Handbook of Short-term Psychotherapy

Techniques in Short-term Therapy

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Psychotherapy as it is practiced today is no longer a homogeneous operation. Entering its mainstream are tributaries from various branches of the biological and behavioral sciences. This is because behavior embraces every constituent of the human being from physiological makeup to spiritual promptings. In Table 11-I the various links in the behavioral chain are delineated, as well as the fields of interest these embrace, and the therapeutic modalities related to each link to which certain syndromes are often assigned. Take as an example the syndrome of schizophrenia.

Schizophrenia is a disease that is variantly attributed to many causes. There are those who regard it as a biochemical affliction, the product of defects in the function of the neurotransmitter dopamine, which, operating in excess, affects the mesolimbic, infundibular, and nigral pathways. Under these circumstances pharmacotherapy would appear to be the preferred approach, neuroleptics, for example, being employed to block the action of dopamine. Others regard schizophrenia as a neurophysiological disorder, characterized by a lack of left cerebral dominance and defective cerebrolimbic functioning that sponsor abnormalities in linear cognitive ability. Adherents of this viewpoint might consider certain forms of somatic therapy suitable under some circumstances, ECT, for instance, as well as some forms of relaxation therapy. Some ascribe schizophrenia to faulty learning and conditioning, considering it a developmental problem, the consequence of severe family pathology with projective use of the child by parents who communicate conflictual “double-bind" themes. A behavioral approach, consequently, might be in order. Then there are those who prefer an intrapsychic explanation, seeing it as a thinking disorder that provokes “primary- process,” primitive, irrational, wishful ideation, with excessive condensation, displacement, and the distorted use of symbols. The result is an interference with proper emotional modulation. This viewpoint sometimes sponsors a psychoanalytic approach. On the interpersonal level certain authorities credit the disease to the mischief of regressive, archaic defenses that encourage detachment, distrust, and extraordinary dependency. Family therapy, group therapy, and psychoanalytically oriented therapy would fit in here. Social forces are considered by some to be the prime culprits, inspiring the patient to assume anomalous social roles terminating in alienation and deviations in task performance. Millieu therapy, casework, counseling, social therapy, and rehabilitative

therapy could be utilized with these factors in mind. Finally, there are professionals who prefer a more esoteric spiritual explanation, viewing schizophrenia as a unique and singular mode of perceiving and experiencing reality. Existential therapy and a crop of philosophical approaches, many deriving their substance from Eastern systems of thought, have their advocates who seek to influence this elusive dimension. Different approaches to treatment thus accord with multiple ways of regarding the disease. Actually, schizophrenia embraces all of the bodily systems, and no one etiological factor can be considered exclusively dominant. And any of the many modalities singly or in combination may in some cases register a beneficial effect.

TABLE 11-1. The Biological and Behavioral Links of Behavior*

THE BEHAVIOR CHAIN	FIELDS	RELATED THERAPEUTIC MODALITIES	SYNDROMES
Biochemical links	Biochemistry	Pharmacotherapy	Schizophrenia (neuroleptics) Mania (lithium) Major depressions (antidepressants) Anxiety states (anxiolytics) Hyperkinetic syndromes of childhood
Neurophysiological links	Neurophysiology	Biofeedback Somatic therapy Relaxation therapy (meditation, relaxing hypnosis) Emotive release	Tension states (relaxation, biofeedback, emotive release) Suicidal depressions (ECT) Physical conditions arising from mental factors (biofeedback)
Developmental-conditioning links	Developmental theory Learning theory	Behavior therapy Cognitive therapy Persuasion Suggestive hypnosis	Phobic reactions (behavior therapy) Habit disorders (hypnosis) Behavior disorders (behavior therapy) Obsessive-compulsive disorders (behavior therapy, persuasion, cognitive therapy) Adjustment reactions Developmental delays
Intrapsychic links	Psychoanalysis Cognitive theory	Psychoanalysis Hypnoanalysis Existential analysis Guided imagery	Personality disorders Neurotic disorders
Interpersonal links	Dynamic theory Role theory Group dynamics Social psychology	Psychoanalytically oriented therapy Group therapy Marital therapy Family therapy Psychodrama Experiential therapy Transactional analysis Cognitive learning	Personality disorders Neurotic Disorders Marital problems Family problems Borderline personality Drug abuse and dependence

Social links	Sociology Anthropology Economics Political science	Milieu therapy Social casework Counseling Social therapy Recreational therapy	Situational problems Psychoses in remission
Spiritual links	Theology Philosophy Metapsychiatry	Religious therapy Eastern philosophical systems Existential therapy	Reactive depression Anxiety states Addictions

- Behavior is a complex entity composed of a chain of interrelated biochemical, neurophysiological, developmental-conditioning, intrapsychic, interpersonal, social, and spiritual links Difficulties in one link will by feedback influence all other links in the chain. Distinctive fields of interest and special theories related to each link inspire a number of therapeutic modalities that are preferred approaches in certain syndromes even though through feedback interventions bracketed to other links may also be effective.

By the same token, practically every neurotic or behavioral disorder may be causally associated with multiple links in the behavioral chain. They too may be approached with a variety of techniques that correspond to different links. This is the rationale of eclecticism, which in short-term therapy is a preferred mode of operation.

The fact that we have so many different approaches to the same emotional problem can in itself be confusing. Because there is so little time available in brief therapy, we will want to select the one method or combination of methods that is most applicable to the specific difficulty. In this respect we can console ourselves in a minor way. No matter what technique we employ, if we are skilled in its use, have faith in its validity, and communicate this faith to the patient, and if the patient accepts the technique and absorbs our faith, it will influence him in some positive way. In resolving a difficulty related to one disturbed link in his behavioral chain, this will influence by feedback other links. Thus, if we prescribe neuroleptics for a schizophrenic with a disturbing thinking disorder, the impact on his biochemistry will register itself positively in varying degrees on his neurophysiology, his general behavior, his intrapsychic mechanisms, his interpersonal relations, his social attitudes, and perhaps even his philosophical outlook. Applying behavior therapy to a phobic will in its correction influence other aspects from the biochemical factors to spiritual essences. Working with modalities that are directed at the intrapsychic structure in a personality disorder through psychoanalysis or cognitive therapy, we may find that all other links in the behavioral chain are affected in a gratifying way. This global response, however, does not in the least absolve us from trying to select the best method within our range of skills that is most attuned to the patient's unique learning aptitudes.

Be this as it may, there are some general principles that are applicable to most patients. First, we start therapy by allowing the patient to unburden himself verbally, to tell his story uninterruptedly, interpolating comments to indicate our understanding and empathy and to keep him focused on important content. Second, we help him arrive at some preliminary understandings of what his difficulty is all about. Third, we select a method that is targeted on that link that is creating greatest difficulty for that patient—biochemical, behavioral, intrapsychic, interpersonal, or social. Fourth, we try to show him how he himself is not an innocent bystander and that he, in a major or minor way, is involved in bringing his troubles on himself. Fifth, we deal with any resistances that he develops that block (a) an understanding of his problem, (b) his productive use of the techniques we employ, and (c) the application of his treatment toward behavioral correction. Sixth, we try to acquaint him with some of the personality distortions that he carries around with him that can create trouble for him in the future—how they developed, how they operate now, and how they may show up after he leaves therapy. And, seventh we give him some homework that is aimed at strengthening himself so that he may minimize or prevent problems from occurring later on. Within this broad framework there are, of course, wide differences on how therapists with varying theoretical orientations will operate. By and large, however, psychotherapists with adequate training should anticipate satisfactory results with the great majority of their patients.

Employing whatever techniques or group of techniques are indicated by the needs of the patient and that are within the scope of one's training and experience, the therapist may be able to achieve the goals agreed on in a rapid and effective way. Where the therapist has become aware of the underlying dynamics, it may be necessary to mention at least some salient aspects and to enjoin the patient to work on these by himself after therapy has ended. On the other hand, the therapist may not be able to achieve desired goals unless interfering dynamic influences that function as resistance are dealt with during the treatment period because the patient is blocked by the resistance against making progress.

In long-term therapy a dynamic theme that explains the patient's personality operations and resistances gradually reveals itself through a leisurely study of the patient's verbalizations, behavioral proclivities, dreams, fantasies, and transference projections. No such casual indulgence is possible in short-term treatment. Piecing together data from the patient's history, general demeanor, interpersonal exploits, associations, and the few fantasies and dreams that are available, and correlating these with

reactions to therapy and to the therapist, as well as to any brief psychological tests that may have been given (e.g., man-woman drawings and exposure to Rorschach cards), the therapist will be able to make some assumptions about the patient's dynamics. These will be a guide in confrontations and interpretive work.

As has been amply illustrated in the past chapters, a number of dynamic themes, present in the great majority of people in our culture, have been repeatedly observed that can guide in bringing some basic problems to light during therapy, recognizing that many configurations exist that are unique for each inpidual. Among familiar themes that have been described are those related to incomplete separation-inpiduation, residual guilt feelings and needs for self-punishment, and devalued self-esteem. It is rare that one sees any patient in therapy who does not possess an abundant share of these leitmotifs, although the ways that they manifest themselves in the character structure and the kinds of symptoms they sponsor are distinctively idiosyncratic.

Working with the operative dynamics constitutes a valuable means of helping a patient to face and, if motivation is present, to alter his repetitive self-defeating behavior. Pointed interpretations of the dynamics underlying ego-syntonic symptoms, traits, and behavior only too frequently result in denial and anxiety, for maladaptive as they are, neurotic conflicts and needs are welded into the patient's habitual coping modes and yield florid gratifications compared to which the pleasures of healthy patterns pale. What is the best way of dealing with such obstructions? A pithy epigram in the Koran contends that "God is with those who persevere." This certainly applies to the undaunted therapist who in the face of obstinate resistance doggedly works against it. In long-term therapy the task of dealing with resistances to a recognition of one's dynamics and managing stubborn oppositional reactions to the relinquishing of destructive behavior consume a bulk of the time devoted to therapy and can tax the endurance of the most resolute therapist. In short-term therapy the task would seem to be doubly complicated since there is only limited time to prosecute the search for conflictual themes and to resolve resistance to their disclosure and rectification. Understandably, one cannot duplicate in 10 sessions what could be achieved with skillfully conducted therapy in 100. Yet, experience bears out the value of bringing to the patient's attention a glimpse of his operative dynamics and demonstrating to him his responsibility in bringing about the disasters that he has hitherto credited to destiny and misfortune.

Confrontation

One technique that has been advocated by some short-term therapists to cut through resistance to understanding one's dynamics is that of confrontation. This is sometimes utilized to get at underlying trends by provoking anxiety or negative feelings. Usually the patient will respond to the therapist's challenges of his behavior with anger that may be promptly suppressed. What will appear instead are disavowal, protest, self-justification, and self-abasement, laying the blame for one's behavior on malevolent circumstances or the dereliction of others. Negative transference rapidly precipitates out. Opportunities are thus rich for interpretation of feelings about and reactions to the therapist. This technique is dramatic and often effective in patients with good ego strength. However, it can drastically hurt the therapeutic relationship in a good number of patients if implemented too early in therapy before proper rapport has been established. The patient is apt to regard the therapist's actions and manner as arbitrary, unjustifiable, recriminatory, malicious, and reflective of the therapist's inability to understand him or to empathize with his suffering and situation. It takes a great deal of skill to select those who are suited for confrontation and to titrate the degree of forcefulness of challenges to the patient's existing strengths. Experienced therapists are capable of doing this even in the first interview with some patients, but the average therapist will be compensated for his efforts with an extraordinary number of dropouts from treatment. In most patients who come for help a minimally provocative posture will be indicated at first; the therapist should work toward the establishing of a good working relationship before battering away at the patient's defenses through strong confrontations.

Selection of fruitful areas for confrontation when it is done is important. Since most patients possess an overly primitive and severe conscience (superego) that provokes guilt, feelings of wickedness, and masochistic behavior, these pathological zones provide a productive area for attack and discussion. Some therapists employ a technique that interprets the symptoms of the patient, no matter what they may be (for example, anxiety, depression, worry, outbursts of anger, conversion reactions, compulsions, phobias, insomnia, anorexia, etc.), as manifestations of self-punishment, the consequences of a guilty conscience (Lewin, 1970). Each symptom is delineated as serving both self-tormenting needs and provocative aims toward others. Even an inpidual's disturbed character patterns are reduced to the masochistic need to suffer and "drive people away so that he can torment himself with loneliness." The patient is helped "to see what he wants to do and what his conscience forces him to do" and how the disparity creates

difficulties. The contrast between a healthy conscience that guides while inhibiting destructive actions and the patient's existing sadistic conscience that viciously torments and punishes is pointed out. It becomes essential for the patient to recognize that an intemperate and merciless conscience is the "common enemy against which the therapist is his ego's strong ally." No immediate interpretations are made of specific conflicts. "The initial confrontations are confined to the patient's need for self-punishment and his masochistic responses to anger."

This focalization, it seems to me, is used as an expedient to provide the patient with a single insight into which he can converge his energies. Since masochism is a common defense, the therapist may not be too far off if its existence is pointed out—that is, of course, if the patient presents even slight evidences of its operation. Obviously, masochism is not the only basis for symptoms, and the therapist should not be sidetracked by using the explanation of masochism as a strategy for breaking up the patient's resistance. The therapist will usually discover, if a search is made for them, additional reasons for some of the patient's symptoms.

Other explanations than masochism may be offered by therapists trained in specific schools of psychology or psychiatry. One universal basic cause is presented for all types of emotional illness, and this single etiological factor is tortured to fit in with every symptom and behavioral manifestation. Thus, the patient may be dazzled by brilliant explanations of the malfunctions of pregenital splitting, or of the Oedipus complex, or of the devalued self- image, or of subversive archetypes, or of conditioned anxiety, or of any of the countless theories around which current psychologically ideologies are organized. While such single explanations may not be accurate, they certainly are convenient and they may be temporarily effective, especially when dogmatically stated. One of the advantages of dogma is that it makes critical thinking unnecessary. And some patients are only too eager to hand over their minds to the therapist who will do their thinking for them—that is, until the treatment ends, after which the patient will begin to reconstitute his own frame of reference and enthusiastically recreate the conditions that got him into trouble in the first place.

This does not mean that we should throw the baby out with the bath. Some of the theories and explanations may be helpful more than temporarily when applied to certain kinds of symptoms and personality problems. Accident proneness, obsessional self-torment, suicidal tendencies, and

hypochondriacal preoccupations, for example, may be indications of a generalized masochism. An explanation such as the following may be offered: "You feel angry at what your parents did to you as a child. But you also feel guilty for your anger and thoughts. So you punish yourself for these thoughts and feelings. Your symptoms and your behavior seem to me to be the results of your punishing yourself. Now what are you going to do about what you are doing to yourself?" More direct suggestions may be: "Whenever you torture yourself with upsetting thoughts, or you get depressed, or you have symptoms (enumerate these) ask yourself, 'Why am I punishing myself?' Tell yourself, 'I've punished myself enough so just stop it!'" Should these explanations and injunctions fail to produce results, some therapists resort to stronger challenges and confrontations.

While aggressive confrontation under these circumstances may prove profitable in some patients with good ego strength, it may not be applicable to sicker patients unless the confrontations are toned down to a point where they are executed in an empathic reassuring way. Even then it may be necessary to wait until a good working relationship has been established, and then only after it becomes apparent that masochistic maneuvers are obviously being employed by the patient in the interests of resistance —"You seem to be punishing yourself by refusing to get well."

The phrasing of questions can be crucially important in helping a patient explore and come to grips with determining problems. For example, the patient states, "I wish I had a father who was like you." The therapist may reply variantly along the following lines: (1) "And I would like to have a daughter (son) like you." (2) "In what way did your own father disappoint you?" (3) "You must be very angry at your father." (4) "Reaching out for another father figure isn't going to help you much. You've got to learn to stand on your own feet." (5) "Your saying that is a manifestation of your continuing dependency." (6) "What is there about me that makes you say that?" (7) "You don't know me well enough to be sure of wanting me as a father." (8) What do you think would have happened to you if I had been your father?" Each of these responses will elicit certain important reactions in the patient and will influence the relationship.

Interpretive Activities

As therapy moves on during the first sessions, the patient's responses to interpretation will become

apparent. If there is rejection of interpretations, lack of tension after a challenging interpretation is made, or bizarre responses, paranoid tendencies, or acting-out without insight occur following interpretations, the patient is probably not amenable to dynamic short-term therapy. In most cases, however, it will be possible to make interpretations and to help the patient acquire an understanding of problems and defenses.

The interpretation of resistance is indicated from the very start of its appearance, particularly where it takes the form of interfering with the working relationship. Should a negative transference appear either in dreams or in the patient's behavior, the therapist must immediately deal with it in as expedient a way as possible.

For example, the response of a patient after the second hypnotic session during which a relaxing cassette tape was made for her was irritation and anger at listening to the tape. Upon urging her to tell me her reactions to the tape, she stated the following.

> Pt. When I tried listening to the tape, I found my mind wandering. When you say, "You are tired and drowsy," tired and drowsy are antonyms. Tired means not relaxed. When you say, "Even your leg muscles are relaxed," why "even"? When you say "the four S's (symptom relief, situational control, self-esteem, self-suggestions)" I say the four asses. I resented you. I want to apologize for my feelings. I am surprised at myself for liking you. When you said last time you might prescribe a drug for my depression, emotionally I felt you wanted to kill me, to immobilize me with medicine. In the tape you say, "You are filled with negative thoughts that we must neutralize," what thoughts? At the end you say "You will relax or fall asleep." They are incompatible. I said to myself about you, "He is so goddamn impermeable, unreachable." I felt this way also about my mother and father. You say, "You will imagine a beautiful relaxed scene." I can't figure out if I should just see something or be in it personally—sitting, lying, or sleeping. The scene I settled on was the bank of a river with a boat—sunlight on the river reflected it on the water. Yesterday I populated the water with a swim. Also I thought this was all nonsense. I tried to open my eyes, but my lids were so heavy they wouldn't open. You say, "Even if you are conscious, the suggestions will be effective." I am conscious. The whole thing gives me a fear of emptiness. This is what I felt with my parents. I have guilt in relation to my parents. With my mother, I rejected her much of my life. I think I identified with my father. I took on his symptoms.

Her reaction provided the basis for our discussion of her transference to me and the possibility that she would reject the tape and its contents, even refusing to listen to it.

I felt I had a sufficiently good relationship to offer an immediate and repeated interpretation of resistance and negative transference. This did help consolidate the working relationship. The patient continued listening to the tape, and she derived a good deal of benefit from it.

Unless the patient is highly motivated and the therapist has been able to establish an early firm working relationship, provoking anxiety too soon by focusing on and interpreting defenses will tend to drive the patient out of therapy. Interpretations should be balanced against the state of the patient's willingness to explore problems and the quality of the patient-therapist relationship. Constant examination and use of the transference to point out habitual patterns of the patient and the origin in past relationships may be helpful. Unlike formal analysis, transference neurosis should be avoided, and deepest character problems remain unexplored since to manage them would require more time than is available in the short span devoted to treatment.

To interpret unconscious or partially conscious impulses prematurely is worse than useless. There are therapists who pining the conflicts of a patient at the first interview bombard him with interpretations that are presumed to put the patient expeditiously on the road to cure. Actually, an astute dynamically oriented interviewer may be able to induce a patient to disgorge a good deal of material related to early drives, including sexual and aggressive impulses and fantasies, to show the patient how these are affiliated with present drives and symptoms, and to demonstrate some transference manifestations that reflect a carryover of childish distortions into one's contemporary relationships. These disclosures, dramatic as they seem and perhaps are, have an effect in the great majority of cases that is diametrically opposite to that which is hoped for. The interpretations fall on deaf ears.

Not long ago I attended a conference on short-term therapy where, to my astonishment, some trained analysts in talking about what they did were naively practicing what Freud himself condemned in his 1910 paper on "Wild Psychoanalysis" (Standard Edition, Vol. 2, pp. 225-226) by confronting the patient with aspects of his unconscious during the first interview. If knowledge about the unconscious, wrote Freud, "were as important for the patient as people inexperienced in psychoanalysis imagine, listening to lectures or reading books would be enough to cure him. Such measures, however, have as much influence on the symptoms of nervous illness as a distribution of menu-cards in a time of famine has upon hunger." Many years ago in my pristine enthusiasm with deep hypnosis, I attempted to uncover in the trance some of the fundamental core conflicts of patients, enjoining them to remember the revelations that they themselves with great emotion pulged, only to discover that the effect on the patient's behavior was barren and bleak. I learned that a much better tactic was to safeguard the information for my own private enlightenment and not waste time convincing patients of my brilliance as

a psychological detective. Once I had established a good working relationship with my patients (and it required more than one session), I could providently guide them with proper interviewing techniques toward coming upon the essential connections of their present topical behavior with fundamental intrapsychic determinants. They would then tell me what I had previously hoped I could smuggle into their minds in a flash. Essentially, I was doing what Freud in 1913 had recommended in his paper "On the Beginning of Treatment" (Standard Edition, Vol. 12, pp. 139-142), that is, to wait until the patient evinced some preconscious awareness of his conflicts.

There are, of course, ways a skillful and experienced therapist can in a roundabout, carefully phrased, and empathic way allude to the essential dynamics by projective techniques such as those described by Arlene Wolberg (1973) in her book *The Borderline Patient*. In this manner one may avoid an escalation of the patient's anxiety or a hardening of resistance, which so often in premature interpretations takes the form of animosity toward the therapist and abrupt termination of treatment. For example, a young woman of 28 came to therapy because of anxiety attacks and a dull paralyzing depression. One of her chief concerns was her 2-year-old child whom she feared she was neglecting so much that he would not survive. The disasters she envisioned ranged from accidental lethal poisoning to a fatal accident. A repetitive nightmare related to her child falling out of a window in spite of her efforts to save him. Her symptoms started shortly after the birth of her child and caused her to give up an excellent position in a firm for which she had worked since graduating from college. It does not require a great deal of imagination to construct a hypothesis of what was going on dynamically. A reckless therapist might reveal to the patient that part of her would like to see her child dead so that she can be liberated back to an independent life and that she undoubtedly resents her role as a woman, which resentment started in her early tomboy days and accounts for her present sexual frigidity. This intriguing explanation, however true it may be, would in all probability set off spasms of renewed anxiety and increase the patient's despair and hopelessness. On the other hand, should the therapist be assured that a therapeutic alliance has been started, he might instead employ a projective technique interpreting somewhat as follows:

> Th. I can understand how upset you must be. Women do take a kind of a beating in our society. There are quite a number of intelligent educated women who when they get married resent giving up their careers. After all, there is little stimulating in washing dishes and pushing a mop. Some of these women fantasy an escape from this trap (smiling at this point as if joking) by imagining that their husbands will in one way or another drop dead, thus freeing them again. But they really don't want their husbands dead. They love their husbands. But this is the

way the human brain works: it operates by peculiar symbols and fantasies that do not mean they will literally be carried out.

What the therapist is doing is employing an example roughly and tangentially related to the patient's problem, but using another person as the target. If she is ready to identify with the example, the patient will begin working on it as it applies to her and her relationship with her own husband and her child. If not, she will pass it by as irrelevant. In the former instance, when the patient opens up, the therapist may gradually be more and more direct in his interpretations, titrating these to the patient's level of tolerance of anxiety while being sure to preserve the working relationship. In the latter instance, that is, where the patient avoids the interpretation, the therapist will drop the subject and wait for a more strategic moment when the patient shows greater awareness before engaging in challenging interpretive work again. In the case of the young woman just cited, my interpretation was completely ignored, but two sessions later she brought up fantasies about the death of her husband, and we were able to discuss her feelings and to make good progress from that point on.

In presenting interpretations the therapist should search for areas where explanations will be most productive and where the most resistances to getting well reside. Among these are nuclear conflicts, derivative conflicts, negative transference; and sundry other resistances.

Nuclear conflicts frequently persist throughout the life of the person and are responsible for symptoms and behavioral difficulties. Example: A patient whose mother died during his infancy and who was raised by a succession of relatives has since childhood been in constant search for a loving, giving, maternal figure. He minimizes relationships with women who are accepting but seeks out liaisons with unstable, rejecting females with whom he acts out the theme of entering a perfect idealized union, only to experience rejection, humiliation, feelings of abandonment, and separation anxiety. A current crisis caused by discovery of infidelity on the part of the young woman with whom he has had a relationship for a year has brought him to therapy. Recognizing the depth of the problem and the impossibility of altering the dependency need in a brief therapeutic effort, the therapist focuses on alleviating the separation anxiety with ego supports. He brings the patient to an awareness of the origins and the destructive behavioral residues of his symbiotic needs and through cognitive approaches helps him to fight off the urge for future entanglements with rejecting women.

Derivative conflicts are closer to awareness than nuclear conflicts, and the patient has better control over them. Example: A patient who has been unable to achieve passing grades at college sees herself as a "loser." Her history reveals a series of failures in achievement and in interpersonal relationships. It becomes apparent that there is operative a fear of success which is equated with being aggressive and destructive toward others. The therapist predicts that this fear of success may sponsor a failure in therapy. Without probing the origins of her aversion toward aggression, the therapist focuses on the various manifestations of the need to fail and through desensitization and other behavioral techniques helps the patient to master anxieties related to a coming school examination. Utilizing the patient's successful passing as a fulcrum, the therapist helps the patient evolve ways of coping with future challenges.

Negative transference will block any productive therapeutic effort. This focus is perhaps the most important of all areas. When manifestations of negative transference appear, its resolution becomes a primary task. Example: A patient after the second session becomes highly defensive and argumentative challenging almost every interpretation the therapist makes. It is apparent that he wishes to avoid establishing a working relationship with the therapist. The therapist, recognizing that the patient is unresponsive and obstructive, confronts the patient with his behavior. A section of the interview follows:

Th. I notice that you constantly disagree with what I say.

Pt. No, should I take for granted everything, like gospel?

Th. It's interesting that you say gospel. Your father, you told me, is a minister.

Pt. Are you trying to tell me that I'm acting as if you are my father?

Th. Are you?

Pt. (long pause) I don't think so, but (*pause*) maybe you're right. I was an atheist ever since I was 6 years old.

Th. You mean fighting the gospel?

Pt. (*laughs*) What you are trying to do here is hardly religion.

Th. But you may be acting with me as if I'm a high priest.

Pt. (*laughing*) You're trying to tell me I'm misbehaving.

Th. This is how you must feel. I certainly don't believe you're misbehaving. You have a right to your own thoughts. What we're trying to do is to find out how you can get along better with people. Any maybe if you can work out a better relationship with me it will help you get along better with others. That doesn't mean I'm always right in what I say. But I think I can be more objective about what you do than you can. And if I point out things that seem like criticism, I'm not trying to be mean or arbitrary. Let's talk it out. It's important for you to decide if I'm right or wrong.

Pt. Doctor, I hope you can be tolerant with me. I know you are right in what you are saying. I'll try.

Th. This doesn't mean you have to take for granted everything I say. After all, I'm not a high priest.

Various other resistances interfere with progress in therapy. It may even be helpful to anticipate resistances if the historical data and initial workup point out areas of impending trouble. Example: An accident-prone patient with an obsessive-compulsive personality seeks therapy for anxiety and depression. From early childhood on he has been fearful of harboring a dreadful disease, the present form of which is cancer. At the fifth session when it becomes apparent that reassurance has failed to allay his fear of succumbing to a cancerous process of the brain akin to that of a colleague in his profession, the therapist confronts him with his masochistic need.

Th. I realize that, as you have told me, doctors make mistakes. But I get the impression that in your case, with so many medical and neurological checks, there is little chance you have cancer of the brain. More important than this is why you have to torture yourself with this idea or with other fears. Like all the other cancers you thought you would develop in the past and didn't.

Pt. Doctor, I tell you, I get so upset. I can't eat or rest. I get up in the middle of the night with a cold sweat.

Th. (firmly) Now listen to me. You are giving yourself a hard time. Now why in the devil do you have to wear a hair shirt all the time. One torturous idea after another. You've always had it. I really feel you've always had it. I really feel you've got a stake in punishing yourself. All the guilt feelings you have about your parents. You must feel that you are a terrible person for feeling the way you do.

Pt. I can't get the thoughts out of my mind about what will happen to me when they die.

Th. Like what?

Pt. (*pause*) I don't know. I'm afraid I can't get along without them. And yet I have these awful thoughts that something terrible will happen to them. [*Obviously the patient is caught in a conflict of dependently needing his parents, feeling trapped, resenting his helpless dependency, fearing that his anger will somehow bring about their death and turning this resentment back on himself. His guilt feeling enjoins him to punish and torture himself. This will probably prevent him from benefit- ting from therapy. To try to take away his masochistic need for self-punishment without dealing with the basis for his guilt would prove either futile or would only be temporarily successful.*]

Th. Now look. You have this need to punish yourself and all the torture you're putting yourself through, and all your

> symptoms and the messes you get into, accidents and all, are, I feel, directly related to this need for self-punishment. The reason I bring this up is that as long as you have this need, you will block yourself from getting well in our treatment. What we are going to do is plan how you can break this vicious cycle.

A treatment plan then was evolved to help him break his dependency ties by getting him to take vacations away from home and then to find an apartment for himself away from his family. Having been enjoined to vent his anger, the patient became increasingly able to tolerate his hostility and to accept his parents for what they were. With support he was able to resist their insinuations that he was a disloyal son for leaving them and for living his own life. A dramatic change occurred in his symptoms, and a 2-year follow-up showed continued improvement and maturation.

Separation anxiety will emerge as the end of therapy approaches. Example: A patient who was making progress up to the seventh session began to experience a return of symptoms. His dreams revealed fears of abandonment, feelings of helplessness, and resentment toward the therapist. A frank discussion of how natural it was to experience fear of being unable to function on his own as therapy threatened to end, and how important in his growth process it was to tackle his fears and master them, brought out early anxieties about going to school, leaving home for college, and breaking up with former girlfriends. Putting his present reaction into the perspective of a pattern that was not so terribly abnormal enabled him to terminate at the set date with feelings that he had the strength to carry on by himself.

Special Applications of Technique

Short-term therapy embraces a heterogeneous group of interventions catalyzed by the therapist's enthusiasm, the patient's faith, and shared hope. While it is true that techniques serve to release important healing agencies, the choice of interventions and the skill with which they are implemented are crucial to success. It is to be expected that modifications in traditional psychotherapeutic techniques will be introduced by certain therapists who fashion their theories around methods that seem to work for them personally. This is all to the good, of course, except where the therapist attempts to incorporate all of psychopathology within his cherished theory and to insist that only his methods are valuable. We may forgive these narcissistic maneuvers should the methods presented have sufficient value to justify experimenting with them to see if they fit in with our unique ideologies and working styles. And we may

be able to modify and shape some of them to our personal advantage. But, acceptance of the theoretical premises for these innovative procedures will require thorough experimental validation.

Sokol (1973), for example, has devised a short-term method for handling "simple" or "endogenous" depressions based on some principles of psychoanalytic theory. The hypothetical assumptions around which the treatment process is oriented contend that several factors must operate to produce a clinical depressive reaction. First, there must be a current loss of some kind, such as the death or removal of a person close to one. This acts as a spark, igniting the explosive mixture of an earlier loss in the child-parent relationship. Second, a primitive, punitive conscience (superego) must exist that will not permit the release of conflictual emotions, particularly hostility. Since hostility cannot be handled by the simple mechanism of repression, more primitive ego mechanisms are utilized, such as denial, introjection, and incorporation. Usually other emotions cannot also be tolerated, and both negative and positive feelings are blotted out. Third, "this leads to further shame and guilt and begins a regressive spiral." If we concede the validity of this hypothesis in order to cure a depression, hostility toward the lost object must be recognized, tolerated, and released. Since the patient cannot do this for himself, the therapist must do it for him. "I reasoned," said Sokol, "that, if the attack came from me, the pressure on the patient's superego would be diminished and the affectionate impulses could be expressed in defending the lost person from this external attacker." Using this tactic brought about a remission in the cases described by Sokol.

Lest one get too enthusiastic about Sokol's method, even though the dynamics may sound plausible, one must remember that only three cases were cited in this study. Moreover, in each case both antidepressants and tranquilizers were coordinately used. Other innovations claiming good results with depression exist and employ different techniques oriented around completely dissimilar theories, for instance, the cognitive therapeutic methods of A. T. Beck (1971, 1976).

In cognitive therapy an attempt is made to rectify conceptual distortions in order to correct the ways that reality is being experienced. Interviewing techniques analyze defects in a patient's views of the world (cognitive assumptions or "schema"), his methods of stimuli screening and differentiation, and the erroneous ideas that mediate destructive response patterns. Homework assignments reinforce the patient's ability to deal constructively and confidently with adaptive tasks. The treatment is short term,

consisting of approximately 20 sessions on a twice-a-week basis. Cognitive therapy for depression is organized around a number of assumptions (Rush & Beck, 1978; Rush et al, 1977). As a consequence of early events, the patient retains a "schema" that makes him vulnerable to depression. Among such events is the death of a parent or other important person. What results is a "pre-depressive cognitive organization." Operative here is a global negative attitude on the part of the patient. Thus he misconstrues situations to a point where "he has tailored facts to fit preconceived negative conclusions" (Rush, 1978).

The patient regards himself as unworthy and assumes this is because he lacks essential attributes to merit worthiness. He assumes his difficulties will continue indefinitely in the future, that failure is his destiny. These characteristics constitute the "cognitive triad" in depression. In treatment the patient is enjoined to keep a record of aspects of his negative thinking whenever this occurs and to connect these episodes with any associated environmental events that trigger them off. The simple quantifying of any symptoms—in this instance negative thinking—tends to reduce them. The therapist, whenever the patient during a session brings up a negative thought, asks the patient to reality test it and then, away from therapy, to do this by himself. Through this means the patient is helped to see how he makes unjustified assumptions ("arbitrary inferences"), how he magnifies the significance of selected events ("magnification,") and how he uses insignificant situations to justify his point of view ("overgeneralization"). Other "cognitive errors" are identified, such as how offensive details are used out of context while ignoring more important constructive facts ("selective abstraction"), how circumstances and thoughts that do not fit in with negative "schemas" are bypassed ("minimization"); how unrelated events are unjustifiably appropriated to substantiate his ideas ("personalization"). The patient is encouraged to review his record of thoughts, to identify themes and assumptions, and to identify past events that support his faulty schemas. Point by point the therapist offers alternative interpretations of these past events. By so doing he hopes that sufficient doubt will develop in the patient so that he will engage in experimental behaviors, recognizing the fallaciousness of his hypotheses, and arrive at different, less destructive explanations for events. A marital partner or family may also be involved in cognitive therapy to reinforce correction of distorted negative meanings.

Step by step the patient is encouraged to undertake tasks that he hitherto had considered difficult ("graded task assignment") and to keep a record of his activities ("activity scheduling") and the degree of

satisfaction and sense of mastery achieved ("recording a mood graph"). Discussions in therapy focus on the patient's reactions to his tasks and his tendencies at minimization of pleasure and success. Homework assignments are crucial. These range from behaviorally oriented tasks in severe depression to more abstract tasks in less severe cases oriented around correcting existing schemas. Should negative transference occur, it is handled in the manner of a biased cognition.

Employing a cognitive model of personality, Morrison and Cometa (1977) have evolved what they call "emotive-reconstructive" short-term therapy (ERT). The theory behind the technique is that unfortunate early childhood stress experiences lead to a "person's inadequate construction of self and others." This produces a playing of faulty roles and self-conceptualizations in later life. Thus some children, not being able to endure their parents as nonloving, distort reality by construing them as loving and themselves as bad. "Essentially locked into the role of bad child as a means of reducing the stress and confusion of paradoxical family communications, inpiduals' subsequent life experiences are but replays of early roles." What must occur to overcome this distortion then is a discovery of key conflicts and a correction of their interpretation. Instead of trying to force this by inappropriate search strategies, as is the case in traditional psychotherapy, a technique of direct experiencing is used by Morrison and Cometa. Patients are asked to shut their eyes and "to immerse themselves in past events by focusing on the contextual surroundings (colors, odors, noises, texture) of early experiences" describing these briefly. Periodically, when the therapist wishes to arouse the expression of a certain feeling, the patient is asked to hyperventilate "by breathing deeply and rapidly for 30- to 60- second time periods." Gestalt and role-playing techniques may coordinately be employed. Support is given and empathy shown when necessary to comfort the patient. Approximately 15 sessions often lead, it is reported, "to a reconstruing of self and significant others, which in turn facilitates the adoption of more productive life roles" toward rapid personality and behavior change. The similarity of many aspects of this ERT technique with Freud's early cathartic method will be recognized.

Another example of the use of a theoretical principle to fashion a clinical approach is provided by Suess (1972). He points out that dynamic short-term therapy is obstructed in the obsessive-compulsive inpidual by rigid tendencies to avoid feelings of excessive intellectualization, self-control, and attachment as well as by great fears of surrendering oneself to hurt and exploitation in any interpersonal relationship. An important objective in interviewing these patients, therefore, is to help them recognize

their feelings by working on those that are aroused in the current interview situation. These, manifested in "verbalizations, voice tone, facial expression, body movement and other nonverbal cues," are dealt with by such phrases as "You sound angry," "You look angry," "You look disgusted," "You appear uncomfortable inside." Present meanings are more important than referral to past history and genetic origins. Whenever the patient attempts a persion by theoretical, philosophical, or intellectual discussion, it is arrested and the focus redirected at feelings, such as being angry, guilty, affectional, depressed, and so on. The defensive nature of silences on the part of the patient should also be interpreted, for example, the incessant and paralyzing need to maintain control. Self-criticism powered by an excessively punitive superego is tempered by suggesting the possibility of less critical attitudes. Focusing on the emotions behind verbalizations rather than the content is important, especially when the patient keeps talking about his symptoms. Intellectualizations and doubts utilized as a way of guarding against recognition of feelings in one's present life may seduce the therapist into engaging in fruitless debates, thus falling into the patient's trap of avoiding feelings. The proper response to these maneuvers, claims Suess, is to expose them as resistances.

Some innovative attempts at prophylaxis of emotional illness have been made. Among these is the work of Stein et al (1969) on brief therapy with seriously physically ill patients. The development of an illness, particularly of an incurable and debilitating nature, imposes a severe strain on any inpidual. Where the patient is unable to accept the imposition of a temporary or permanent handicap, where his security is threatened and his self-image damaged by the realization of his vulnerability, pathological psychological reactions (particularly anxiety, depression, tendencies toward denial, anger, and a variety of neurotic and occasionally, in those with fragile ego strength, psychotic manifestations) will impose themselves. Because the patient may as a consequence become a psychiatric casualty, psychotherapeutic interventions instituted as soon as possible are urgent.

At the Central Psychiatric Clinic in Cincinnati an early-access brief treatment subpision (Stein et al. 1969) accepts patients who preferably have severe physical problems of recent origin. Up to six sessions are given, each lasting from 15 to 50 minutes, spaced on the average of one visit each week. In the majority of these patients symptomatic improvement and restoration of satisfactory functioning has followed this brief treatment (Gottschalk et al., 1967). The treatment process is best organized by (1) handling the tendencies to denial, (2) managing a shattering of the sense of mastery, and (3) dealing

with the conviction of impaired body integrity.

Handling of the tendencies to denial is crucial. Blank unbelief often operates as a primary defense to insulate the patient from the implications of his illness (Lindemann, 1944). Such denial, interfering with the true assessment of the reality situation, constitutes a great danger for the inpidual. In coronary illness, for example, the patient may engage in dangerous overactivity, neglect of his diet, and forgetting to take essential medications. It is, therefore, important to review with the patient his ideas of his illness and his attitudes toward it especially his hopelessness. By careful clarification coupled with reassurance we may be able to correct existing misconceptions and cognitive distortions. The relationship with the therapist can greatly help the patient to accept a factual assessment of his situation. The therapist here serves "in a role similar to the protecting parent who makes painful and threatening reality less intolerable to the child, thus enabling the child to accept and face reality, with its hazards, rather than having to deny and 'shut out' (Stein et al., 1969).

Managing a shattering of the sense of mastery is important, especially in those persons who habitually must maintain control. The fear that an illness can strike without warning and that it may be a harbinger of other unknown and perhaps more serious physical disasters destroys the inpidual's confidence in his own body. Reassurance that anticipated catastrophes are not inevitable and that preventive measures are a best means of helping to avoid unwelcome troubles may quiet the patient's fears. Encouraging the patient to ventilate fantasies associated with the illness, the therapist is then in a better position to offer advice concerning specific medical and neurological consultation resources.

Dealing with the conviction of impaired body integrity involves restoring faith in one's body. This is especially necessary in traumatic injuries and surgical procedures. To some extent a reaction of fatigue and a reaction of depression temporarily follow even relatively minor accidents and operations. But after serious operations, such as breast and limb amputations and effects of mutilating accidents, a prolonged period of upset can be expected. With the advent of open-heart surgery many untoward residual psychological sequelae have been reported. Severe anxiety and psychotic reactions are especially threatened in persons whose adaptive balance is precarious, It does not require intensive probing to recognize how angry a patient is at what has happened to him. Such anger may be displaced or projected onto family members and even on the patient's physician, and this may alienate the patient from

essential sources of support and comfort. Opening up discussions around this dynamic can be most constructive.

Brief Group and Family Therapy

Brief group psychotherapy is an economical way of handling patients who have the motivation and capacity to interrelate in some way in a group. As a diagnostic and intake procedure it has been employed with success in certain clinics (Peck, 1953; Stone et al, 1954), particularly where there are waiting lists and an undesirable delay in assignment to a therapist. Here the group serves as more than a holding operation, some patients benefitting sufficiently from the group contact so that further inpidual treatment is not needed. At the Metropolitan Hospital Center in New York, Sadock and his colleagues (1968) have operated a short-term group therapy service for socially and economically deprived patients as part of a walk-in clinic. At the initial interview the 10 sessions' limit is explained by the social worker with the addendum that should this be insufficient, longer therapy might be arranged. One-hour sessions are held weekly, conducted by a cotherapist team of psychiatrist and social worker. No more than eight patients are in a group with new patients added as vacancies occur. The average number of sessions attended is five. The patient population is heterogeneous educationally, racially, and diagnostically. Where necessary, community agency contact is made for environmental alterations. The group discussions are pointed toward problem solving, each new member, after being introduced, being encouraged to give biographical data and to relate the problem that brought him or her to the clinic. Reactions of other members to the patient's account and suggestions for coping with problems are encouraged, and goals are formulated. Approximately two-thirds of the patients have been rated as improved at the end of their treatment.

A good deal of literature has accumulated on the subject of brief group therapy, and a number of different models having been described in the first chapter of this book. Some reports on the efficacy of short-term groups are especially enthusiastic. Trakas and Lloyd (1971) working with an open-ended group of patients for no more than six sessions reported twice as much improvement as was the case in patients receiving other kinds of help, including long-term group therapy. Waxer (1977) introduced motivated patients from a general hospital psychiatric ward into a group for no more than one month and was also very optimistic about the results. On the other hand, McGee and Meyer (1971) compared

two groups of schizophrenics utilizing various rating materials and found that long-term groups were more effective.

The kinds of patients, their preparation for therapy, and the skill and personality of the group therapist are obviously crucial elements in determining the results in short-term groups. The therapist's attitude toward group therapy and his interest in working with a group are crucial for success.

A few pointers may be helpful. One way of approaching a patient to enter a group is suggested in this excerpt:

> Th. I believe that your type of problem will be helped best in a group setting. We will have about six sessions.
>
> Pt. Will that be enough to cure this condition?
>
> Th. You should get enough out of therapy to have gotten started on the road to getting better. Whether you will be all cured is hard to say. Generally, after so short a time in treatment your symptoms should be improved, and you will have an idea of how you can go about continuing to get well and stay well.

Should the patient show resistance to entering a group, this is handled as in long-term group therapy (see Wolberg, 1977, p. 706).

At the first group session members are introduced by their first names and the confident nature of the meetings emphasized. The obligation to come to all sessions is stressed, patients are told that the number of sessions is so few that the sooner they open up and focus on their problems, the faster they will get better.

> Th. You have an opportunity to talk about things here that you ordinarily keep secret. Just opening up and putting your feelings into words will help. What you want to do about upsetting matters will be your own decision, but you should be able to think more clearly about what to do as a result of your group experience and the help you get from the discussions. When you are ready, you will want to take action and that should set you on the road to getting well.
>
> Pt. But what should I talk about?
>
> Th. The best way to start is to talk about what brought you into therapy, how it began and what has happened up to the present.

Should the patient delve too much into past history, he should be discouraged, as should any too detailed theorizing about his condition. The focus should be on the present, and it is emphasized that no

matter what has happened to a person in the past, one can change if one has the desire for change. As patients begin to talk, their reactions to the group and to the therapist will become manifest. Some patients will try to convert the group into a private session; they are then asked to address their remarks to the group rather than the therapist. The management of the group session as well as special problems that occur is described elsewhere in detail (Wolberg, 1977, pp. 708-719).

Most patients when they enter a group are highly intolerant of criticism, which they anticipate will happen should they reveal themselves. In a well-conducted group the patient becomes capable of distinguishing between destructive, hostile attacks and constructive criticism motivated by a desire to help. Moreover, he begins to realize that some critical comments are really not personal but are projections that are being falsely directed at him. Such exposures help many patients become less critical of themselves, less rigid and defensive, and more accessible to reasonable values. These learnings may generalize outside of the treatment session and influence relationships with others. Less hostile to themselves, they are more lenient with persons with whom they are related. Cooperative and tender impulses emerge.

A number of stratagems may be employed in the group to facilitate activity. One technique is to ask each member of the group to talk about any fears he or she had as an adolescent. Group members often are able to talk more easily about past fears and problems, especially those they have overcome, than present unresolved ones or about situations with an immediate stress potential. Patients can find comfort in listening to how other persons have had to cope with difficulties similar to their own. Once past fears are aerated, present concerns are taken up about some common problem. Should patients be on a hospital ward, they may be questioned as to how each feels about a routine that some have found distasteful. Once the ice is broken and communication is flowing, more personal immediate problems may be approached.

An interesting technique that may be used with patients who are not too sick, in a group that is inactive and bogged down, is asking for a volunteer to leave the room so that the rest of the group can talk about him, airing their impressions of the kind of a person he is. After a short period the patient is invited back into the room and asked to relate how he felt when he was out of the room, what thoughts came to him, and what he believes the group felt and said about him. Then another volunteer patient leaves the

room, and the process is repeated. Later when the group is more integrated, the patients may compare how they originally felt about each other with changes in their perceptions. This technique can stir up a great deal of feeling and anxiety and should be restricted to patients with good ego structures. Inpidual sessions may coordinately be held to handle anxieties.

Role playing and psychodrama may also be utilized in some groups to help a patient act out what he feels about different people important to him as well as to rehearse new patterns and different ways of relating. Videotape recording and feedback may also be employed as a way of giving the patient insight into paradoxical and ambiguous behavior and communications.

Since groups are usually open-ended and patients enter therapy at various levels of psychological sophistication and readiness for change, the therapist will have to display a considerable degree of flexibility in the methods utilized at different times. Particularly difficult is work with actively psychotic patients. The conduct of such a group will call for methods of a special kind, such as those didactically oriented toward an educational goal (Druck, 1978; Klapman, 1950, 1952; Preston, 1954; Standish & Semrad, 1963). Here topics are chosen that deal only tangentially with the patient's affects and conflicts. Thus if patients wish to discuss hallucinations and delusions, a general discourse is given on hallucinations and delusions and not any inpidual's delusions as a personal problem.

In a brief group therapy with the socially and economically deprived there are advantages in having the group composed of peers who can identify with each other's experiences and tribulations. The therapist is often regarded as a representative of bureaucratic authority, and the presence of persons with similar socioeconomic backgrounds is desirable to lend support to the patient and to interpret what is being felt.

Because hospitalization is considered as sponsoring regressive patterns and destroying self-confidence and social relationships, alternatives to psychiatric hospitalization have suggested family group approaches on the basis that the family is actively involved in sponsoring and maintaining pathology in the presenting patient. At the Colorado Psychopathic Hospital a Family Treatment Unit set out to test the hypothesis that family-oriented crisis therapy has advantages over other methods (Pittman et al, 1966). The unit is manned by a team of psychiatrist, psychiatric social worker, and psychiatric

public health nurse and operates 24 hours a day. All cases considered candidates for immediate hospitalization and who live not too far from the hospital are scrutinized for treatment by the Family Treatment Unit. Usually the crisis is brought on by a change in role demanded of one or more family members produced by some shift in the family situation.

At the unit, work is done with the family to bring the members to a realization that the designated patient is not the only cause of the crisis and that a solution will not appear with his removal to a hospital. Rather, the entire family is involved and, therefore, responsible for bringing about solutions. The behavior of the designated patient is interpreted as an attempt at communication. An interpretation is also made of the family role changes that led to the crisis, with firm but empathic confrontation of all members of the family as to their part in the patient's upset. Their responsibility is outlined, the around-the-clock availability of the therapist explained, and a home visit scheduled within 24 hours. Tasks are assigned to each family member. The patient and family are informed that any insistence on hospitalization is a way of escaping responsibility and that the crisis will be resolved only if family roles and rules are altered. In this way each family member is given something to do, such as cleaning the kitchen, writing a letter, taking medications, and so on. This is a way of testing the family's cooperation. A member of the team may actually participate in helping with one of the tasks. The patients and occasionally family members may be given psychotropic medications in adequate dosage if necessary.

The next step is the home visit to observe the family interactions and if necessary to renegotiate role assignments. At first the family as a unit is seen daily, at which time the behavior of the members is monitored. The therapist may apply direct or indirect pressure to encourage one or another person (patient or family member living within or outside the home) to change. The focus is on the firm and uncompromising need to accept responsibility. The patient may be instructed to communicate more clearly and not through his symptoms. This often dramatically produces improvement.

With this technique hospitalization was completely avoided in 42 of 50 cases, only an average of six home or office visits per family being needed. Ten of the 50 families called over a month following discharge about a subsequent crisis, which was usually handled over the telephone; several required one or two office visits.

Short-term family therapy has had increasing acceptance in clinics devoted to crisis intervention, the theoretical base being that behavior disturbance is a product of a continuing family system disorganization rather than rooted in inpidual pathology. Combining principles from group therapy and family-centered educational approaches, the practitioner functions as both therapist and educator (Guernsey et al, 1971; Wells, 1974).

In family therapy the therapist must utilize a much more challenging and confronting technique than in ordinary group therapy since the interlocking neurotic family mechanisms are extremely rigid and self-perpetuating. Yet, the degree of challenge must be titrated against the quality of the relationship that exists between the therapist and the family being treated. The therapist must also be ready to expose himself to challenge. Growth is not restricted to the participants of the group; it also involves the therapist.

Multiple family therapy especially has increased in popularity in recent years (Laqueur, 1968; 1972), and an excellent article on its literature, rationale, and some of its techniques has been written by Luber and Wells (1977). In multiple family therapy "the families and their members can become mutually supportive of each other in confronting stressful areas; intense family feelings are more diluted in the group context, and hence more approachable, and families can learn by observation and identification with other families" (Luber & Wells, 1977). Many families may be helped with a time-limited approach in this way, and for those who require a longer period of treatment the kinds of problems needing further help will have been identified.

Donner and Gamson (1968) have described their experience in dealing on a short-term basis (16 sessions) with groups of families experiencing problems with adolescents. The objectives were (1) to provide a setting conducive to exploration of family problems that contributed to difficulties of the adolescent members, (2) to help families acquire new and better solutions to quandaries confronting them, and (3) to employ insights gained as a means of recommending further therapy if needed. Evening sessions of 1 1/2 hours once weekly were conducted, usually by a cotherapist team. Out of their experience a number of techniques are recommended. At the initial session the group is instructed that a problem in one family member involves not only the member but the entire family. One should not regard any member as "the bad one" or "sick one" because when trouble starts, there is something going

on in the entire family. A family exploration of the problem enables them to deal with the cause. "All of us together will try to understand what is going on in the different families that contribute toward the young people's difficulties, and each can make contributions to the others." The group is told that since family members in one family live so closely, they may not be able to see the problem as clearly as when they see the same problem going on in another family. By observing how other families solve their problems each family may obtain valuable insights. Feelings should be ventilated freely with no restrictions, and there must be no punishment at home for what is said. Other ground rules are that all present members must attend each session (father, mother, adolescent, and, if possible, other siblings). Families during this treatment process are not to socialize outside the group since this will affect how they interact in the group.

As family members air their anger, despair, hurt, and indignation, new ways of dealing with problems generally emerge. "The families lose their feeling of having something wrong about them, which isolates them from others." The changes in one family group reinforce changes in the others; the families become active helpers of one another.

Common Questions about Techniques in Short-Term Therapy

There is a great deal of current interest in biochemical causes of emotional problems, and particularly chemical neuro-transmitters, that may be influenced by pharmacotherapy. Do you believe that this minimizes the role of psychotherapy? Certainly it would be quicker and cheaper to give a person a drug rather than to spend session after session in interviewing.

What you are asking is whether drugs eventually will replace psychotherapy. A current article in a national magazine implies that we will in the not too distant future be able to control all behavior by injecting or extracting chemicals into and from the body. In my opinion, this frightening possibility is quite remote. In explicating neurotransmitters, or any other chemicals, as the ultimate ingredients in behavior, biochemical enthusiasts commit the same kind of error that the classical Freudians made in deifying the Oedipus complex as the fountainhead of all mortal blights. Both neurotransmitters and the Oedipus complex may come into play, but they are merely some of the agencies that are operative in the complex series of transactions that constitute human behavior. Biochemical, neurophysiological, developmental-conditioning, intrapsychic, interpersonal, social, and spiritual factors are all vital links in

the behavioral chain, influencing each other by feedback. No one link is most important. Every thought, idea, wish, and fantasy has its biochemical correlates. Conversely, biochemical changes, including the influences of psychotropic drugs, resonate throughout the entire chain affecting other links. But while drugs may mollify, it has been demonstrated that they will not solve the manifold social, interpersonal, and other distortions that are ubiquitous. Actually, more people are being funneled back into hospitals in spite of medications than ever before. So let us give biochemistry and pharmacotherapy their proper due without encouraging the public to seek cures for spiritual, social, interpersonal and emotional ills in their local drug stores. In short, it is foolish to anticipate that drugs will ever replace good psychotherapy.

Can you give examples of what you mean by eclectic therapy?

It is a rarity today to find a therapist who confines himself to one specific technique. There are several ways of alleviating psychological distress. Among the most recent entries into the therapeutic arena are the modern somatic therapies that aim at rectification of existing neurophysiological and biochemical distortions. An effective therapist may, from time to time, have to prescribe or refer his patient for prescription of neuroleptics for schizophrenic and other psychotic reactions, anti- depressants (Tofranil, Elavil, Sinequan, Nardil, Parnate, etc.) for deep depressions, anti- manic medications (Lithium for manic attacks), minor tranquilizers (Valium, Librium, Serax, etc.) for severe anxieties, sedatives and hypnotics for the temporary relief of insomnia, and electric convulsive therapy for suicidal depressions. So doing will result in correcting rapidly a host of symptoms that interfere with psychotherapy.

A second mode available to the therapist is perting the patient and producing a calming effect through biofeedback or relaxing exercises, like meditation, hypnosis, and autogenic training. A third way is flooding the mind with philosophical, persuasive, or suggestive formulations, as in cognitive therapy. A fourth group of techniques attempts to pert the patient through externalization of interests, music therapy, dance and movement therapy, poetry therapy, social therapy, and occupational therapy. A fifth mode is alteration of the environment to reduce stresses being imposed on the patient and to surround him with constructive stimuli. Among the tactics employed here are guidance, milieu therapy, marital therapy, family therapy, therapeutic counseling and casework, and supportive group therapy. A sixth mode aims at rectifying faulty habits and developing new and more productive patterns through behavior therapy, role playing, and cognitive learning. A seventh mode explores unconscious conflict

and releases latent creative potentials through dynamic psychotherapy, existential analysis, transactional therapy, experiential therapy, hypnoanalysis, narcoanalysis, exploratory art and play therapy, visual imagery, and analytic group therapy. As has been stressed, however, techniques in each of the modes do not confine their influence to one area. They will influence other parameters in cognitive, emotional, and behavioral areas.

Isn't the principle of eclecticism an invitation to confusion that ultimately defeats its purpose?

If you are referring to eclecticism as a mixing of various theories into one "grand stew," yes. It is foolish to attempt to apply theories related to one area of functioning, say the biochemical link, to another area, for example, the intrapsychic and interpersonal links or vice versa. All you will achieve is confusion. Even if one attempts to mix different theories that relate to a single link in the behavioral chain, the result can be a mess of scrambled ideas that explain nothing. On the other hand, if eclecticism refers to a technical blending of methods, each of which is suited for a different dimension of functioning, you can through such blending enhance the efficiency of your operations. For example, in a severe depression you may want to correct the pathology in the biochemical link by prescribing imipramine. You may also simultaneously decide to deal with the intrapsychic problem by utilizing psychoanalytic psychotherapy or cognitive therapy. Moreover, if a family problem exists, you will be wise to do some family therapy. These blended techniques enhance each other. After all, if a surgeon had only one technique at his disposal, like appendectomy, it would be silly to try to treat every stomachache or bowel cramp by taking out the appendix.

If a patient does not respond to the techniques you are using even though there appears to be a good therapeutic relationship, what do you do?

The first thing is to search for transference that may not be apparent on the surface. The patient's resistance to the therapist and to relinquishing his illness may be masked by a complaint and seemingly cooperative attitude. Often transference becomes apparent only by observing nonverbal behavior or by searching for acting-out tendencies away from therapy. It may be detected sometimes in the patient's dreams. Once transference is confirmed, confrontation, frank discussion, and interpretation are in order. Another reason why the patient may not be responding well to treatment is that the proper techniques

are not being employed that accord with the patient's learning capacities. For example, some patients cannot seem to utilize the abstract concepts of interpretive techniques. They do better with role playing or assertive training. Other patients respond better to relaxation methods. One may fruitlessly work with an alcoholic and his family, yet will find that he improves immediately with an inspirational supportive group patterned after Alcoholics Anonymous. To do good short-term therapy, the therapist must be flexible and exploit a range of eclectic techniques. If certain techniques best suited for a patient are not within one's range of skills, one should refer the patient to a specialist. Whether the patient is to be transferred entirely or seen jointly will depend on the specific problem and on how advisable it is to maintain a therapeutic relationship with another professional as a cotherapist.

How important are the therapist's attitudes in short-term therapy?

Attitudes are important, for instance, enthusiasm and conviction about what one is doing. Beginning therapists, in their eagerness to help, often communicate enthusiasm that catalyzes therapy. Apparently experience for some reason dampens enthusiasm, therapists becoming more "scientific," cautious, and conservative about their healing powers. Such attitudes have a dampening influence. Somehow the therapist must get across to the patient conviction in the validity of his approach. This enhances both the placebo effect of therapy and consolidates the patient's faith in the therapist, thus strengthening the therapeutic alliance. A show of confidence on the part of the therapist will help carry the patient through the resistance phases of treatment. Where the therapist anticipates a long period of treatment, cues may be released that play into the patient's dependency and fears of separation, thus prolonging therapy.

When is countertransference most likely to appear?

Countertransference is likely to appear among therapists at any phase of treatment, selective characteristics in patients sponsoring aversive reactions that can interfere with progress. Serious psychiatric impairment in patients is an especially prominent stimulus that sparks off untoward responses in many professionals. This was borne out in a study of the reactions of nonpsychiatric physicians to medical patients (Goodwin et al., 1979). The most disliked patients were those who possessed strong psychopathological characteristics. The author of the article concluded that the emotion

of dislike in physicians was a sensitive clue to psychiatric impairment in patients. Recognition of the inappropriativeness of one's negative feelings gives one an opportunity to examine those feelings and to control them, thus helping to avoid adverse effect on therapy.

Can countertransference ever be used in a therapeutic way?

Yes. Therapists recognizing that their own neurotic feelings are being activated may look not only into themselves, but also into what neurotic needs and drives in their patients are activating their personal reactions. They may then bring up these provocations as foci for exploration. They may ask, "is the patient aware of aberrant impulses and behaviors? What does the patient want to accomplish by them?" Confronting the patient with his behavior may have a therapeutic impact on him.

Are negative feelings in the therapist always evidence of countertransference?

Of course not. The patient may be acting in an offensive and destructive way, legitimately stirring up irritation and anger in the therapist. There is no reason why, when a working relationship exists, the therapist should not confront the patient with his behavior in a noncondemning but firm manner.

Can you describe what is meant by the "need for activity" in short-term therapy?

The need for activity on the part of the therapist is explicable on the basis of the limited time available for treatment. Passive waiting for the patient to work through his problem within a few sessions will bring meager results. It may be necessary to guide, support, exhort, and confront the patient as forcefully as is required at the moment, always mindful of the need to preserve a warm therapeutic climate. Activity in therapy may require ancillary services of physicians, lawyers, social workers, teachers, and other professionals as well as whatever community resources are needed at the moment. Especially in crisis intervention, assistance with economic, housing, and other situational problems may be necessary. By his activity the therapist communicates the expectations "that an early resolution of the presenting crisis is achievable. *Often it is exactly that expectation which serves as the primary therapeutic agent*" (Amada, 1977) Activity will require an abandonment of anonymity and the revealing of oneself as a genuine person rather than as a professional automaton. This does not mean a relinquishing of the proprietaries of an ethical therapist-patient relationship, but rather a loosening of the straightjacket of

rigid formality and detachment that are so destructive to good rapport. Activity may take the form of putting into words the nebulous feelings of the patient, and it may even be expressed in direct advice giving through presenting the patient with several options and helping him to make the proper choice.

How active should the therapist be? What if by nature the therapist is a passive person?

Activity is the keynote of short-term therapy. This does not mean the therapist should do all the talking. Even a therapist who is quite quiet and reserved can adopt a style of greater activity, avoiding sitting back and allowing the patient to ramble on with verbal inconsequentialities. By utilizing the principle of selective focusing (Wolberg, 1977, pp. 366- 370), searching for evidences of transference and countertransference, immediately dealing with resistances when they arrive, changing from one technique to another when the former proves ineffective, and posing challenging questions and confrontations, a good degree of activity will come into play.

In focusing on a limited area, do we not stand the danger of neglecting important parameters of a person's life?

In short-term therapy it is pragmatically necessary to circumscribe the number of variables with which one deals during the interview. By concentrating on a limited area for focus and confining one's work to that area, some therapists feel they achieve the greatest impact. The patient reveals his problem through multiple channels: the way he walks, the way he sits, his bodily movements in talking, his facial expressions, revelations of his past life, his current entanglements, his dreams, the manner of his relationship to the therapist, and so on and so on. The therapist may decide to work with one constellation, let us say the inpidual's present relationships, perhaps focusing on his immediate family. The hope is that by altering the character of the family interactions a chain reaction will have been started to influence other relationships and ultimately the deepest patterns of one's thinking and feeling life. Memories of past difficulties may sometimes break through with a reappraisal of one's past existence. Indeed, a complete revolution may take place in the personality structure. Or we may focus on a specific symptom—exploring its history, the events or conflicts that initiate it, the circumstances that ameliorate it —and even start a regimen to control it. We may then find that with symptomatic improvement other dimensions of the personality are positively influenced.

Once a focus is chosen, should you ignore or direct the patient away from material brought up that has nothing to do with the focus?

Because there is so little time available, it is unproductive to deal with all of the random events and ideas the patient brings up during a session. Often these are advanced in the interests of resistance. Yet there will occur incidents of great concern to the patient that on the surface have little to do with the area of focus. To ignore these will indicate to the patient disinterest and lack of empathy, apart from it being bad therapy. For example, if a core problem is destructive competitiveness issuing out of rivalry with a parent or sibling and the patient has that morning found a lump on her breast, it would be foolish to bypass the patient's desire to talk about the incident. Even lesser areas of trouble preoccupying the patient should in commanding attention challenge the therapist to find a connection with a deeper focal problem. This can be done in most cases even though the route chosen may be devious. Thus a patient with a core problem of passivity and lack of assertiveness, a product of incomplete separation-inpiduation, is intent on talking about an art exhibit he had attended at a local museum. Underneath the great admiration for the artist is, it seems, a feeling of envy and despair at one's own lack of productiveness. The patient may then be brought back to the core problem with the statement, "How would you compare your own talents with those of the artist?" If a therapist cannot find any connections, a question like "What does that have to do with your own basic problem we have been exploring?" will usually help the patient resume dealing with more significant material.

How much advice giving should be used in short-term therapy?

Advice giving in psychotherapy should be handed out sparingly and selectively—and only when patients cannot seem to make an important decision by themselves or if their judgments are so faulty that they will get into difficulties should they pursue them. Even in the latter case it is best to present alternatives to the patients for their own choice and to continue questioning them as to why they find it difficult to pursue a constructive course of action without help.

Is telephoning the therapist permissible in short-term therapy?

In short-term therapy, and especially in crisis intervention, the availability of the therapist can be most reassuring. While the therapist does not encourage the patient to telephone as a routine, telling the

patient to call if an emergency arises can allay anxiety and present the therapist as a caring person, thus bolstering the therapeutic alliance.

What is the conventional number of sessions that should be spent in short-term therapy?

A good deal of variation exists in the times allotted to short-term therapy. These range from 1 session to 40, the frequencies varying from once to three times weekly, the session lengths from 15 minutes to 2 hours. On the average, however, there are approximately 6 sessions over a 6-week period in crisis intervention, from 7 to 15 sessions over a 4-month span in supportive-educational short-term therapy, and as many as 40 sessions in dynamic short-term psychotherapy. Most sessions are for a 45-minute "hour." Some therapists establish a set number of sessions at the first interview and firmly adhere to a termination date. Other therapists are more flexible and determine the length of treatment according to the response of the patient to therapy.

How effective is the firm advanced setting of the number of sessions, and if effective, shouldn't this be a routine with all patients?

The firm setting of limits of time on therapy, originally described by Rank (1947) and Taft (1948), has been beneficially employed by many therapists (Haskell et al, 1969; S. Lipkin, 1966; Meyer et al, 1967; Muench 1965; Shlien, 1964; Shlien et al, 1962). An interesting finding is that a termination date accepted as an immediate reality will influence the process of therapy and stimulate greater patient activity than where an unlimited number of sessions seduces the patient into complacent torpor. The research done tends to support the advantages of restricting sessions in short-term therapy to a designated figure. Again, the therapist will have to exercise sufficient flexibility so as not to subvert his clinical judgment to a rigid rule. In certain cases he will want to keep his options open, merely mentioning to the patient that he will limit the number of sessions and that he will decide on the exact number soon after therapy has started. The therapist may quote the figure as soon as he has a better idea of the extent of the problem and the capacity of the patient to achieve projected goals.

How flexible should one be about appointment times, which usually are spaced at weekly intervals?

A certain flexibility of appointment times will be required, particularly in crisis intervention when

double and triple sessions, several sessions on the same day, and the spacing of sessions are determined by the patient's rather than the therapist's needs. Also during the first week of therapy with patients who are extremely anxious three sessions will be needed for adequate support, reassurance, and the consolidation of a relationship. Weekly sessions thereafter usually suffice. Then there may be a tapering off to one session in 2 weeks and the next in a month, followed by termination. Should there be no improvement with weekly sessions, an additional weekly session in a group may be helpful, the group therapy also being conducted on a short-term basis.

What do you do about taking a vacation in the middle of a patient's therapy?

Preparing patients for vacations or other absences of the therapist is often overlooked. Sufficient notice should be given to allow at least two sessions before the therapist departs in order to observe and manage the patient's reactions. Naturally, if a verbal contract was made with the patient that included the time of termination and no notice had been given the patient that there would be an interruption of treatment, springing a vacation on the patient can have a bad effect on the relationship. In the absence of a definite contract involving the exact date of sessions or the date of termination no difficulty should be encountered where the patient has been forewarned at least two sessions in advance, except in the instance of prolonged vacations (a contingency that can occur particularly in older therapists by virtue of their having achieved sufficient levels of age, fatigue, or economic security).

What do you do if a patient keeps talking about how hopeless he feels about getting well and little else?

Patients often express hopelessness about getting well soon after they start therapy. To such lamentations the therapist may reply, "These are resistances fighting back as soon as you begin making efforts to get well. They will pass if you disregard them and go ahead with the plan of action we discussed." No matter how pessimistic the patient may seem about himself, the therapist should retain an optimistic stance: "No matter how bad and impossible things seem, if you keep working on your problems, you can get better." Naturally, an analysis of why the patient feels hopeless with proper interpretation of his masochism would be indicated. If the therapist knows how to do cognitive therapy, he might try to use this next. In the event the patient is severely depressed, and particularly where there is early morning awakening, loss of appetite, or retardation, an antidepressant should be prescribed

along with any of the other measures recommended above. Should negative discouraging thoughts persist, the patient may be taught methods of behavioral aversive control (Wolberg, 1977, pp. 694-695).

How soon should you deal with angry, negative attitudes that a patient manifests toward you, expressed by criticizing your clothes, your office furniture, etc.

The maintenance of a positive warm working relationship is, of course, the best therapeutic climate. Whenever negative feelings threaten, unlike long-term therapy where they may be allowed to foster regression and then analyzed, they must immediately be explored and dissipated as rapidly as possible to restore the patient's confidence. By the same token, in personal dress and grooming the therapist should not appear so offbeat as to offend the sensibilities of his patient. On some level the therapist becomes a model for the patient. The arrangement and furnishings of one's office should also reflect orderliness and good taste.

Are there any risks in seeing another member of a patient's family, such as a husband or wife?

Yes. A hostile member may utilize the interview as a way of attacking the patient by misquoting for the patient's discomfort something the therapist has said that is detrimental to the patient. An example is the following letter received from a patient who did well in short-term therapy. I had an interview with the wife during which she vented her anger at her husband. She refused to consider marital therapy or inpidual treatment for herself even though I felt I had made some contact with her when I saw her.

> Dear Dr. Wolberg:
>
> For some time, I have been taunted by Mrs. G with derisions based on specific remarks she firmly states you made to her concerning me. These statements are that I am "hopeless," that I will "never get better," that I am "too old to get help," and worse than all, that I have "neither the desire nor the inclination to get better." These remarks have been repeatedly hissed at me, and although I have tried to discount and erase them as statements from you, they have been repeated and I am deeply hurt and humiliated that they may possibly have had you as their source.
>
> As you will recall, I came to you in a desperate emotional state pleading for help. I had a severe anxiety and depression and the distressing symptoms of muscle spasm. I attributed these to the conflict at home, particularly the interactions between my son and his mother. How could I not have the desire nor the inclination to get better? I developed a very effective rapport with you and after a few months my symptoms left me. Some two months later, the situation at home sporadically erupted, and it soon developed that Mrs. G was the common denominator (not my son) as the provoking and disturbing influence at home, that her cruelty and constant agitation created the daily environment of hostility and chaos at home and these had their dire effects upon me and my son. This proved to be true because every symptom of anxiety, fear, and depression left me when Mrs. G left last June for Florida.

She returned home a few weeks ago and the turmoil, cruelties, and hostilities returned with her. I had reached a state of internal stability and equanimity while she was away, but now her daily tirades have resumed, opening up old wounds, and particularly referring to you as making the specific remarks I have already stated. I realize she is doing this with sadistic intent, and although I have every reason to discount and disbelieve such statements from you, I do feel deeply hurt and I do not want to go on thinking that you might, for some reason, have given her these terrible impressions. Except for what is understandably a personal hurt with the weapon she is using against me, I am otherwise feeling fine. I felt I should write you of this and give you an opportunity to let me know the truth of what you did or did not relate to Mrs. G Your reply will remain strictly between us, but I do owe it to myself to seek the truth.

Cordially,

Mr. G

Crediting certain remarks to the therapist is bound to affect the relationship with the patient. The best way to handle the misunderstanding is to arrange a joint session with the patient and other family member avoiding accusations about who said what about whom. The therapist may then in a noncondemnatory way help clarify what has been happening. This can be a sticky situation and will call for a great deal of tact. That incidents such as the one cited in the letter above can occasionally occur should not discourage the therapist from seeking interviews with other family members.

Can supportive therapy be anything more than palliative, and isn't dependency encouraged in this kind of treatment?

The supportive process may become more than palliative where, as a result of the relationship with the helping agency, the person gains strength and freedom from tension, and substitutes for maladaptive attitudes and patterns those that enable him to deal productively with environmental pressures and internal conflicts. This change, brought about most effectively through the instrumentality of a relationship either with a trained professional in inpidual therapy or with group members and the leader in group therapy, may come about also as a result of spontaneous relearning in any helping situation. Some dependency is, of course, inevitable in this kind of a therapeutic interaction, the adequate handling of which constitutes the difference between the success or failure of the therapeutic relationship in scoring a true psychotherapeutic effect. Dependency of this kind, however, can be managed therapeutically and constitutes a problem only in patients who feel within themselves a pathological sense of helplessness. The sicker and more immature the patient, the stronger his dependency is apt to be. It is essential that the helping agency be able to accept the patient's dependency without resentment, grading the degree of support that is extended and the responsibilities imposed on

the patient in accordance with the strength of the patient's defenses. (See also the second and third questions that follow.)

Where the aim is the simple alleviation of symptoms and no personality alterations are deemed necessary, what tactic should be used?

The therapeutic tactics essential for the modest aim of symptom relief are uncomplicated, consisting essentially of developing a working relationship, encouraging emotional catharsis, giving proper support, guidance, and suggestions, employing techniques such as behavior therapy and relaxation procedures where these are indicated, and, if necessary, temporarily administering psychotropic medications.

Isn't symptom control a very superficial therapy, and doesn't it often result in a return of symptoms?

There are still a substantial number of therapists who believe methods aimed at symptom control, while rapidly palliating suffering and perhaps even reinstating the previous psychological equilibrium, operate like a two-edged sword. Justifiable as symptom control may seem, these skeptics insist that it fails to resolve the *underlying* problems and difficulties that nurture the current crisis. Irreconcilable unconscious needs and conflicts continue to press for fulfillment, and, therefore, they insist, we may anticipate a recrudescence or substitution of symptoms. These assumptions are based on an erroneous closed-symptom theory of personality dynamics. Symptoms once removed may actually result in productive feedback that may remove barriers to constructive shifts within the personality system itself. Even though these facts have been known for years (Alexander, 1944; Alexander & French, 1946; Avnet, 1962; Marmor, 1971; Wolberg, 1965) Marmor, 1971) and have been corroborated in the therapeutic results brought about by active psychotherapeutic methods, the time-honored credo branding symptom removal as worthless persists and feeds lack of enthusiasm for symptom-oriented techniques. (See also the second question above and the question that follows.)

Does therapy focused on helping or removing symptoms prevent a person from achieving deeper changes?

The evidence is overwhelming that symptom-oriented therapy does not necessarily circumscribe the goal. The active therapist still has a responsibility to work through much of the patient's residual

personality difficulties as is possible within the confines of the available time, the existing motivations of the patient, and the basic ego strengths that may be relied on to sustain new and better defenses. It is true that most patients who apply for help only when a crisis cripples their adaptation are motivated merely to return to the dubiously happy days of their neurotic homeostasis. Motivation, however, can be changed if the therapist clearly demonstrates to the patient what really went on behind the scenes of the crisis that were responsible for his upset. (See also the preceding question and the third question above.)

What do you think of Gestalt therapy, and is it useful in short-term therapy?

Gestalt therapy is one of the many methods that if executed properly by a therapist who has faith in its efficacy can be extremely useful. Some of the techniques, like the empty chair technique, are especially valuable as a means of stimulating emotional catharsis, arriving at an understanding of suppressed and repressed feelings, and providing a platform for the practice of behaviors that the patient regards as awkward or forbidden. As with any other technique, resistances are apt to erupt that will require careful analysis and resolution.

What is "ego-oriented psychotherapy"?

Sarvis et al (1958) have written about the effectiveness of time-limited "ego-oriented psychotherapy" without setting up predetermined criteria for motivation or readiness. No arbitrary topic is set, but focus "is a process arising out of the interchange between the patient and therapist." The authors conceive of therapy as being open-ended, applicable at any point in the "adaptive-maladaptive integrations of existence." They regard it as a "limited" dynamically directed form of psychotherapy that is distinguished from psychoanalysis and psychoanalytically oriented psychotherapy in both process and goals. A crucial focus is what has brought the patient to therapy at the time he applies for help (why now?). Frequency of sessions is flexible, depending on the needs of the patient; the total time devoted to therapy is limited though not predetermined in advance. The therapist "tries actively to empathize with, conceptualize, and interpret the patient's material—particularly preconscious trends, the current therapeutic interaction, and the evidence of transference, in terms of ongoing integrative adaptations rather than toward regressiveness."

What are the objectives of cognitive approaches to therapy?

Recent cognitive approaches attempt to improve problem-solving operations as well as to enhance social adjustment. Where rudiments of adaptive skills are present and where anxiety is not too paralyzing, the inpidual in a relatively brief period with proper therapy along cognitive lines may be able to reorganize his thinking strategies and to find alternative solutions for problems in living that are much more attuned to a constructive adjustment. Intervention programs along cognitive lines have been described that are applicable in a variety of clinical and educational settings (Spivack et al., 1976). In my opinion, the techniques related to cognitive approaches can be implemented within a dynamic framework.

Is "cognitive therapy" of any value as a method in short-term therapy?

Preliminary studies are encouraging, but whether it is superior to other methods in certain conditions is difficult to say and will be judged by further research. The many factors that influence all psychotherapies for better or worse undoubtedly apply also to cognitive therapy. It has particularly been recommended in depression, but it is doubtful that it is a substitute for antidepressant pharmacotherapy, especially in endogenous depression. It may, as a psychotherapeutic adjunct, function here as a prophylactic retarding further attacks. Cognitive therapy is most helpful in patients with biased and faulty thinking problems, obsessional and phobic patients responding positively to a well-conducted and skillfully operated program. An important thing is how cognitive therapy is done and the faith of the therapist in its efficacy. To a therapist who believes in its value and who dedicates himself to the arduous task of altering established cognitive frames of reference, it may be a preferred approach. Other therapists may be more dedicated to and get better results with techniques with which they have a special personal affinity.

Are there any drawbacks to using behavior therapy in dynamic short-term therapy?

Not at all. It can be quite useful. Where the therapist is oriented toward behavior therapy, he will approach some of the patient's difficulties as manifestations of faulty learning. He will usually start therapy with a behavioral analysis. The symptom to be altered is analyzed to determine what benefits the patient derives from it. Explorations will deal with identification of factors that touch off and

reinforcements that sustain the maladaptive behavior and of elements that reduce such behavior. Action rather than insight is accented. A method that helps to encourage motivation is the keeping of a daily diary that scores the frequencies of symptomatic occurrences. Simple score keeping has been found to reduce the number of symptomatic upsets. The patient's positive efforts to control, alter, and reverse his maladaptive behavior are rewarded by attention, praise, and enthusiasm. The patient's reactions to the techniques should be observed, the therapist being alerted to transference and resistance. There is no reason why dynamic principles cannot be applied to what is happening during behavior therapy or any kind of therapy. (See also the following question.)

Can behavior therapy be used for conditions other than phobias?

Yes, for various conditions like obsessions, hypochondrias, depression, and habit disorders where the symptoms are circumscribed and the events that produce the symptoms are identifiable. Behavior therapists utilize behavioral techniques along with other methods like pharmacotherapy and various kinds of psychotherapy. More and more therapists are seeing the advantage of utilizing behavior therapy within a dynamic framework. Increasing numbers of analytically trained therapists are finding desensitization, assertive training, and other forms of behavior therapy useful in their work. (See also the preceding question.)

What is the value of hypnosis in short-term therapy?

Hypnosis is chiefly employed as a catalyst in psychotherapy. It potentially facilitates the therapeutic process in a number of ways. First, hypnosis may exert a positive influence on the relationship with the therapist by mobilizing the essential hope, faith, and trust that are parcels of every helping process and by cutting through resistances that delay the essential establishing of rapport. This is especially important in detached and fearful inpiduals who put up defenses against any kind of closeness and hence impede the evolvement of a working relationship. Second, hypnosis, owing to its enhancement of suggestibility, will promote the absorption by the patient of positive pronouncements, verbal and nonverbal, that may alleviate, at least temporarily, symptoms that interfere with exploratory techniques. Third, hypnosis often expedites emotional catharsis by opening up founts of bottled-up emotion, thereby promoting temporary relief and signaling some sources of residual conflict. Fourth, impediments to

verbalization are often readily lifted by even light hypnosis. Fifth, where motivation is lacking toward inquiry into sources of problems, hypnosis, through its tension-abating and suggestive symptom-relieving properties, may help convince the patient that he can derive benefits from treatment if he cooperates. Sixth, by its effect on resistances hypnosis may help expedite such insight techniques as imagery, dream recall, and the release of forgotten memories. Seventh, hypnosis may light up transference, rapidly bringing fundamental problems with authority to the surface. Eighth, by dealing directly with deterrences to change hypnosis may expedite the working-through process, particularly the conversion of insight into action. Toward this end, teaching the patient self-hypnosis may be of value. Finally, hypnosis may sometimes be helpful in the termination of therapy, enabling the patient who has been taught self-relaxation and self-hypnosis to carry on the therapeutic process by himself.

Is hypnosis ever used with a psychomimetic drug to speed up therapy?

Ludwig and Levine (1967) claim substantial therapeutic changes of a reconstructive nature through the use of a combination of hypnosis and LSD administration in a technique they term "hypnodelic therapy." Few other therapists use this combination.

What are the principle objectives of dynamic psychotherapy, and how are these objectives reached?

In dynamically oriented therapy the objective is to bring the inpidual to an awareness of prevailing emotional conflicts, the defenses employed in avoiding such awareness, the way such conflicts originally had developed in the past, the influence they have exerted on development, the insidious ways they pollute one's present existence, and their relevance in sponsoring existing symptoms and complaint factors. Such clarification is in the interest of helping to face anxieties and to develop new ways of relating to oneself and to people. Interpretations, the chief methodological tool, are targeted on defenses at the start, on any existing anxiety, and finally on the drives and impulses that are being warded off. Essential is the maintenance of sufficient tension in the interview to create an incentive for handling and working through of the initiating conflicts. A most fertile arena for exploration is the transference, which presents the patient with a living example of some of the core conflicts in action. Most vitally transference interpretation enables the linking of what is going on in the present with important determinants in the past. Transference may not be displayed exclusively toward the therapist. It may be projected toward

others outside of the treatment situation.

In dynamic therapy shouldn't the chief aim be the developing of insight in the patient since without knowing the causes a cure is impossible?

Many therapists still believe that understanding the causes of a problem is tantamount to a cure. The search for sources then goes on relentlessly. Should improvement fail to occur, the patient is enjoined to dig deeper. Obviously, one task of therapy is to determine underlying causes; but we are still at a stage where our knowledge of which causes are paramount is not yet too clear. However, practically speaking, assigning to symptoms some reasonable etiology that the patient can accept serves to enhance self-confidence and to lower anxiety and tension levels. The patient may then be willing to experiment with more adaptive patterns. If no more than a placebo, then, insight can serve in the interests of expediting therapeutic goals.

Obviously, the more perceptive and well trained the therapist, the more likely will the patient be helped to arrive at underlying etiological factors. But, however, accurate these discoveries may be, a tremendous number of elements other than insight enter into the therapeutic Gestalt. Again, this is not to depreciate insight, but rather to assign to insight a significant but not exclusive importance.

How important is dream analysis as an adjunct to whatever techniques are being used?

Dream analysis constitutes a vital means of helping patients recognize some of their fundamental problems and their own participation in fostering neurotic maladjustment. Working with college students, Merrill and Cary (1975) found that focusing on dreams lowered resistance to self-experience in students struggling with the independence-dependence conflict. It also reduced acting-out by encouraging the acceptance of disowned feelings. A dream is best utilized in relation to current experience, though its roots in past conditionings are not neglected especially when transference elements are obvious in the dream. (Chapter 12 deals extensively with the use of dreams in short-term therapy).

Are psychoanalytic techniques, such as dream analysis, imagery evocation, interpretation of resistance and transference, and other modes of exploring the unconscious absolutely essential toward promoting depth changes in the personality?

It is sometimes pointed out that a number of patients do achieve considerable personality growth when treated by a therapist who utilizes supportive and educational methods exclusively, purposely avoiding probing for conflicts and dealing only with manifest symptoms and problems. There are a few patients whose repressions are not too severe, whose defenses are not too rigid, and who possess a strong readiness for change. If the therapist is nonjudgmental and empathic, the therapeutic relationship itself can serve as a corrective emotional experience. The conception of punitive authority is altered, and softening of the superego results in strengthening of the self-image. This, however, is more likely in long-term than in short-term therapy. Most people do require some challenge in order to change, and a certain amount of anxiety needs to be tolerated to give up old habits and patterns exchanging them for unfamiliar ways of behaving. We see this during and after crises when people realize that their usual adaptations are ineffective and can only get them into more trouble. During short-term therapy confrontations and interpretations impose on the inpidual challenges with which he must come to grips. A purposeful focusing on unconscious material can be most helpful in promoting self-understanding, which may then act as an incentive for change.

Does one have to be a psychoanalyst to deal with resistance?

Of course not. But the therapist who has no understanding of psychoanalytic theory and method is at a disadvantage in dealing with resistance. In my supervisory work I have gotten the impression that it is resistance that principally accounts for failures in the active approaches like hypnosis and behavior therapy. Referrals to me of a sizable number of patients who were unable to achieve satisfactory results with nonanalytic therapies, revealed in practically every case that transference had interfered with positive responses to the therapist's methods. Such reactions occurred with me also, but I was soon able to detect them from the patient's associations and dreams. They then constituted the focus in our therapy. For example, in several cases referred to me for hypnosis by experienced hypnotherapists who were unable to induct a hypnotic state, I was able easily to detect the transference resistance that interfered with hypnotic induction. Without exception, once this impediment was brought to the surface and explored with the patient, he was able easily to achieve a satisfactory trance.

Some authorities insist that transference is not a problem in short-term therapy since the time element is too brief for its appearance. Other authorities base their entire strategy around the detection and exploration of transference. What is the discrepancy?

In dynamic short-term therapy transference is a key dimension and should always be looked for. It is often purposefully bypassed or overlooked when the therapist decides to act like a giving, helpful, active, benevolent authority, symptom relief being expedited by this kind of relationship. In nondynamic short-term therapy a benevolent type of transference thus may be desirable for results. We are not so much concerned with this form of transference. We are more vitally concerned with another type of transference that acts as resistance to treatment manifesting itself in distrust, hostility, excessive demands for love and attention, sexual impulses, and so forth. Progress will be interrupted unless this show of transference is resolved. Whether it can be resolved depends on the skill of the therapist and the patient's motivation and ability to work it through. Sicker patients may require an extended period of treatment to overcome such destructive transference. Where a therapist is trained to detect transference (e.g., by observing nonverbal behavior, slips of speech, acting-out, dreams, etc.) and deals with it by appropriate interpretation, it may serve as a means toward helping the patient to understand some of the deepest conflicts. In summary, while the therapist may not wish to interfere with a positive transference, indeed he may employ it as a prod toward symptom relief and positive corrective behavioral actions—a negative transference will definitely require attention and resolution. In some cases negative transference will appear toward the end of therapy as termination poses a threat. This is especially the case where separation-inpiduation has been impaired.

Would you utilize other techniques when the chief method employed is group therapy or family therapy?

Group therapy or family therapy does not restrict the use of any other techniques that might help any of the members. These include pharmacotherapy, inpidual therapy, milieu therapy, and so on.

Isn't electroconvulsive therapy passe?

By no means. It still is a most, if not the most, effective treatment measure in deep suicidal depressions. In excited manic and schizophrenic patients it also is occasionally used when lithium and neuroleptics fail to quiet the patient down.

Is drug therapy still warranted in depression, and if so, what is its rationale?

Definitely it is warranted. There are different kinds of depression, of course, for example,

depression as a primary condition and as secondary to anxiety or hostility. There are certainly biological correlates in depression. The latest hypothesis is that in depression there is a deficiency of neurotransmitters, that is, of catecholamines at the adrenergic receptor sites in the brain, particularly a deficiency of norepinephrine, and also a deficiency of indoleamines (serotonin). Antidepressant drugs, namely the tricyclic antidepressants (Tofranil, Elavil, Sinequan), increase the concentration of neurotransmitters at the receptor site by blocking their reuptake from the synapse. When tricyclic antidepressants are used, they must be given in adequate dosage (inpidually regulated) and the effects may not be apparent for 3 to 4 weeks. After the depression lifts, the dosage is lowered to as small a maintenance dose as symptom control requires. Another way of increasing the concentration of neurotransmitters in the brain and lifting depression is by preventing their metabolism through inhibiting the enzyme monoamine oxidase (MAO). Usually the response to the MAO inhibitors (Nardil, Parnate) is also delayed. Psychostimulants like dextroamphetamines (Dexamyl), for example, are sometimes cautiously used in mild depressions. Where depression is secondary to anxiety, tranquilizers (Librium, Valium) occasionally help, but because of the danger of habituation, tricyclic antidepressants or low doses of neuroleptics (Mellaril) are preferred. In primary depression complicated by anxiety tricyclics (Elavil, Sinequan) are the drugs of choice. A patient taking antidepressants should be seen periodically by a physician, preferably a psychiatrist acquainted with drug therapy, where the therapist is a nonmedical person, since side effects are common.

Is lithium helpful in schizophrenia?

Neuroleptics are the preferred drug. A few studies do reveal that in some cases lithium may be useful, but the subgroups that respond have not as yet been identified.

How do neuroleptics operate?

Neuroleptics block the dopamine receptors in the brain interfering with dopamine transmission. Some of the symptoms of schizophrenia are believed to be the product of dopamine excesses.

Which neuroleptics are preferred in schizophrenia?

There are several classes of neuroleptics: first, the phenothiazines (Thorazine, Mellaril, and

Prolixin); second, the dibenzoxazepines (Loxapine); third, the butyrophenones (Haldol); fourth, the thioxanthenes (Navane); and fifth, the dihydroindolones (Moban). Other classes will probably be introduced as well as additions to each class. There is little difference among the various drugs, but occasionally a patient may develop an intolerance to specific drugs and not to others. Some patients do well on drug therapy; some do not respond at all; and still others respond so badly that they have to be taken off medications.

Should neuroleptics be used with psychotherapy in schizophrenia?

It has been shown in schizophrenia that adequate dosages of neuroleptics coupled with family therapy are followed by the smallest number of relapses. Great flexibility is necessary on the part of the therapist, experimenting with other modalities also since special techniques will suit some patients and not others. Perhaps the most important therapeutic agency is a good relationship with the therapist. Psychotherapeutic techniques are valueless without this.

Should neuroleptics always be employed in schizophrenia?

By no means. Actually, they are being overemployed and in some cases used without proper supervision and follow-up. Young patients in their first attack, especially those going through an identity crisis, often do well without drugs. Where symptoms are too disruptive, however, neuroleptics should be used.

If neuroleptics are useful in schizophrenia, why shouldn't they be given indefinitely?

There are some disagreeable side effects and sequelae with neuroleptics, especially when given over a long period and in large dosage. Tarpe dyskinesia is a neurological condition that affects as many as 40 percent of patients on prolonged drug therapy. Once tarpe dyskinesia has become entrenched, it may plague the patient permanently even after the drug is withdrawn. Neuroleptics should, therefore, be lowered in dosage after the desired effect has been achieved, and periodically they should be withdrawn (drug-free holidays) to see how the patient reacts.

After an acute episode of schizophrenia and the patient is relatively symptom- free, should neuroleptics be continued?

Yes, for a while, if the patient has been on neuroleptics. The relapse rate is greater where drugs are not continued. Roughly after the first attack the patient should continue on medication for 1 to 1/2 years. After a second attack they should be prescribed for 2 to 5 years. After a third attack they may have to be used indefinitely with occasional drug-free holidays. Supervision is essential to see that the medications are taken and to adjust the dosage to lessen side effects and sequelae.

When would you prescribe sleeping pills, and which would you recommend?

While benzodiazepines (Valium, Dalmane) are safer than barbiturates, they should very rarely if ever be given to new patients for insomnia for more than 2 to 4 weeks. Beyond that time consistent use causes them to lose their effectiveness. Occasional use of hypnotics, however, can prove helpful, as when a temporary stress situation interferes with sleep. Dalmane (flurazepam) in the 15-milligram dosage is generally as effective as the 30-milligram dosage, many persons also find 5 milligrams of Valium (diazepam) effective.

In matching patient and method how valuable is a developmental diagnosis, that is, knowledge of where in the patient's development the primary arrest occurred?

Matching patients and methods is still an unsolved problem. A number of attempts have been made to establish criteria for a patient-method alignment, for example, the symptomatic diagnosis (like behavior therapy for phobias, an inspirational group such as AA for alcoholism, etc); the characterologic diagnosis (like the personality typologies proposed by Horowitz, see p. 217); responses to hypnotic induction (Spiegel & Spiegel, 1978); and the developmental diagnosis (Burke et al., 1979). The latter authors believe that therapeutic methods may be selected to resolve conflicts which develop in different stages of development (Erikson, 1963). Thus Mann's technique (1973) of focusing on separation-inpiduation, in an empathic "feeling" atmosphere, would seem most useful with passive-dependent patients unsuccessful in resolving the adolescent's conflict of "identity vs. role confusion." Here the struggle over termination of therapy brings the early separation-inpiduation conflict to the fore and gives the patient an opportunity to resolve it in a favorable setting. The hypothesis is that if patients successfully master separation from the therapist, they will move on to greater inpiduation and overcome

their dependency needs. Patients who in their development have moved beyond the crisis of identity toward the "First Adult Life Structure" (Levinson, 1977) and, in their efforts to establish intimate relations, have been blocked by resurgence of oedipal conflicts are well suited to the intellectual, interpretive, confrontation style of Sifneos and Malan. Problems of the latency period that emerge during the midlife transition brought about by challenges of "productivity, creativity, and the maturity to deal with new generations at home and at work" would be suited most for a "corrective action" approach such as that of Alexander and French, the maximum therapeutic effect coming "from transference manipulations and a managerial stance by the therapist." Under these circumstances. Burke et al (1979) contend, a careful developmental diagnosis will help identify patients who can benefit from psychotherapy; it can also help in the selection of an appropriate therapeutic method.

However, none of these selection schemes, involving symptom manifestations, character structure, or developmental conflicts, has been proven entirely reliable. This is because of the interference of numerous miscellaneous patient, therapist, environmental, transferential, countertransferential, and resistance variables. The very choice of a diagnosis and the identification of the prevailing developmental conflict around which the therapeutic plan is organized is subject to the therapist's bias as is the method to which the therapist is attuned. This bias will prejudice the patient's response. A therapist who applies himself to a favorable technique with enthusiasm and conviction will expedite the patient's progress, whereas the same technique used casually and unenthusiastically may have a minimal effect on the patient. The style of some therapists and their investment in their theories will support or militate against the effective use of any of the methods such as those proposed by Sifneos, Malan, Davanloo, Alexander and French, Lewin, Beck, and others. In summary, at the present stage of our knowledge we cannot be sure that a selected method exists for every patient we treat. Our options must remain open, and we must be willing to change our methods when a selected technique proves to be sterile.

Conclusion

A wide variety of techniques is available to a therapist, their selection being determined by the existing symptoms and complaints of the patient, the familiarity of the therapist with applicable methods, and the patient's willingness and ability to work with the chosen interventions.

Whether we attempt to influence the patient's biochemistry through pharmacotherapy, or his neurophysiology through other somatic therapies or relaxation procedures, or his habit patterns through behavior therapy, or his intrapsychic structure through psychoanalysis, or his interpersonal reactions through group or family therapy, or his social behavior through milieu therapy, or his philosophical outlook through existential therapy, the patient will react globally to our ministrations, every aspect of his being, from physiological makeup to higher psychic processes, being influenced through a feedback effect.

The proper use of techniques calls for a high degree of expertise. Required are qualities in the therapist that permit establishing rapidly a working relationship with the patient, a dealing with motivational deficiencies and other resistances as they develop, and a managing of those personal reactions that are prejudicial to maintaining an objective and empathic therapeutic climate. The atmosphere for the most effective operation of techniques may periodically call for support and reassurance tempered by sufficient maintenance of tension during the interviewing process to promote incentives for exploration and for experimentation with new patterns of behavior. Confrontation may periodically be required to break through resistances to change, but confrontation if used must be carefully titrated against the patient's tolerance of anxiety. Interpretive activities on some level are required, especially when resistance to the therapist, to the therapist's techniques, and to change paralyzes the therapeutic effort. The most effective detecting of and dealing with such resistances necessitates understanding of how to implement dynamic interventions such as the use of dreams and the analysis of transference.

Short-term therapy, even where the methods are supportive or reeducative, as has before been repeatedly emphasized, is much more effective where it is skillfully executed in a psychodynamic framework. No more than a few interviews conducted along dynamic lines may be needed to unbalance the shaky homeostasis that has ruled the patient's existence and to make possible beginning constructive changes in the way that the patient relates to himself and others. Where the inpidual has been brought to some recognition of the initiating factors precipitating the difficulties for which he sought help, where he becomes cognizant through interviewing of the presence of some pervasive personality problems that sabotage his happiness, where he relates aspects of such problems to his current illness, and where he gains a glimmer of awareness into early sources of difficulty in his relationship with his parents and

other significant persons, he will have the best opportunity to proceed beyond the profits of symptom relief.

By pointed questioning the patient is encouraged to put the pieces together for himself, particularly to figure out the circumstances that have impaired his adjustment prior to coming to treatment. There is an exploration as to why the patient is now unable to work out his present difficulty by himself, coming hopefully to a realization of the resistances that prevent a resolution of problems. The patient, encouraged in self-observation, is taught how to relate symptoms to precipitating happenings in the present environment as well as to inner conflicts within himself. What we are trying to do is to mobilize some insight into the underlying difficulties. We must modestly admit that some of the insights we offer the patient are not always complete or even correct. Even though they are partially valid, however, they often serve to alleviate tensions by providing an explanation that may help the process of stabilization.

The nonspecific windfalls of insight do not invalidate the specific profits that can derive from a true understanding of the forces that are undermining security, vitiating self-esteem, and provoking actions inimical to the interests of the inpidual. In opening up areas for exploration, the short-term therapist must confine himself as closely as possible to observable facts, avoiding speculations as to theory so as to reduce the suggestive component. The more experienced the therapist, the more capable he will be of collating with minimal delay pertinent data—from the patient's verbal content and associations, gestures, facial expressions, hesitations, silences, emotional outbursts, dreams, and interpersonal reactions—toward assumptions that, interpreted to the patient, enable him to reflect on, accept, deny, or resist them. Dealing with the patient's hesitancies to the acceptance of interpretations and to the utilization of his expanded awareness toward actions that may lead to change, the therapist continues to examine his original assumptions and to revise them in terms of any new data that present themselves.

Even though a therapist may utilize a variety of techniques, their employment within a dynamic framework seems to catalyze the therapeutic process. The patient's unique response to the methods employed (interviewing, confrontation, behavior modification, hypnosis, etc.) will almost inevitably expose habitual characterologic styles and perhaps resistances that can become an important focus during treatment. Where the patient manifests a desire to examine his reactions, the results may be particularly gratifying. And where a transference situation can be detected and explored, and its genetic

roots understood, an enduring imprint may be etched. The therapist should, therefore, be alerted to any behavior or attitudes that in any way reflect transference. Often such behavior is not manifest and is detected only in dreams and acting-out. Even though time in therapy is short, the therapist, if sufficiently perceptive, will detect some transferential behavior in the way the patient relates to the therapeutic situation, especially if the therapist is active and provocative. And yet in a considerable number of cases the patient may control or mask his transferential responses so that they are not at all apparent. Here, all is not lost; since with the other data available, one may still be able to establish a consociation between the patient's symptoms and complaints, character structure and the genetic roots of the prevailing neurotic needs and defenses. A hopeful prospect is that therapeutic change will not cease at the termination of the short-term contact but will continue the remainder of the inpidual's life.