THE TECHNIQUE OF PSYCHOTHERAPY

SHORT-TERM PSYCHOTHERAPY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

feel about what I have said?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Post-Therapy Self-Observation

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

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

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

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

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

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

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

overcome it."

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

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

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

Notes

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