but they too fear excessive passivity, and they may, in relation to mother figures, feel as if they are breast-seeking and homosexual.

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

As if this weren't enough, a third motor gets going along with the other two. High dependence means low

independence. A person with low feelings of independence suffers terribly because he does not feel sufficient unto himself; he does not feel competent. He feels nonmasculine, passive, helpless, dependent. It is hard to live with such feelings, so he may try to compensate by being overly aggressive, overly competitive, and overly masculine. This may create much trouble for the person because he may try too hard to make up for his feelings of loss of masculinity. He may have fantasies of becoming a strong, handsome, overly active sexual male, and, when he sees such a figure, he wants to identify with him. This may create in him desires for and fears of homosexuality, which may terrify some men who do not really want to be homosexual. Interestingly, in women a low-independence level is compensated for by her competing with men, wanting to be like a man, acting like a man, and resenting being a woman. Homosexual impulses and fears also may sometimes emerge as a result of repudiation of femininity.

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

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

To complicate matters, some of these drives get sexualized. In dependency, for instance, when one relates to a person the way a child or infant relates to a parent, there may be experienced a powerful suffusion of good feeling that may bubble over into sexual feeling. There is probably a great deal of sexuality in all infants in a very diffuse form, precursors of adult sexuality. And when a person reverts emotionally back to the dependency of infancy, he may reexperience diffuse sexual feelings toward the parental figure. If a man relates dependently to a woman, he may sustain toward her a kind of incestuous feeling. The sexuality will be not as an adult, but as an infant to a mother, and the feelings for her may be accompanied by tremendous guilt, fear and perhaps an inability to function sexually. If the parental figure happens to be a man instead of a woman, the person may still relate to him like toward a mother, and emerging sexual feelings will stimulate fears of homosexuality. [*If the patient is a woman with sexual problems, the parallel situation of a female child with a parental substitute may be brought up. A woman may repeat her emotions of childhood when she sought to be loved and protected by a mother. In body closeness she may experience a desire to fondle and be fondled, which will stir up sexual feelings and homosexual fears.*] In sexualizing drives for independence and aggressiveness, one may identify with and seek out powerful masculine figures with whom to fraternize and affiliate. This may again whip up homosexual impulses. Where aggressive- sadistic and self-punitive masochistic impulses exist, these may, for complicated reasons, also be fused with sexual impulses, masochism becoming a condition for sexual release. So here we have the dependence motor, and the resentment-aggression-guilt-masochism motor, and the independence motor, and the self-devaluation motor, with the various compensations and sexualizations. We have a very busy person on our hands. (*At this point the patient revealed that he had become impotent with his wife and had experienced homosexual feelings and fears that were upsetting him because they were so foreign to his morals. What I said was making sense to him.*)

In the face of all this trouble, how do some people gain peace? By a fifth motor, that of detachment. Detachment is a defense one may try to use as a way of escaping life’s messy problems. Here one withdraws from relationships, isolates

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himself, runs away from things. By removing himself from people, the inpidual tries to heal himself. But this does not usually work because after a while a person gets terrified by his isolation and inability to feel. People cannot function without people. They may succeed for a short time, but then they realize they are drifting away from things; they are depriving themselves of life's prime satisfactions. Compulsively, then, the detached person may try to reenter the living atmosphere by becoming gregarious. He may, in desperation, push himself into a dependency situation with a parental figure as a way out of his dilemma. And this will start the whole neurotic cycle all over again.

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

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

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

Sometimes I draw a sketch on a blank paper showing "high dependence," "low dependence," "devalued self-image," "resentment- guilt-masochism," and "detachment," and repeat the story of their interrelationship. I then ask the patient to figure out and study aspects that apply to him. If a general description of dynamics is given the patient, along the lines indicated above, a little insight may be inculcated that can serve as a fulcrum for greater self-understanding. The insight may be temporarily reassuring at first; then it seemingly is forgotten with a resurgence of symptoms. A review of what has occurred to stimulate an attack of anxiety may consolidate the insight and solidify better control. An important tool here is self-observation, which the therapist should try to encourage and which will help the "working-through" process, without which insight can have little effect.

Conclusion

In dynamic short-term therapy the most productive focus is often on some aspect of a nuclear conflict. Since the patient usually defends himself against revealing significant unconscious content, the therapist will have to arrive at it by observing its manifest derivatives. These may be highly disguised and symbolized. However, a sensitive and astute therapist will be able to detect vital undercurrent forces from the patient's verbal and nonverbal behavior, from periodic transference displays, and from dreams, fantasies and acting-out tendencies. These manifestations will be especially prominent during periods of resistance to techniques that the therapist is implementing. Accordingly, the therapist should alert himself to what lies behind the patient's inability or refusal to respond to treatment interventions. A general outline of dynamics presented to the patient with the object of stirring up some tension in the interview and hence expediting explorations, or of working toward fitting the patient's special problems and mechanisms into the outline, is sometimes helpful.