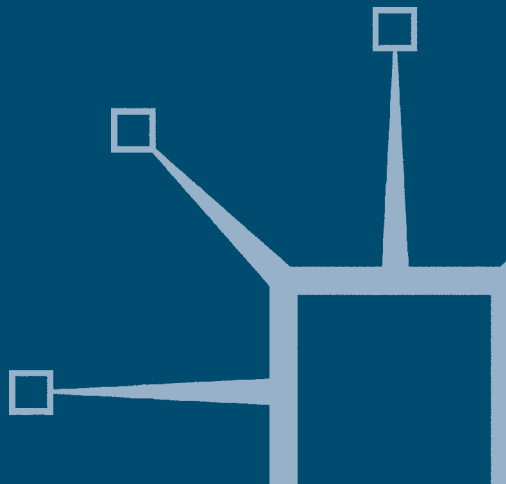


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SHORT-TERM PSYCHOTHERAPY

A Psychodynamic
Approach

ALEX COREN

palgrave



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ALEX COREN

The author and publishers are grateful to both Faber & Faber and Alfred A. Knopf, a division of Random House Inc., for permission to reproduce copyright material from Lorrie Moore's *Birds of America*.

'Look,' Aileen said. 'Forget Prozac. Forget Freud's abandonment of the seduction theory. Forget Jeffrey Masson – or is it *Jackie* Mason? The only thing that is going to revolutionize *this* profession is Bidding the Job.'

'I specialize in Christmas,' said the psychotherapist, a man named Sydney Poe, who wore an argyle sweater vest, a crisp bow tie, shiny black oxfords, and no socks. 'Christmas specials. You feel better by Christmas or your last session's free.'

'I like the sound of that,' said Aileen. It was already December first. 'I like the sound of that a lot.'

Lorrie Moore, *Birds of America*

INTRODUCTION

Joan

Joan, a 52-year-old woman, came for counselling at the suggestion of her general practitioner. Her presenting problem had been an argument with her husband over the extent and nature of her contact with her family of origin. Tearful throughout the initial meeting, she described how her own family had never accepted her marriage to her husband. She acknowledged that he was a difficult man, who had himself had a disruptive childhood and was prone to periodic depressions, but she was attached to him and found her family's rejection of him painful. It was as though she was continually being asked to be an intermediary (or to choose) between her husband and family.

Joan had been born and brought up in North America. Her family was described as comfortable and had been part of the same small community for some generations. Her father was an eminent doctor, her mother an artist. Joan was the youngest of three children and felt that while her elder two siblings were given every opportunity to fulfil their potential she was, despite the family's high expectations of her, never encouraged to develop her own life separate from them. Her elder brother became a doctor and her sister a lawyer. She described her father as patrician and emotionally distant, although he could be kindly, while her mother, while emotionally more expressive, could be cruel and vindictive. Her mother had been prone to depressions which Joan as a child had felt responsible for; on these occasions she had attempted to be particularly good in the hope of pleasing her mother and cheering her up. Her mother had died some months previous to the consultation, berating Joan for her unwise marriage from her deathbed.

Joan met her husband while studying abroad and married him in the face of her family's reservations. He, although successful in his chosen career, disliked 'talking about feelings', felt Joan should sever contact with her family, and would berate her for being 'weak and suggestible'. The marriage, although at times turbulent, had lasted some 30 years and had produced two children who had recently left home to pursue their careers. Joan was preoccupied with helping them in

any way she could, which involved daily contact with her daughter who wished to go to art college and fretting about her son; she was sure that despite his success in his chosen field, he was 'worried about something'.

In the session Joan was talkative, tearful and felt trapped by the demands on her. She was suspicious of the counsellor, asking about his theoretical orientation and training. Her husband would be furious had he known she had come; though her children had advised her to come, this only made her feel more guilty, thinking that it implied that she had failed them as a mother. The counsellor felt somewhat intimidated, not quite knowing how to proceed yet wanting to be of some help to both Joan and the referring general practitioner.

Trevor

Trevor was a 42-year old executive in a software company. He sought therapeutic help because he thought his life lacked meaning and direction. Indifferent towards most things, he clung to his working life, which was 'always there and predictable', but felt he had no motivation to do anything 'for anyone, even myself'. He had been meaning to seek help for some years but had 'never got round to it'.

Needing some prompting, he explained that he could take little pleasure from his young child and found his relationship with his wife lacked vigour and spontaneity.

He had grown up as an only child in the north of the country. This was described as safe and secure until the age of seven when his parents separated. This came as a complete shock to him, since he had no indication that his parents did not get on; subsequently it transpired that both parents had other partners whom they married within a year of the separation. Trevor lived with his easy-going and relaxed mother and her new husband until the age of 12 when his mother, whose increasing depression Trevor had mistakenly seen as a reflection of her easy-goingness, separated from her husband and Trevor went to live with his father in a town some miles away. His father's new family, which included two step-siblings, was one where emotions were not discussed, which he found very difficult. Trevor dealt with this disruption by becoming a fretful and anxious teenager, developing a range of psychosomatic illnesses while spending all his spare time in his room with his computer, which he had brought from his previous home. Trevor had been a passive child who had feigned illness in order to avoid going to school where he felt he did not fit in well. He felt under-stimulated by school, preferring to spend the time at home on his own with his computer. By his own admission he had become sad and lost, with 'no one really caring what

I do'. He had always found relationships with women difficult and married his first girlfriend, who was the first female to notice or take an interest in him.

Trevor was not sure how therapy might help and was unable to articulate any version of what a more fulfilled life for him might consist of; he lacked the motivation even to think about this. During the session he frequently looked at his watch and twice needed to consult his pocket electronic notebook to confirm where he next needed to be. The session had a desultory flavour where time passed slowly, as Trevor attempted to address the questions his counsellor put to him.

Joan and Trevor both sought therapeutic help. It is the contention of this book that both can be helped by short-term, time-limited interventions. While reading this book the reader is invited to think about the nature of the difficulties Joan and Trevor experienced and to come to some tentative suggestions as to how their difficulties could be formulated and addressed using a short-term, time-limited, therapeutic approach. My own framework is described towards the end of this book on pages 204–6.

The majority of therapeutic encounters today are brief. Frequently this is by default rather than by design: a client will leave, vote with their feet or drop out before the therapist is (or believes their client is) ready to finish. This is very different from therapies which from the outset are time-limited and use the framework of time to facilitate therapeutic change. This book is an attempt to address and describe planned time-limited therapies.

Clinical practice would suggest that brief therapy is what most clients receive, and that for a variety of reasons it is likely to form an increasingly large part of a clinician's workload. While this is increasingly the case, it is of interest that many clinicians still view open-ended or time-unlimited therapy as the default option and the framework from which brief therapies are viewed and evaluated. That this continues to be a clinical illusion may well be based on the fact that many clinicians spend more time – and are more comfortable with – their longer-term clients (Messer and Warren 1995); but it is also likely to reflect a deep-seated suspicion of brief therapies. Indeed, to call time-limited therapies 'brief' already implies that there is something which is the oppo-

site of brief and therefore by definition all that 'brief' is not – relaxed, leisurely, thorough and timeless. It is for this reason that I have attempted (and it has been difficult) to avoid using 'brief' in this book. Wherever possible I have tried to use the terms 'short-term therapy', 'focal therapy' and 'time-limited therapy' (TLT), in order to transcend the evaluative 'brief therapy', which for many clinicians is too emotionally laden.

Many time-limited therapies are not particularly brief, but what distinguishes them is the open acknowledgement that the therapeutic frame needs to incorporate and use time as a therapeutic resource. To deny this is to deny our own relationship with – or transference to – mortality and the fact that, as human beings, our time is finite. The limitation on time gives each therapy a definite beginning, middle and end – resembling life itself – and, again like life, has the effect of preventing a therapy becoming aimless and drifting towards an end that is unclear and often unsatisfactory.

Recent years have witnessed an increasing interest in focal therapies. In part this can be seen as a consequence of the increasing pressure on both public and voluntary sector therapeutic services, where the availability of open-ended therapies has become severely restricted. However, this renewed interest is not merely the result of financial restrictions and long waiting lists. There is now an increasing body of knowledge which is suggesting that time-limited therapies can be clinical treatments of choice – in addition to merely being cost-effective – for an increasingly wide range of psychological and emotional problems.

This has posed theoretical and clinical problems for those therapies which traditionally have been open-ended and reliant on the measured and unhurried development of the therapeutic relationship. Of particular interest in this context are therapies stemming from psychoanalytic theory and clinical practice. While many therapies, of diverse therapeutic orientations, are now *de facto* time-limited in their application, psychodynamic theories have, with a few notable exceptions, struggled to incorporate more focal or time-limited approaches. As psychodynamic therapies get longer, as a result of increasing theoretical interest in early and primitive stages of development, they are in danger of retreating into private practice, having seemingly little to offer busy public sector services. Clinicians struggle to incorporate the

timelessness of analytic psychotherapy into a world, both internal and external, where time is finite. I believe this is particularly unfortunate, because psychodynamic insights, and clinical skills, are potentially of great value in understanding and expediting the therapeutic processes of focal therapies. The understanding of such issues as transference and counter-transference, the therapeutic alliance, un- and preconscious metaphors, developmental theory and the use of self in the therapeutic dyad, can all be helpful in applying a time-limited therapeutic framework.

How brief *is* brief? In a sense, there are as many definitions of what time-limited therapy is as there are therapists and clients. Short-term work can range from a one-off consultation to over a year's weekly work; the definition is often dependent on the therapist's own professional training, theoretical orientation and background. As we shall see, there is a wide variation in the length of therapies among time-limited therapists, who differ not only from open-ended therapists but also between themselves, on a whole range of issues. My own preference is to distinguish between what we could call a 'focal consultation', or 'conversation', which may be in the region of four sessions, and 'planned focal therapy', which can involve treatments which can stretch over some months. The important point is that there is a preset time limit from the outset of treatment, and the use of this framework is what gives focal therapy its distinguishing feature. This does not exclude intermittent focal therapy where the client returns for a circumscribed number of session over a period of time.

As we move into a world where economic factors, third-party financial providers of therapeutic help and most importantly the preference of the recipients of therapy themselves are influencing the parameters of therapeutic work, it behoves us as clinicians to seriously take stock of what we offer and to attempt to evaluate and articulate what it is we do and why we attempt it. This book is an attempt to demonstrate the advantages, as well as the limitations and dangers, of time-limited therapy.

Beginning with a historical overview of the development of short-term interventions based on psychoanalytic theories, the book reviews the current situation and examines a variety of more focal therapeutic orientations in an attempt to tease out the similarities between them. To facilitate this I have used *italics* to draw

attention to core themes in relation to modern short-term therapies as they occur in the text.

Chapter 1 looks at the theoretical foundations of the early pioneers of short-term therapy. This will trace the development of focal therapies and elucidate the theoretical and clinical rationale for time-limited approaches, and the reasons why they became either discredited or abandoned.

Chapters 2 to 4 provide a critical overview of the current field, and outline what I consider to be the major current clinical therapeutic orientations. Given the plethora of treatments available, I have of necessity had to make subjective decisions as to what to include and have used as my guide either those therapies which are widely practised or those that have some links – however peripheral they might appear initially – to psychodynamic theories.

Chapter 5 draws on the strengths of the various approaches outlined to describe a model of focal therapy which incorporates what I consider to be their strengths together with a framework for their clinical application. Of particular interest is how issues of process and frame of therapy can be understood and used with specific reference to transference metaphors, core concepts and personal schemas, automatic thoughts, relational concepts and narrative beliefs about the self. A model is described which seeks to incorporate these concepts into a flexible clinical framework for time-limited therapies.

Chapter 6 looks at how concepts such as narrative and attachment can inform short-term therapeutic approaches. The importance of therapeutic surprise, the use of both the therapists' and the clients' idiom, and the particular nature of the therapeutic relationship as manifest in metaphor in short-term therapy will be discussed.

Chapter 7 addresses the issue of clinical assessment and describes the differences in the assessment process between time-limited and open-ended therapies. The concept of borderline personality organisation is discussed with particular reference to assessing for short-term therapy.

Chapter 8 looks at the differences in therapeutic technique and practice between longer- and shorter-term therapies. It highlights and discusses some technical difficulties which are

likely to be problematic for clinicians coming from open-ended frameworks.

Chapter 9 addresses the challenges and potential problems, for both the clinician and the client, of time-limited therapies. This includes some discussion of the wider social – and ethical – implications of the increasing use of focal therapies in an age of managed care and employment assistance programmes which can be perceived, and experienced, as non-clinical attempts to set the framework for treatments.

The training and supervisory needs of the time-limited focal therapist are discussed in Chapter 10. That this is a crucially important area in clinical practice is stressed throughout the text, and there are significant differences here with the training for, and supervision of, clinicians practising open-ended therapies.

Chapter 11 looks at the clinical application of a time-limited model to various contexts and discusses how it can be applied to varied and diverse settings.

(I have used the terms ‘patients’ and ‘clients’ interchangeably depending on the usage, practice and context in which the terms appear.)

Just how difficult working briefly is was brought home to me in the writing of this book. Attempting to be concise, I ended up with a text nearly double the length of this the published version. It is always tempting to use a paragraph where a sentence will do!

THE HISTORY OF SHORT-TERM THERAPY IN THE DEVELOPMENT OF PSYCHOANALYSIS

In analysis one asks: How much can one be allowed to do? . . . in my clinic the motto is: how little need be done?

– D.W. Winnicott (1990)

Freud was the original brief therapist. If symptoms, as originally suggested, were caused by traumatic memories which were repressed – or forgotten – then it followed that if these memories could be recalled, and the feelings associated with them experienced, the symptoms would abate. Hypnosis was the preferred mode of treatment, beginning with Breuer's treatment of Anna O. (Freud 1955). This was thought to be efficacious because recovery depended on the patient remembering something which was excluded from conscious thought or experience. Freud, noticing that not all patients could be hypnotised, developed the 'cathartic' method where the patient would lie on the couch and, often with the aid of gentle pressure on the forehead and the therapist's active urging, 'forgotten' memories and feelings were recalled. These techniques were to become the forerunners of psychoanalysis. However, these early and experimental treatments were brief and symptom-focused, and relied heavily on the active intervention of the therapist. In this they were very similar to modern focal therapies where brevity, therapeutic activity and a central organising focus are central themes.

The legacy of Freud

Freud suggested that the patients who would benefit from psychoanalysis included those who were highly motivated, reasonably intelligent and showed a 'positive attitude' towards therapy and the therapist. Motivation was important, Freud stressed, because of the resistance which would surface once the patient became aware of 'the direction in which the treatment is going'. The therapist had to be firm in encouraging and insisting on the patient's ability to remember while at the same time allowing himself to be appropriately supportive and educative both in terms of talking about the process of treatment and in 'making the unconscious conscious'. This would enlist the patient as a collaborator rather than condemn them to being a passive and dependent receptacle of the therapist's wisdom. Transference only became the central feature of the treatment much later, although even at this time Breuer and Freud recognised that 'material may be considered *either in the transference or in the memories of the past*' (Flegenheimer 1982, p. 22, my italics.).

Freud believed that psychoanalysis was not applicable to the 'most serious' cases and could be used only for the milder ones. Ironically, today the reverse is claimed by the proponents of psychoanalysis: psychoanalysis is applicable for more serious pathology, less so for minor developmental problems. It is interesting to note a similar debate among contemporary time-limited therapists.

Freud's early treatments only lasted a few weeks or months. Given the nature of his theories at the time – that a combination of interpretation and insight would lead to recovery – the therapist need only make a correct interpretation and the patient need only accept it for the symptom to abate. If the patient resisted the therapist would make every effort to convince the patient of the correctness of the interpretation. Early analyses, including Freud's self-analysis, were very brief. Gustav Mahler's treatment consisted of one four-hour session, while an initially sceptical Bruno Walter was successfully treated in five or six interviews spread over a period of time (Walter 1947). Lucy R. was seen regularly over a nine-week period, a therapeutic frame which would be seen as standard by many modern time-limited therapists, while Katharina (Freud 1955) was seen once. Katharina's con-

sultation is of particular interest since it resembles many of the theoretical and clinical applications of contemporary short-term therapies.

Freud was walking in the Hohe Tauern mountain range 'so that for a while I may forget medicine and more particularly the neurosis', when he was approached by Katharina enquiring whether he was a doctor. Freud, surprised and interested to 'find that neurosis could flourish in this way at a height of over 6,000 feet', entered into what he called a '*conversation*' (rather than a consultation) with her. Katharina complained of periods of being 'out of breath' and, after enquiring about the context in which they occurred and their associations, Freud was able to *reframe the symptom* within a psychological framework. Freud was sure that the episodes of breathlessness were anxiety attacks; '[S]he was choosing shortness of breath out of the complex of sensations arising out of anxiety.' By questioning her on the exact nature of the symptom (*start where the patient is* and do not be afraid to be active in asking questions and taking control) he was able to explore possible formulations for Katharina's difficulties. Freud's (1955, pp. 125–34) account of his meeting with Katharina is worth quoting in some detail. (Italics highlight the similarities between early Freud and modern time-limited therapies, particularly in the areas of brevity, focus and therapist activity.)

Was I to make an attempt at analysis? I could not venture to transplant hypnosis to this altitude but perhaps I might succeed with *simple talk*. I should have to try *a lucky guess*. I had found often enough that in girls anxiety was a consequence of the horror by which a virginal mind is overcome when it is faced for the first time with the world of sexuality. So I said '*If you don't know I'll tell you how I think you got your attacks.*' [This can be seen as a tentative and humble reconstructive formulation similar to modern focal approaches.] At that time, two years ago [the time of the initial attack], you must have seen or heard something that very much embarrassed you, and that you had rather not have seen.

Katharina went on to relate seeing her 'uncle' (discretion led to Freud only subsequently revealing that 'Uncle' was actually Katharina's father) in a sexually compromising position with her

cousin which led to the breakup of 'Uncle's' marriage. Katharina blamed herself for this and goes on to recall 'Uncle's' attempts to seduce her. Freud ends by saying:

If someone were to assert that the present case history is not so much an analysed case of hysteria as a case solved by *guessing*, I should have nothing to say against him . . . I hope this girl, whose sexual sensibility had been injured at such an early age, derived some benefit from our conversation. I have not seen her since.

While Freud can be accused of 'leading the witness' as a result of his activity, questioning and focus (which as we shall see is a common criticism of brief therapists), and appears to have placed reliance on what he termed 'guesswork', he is perhaps unnecessarily defensive about this, since his interventions are based on both his clinical experience and his theory of neurosis. Freud was left not knowing the outcome of his conversation with Katharina, leaving us, and possibly him too, curious – an outcome common to many contemporary focal therapists. As Groves (1996, p. 447) points out, Katharina:

shows [Freud's] willingness to adapt the therapeutic frame to the temporal situation of the 'patient' . . . it is equally remarkable for the artistic tension and narrative force that survive translation and partly explain Freud's being nominated in the late 1920s for the Nobel Prize – not in medicine but in literature.

Freud eventually replaced the cathartic method with free association, which required therapeutic passivity and increased the likelihood that patients would regress and become more dependent on the process of therapy. They were also more likely to form a transference neurosis (a specific illusion of the therapeutic relationship) which would take more time to analyse and treat. Trauma theory was supplanted by the Oedipus complex. Issues of resistance, character analysis, working through, and difficulties over termination can all be seen to be a consequence of the new analytic technique of free association, and ensured that therapies were destined to become longer. Therapists became less active, challenging or supportive, and interpretations, both in relation to the therapist (that is, trans-

ference) and in relation to the patient's early history (that is, reconstruction), became central to the treatment and to therapeutic change.

Therapeutic grandiosity, in the belief (and hope) that all aspects of mental life could and should be analysed, led to therapies developing a sense of timelessness which therapists, in thrall to the new 'science', did nothing to dissuade. With the loss of any sense of finite time there was consequently no need for a focus and a reduced urgency for symptom relief or symptomatic attention. If therapies were becoming longer they had almost by definition to become more rigorous; what other rationale could there be for the increasing length of time patients spent in the consulting room? Rigour and depth still remain contentious issues in contemporary debates about long-term versus short-term treatments. In psychoanalysis and psychoanalytic psychotherapy, increasing knowledge has led to the inevitable belief that treatments need to be longer; we could however infer that knowing more about them should make them shorter.

The fact that many of the early cases treated by the cathartic method improved while others treated by free association showed less progress did nothing to dampen psychoanalytic zeal. Therapies became longer and longer and, as in many fundamentalist sects, anything that deviated from the true faith was rejected and ostracised. This may go some way to explain why psychoanalytic clinicians have become so suspicious, uncomfortable and uneasy with the idea of TLT, and are tempted to regard it as somehow an inferior and diluted version of the 'real thing' (Coren 1996).

However, therapeutic passivity was not the only option for Freud at the time. Some believe he took the wrong turn:

It needs to be stated categorically that in the early part of the century, Freud unwittingly took a wrong turn which led to disastrous consequences for the future of psychotherapy. This was to react to increasing resistance with increased passivity. (Malan 1992)

There is a long and honourable tradition of brief psychoanalytic psychotherapy and it is to its original proponents that we now turn.

Otto Rank and birth trauma

Freud had proposed a theory which was increasingly dominated by the ideas and philosophy of medicine. The 'drive-structural theory', as it was called, relied heavily on the belief that there were instincts or drives which were seeking release and which were confronted by an 'ego' or sense of self, which mediated between the individual and his environment. Essentially an intrapsychic, one-person, theory, it paid relatively little attention to the involvement of other people. As a consequence, its clinical applications viewed the therapist as a detached observer or, if intervention was required, guide. Many of Freud's contemporaries became uncomfortable with these ideas and began to posit clinical approaches which were more based on relational, that is two-person, concepts. Among the earliest dissenters were Otto Rank and Sandor Ferenczi.

Rank, emphasising the trauma of biological birth, drew attention to this event as a metaphor for separation, individuation and development for all individuals. Rather than view anxiety as a consequence of the individual's struggle to contain impulses, more especially sexual and aggressive drives, Rank saw it as a response to a 'primal fear, which manifests itself now as a fear of life, another time as a fear of death' (Rank 1929, p. 123). Implicit in his view is the belief that therapy, like life, would need one day to end, and that in every therapeutic hour issues of separation and individuation would be in evidence. Rank saw the patient as being in a relationship with the therapist which must end one day, and the acceptance of this became the core ingredient of any successful therapy. The patient was encouraged to *individuate and separate* from the therapeutic process, and, since this involves similar issues to those experienced in the original birth trauma and its metaphoric equivalents, it is this element of therapy which is curative. Rank thought patients needed to be actively empowered to express their will, and thought the danger of Freudian therapy was that the patient would passively capitulate to the therapist's new explanation for their behaviour or feelings. Along with this, he was the first to express concern that long-term, open-ended therapies, while enabling the therapist to learn more about psychological and psychic functioning, were unlikely to cure, or help, the patient as quickly as possible. Rank was among the first to

espouse a *developmental model for psychoanalysis* rather than one circumscribed by ideas of medical cure. These ideas continue to inform some of the contemporary 'lifetime models' of brief therapy. Rank advocated:

- Emphasis on present experiences and relationships.
- Emphasis on transference, especially in relation to the primary attachment to the mother, rather than any sexual or aggressive manifestations of 'drives or instincts'.
- Setting a termination date for therapy.
- Open exploration of feelings and thoughts – and their clinical resistances – in relation to the therapeutic dyad.

Termination dates were set according to when Rank thought the patient was 'struggling with the will to individuate' (Messer and Warren 1995). For Rank the patient is always aware that the treatment must one day be finished. Not surprisingly, given Rank's belief in the trauma of birth and intrauterine life, he believed most patients would choose a period between seven and nine months in treatment, repeating the original period of gestation. Issues of dependency, separation and relatedness were central to any therapy, and needed to be incorporated into the therapeutic frame. Individuation, the fundamental goal of therapy, could be addressed best through acknowledging and working with limited time. Rank's views on this are similar to those held today by James Mann; setting a time limit assists the patient in accepting the reality of finite time. The theory of the birth trauma and time limits led to treatments often only a few months long and heralded the ending of Rank's relationship with Freud in 1926.

Sandor Ferenczi, mutuality and the theory of trauma

Ferenczi, like his early collaborator Rank (Ferenczi and Rank 1925), was concerned about increasing therapeutic passivity, intellectualisation (fear that psychoanalysis was becoming an academic and pedagogic discipline) and the increasing lack of any affective contact between patient and therapist. Believing that

by placing paramount importance on the *emotional experience* of therapy shorter therapies would result, Ferenczi experimented in increasing the emotional content of sessions, challenging the belief that the therapist should be a blank screen, and raised issues, alive today, about therapeutic neutrality which had become a cornerstone of psychoanalysis. Uneasy with the increasing academic preoccupation of psychoanalysis in its desire to become a profession allied to science and medicine, Ferenczi believed that psychoanalysis had become confused as to whether it was an academic, intellectual discipline or a clinical treatment aimed at curing distressed people. Believing that Freud had lost interest in the therapeutic aspects of psychoanalysis (that is, in essence, a relationship between two people centred around curing the patient's 'pain'), Ferenczi advocated *active* involvement with patients during the therapy. While therapeutic passivity and inactivity were justified by those claiming scientific objectivity and neutrality for psychoanalysis, Ferenczi believed that vulnerable patients needed interpretations and scientific integrity less than support, encouragement and therapeutic 'nourishment' (Stanton 1990).

Together with Rank, Ferenczi held that childhood deprivation and conflict led to neurosis. As a consequence, he believed that deeply distressed or disturbed patients needed sometimes to be held and physically comforted and that to withhold this would be cruel if not sadistic. Ferenczi suggested that therapeutic activity could redress the earlier parental failures that the patient had experienced and had brought them into therapy. Freud dismissed this by calling it 'the kissing technique', something from which Ferenczi's reputation in mainstream psychoanalysis never fully recovered, but in retrospect we can see how Ferenczi was attempting to stress the *importance of process* (that is, the therapeutic relationship), rather than understanding, in therapy; he stresses this in a letter to Freud dated 17 January 1930: 'I do not share . . . your view that the therapeutic process is negligible or unimportant, and that simply because it appears less interesting to us we should ignore it' (quoted in Dupont 1995, p. xiii).

Rejecting the 'rigidity of analysis', Ferenczi advocated active and flexible interventions. Believing that Freud was becoming a pedagogue, teaching his patients what their symptoms meant and

represented, Ferenczi wanted to establish a new *cooperative therapeutic relationship* and thereby empower his patients. Uncomfortable with what he viewed as the hypocrisy and conceit of certain analytic stances, he linked 'the trauma of the powerless child' in the face of the adult world with the trauma of the patient faced with an overbearing analyst:

Ferenczi draws parallels among the child traumatized by the hypocrisy of adults, the mentally ill person traumatized by the hypocrisy of society and the patient, whose trauma is revived and exacerbated by the professional hypocrisy and technical rigidity of the analyst. (Dupont 1995, p. xviii)

Ferenczi believed that patients suffered from childhood deprivations and also that rigid therapies were likely to revive and repeat the childhood traumas they were attempting to cure. Inflexible therapies, and by implication therapists, could damage your health by subjecting you to a further trauma. This then became merely a repetition (as opposed to repairing or healing) of previous traumas. Uneasy with a theory which was increasingly becoming transformed into a rigid dogma, he was concerned that patients who were excluded from the increasingly rigid criteria of analysability were being effectively denied any therapeutic help. This was in itself traumatising. Ferenczi believed that all patients who asked for help should receive it, and it was up to the therapist to decide and devise the most appropriate therapeutic response. As a consequence Ferenczi had the most difficult patients referred to him by his colleagues.

At the time these were radical ideas. They can be seen to predate modern concepts of the multidisciplinary team where patients are allocated to the treatment which most suits their needs rather than having to adapt to a single, possibly inappropriately rigid, therapy. This issue is also of central significance when assessing for time-limited therapies.

Ferenczi's view about trauma included a belief that therapists were often defensive about their own feelings and experiences in a manner which was unhelpful, and often harmful, to their patients. His response to this was the idea of 'mutual analysis'. When the therapist found himself struggling to help or provide support, he was encouraged to acquaint the patient

as sincerely, as he can, with his own weaknesses and feelings. The analyst thus allows his patients to know better where they stand with him; even if in that way the patients must confront and assimilate some painful realities, they will cope better with these than with feigned friendliness. (Dupont 1995, p. xx)

Ferenczi undertook these early experiments in the use of what we now call 'counter-transference' by having double sessions, or alternating sessions – one for the therapist and one for the patient. This clearly became extremely problematic, not least in respect of boundaries and confidentiality, but was designed to address the power imbalance in therapy as well as to enable both therapist and patient to 'place themselves in relation to the other with greater assurance' (Dupont 1995, p. xxi). Ferenczi's experiments in mutual analysis failed, not least since they led to the roles of patient and therapist becoming blurred. Ferenczi eventually recognised the difficulties in this method, but mutual analysis can be seen as an early way of understanding and using counter-transference interpretations, especially in relation to the therapist's blind spots. This has particular relevance to short-term therapy.

Alfred Adler

Mention should be made in this section of Alfred Adler, with particular reference to his contribution in the development of time-limited therapies. Taking up the issue of power in relationships, Adler saw the sense of powerlessness as rooted in the child's earliest reality. He proposed that the child has a primary wish to achieve mastery, and that this was rooted in social reality. Believing Freud was wrong to pay so little attention to reality factors in the child's (and by definition the adult's) development, Adler's thinking extended into social and educational areas. Adler believed that psychopathology arose because of

a mistake in the whole style of life, in the way in which the mind has *interpreted its experiences*, in the meaning it has given to life, and in the actions with which it has answered the impressions received from the body and its environment . . . these *mistaken impressions* are acquired in early childhood. (Adler 1958; my italics)

In striving for unattainable personal goals and the pursuit of personal superiority, the individual was in danger of losing sight of his relatedness to others. While Adler was one of the first analysts to place the individual in a social and relational context, it is his therapeutic techniques which are of interest to us. Adler helped the patient to understand and recognise '*faulty beliefs*', which were not necessarily in the realm of consciousness. The patient had the '*courage*' to do so as a result of his relationship with the therapist. Adler's approach took the form of '*discussions*' around the patient's misconceptions and how they related to his life. His therapeutic technique, while empathic and intuitive, also included '*guessings*', which were tentative suggestions and hypotheses which could be confirmed, negated or changed by subsequent material. He was also attentive to physical appearance, manner, posture and the symptom in giving clues to the faulty maladaptive beliefs which caused the patient difficulties. As we shall see, these are themes that recur in contemporary short-term therapies.

Ferenczi Rank and Adler had become concerned at the increasing amount of time that analyses were appearing to take and the clinical application of theories that they thought were becoming increasingly impersonal. They emphasise how the patient's early deprivation or conflicts are repeated in the therapeutic relationship, advocate a more active therapeutic stance rather than the purely interpretative, and, in their belief in focusing on the symptom and its relationship to earlier deprivations or traumas, can be seen to be advocating a form of treatment which mainstream psychoanalysis found difficult to incorporate. Because of this they were in time condemned to '*the psychoanalytic Gulag; the world of not psychoanalysis*' (Mitchell 1997, p. 15).

Alexander and French

Alexander and French (1946) considered their work an extension of the more relational models of Ferenczi and Rank. They shared Ferenczi and Rank's belief that problems were related to previous deficiencies in environmental provision and parenting, and their treatments reflected this in having an explicitly reparative aim.

Alexander and French challenged the importance of facilitating the expression of repressed memories, historical reconstruction and interpretations. What was mutative in therapy, they believed, was the patient's emotional experience, rather than the correct interpretation. Therapy needed to be an emotionally intense and short experience. Like Ferenczi and Rank, Alexander believed that long therapies often drifted into intellectualisation and consequently became less emotionally involving:

An extreme generosity with interviews is not only uneconomical but, in many cases, makes the analysis less penetrating. Daily interviews often tend to reduce the patient's emotional participation in the therapy; they become routine, and prevent the development of strong emotions. (Alexander in Barton 1971, pp. 28–41)

In this context, it is of interest to note that the belief that it is only long-term therapies that can be emotionally intense is a relatively recent development.

The 'corrective emotional experience', as it became known, was based on the *new experience of an old conflict*. Moreover, the repetition of previous experiences in the therapeutic relationship (although anticipated in that the patient would seek, consciously or unconsciously, to repeat previous patterns) needed to be met by a new and different therapeutic response. It was these differences which were seen to be therapeutic. An example would be of a patient who, subject to hostile and rejecting parenting, would expect the same, or a similar, response from the therapist only to be met with the opposite: that is, a therapist who could be both accepting and nurturing. This was what was held to be curative:

Because the therapist's attitude is different from that of the authoritative person of the past, he gives the patient an opportunity to face again and again, under more favourable circumstances, those emotional situations which were formerly unbearable and to deal with them in a manner differently from the old. (1971, p. 67)

What was required was the '*principle of flexibility*'. Alexander believed that therapists had tended to select their patients to fit their technique or theoretical base and that few had attempted 'to

adapt the procedure to the diversity of cases they had encountered' (Barton 1971, pp. 28–41). Consequently he advocated the principle of clinical flexibility to ensure that the therapist – or therapy – can adapt the technique to the needs of the patient rather than the other way round.

Alexander was aware of the danger of dependency, and advocated that treatment be interrupted for periods so that patients could actively work on their real-life problems without the therapist. Alexander made the point that many analyses had been vitalised by an unexpected absence or change on the part of the analyst, which he believed could precipitate more 'relevant' material than the weekly or daily routine. On the grounds that 'the analytic process is not confined to the analytic interview', he believed that what patients did *between sessions was as important as what happened in them*. Sessions were then arranged flexibly, which aided the independence of the patient and acknowledged real-life events outside the consulting room.

Patients were encouraged to focus on current life problems rather than the past, which was only seen as relevant if it was in any way related to the current problem:

The nearer the analyst can keep the patient to his actual life problems, the more intensive and effective the therapeutic process is. From the point of view of . . . research it might be advisable to encourage the patient to wonder back into . . . his early youth. Therapeutically however such a retreat is valuable only insofar as it sheds light on the present. Memory material must always be correlated with the present life situation, and the patient must never be allowed to forget that he came to the physician not for an academic understanding of the etiology of his condition, but for help in solving his actual life problems. (as quoted in Groves 1996, p. 36)

Alexander also cautioned against what he termed 'transference gratification'. Alexander was aware that Freud had struggled with the possibility that the gratifications that the transference relationship may offer might outweigh, or replace, the desire to be cured. Freud had remarked that transference impasses had, in the early years of his practice, led to difficulty in persuading the patient to continue with therapy, while in his later years they had led to his difficulty in inducing them to give it up. The notion of the impasse, and the need to focus actively on it, is important in

short-term therapies. For Alexander the transference relationship ran in parallel with real-life experience; it was less a repetition than a rehearsal, and in essence must be orientated towards the present and future. Therapy must be in the service of life, not the other way around. Transference can also provoke compliance. Having discovered the analyst's 'predilections', the patient may 'bring interesting material and give the impression of deepening insight and steady progress', and while 'the analyst may believe they are engaged in a thorough "working through", in reality the procedure has become a farce . . . procrastination on behalf of the patient' (Groves 1996, p. 38).

Regression, seen in psychoanalysis as the means by which early conflicts became accessible, was thought of by Alexander less as evidence of the depth of an analysis than as 'a neurotic withdrawal from a difficult life situation back to childhood longings for dependence gratifiable only in fantasy'. Thus regression can be a defence which needed to be interpreted. The principle of flexibility ensured that regressions, where untherapeutic, were avoided.

Alexander's concept of the 'corrective emotional experience' was criticised as a 'manipulation' of the transference, not least by attempting to provide a therapeutic response diametrically opposite to the one the patient would expect. In response to this, and to accusations that the concept of flexibility was artificial, Alexander countered that it was less a manipulation than was analytic neutrality and the emotional non-participation of the traditional analytic approach.

Commenting that Freud himself had come to the conclusion that the time comes when the analyst must encourage the patient to 'engage in those activities he avoided in the past', Alexander believed that

curbing the patient's tendency to procrastinate and to substitute analytic experience for reality (by careful manipulation of the transference relationship, by timely directives and encouragement) is one of the most effective means of shortening treatment. (Groves 1996, p. 42)

It is perhaps ironic that these issues have become contentious again in contemporary psychoanalysis specifically in relation to

Lacan, who found five-minute sessions more effective than the standard fifty-minute analytic 'hour'.

The work of Alexander together with that of Ferenczi and Rank not only offered a coherent blueprint for how psychoanalytic concepts could be used in shorter therapies but also presaged a shift from the one-person drive-structural, instincts, defence model to modern object relations theory, which recognised a therapeutic relationship in which both parties were constantly relating and influencing each other. The therapeutic relationship was now becoming the central feature of therapeutic improvement or change, no longer merely a blank screen for the projection of the patient's fantasies. However, in their time, brief treatments and their exponents were severely attacked by the psychoanalytic establishment and suffered a period of often malign neglect. Psychoanalysis believed – and some would say continues to believe – that notions of brevity and relationship are incompatible. It was the work of Michael Balint and his colleagues which led to time-limited therapies being rediscovered.

Michael Balint

Balint had been analysed by Ferenczi and shared with him the belief that patients attempt to obtain the unconditional love in therapy which had been denied them in childhood. This he came to term 'the search for the primary love object'. Like Ferenczi he recognised that the increasing lengths of psychoanalytic treatments were actually providing new 'obstacles to cure'. The work of Balint and his colleagues (1972) implicitly recognised that previous attempts at describing briefer therapies had foundered on issues of therapeutic 'activity' and 'manipulation'. They had been rejected by the psychoanalytic establishment because of their apparent disregard of the value of transference interpretations. Since psychoanalysis had not been able to incorporate these new techniques, Balint attempted, through stressing the importance of interpretation, to place focal therapy back onto a continuum with psychoanalysis. Balint's initial attempts at focal therapy foundered, perhaps not surprisingly, because of familiar

concerns among his colleagues over whether the new techniques and methods might challenge and endanger pure psychoanalysis. Balint however persevered and a focal therapy workshop was set up at the Tavistock Clinic from which Balint and colleagues (Ornstein and Enid Balint) wrote up a single case-study – a Mr Baker, who presented with episodic paranoid jealousy. He was seen by Balint for 27 sessions over a 15-month period and followed up for a further four and a half years. Mr Baker had initially only asked for five or six sessions. The case-study makes interesting reading for modern brief therapists for the light it throws on Balint's attempts to apply psychoanalytic concepts to focal therapy while still placing importance on central psychoanalytic tenets such as interpretation and instinct theory. Balint's focal therapy can be seen to develop themes outlined by both Ferenczi and Alexander. Primacy was placed on the *developing relationship between the patient and the therapist*. The psychopathology of Mr Baker – which most analysts would have considered severe, and at times during the treatment led to the possibility of hospitalisation – was of less importance than the developing therapeutic relationship and interaction between Balint and his patient. Primacy was placed on viewing treatment as a *process* between two people.

In the account of Mr Baker's treatment the workshop pioneered the use of an assessment form, which placed emphasis on the specific quality of the doctor–patient relationship, salient features (that is, *important moments*) of the initial interview, and the importance of having *focal aims*. Mr Baker's treatment roughly followed the two focal aims which were set in the initial interviews.

Having a well-defined focal aim brought up the issue of *selective attention and selective neglect* specifically in relation to interpretations. The focal therapist could not pay equal attention to all material; 'of all that the patient offers only those aspects are interpreted that facilitate and enhance the work on the chosen focus (in Balint *et al.* 1972, p. 134).' This is not to say that whatever appears unrelated to the focus is ignored, but that the therapist has to choose what to 'name and respond to'. In this way the therapist chooses what to interpret and influences the direction and process of the therapy. This was a very new concept of interpretation.

Balint believed attention had to be paid to material within the orbit of the focal aim. He acknowledged that interpretations can be manipulative but are tentatively offered and confirmed or rejected by the patient's ensuing material. They assist in defining the focus and are amenable to change and development.

Therapeutic flexibility included seeing Mr Baker with his wife – and occasionally only seeing his wife – as well as on occasion seeing Mr Baker's friends, which Balint termed 'milieu therapy'. Recognition is paid to the work that goes on outside the therapy and that this might be as important as the work done in sessions. The notion that therapies may be incomplete and yet beneficial was radical and new. In a letter to Balint, Mr Baker says 'You, Dr Balint, started something very important and I was able to finish it . . .' (in Balint *et al.* 1972, p. 121).

The 'focal workshop' led to early attempts to delineate criteria for those who may benefit from shorter therapies. These included:

- a willingness/ability to explore feelings;
- a willingness to work within a therapeutic relationship based upon interpretation;
- the therapist's ability to understand the patient in dynamic terms;
- the therapist's ability to formulate some kind of circumscribed treatment plan. (Malan 1963)

Balint viewed therapeutic change as a three-stage process. The therapist had to 'accept' what the patient offered, 'understand' it and then 'interpret' it at the appropriate moment. Consequently, focal therapy could be seen as being a form of applied psychoanalysis; the interpretation of un- and preconscious material was still seen as being central and mutative. In this way Balint hoped to bridge the gap between the early brief therapists who were seen as challenging, and being a threat to, psychoanalysis and the psychoanalytic profession. Central to this was a clear therapeutic aim, a focus which enabled the aim to be achieved and the necessity not to be sidetracked by the wealth of analytic material.

In the next chapter we look at how concepts highlighted by the early brief therapists have developed over time.

Summary

In this chapter we have:

- Traced the development of shorter-term psychoanalytic ideas in the work of Freud, Rank, Ferenczi, Adler and Balint.
- Seen how, and discussed the reasons for, psychoanalytic therapy becoming longer and open-ended.
- Highlighted the concern expressed by a number of psychoanalysts at the increasing length of treatments.
- Suggested that the work of Alexander and French can be seen to be a link between early psychodynamic treatments and modern time-limited approaches. Particularly important are:
 - The concept of therapeutic *flexibility*.
 - The need for an assessment and the setting of *therapeutic goals*.
 - The importance of focal goals involving some *benign neglect* of other therapeutic material.
 - The ‘manipulation’ of intervals between sessions, which predates the importance modern brief therapists give to the ‘therapeutic frame’.
 - The early acceptance by Alexander and French among others that the *meaning of the time frame* had to be recognised and brought into the treatment process.
 - Viewing the transference as non-neurotic and the importance of the *real-present-therapeutic relationship*. This served to decrease the ‘irrational’ elements of the transference and stressed the reality orientation of the treatment.
 - The need for therapeutic eclecticism depending on the needs of the patient.
 - The use of the present as a link with, rather than a consequence of, the past.
 - The importance placed on *influence, activity and direction*.
 - The suggestion that the therapist could be transformed from a passive listener to an *active participant and/or observer*.

SHORTER-TERM PSYCHODYNAMIC THERAPIES

But Freud 'disputes the pessimistic poet's view that the transience of what is beautiful involves any loss in its worth. On the contrary, an increase! Transience value is scarcity value in time. Limitation in the possibility of an enjoyment raises the value of the enjoyment.' Freud, for whom exclamation marks were themselves a rarity, insists that it is impermanence that confers value; it is the fact of death of the prodigal forms of transience that creates pleasure. It is life as provisional and therefore pleasurable that Freud celebrates . . . it is the passing of things that is the source of our happiness.

– Adam Phillips, *Darwin's Worms*

Early psychoanalysis was symptom-focused and active. As we have seen, resistance and the transference neurosis led to therapy becoming longer, unfocused and passive. It is possible that the embarrassment felt by the analytic profession towards hypnosis and the cathartic method has contributed to the vehement response to which short-term therapies have been subjected by the analytic community. The interest now shown by the analytic community in shorter therapies is a recognition that analysis is going back to its origins. However, it is not without considerable ambivalence that therapists are becoming more focused and active.

For psychoanalysis, focal time-limited therapy is nothing less than the return of the repressed. As we have seen, the early Freud was often an extremely brief therapist and in the main a successful one. What has had to be repressed is the history of the profession where short and active treatments were both popular and effective. Ambivalence felt towards short-term dynamic therapy is embedded in the historical development of psychoanalytic

thought and clinical practice. Concern that 'pure' psychoanalysis would need to be diluted when faced with large-scale demand has led to concern that the dilution of purity will be as a result of expedience rather than design. Dilution would be seen as a departure from analytic truth – this despite the fact that the early brief therapists were keen to see shorter therapies as *different* from open-ended psychoanalysis.

This historical legacy continues to exert considerable influence on the development of dynamic time-limited therapies. Contemporary brief therapies differ from long-term therapies and among themselves, particularly in relation to therapeutic activity, focus, what constitutes brevity and the selection criteria. In this chapter we look at a range of clinical approaches to time-limited therapy, beginning with those that are most similar to the early analytic approaches. We start with Sifneos, Davanloo and Malan, who by placing emphasis on interpretation, insight and the transference relationship can be seen to continue in the mainstream of analytic tradition.

Peter Sifneos: anxiety-provoking and anxiety-suppressive therapies

Peter Sifneos (Sifneos 1972, 1979) distinguishes between anxiety-suppressive and anxiety-provoking short-term treatments. His anxiety-provoking technique is based upon careful selection criteria, early and active use of transference interpretations, and confrontation. Relatively little attention is paid to termination.

Sifneos places a high emphasis on the first meeting with a new patient, seeing it as a microcosm of therapy. Active himself as a therapist, he expects the same response from his patient.

Anxiety-provoking therapy is applicable to any patient with well-circumscribed neurotic symptoms, and aims at limited-dynamic change, emphasising problem-solving and crisis intervention. Anxiety-suppressive therapy is aimed at the more disturbed patient and is more supportive in nature.

In *anxiety-provoking therapy*, Sifneos includes only patients who can be seen to have problems at an oedipal level of functioning. Clinical assessment requires some evidence that the patient's difficulties have originated from the oedipal stage of development,

a legacy of a three-person relationship. A patient thought to evidence pre-oedipal problems, a result of a faulty or disturbed dyadic relationship, is thought to be inappropriate for anxiety-provoking therapy, since they would have difficulties establishing the basic trust fundamental to the forging of a working therapeutic alliance and terminating treatment. This continues to be an important distinguishing criterion used by some contemporary time-limited therapists.

Treatment is seen as 'anxiety-provoking' because it confronts the patient's defences directly, rather than attempting to 'interpret the meaning or function of the defences' (Flegenheimer 1982, p. 65). Transference is interpreted rigorously, as is any form of resistance. Resistances are attacked directly, but only on the basis of 'data' received from the patient.

Sifneos does not use the framework of a definite termination date. No time limit is set, but the patient is informed from the outset that the treatment will only last 'several months', and is encouraged to share responsibility for the decision of when to terminate. Termination is in part the patient's responsibility, which decreases their dependence and passivity. What assists termination is 'the diligent avoidance of all pregenital issues throughout the treatment process' (Flegenheimer 1982, p. 75). What this means is that issues around separation anxiety, and the development of an unhelpful transference neurosis, are kept to a minimum. Sifneos suggests that these problems can be avoided by stringent selection, the patient sharing responsibility for the treatment, and the 'selective neglect' of all pre-oedipal material. Sifneos's anxiety-provoking therapy has a maximum of 20 sessions, and mostly lasts between 12 and 16 sessions.

His selection criteria are carefully drawn and include:

- Ability of the patient to present with a circumscribed complaint.
- Evidence of a meaningful relationship during childhood.
- Capacity to relate to the therapist in the first meeting and to be open in expressing feelings.
- Psychological sophistication and intelligence.
- Motivation for change over and above symptom relief.
- Ability to see symptoms as having a psychological dimension.

- Emotional honesty and capacity for introspection.
- Able to participate actively in treatment.
- Curiosity.
- Realistic view of what can be achieved in therapy and a willingness to make 'the necessary sacrifices'.

The focus of this therapy is extremely narrow:

the failure to grieve a death, inability to finish a project because of success fear, triangular futile love relationships – the standard grist of the analytic mill – these high level neurotic conflicts are the province of anxiety provoking therapy. (Groves 1996, p. 5)

One of the objections that Sifneos himself acknowledges is that the selection criteria have included mainly patients who 'were so healthy that they do not require any treatment at all'.

Sifneos contrasts anxiety-provoking therapy with *anxiety-suppressive therapy*. This is aimed at less-healthy patients who might be discomforted by the confrontational stance of anxiety-provoking therapy. It is aimed at more disturbed, by implication pre-oedipal, patients and is more supportive in nature and includes environmental manipulation, reassurance and if necessary, medication. Crisis support could last up to two months, brief therapy from two months to one year, while for patients with long-standing psychological difficulties and a history of poor interpersonal relationships longer-term therapy may be indicated. However, the selection criteria are similar to those for the anxiety-provoking therapies. Patients receiving anxiety-provoking therapy are seen weekly over a period of time, but anxiety-suppressive patients are frequently seen more intensively, often a number of times in a week, but sometimes only for a few minutes. This reflects the more crisis-oriented and supportive direction of the therapy.

These two types of therapy are offered to different clinical populations, and recognize that treatment needs to be tailored to the patient's presenting problem and psychopathology. However, insight and interpretation are still seen as central to progress and cure, and the 'one-person psychology' of the drive-structural model predominates.

David Malan and the triangle of insight

David Malan had worked with Michael Balint in the focal workshop at the Tavistock Clinic. Having initially thought that they would attempt to apply analytic techniques to relatively healthy patients who presented with acute problems, they ‘found none . . . we were then forced to take on any patient who came for treatment’ (Malan 1979). Believing at first that they would need to use ‘superficial techniques’, they were surprised to find that patients responded well to ‘deeper interpretations’. Attempting to avoid transference interpretations, they found that as psychoanalysts they were ‘conditioned’ to respond to transference material with transference interpretations. As a result they ‘stumbled’ on a surprising and unexpected finding: that even patients with long-standing difficulties appeared to achieve both symptomatic and dynamic relief in a brief time scale using a ‘deep’ technique (transference interpretations). Particularly therapeutic appeared to be interpretations linking the current interaction with the therapist with significant figures from the patient’s past.

In the initial interview a focus was sought and a trial interpretation attempted. This gauged the patient’s initial suitability for brief work and became the cornerstone of their assessment process. The focus tended to be relatively narrow and defined by the therapist.

Trial interpretations were seen as important not only in estimating the patient’s suitability to work with interpretations in the therapy, but also in enabling a therapeutic alliance to be formed. If the interpretation was helpful in the first session then therapeutic work could start. Care would be taken before making one, since the therapist has to have some confidence that the patient will be able to make constructive use of it rather than experience it as persecutory. The interpretation should be linked to the area of the focus and serves to find – or reformulate – a tentative focus. If the focus was correct then the patient was likely to become more intensely engaged and more committed to the treatment, and to produce more material. The therapist’s formulation of the focus was done on the basis of the triangle of insight. Assurance was sought that the focus is acceptable to the patient. This was done by gauging the response to trial interpretations, the ease with which the patient talked about feelings and problems, and the

degree to which they displayed positive motivation to engage in the treatment and consider change.

Brief intensive psychotherapy was then indicated, providing the following factors were not in evidence:

- Prediction (on the therapist's part) that issues were too involved, complex or deep-seated.
- Severe dependence and other unfavourable transference manifestations.
- Depressive or psychotic decompensation.
- Suicidal tendencies.
- Uncontrollable acting-out.

The patient needed to be able to make substantive contact with the therapist, and to be motivated for change. Recognising that difficulties in termination were likely to pose problems in briefer work, patients who appeared to have complex or deep-seated issues in this area were deemed inappropriate, 'since there [seemed] little hope of working [these] through in a short time' (Malan 1975, p. 69). Inevitably these selection criteria included some patients who presented with pre-oedipal problems, but Malan increasingly came to believe that this was not necessarily a contraindication for brief intensive therapy. Of more importance was the capacity to have formed previous meaningful relationships. This was highly correlated with good outcomes and a positive indicator as to how the patient would respond to the therapist.

Central to the technique was clarification and interpretation of the *triangle of insight or persons*. This was the three-way link between the here-and-now relationship with the therapist, similar feelings which had been directed toward significant people in the patient's past, and the problem as it manifested itself in the patient's current relationships. The *current* conflict was frequently associated with the precipitating factor which brought the patient into treatment and was observable in the therapeutic relationship. The *historical – or nuclear –* conflict can be a result of 'early traumatic experiences, . . . family constellations or *repetitive patterns*'. (Malan 1976, pp. 247–57) The closer the current and nuclear conflicts the better the prognosis. In Malan's example of 'The Man with the Headaches' (Davanloo 1978), who presented with

anxiety symptoms and chest pains precipitated by the cardiac illness of his father, the current and nuclear conflict were virtually the same, which ensured that the therapy will 'role out in front of you automatically'. The patient would always be talking about his core conflict and the therapist would merely have to make focal interpretations.

The triangle of insight links with another psychoanalytic triangle – that of *impulse*, the resultant *defence* and consequent *anxiety*. This is in keeping with the Freudian belief that it is censored desire which causes symptoms. In therapy, it is the clarification of this in relation to the triangle of insight which is helpful.

Initially, no time limit was set at the beginning of treatment. Patients were told that they would be seen for a matter of months and if further treatment was indicated they would be referred for longer-term therapy. However, as confidence in the new technique grew, a time limit was set from the start. Malan eventually set a time limit of between 20 to 30 sessions from the outset of treatment and went on to recommend 20 sessions for 'an ordinary [straightforward] patient with an experienced therapist' and 30 sessions for 'an ordinary patient with an inexperienced therapist' (Flegenbeiner 1982, p. 108). Malan thought time limits

give therapy a definite beginning, middle, and end – like the opening, middle and end game in chess – and help to concentrate both the patient's material and the therapist's work, and to prevent therapy becoming diffuse and aimless and drifting into long term involvement. It enables the prospect of termination to be brought in quite naturally as the time for this approaches; and often this enables a therapy that had been in danger of becoming diffuse to become clear and focal again. To adapt Dr Johnson, being under sentence of termination doth most marvellously concentrate the material. (Groves, 1996, p. 391)

Malan went on to believe the setting of a termination date, as opposed to a specific number of sessions, was preferable, since it dealt with the 'chore' of keeping track of missed sessions and the possible ambiguity as to whether they counted towards the total. Despite the time limit, the patient was given to understand that he could see the therapist on an ad hoc basis after the therapy was finished. In contrast to other approaches, Malan does not believe that this compromises the emotional impact of termination.

Malan believed that the need for therapeutic activity stemmed from the need to keep the therapy in focus, given the wealth of material that can be produced. Activity included '*selective interpretation, selective attention, and selective neglect*' (Malan 1976). Material was selected according to its proximity to the focus.

Malan acknowledged that termination may need specific attention in short-term therapy particularly with patients where separation factors are paramount. In patients where the focus was more on oedipal issues, termination might not be central, but in extending briefer therapies into his work with pre-oedipal patients he recognised that endings were crucial and must be incorporated into the treatment.

Malan, however, used the standard techniques of psychoanalysis: interpretation of the transference, of defences and of the 'nuclear' or 'core' conflict. At pains to stress the technical similarities between psychoanalysis and brief intensive psychotherapy, he believed that 'interpretations used differ in no way in any form of psychoanalytic therapy; that is, the interpretation of resistance, fantasies, and transference'.

Using techniques not dissimilar from open-ended analytic treatments, Malan's outcomes suggested that the beneficial effects went well beyond mere symptom relief. Rather than being superficial, Malan's brief intensive psychotherapy included an understanding of the underlying dynamic conflicts and their origin.

Malan's work, especially in the areas of the therapeutic triangles and the use made of the transference, has come to resemble the 'intensive short-term dynamic psychotherapy' of Habib Davanloo.

'We cannot wait for the material to bubble up' – the work of Habib Davanloo

Habib Davanloo's intensive short-term psychotherapy includes many of the clinical techniques of Sifneos and Malan, including the use of trial interpretations to test the patient's motivation and the capacity or willingness to work briefly in an intensively analytic way. Davanloo suggests that the patient's response to a

period of trial therapy is the best indicator of their suitability for the treatment. Other criteria considered important include:

- Some evidence of reciprocity (give and take) in relationships, particularly in relation to the therapist.
- Access to specific feelings or affects and whether they can be tolerated (for example, anger).
- Affective, rather than intellectual, response to interpretation.
- Flexible defences.
- Transference and counter-transference reactions.

Davanloo initially believed motivation, especially if increased after interpretations, to be an important criterion, but more recently has viewed the need for patient motivation to be 'a criterion created by therapists who cannot treat highly resistant, complex patients' (in Groves 1996, p. 378).

Contraindications include those patients who present with 'intense reliance on projection, massive denial, major reliance on acting out in dealing with conflicts, acting out combined with projections, or a few rigid persistently used ego defense mechanisms' (Davanloo 1978, p. 19).

Davanloo (1990) has described the trial therapy as serving to 'unlock the unconscious'. The most important aspect of this period of trial therapy is to acknowledge and confront the patient's resistance (often evidenced by passivity, withdrawal and vagueness) especially in relation to its manifestations in the transference. This frequently mobilises anger, which is then defended against, but produces more material in relation to the patient's central conflict. A similar triangular link is then made between the patient's material in relation to the therapist (T), significant figures in the patient's current life (C) and significant people in the past, for example, a parent who 'may have taught such [relational] patterns in the first place' (P). Davanloo terms this the 'triangle of persons (TCP)'. As with Malan, this is seen in relation to a further therapeutic triangle, 'the triangle of conflict'. The triangle of conflict is similar to Malan's impulse – defence – anxiety triangle. Davanloo terms this the DAI triangle – *defence*, *affect* and *impulse*. The closer the congruity between these two triangles the more effective the treatment is likely to be. The earlier that interpretations in the triangle of persons can be made, the

shorter the likely treatment. It follows that feelings – (which may be denied or defended against by passivity or vagueness) towards the therapist or treatment – need to be addressed from the beginning of the trial therapy. We return to these triangles in the next chapter. Davanloo also makes use of what he calls ‘subtly-loaded words’ (1980, p. 63) in order to speak to some fundamental, often unconscious, trait in the patient, a theme we also return to in the same chapter. The therapist formulates the presenting problem in relation to the therapeutic triangles, which enables the patient and the therapist to agree on the focus for treatment at the end of the period of trial therapy.

Davanloo’s technique not only is aimed at oedipal or neurotic problems but also is described as benefiting patients who may evidence personality problems of long duration. These often include patients for whom more than one focus is indicated.

What is most apparent in Davanloo’s work is the direct and, some would say, relentless attack on the patient’s passivity, withdrawal or vagueness. These are seen as defensive choices on the part of the patient. The ‘gentle but relentless’ confrontations are particularly designed to elicit feelings of anger or resistance. The patient’s powerful emotions, particularly towards the therapist, are defended against, but the therapist’s constant interpretation of these leads to their expression in the therapy. The acceptance of these uncomfortable feelings, without any negative consequences in the therapy, further strengthens the therapeutic alliance and increases patient motivation. The patient shares responsibility for the treatment, and warded-off feelings and behaviour in the therapy are actively pointed out to the patient.

While no definite time limits are set, treatments appear to last between 2 and 40 sessions, depending on the patient’s psychopathology and the complexity of the focus. Davanloo (1978, 1994) sees short-term therapies as on a continuum depending on the central structure of the patient’s conflict. Oedipal problems are treated in ‘two to fifteen’ sessions, while ‘deeper problems produce excellent results in twenty-five to thirty-five, or an upper limit of forty, sessions’. Treatment is ended when there is evidence of improvement – or change – in one or more areas of the triangles described above.

The assault on defences and the concentration on the patient’s anger and resistance makes this a potentially problematic tech-

nique. Davanloo's method demands the utmost therapeutic neutrality and control on behalf of the therapist, and an ability to pick up and focus on the early, and frequently slight, manifestations of resistance. However, neutrality does not mean a passive therapist. For Davanloo, activity does not mean having to be directive; one can be extremely active yet non-directive. There is no place for a passive therapist in this treatment, since 'we cannot wait for the material to bubble up'. Termination is not viewed as a major issue and, with the less-disturbed patients, can be dealt with in one session, while in treatments with multiple foci or with more disturbed patients, termination is addressed in the last two to six sessions.

Resistance is dealt with by relentless questioning. 'Interpretation of the negative transference is highly essential. I would also emphasize the importance of early and repeated interpretation of resistance and ambivalence . . . which are of great importance in maintaining the therapeutic alliance' (Davanloo 1978, p. 344). What can be seen as potentially disquieting is the frequent repetition of an interpretation until the patient is ground into submission and agrees with the therapist. Paradoxically, these 'bulldozer' techniques make Davanloo's therapy potentially helpful to obsessive and phobic patients, who had been thought to be unresponsive to briefer treatments, by addressing the split between their feelings and intellect (Flegenheimer 1982). In some ways the technique can appear confrontational and aggressive, but Davanloo's method can serve to remind us that aggression can be a reflection of a wish to reach out and communicate with people.

Sifneos, Malan and Davanloo follow closely in the psychoanalytic tradition, by placing great emphasis on interpretation, transference and the importance of insight. The drive-structural model of the mind of id, ego, superego and impulse, defence, anxiety is central to their frameworks. Allowing for modifications of psychoanalytic technique, change is based on those factors found in psychoanalysis: deep interpretations, aimed at the unconscious, which make distinctive emotional contact and lead to insight. They assume that any assessment for short-term therapy would essentially be along these modified psychoanalytic lines and that the establishment of a focus is achieved within this context. If a focus cannot be determined within the first few interviews then

short-term intensive therapy is not indicated. Central to Malan's approach is selective listening and selective interpreting in the context of the focus. Davanloo concentrates on repeated confrontation of the patient's defences in order to expose the hidden feelings and conflicts, while Sifneos confronts the patient's 'impulses as well as teaching patients about their psychodynamic' (Messer and Warren 1995, p. 92).

What we can see here are the attempts to place short-term therapies within the context of psychoanalysis. Unlike Alexander and Ferenczi, who were viewed, perhaps somewhat erroneously, as proposing a heretical and threatening model of analysis, these writers, by using basic psychoanalytic techniques, were not seen as a challenge to psychoanalysis. Thus they were able to present themselves as following in the mainstream psychoanalytic tradition and, if somewhat uneasily, to be incorporated within the psychoanalytic fold. However, this did not mean the acceptance of short-term therapies but, rather, led to a renewed debate on their efficacy and whether they constituted a treatment that could be called analytic. These debates led to the notion that short-term dynamic therapies might be 'different' from psychoanalysis while still making use of fundamental analytic ideas in clinical practice. What we also begin to see, in the importance placed on the patient's interaction with the therapist, is a move towards the 'object-relational' model of therapy, where the patient's use of the therapist as a microcosm of relationships in the real world gradually replaces the emphasis placed on the drive–instinct, observer–observed model of early psychoanalysis. The idea of a two-person psychology is introduced which liberates the therapist from the stance of passive observer. Therapist and patient can potentially be part of a dyad that constantly interacts, and it is this recognition that enabled focal therapies to further develop.

Summary

In this chapter we have discussed:

- The work of Sifneos, whose
 - Anxiety-provoking therapy:
 - Is in general longer.

- Is less crisis-oriented.
- Works with the transference.
- Has a narrow focus.
- Exhibits a high level of neurotic conflict.
- Keeps the therapist detached, which reinforces focus and is challenging; discourages dependency.
- Focuses on the oedipal level.
- Anxiety-suppressive therapy:
 - Is supportive.
 - Both acknowledges the transference less and works in it less.
 - Maintains a flexible time frame and frequency of sessions.
 - Is amenable for more disturbed patients.
- Malan’s brief intensive therapy:
 - Maintains a clear if narrow focus.
 - Makes explicit use of trial interpretations in the initial meeting.
 - Places central therapeutic importance on the triangle of insight:
 - past history
 - present conflict
 - ‘transference’ in the here and now towards therapist.
 - Makes extensive use of transference, interpretation and insight.
 - Sets a termination date (as opposed to number of sessions) from the beginning of treatment.
- The work of Davanloo, which
 - Attacks passivity, vagueness and withdrawal, seeing this as a reflection of the patient’s defences.
 - Advocates a period of trial therapy.
 - Concentrates on feelings which are denied or defended against, especially anger and resistance.
 - Sees therapeutic change is effected by linking the triangle of persons (TCP) with the triangle of conflicts (DAI).
 - Places great emphasis on resistance and negative feelings towards the therapist or treatment which have to be interpreted immediately.

APPLICATION OF PSYCHOANALYTIC THEORY AND PRACTICE IN CONTEMPORARY TIME-LIMITED THERAPIES

Men are troubled not so much by things as by their perception of things.

– Epictetus

Psychoanalytic theory and, by implication, clinical practice have struggled to embrace two competing views: the drive model with primacy given to instincts (drives) and desire, and the object relations model which stresses the individual's interactive relationship with others. It follows that short-term therapies based upon the former will be occupied with the interpretation of drives and their defences and will place primacy on classical techniques of interpretation and insight. As psychoanalysis and its applications have become more 'relational and less drive orientated' (Aron 1990), more emphasis has been placed on the therapeutic relationship of transference and counter-transference, especially the here-and-now interactional components of the therapeutic relationship. Less attention is paid to unconscious conflicts than to attempts to master real-life daily experience; as a result, the focus has moved to maladaptive relationships and their consequences rather than pathological factors within any given individual. There is now widespread recognition that members of the therapeutic dyad influence each other and that this mutual subjectivity has become the focus of many relational focal therapies.

Relationships to others, and the impact these have on the sense of self, are the central feature of the brief therapies in this chapter. There is always an 'other' with whom one is interacting, although that other may be an internal template or construct of one's own making. It is the *mental representation* of our interactions with others that is of primary concern.

As a consequence, these theories place less emphasis on a single organising focus for their work. The focus can be more diverse, couched in terms of personality traits or character, and the therapeutic emphasis is more on here-and-now interactional experience both in the consulting room and in the real world. Less emphasis is placed on specific selection criteria. As one would anticipate from a theory that places relationships at its centre, less importance is placed on individual patient characteristics, while greater importance is given to the personal qualities brought by both patient and therapist to the therapeutic encounter.

These theories also highlight a different understanding of the transference. Rather than viewing transference as neurotic templates from the past which need interpreting, there is more emphasis on the here-and-now, in-the-room transference. The therapist is not a blank screen and a receptacle for the patient's projections. Transference is viewed as an expression of the interpersonal reality of the patient which has been shaped by his personal experience, background and development. These internalised relationships, which constitute the object-relational transference, 'consist of ideas or beliefs about the self, others and [the] interaction between self and others' (Messer and Warren 1995). How this is manifested in the consulting room and its relation to the interactional focus is the source of transference interpretations. In order for this to be successful the therapist needs to be aware of his own counter-transference and how it impacts on the therapeutic dyad.

Some of these theories also bear a passing resemblance to the work of Alexander and the 'corrective emotional experience', by stressing the importance of a new experience in the therapeutic relationship, where insight and interpretation are of less importance than the affective quality of the relationship between the patient and the therapist.

A variety of contemporary therapies have been developed

which lend themselves to a limited time frame and have drawn on psychoanalytic object relations theory.

The Vanderbilt Group

The 'cyclical maladaptive pattern' (CMP) of the Vanderbilt Group (Binder and Strupp 1991; Strupp and Binder 1994; Levenson 1995), although initially not specifically directed towards time-limited therapy, has led to the articulation of a 'time-limited dynamic psychotherapy' (TLDT), which stresses the interactional model of the contemporary psychoanalysis.

The central assumption of TLDT is that the patient's difficulties stem from disturbed interpersonal relationships. These were learned in the past and are maintained in the present. The patient, with the therapist as a participant observer, re-enacts these difficulties in the therapy. The focus can be wide, that is, a personality trait, although it is assumed that there is one primary and identifiable relationship pattern.

Central to this is the cyclical maladaptive pattern. This is a working model of behaviour and action, originally outlined by Peterfreund (1983) and defined as

a central or salient pattern of interpersonal roles in which the patients *unconsciously* cast themselves; the complementary roles in which they cast others; and the maladaptive interactional sequences, self-defeating expectations, negative self appraisals, and unpleasant affects that result. (p. 140)

These categories, together with the therapist's countertransference, provide a picture of the patient's primary interpersonal way of relating. Formulating the patient's difficulty is done in the context of the CMP. Of particular importance are the internal representations of self and others, the interactions with others and the effect these have on the patient's beliefs about the self.

TLDP focuses on repeated interactional traits and views the transference as a reflection of interactional experiences and beliefs. Primacy is given to a new experience in the therapeutic relationship (where the therapist is part of the process) rather than interpretation and insight. Proponents of TLDP suggest 20 to 30 sessions. However, emphasis is less on the exact number of ses-

sions than on the cultivation of a time-limited attitude on behalf of both therapist and patient.

The framework of the therapy is derived from psychoanalysis, but it also begins to make use of object relations and self psychological theories. In looking at, and encouraging thinking about, the interaction between self concepts and how they effect relationships with other people, it also takes in some cognitive-behavioural ideas.

Stress response system

The 'stress response system' is a 12-session therapy (Horowitz 1991) which offers a phase-specific, interpersonal treatment of traumatic loss. In this treatment the focus is on loss and mourning, but is based on a relational view of personality development. Central to the treatment focus are what are termed 'personal schemas', which are 'internalized representations of self, others and relationships' (Groves 1996 pp. 101–31). Traumatic events are perceived, experienced and processed through personal schemas, which in effect function as personal mental structures which help us to organise and give meaning to experience. An example Horowitz gives is that of a young woman's reaction to the sudden death of her father. After dealing with the acute phase of mourning the loss, the remainder of the 12 sessions was spent looking at her conviction of herself as weak and flawed with a corresponding belief that her father had disliked and rejected her because she had not lived up to his ideals. These are what Horowitz terms personal schemas, or schematic representations, which underlie our reactions to sudden traumatic events and need to be central to therapy. Therapy is exactly 12 sessions and the issues, which both patient and therapist need to focus on in each session, are outlined in advance. (For an outline of the prescribed treatment phases see Horowitz 1986, p. 31.)

Using the well-observed responses to traumatic stress, a distinction is made between responses of:

- 'Intrusion and repetition', where the therapist needs to be supportive in enabling the patient to reduce and manage overwhelming anxiety.

- ‘Denial and numbing’, where there is active encouragement by the therapist of the emotional expressions of feelings that have been denied or have been feared to be too frightening and consequently avoided or repressed.

What is interesting is the attempt to link personality traits with specific clinical techniques and therapeutic aims. Hysterical personalities tend to be overwhelmed by global anxiety and need help in clarifying and binding emotions, while the obsessive-compulsive personality, preoccupied with details as a way of warding off emotion, needs to be assisted in tolerating emotions and helped to ‘hold on’ to the source of the anxiety. Horowitz draws attention to the differing responses to the same situation by two personality traits or types, which will have different clinical implications.

Although the treatment is aimed at a narrow and relatively healthy population it is an interesting and helpful approach to post-traumatic stress disorders. Of particular relevance is the importance placed on the relational aspects of coping with sudden loss or trauma.

IDE therapy

‘Interpersonal, developmental and existential therapy’ (IDE; Budman and Gurman 1988) attempts to integrate interpersonal, developmental and existential conflicts into a therapeutic framework which is time-sensitive and highly focused. Taking issue with long-term therapies, which they see as inevitably leading to therapeutic drift, the major feature of IDE is the belief that most therapeutic benefit occurs early in treatment; the law of diminishing returns applies. Combining developmental, existential and interpersonal paradigms, IDE is based on the premise that during the patient’s early development there has been some ‘faulty learning’. This can be either conscious or unconscious, but importantly becomes ‘a *template* for future behaviour and relationships’. It is this template which influences feelings, behaviour and relationships. The key question is ‘Why has this person come for help now?’, and is viewed from a perspective that is both environmental and developmental (an ‘obsessive fear of death is rather

different at age twenty-five than it is at age seventy five'). The focus is then related directly to the patient's life stage. There is a flexible attitude to time. Therapy appears to be between 20 and 40 sessions in length and includes the variable spacing of sessions. Rather than 'the more therapy the better', therapy is seen as the springboard for change which happens outside or after the completion of therapy.

The use made of the time can be a major therapeutic variable and an important intervention which needs to be acknowledged for each individual patient. However, the flexible use of time, which in IDE includes follow-up appointments and further courses of therapy when a developmental obstacle is encountered, is very different from using time as a central organising framework for therapy.

Time, or more specifically time limitation, as the fundamental aspect of treatment is noticeably absent from these relational models. They also in the main do not give any clinical rationale why a certain number of sessions are indicated.

The work of James Mann

James Mann's time-limited psychotherapy (1973, 1992) deals explicitly with the therapeutic use of time. The central therapeutic issue is the relationship to time; time is always running out. Mann believes the limitless time of longer-term therapies functions to deny the reality of finite time. Symbolically, it functions against acknowledging our own ending – death. For Mann the link between time and reality is insoluble. In offering precisely 12 sessions there is no ambivalence in relation to time and the limited time frame is used to influence the therapeutic process and is the major therapeutic variable. Mann is interesting in his description of time as gendered ('father' time and 'limitless' maternal time), developmental ('child' versus 'adult' time) and the importance placed on the literalness of time. His therapeutic hour is 60 minutes as opposed to the more usual 50. By calling an hour 50 minutes, the therapist, Mann believes, is denying the reality and the true nature of time, which functions as a denial of our mortality.

Therapy revolves around issues of separation and individua-

tion, and focuses on what Mann terms the *chronically endured pain* – a generalised, often relational, difficulty which leads to negative feelings which the patient harbours towards himself. The ‘pain’ has been recurrent over time and linked to features in the past which continue to be active in the present. Particular attention is paid to the way the central issue is conveyed, be it through words, actions, feelings or behaviour (and also the time in the session when this occurs). Mann (1992) describes a phase-specific, 12-session treatment which, with its emphasis on separation and individuation, lends itself particularly well to developmental difficulties in these areas.

The suggestion that the way in which we give meaning and relate to time is inseparably related to our own mortality and to issues of loss and separation has also been highlighted by other psychodynamic authors interested in short-term therapies (Molnos 1995). In this light, the difficulty that the therapeutic profession has in relation to shorter therapies can be seen as evidence of a denial of the horror of time. As Mann points out, every therapy evokes this, whether the therapist is aware of it and chooses to use it to facilitate therapy or not. Mann’s approach, dominated as it is by the single theme of separation–individuation, may not be applicable to all patients, although, as it is a ubiquitous human developmental task, one could argue that the majority of people seeking help are likely to present with issues in this general area.

Interpersonal therapy

The specific issue of loss is addressed in the ‘interpersonal therapy of depression’ (IPT). The work of Klerman (Klerman *et al.* 1984/94), based on his treatment of depressed patients, is predicated on the assumption that depression occurs in an interpersonal context. This follows in a direct tradition from Freud, who had indicated as early as *Mourning and Melancholia* (1917) that depression is related to loss. For Freud, depression and grief were related to the loss of a person (or object); Klerman links depression with attachment theory. Current relationships are based upon the nature of early childhood attachments, which are refined rather than repeated in adolescent and adult experiences.

IPT takes its starting point from the belief that close and satisfactory attachment relationships are a protective factor against depression and that when these attachments are disturbed or disrupted depression is more likely to occur. Treatment focuses on present rather than past functioning in relationships, and concentrates on interpersonal phenomena such as changes in a person's role vis-à-vis others, or what are termed 'role transitions', which involve life events necessitating the move from one social role to another. 12 to 16 weekly sessions are suggested. IPT describes phases of treatment and the tasks to be completed at each phase, and has become attractive to purchasers of mental health services, as it is 'manual-led' (that is practitioners can implement the treatment from following a manual) and can be learnt easily by lay people.

While IPT appears to have little in common with the more dynamic therapies, the importance it places on attachment and current relationships (especially the issue of transition and development as a result of current relationships) warrants its inclusion and provides a convenient link to the therapy that attempts to integrate the analytic, the relational and the cognitive.

We now move on to discuss therapies which have a more cognitive approach. These are not necessarily psychodynamic in orientation, and do not view the use of the limited-time framework as a central part of the therapeutic process. However, they do share common features with focal dynamic therapies, which we discuss in the next chapter.

Cognitive analytic therapy

'Cognitive analytic therapy' (CAT), as its name suggests, is an integrative model of therapy. It incorporates psychoanalytic, cognitive and object-relational ideas into a brief, time-limited, structured therapy applicable to a variety of clinical settings. Developed by Anthony Ryle (1995, 1998), it makes use of the repertory grid techniques described by Kelly (1955). Kelly's 'personal construct theory' was based on the view that the individual is 'constructed' by the way he construes and anticipates events. Change is therefore possible by placing the 'old self' in a

'new role'. These constructs, linked to ascribed or perceived roles, operate as *personal templates* through which an individual's experience, and actions, are processed in order for them to be made sense of and mastered. Personal constructs are relative and fluid and can be 'mapped' by what are termed 'repertory grids'. These 'maps' were used by Ryle as a means of identifying his patients' problems and used in therapy to facilitate and chart therapeutic progress and change. Construct theory suggests that the self can be permeable and created 'as we go along', rather than being dependent on one's personal history, and can either be dictated from inside or imposed from without.

Cognitive analytic therapy's model is one of a partnership which helps the patient understand the nature of their behaviour patterns. The transference is actively used to facilitate this understanding through what are termed 'reciprocal relationships'. These are roles which are repeated over time and which the patient will attempt to elicit in the therapeutic relationship. In essence they are the predictions, developed from our earliest relationships, of the responses of others to one's actions and behaviour. Therapist and patient are engaged in a joint endeavour to discover and describe the patient's 'harmful procedures', and, in a manner similar to that described by Alexander, the therapist offers the client a different experience either by behaving differently from the patient's expectations or by drawing attention to familiar patterns of behaviour as they occur in the sessions. This is achieved through an active partnership rather than the patient's gradual recognition through insight and interpretation. The object is to 'remove the self-defeating blocks to growth' and to enable the patient to 'develop a self-observing and self-integrating capacity' (Ryle 1995).

The treatment is time-limited to 16 sessions divided into 3 stages. Sessions 1 to 3 involve initial information-gathering leading to a reformulation of the patient's problem. During these sessions the developing therapeutic relationship and the patient's history will lead to the identification and listing of the patient's:

- 'Target problems' (TPs). These consist of descriptions of the patient's problems which they wish to address in therapy.
- 'Target problem procedures' (TPPs). These are statements which list and describe how the patient creates and maintains

the actions and experiences which lead to and reinforce the target problems. During the course of treatment these TPPs are actively monitored through diary-keeping and acknowledged as they are evidenced 'in narratives brought to the therapy and as they are enacted in the therapy relationship'.

From this process the core neurotic patterns are discovered. These can be conceptualised in terms of dilemmas, traps and snags.

'Dilemmas' consist of 'false choices and narrow options'. Although unhappy with it, we behave in certain ways because we fear that alternatives would be even worse. 'Traps' are 'vicious circles' where, feeling bad about ourselves, we behave and think in ways which confirm our 'badness'. Traps may also include the fear of hurting others, avoidance, trying to please, and so on. 'Snags' (often evidenced as 'yes, buts') are self-imposed obstacles which arise out of guilt or fear. These become particularly prominent if we are apprehensive about pleasure or success.

At the end of the first session the patient is given a 'psychotherapy file' to take away and read. This is a form of self-monitoring derived from cognitive therapy where patients are asked to list unwanted behaviour, variable moods and symptoms. This enables their antecedents, the thoughts and feelings experienced at the time, and their consequences to be highlighted. The file forms the basis for an 'exploratory conversation and as a way of introducing the patient to new forms of self reflection' (1997, p. 14). The file helps to note and record how these patterns of feelings and behaviour are observable and occur over the course of therapy. In the fourth session a draft reformulation letter is introduced, which includes the listing of the target problems and how these core neurotic problems are enacted and reinforced by the target problem procedures. 'Reformulations' are central to the treatment and consist of a letter written to the patient which highlights past experiences and difficulties, coping mechanisms used by the patient to deal with his problems, the identification of TPs and TPPs, and examples or predictions of how these procedures are in evidence in the therapeutic relationship. The letter attempts to include the patient's own words and metaphors. A copy of the letter, after discussion and agreement over its contents, is then held by both patient and therapist. The reformulation letter can

also take the form of a 'sequential diagrammatic reformulation' (SDR) which traces, in diagrammatic fashion, how the current procedures serve to reinforce or maintain current unhelpful patterns. This flow chart, or 'scaffolding', is thought particularly helpful for patients who may have difficulty with a letter or are 'more poorly integrated'.

Sessions 5 to 16 focus on the reformulation letter. Change is brought about via a new experience (a cooperative, non-collusive therapeutic relationship), and through the experimentation with new behaviours (role play, discussion, graded exposure to the feared situation). Homework tasks and diaries are used to facilitate these aims. Attempts by the patient to engage the therapist in enacting the TPPs need to be promptly identified, and all process material including the transference has to be linked with the reformulation. A 'descriptive transformation' of the patient's story is attempted – this, rather than interpretation, leads to change. This process is termed 'the three Rs': 'reformulation', 'recognition' and 'revision'.

Termination, which is borne in mind from the beginning of treatment by numbering every session, becomes increasingly an issue and needs to be addressed by sessions 10 to 12. The patient's feelings about the ending, including reservations about the therapist's shortcomings, what has been achieved in therapy, and anxiety about the future, are incorporated into the reformulation by way of a 'goodbye letter'. The patient is also asked to write a goodbye letter. This is discussed with the patient and includes a realistic review of what has been achieved, based on the evidence presented by the patient. A follow-up session, focusing on reviewing the joint work rather than continuing the therapeutic process, is offered some three months after the termination of treatment.

Ryle's more recent (1998) work has extended the CAT approach to the treatment of a more disturbed population. Acknowledging the fact that people with borderline personality disorders are in general thought to be contraindicated for time-limited therapy, Ryle proposes a 24-session model of CAT for patients presenting with problems which have what are termed 'borderline features'. These include: labile, unstable and volatile moods, variable self-image, self-neglect or self-harm, a history of destructive and unstable relationships, impulsivity, and identity diffusion. These

tend to be traits rather than symptoms and are perhaps best described as 'borderline personality organisations' (Kernberg 1975) rather than viewed as a specific disorders. (See Ryle 1998 pp. 3–10 for a helpful discussion of this problematic concept.)

Given the sudden and volatile mood swings in this population, a central feature of CAT is the development of the 'self state sequential diagram' (SSSD), which monitors the awareness of self and others. The self state diagram differs from the SDR described above by showing how feelings, roles and behaviour and action originate from different 'self states' within the personality. Self states are defined as including 'mood(s), access to, and control of, emotion, and reciprocal role patterns . . .'. These self states, which are often split off and of which the patient remains unaware, are manifest in relationships with others or in relation to other parts of the self. By plotting these different self states and the transitions between them, and isolating the factors which prompt or trigger sudden mood swings, these switches of states can be monitored and their relationship to each other identified and discussed. This acknowledges the discrete self states in this population which, while coexisting, tend to be experienced as dissociated entities in the personality. The therapeutic aim is to achieve some integration between these dissociated states. It is through identifying and monitoring the SSSDs that the integration of these different self states is achieved. 24 sessions are recommended for these patients, with follow-ups at one-, two-, three- and six-month intervals in recognition of the extreme difficulties these patients face with termination. Recent trials of CAT with severely disturbed patients have shown some positive outcomes (Ryle 1998).

Cognitive behaviour therapy

Cognitive therapies focus on how individual emotions are influenced by cognitive processes and structures. Their basic premises include the following:

- Behaviour and affect are mediated by cognitive processes.
- Maladaptive behaviour and affect are correlated with maladaptive cognitions.

- The task of the clinician is to identify these cognitions and modify them through an active and experiential treatment.

Cognitions are defined increasingly widely and are seen to include thoughts, attitudes, assumptions, abstract beliefs, values, fantasy, dreams and imagery. At the centre of cognitive therapy is the 'cognitive triangle', which is represented as consisting of the event, emotions and cognition. This can also be represented as the interrelationship between thoughts, moods, physical reactions and behaviour. By changing thoughts one can change feelings and vice versa.

Beck (1979) traces these ideas back to Adler, who believed patients suffered from 'mistaken opinions' and 'faulty beliefs' which are mediated and corrected through the relationship with the therapist. Ellis's 'rational-emotive therapy' (1973) started from the standpoint of an individual's 'core irrational ideas', which included the prescriptive and potentially personally harmful 'shoulds, oughts and musts.' Rational emotive therapy was described as a treatment lasting up to 20 sessions following the ABC method: A is the 'activating experience', B the individual's belief system, and C the emotional consequence of A and B. Treatment proceeds until it reaches point D, where the therapist *dis*-putes the irrational beliefs with empirical evidence and logical reasoning.

Beck suggests that events are processed by fleeting and barely conscious 'automatic thoughts' which mediate between an event and the perception, feeling and behaviour associated with it. These automatic thoughts, in effect the individual's unique and personal interpretation of events in the world, help identify an individual's central belief system. In essence these automatic thoughts are predicated on how people see themselves in the world. The assumption is made that people are less troubled by disturbing events themselves than by the beliefs and meanings they ascribe to them. The subjective meaning of the event is as important as the event itself.

Automatic thoughts are related to the individual's 'core beliefs', which operate as a set of key assumptions about ourselves, others, and ways of being in the world. The internal dialogues that people have with themselves ('self-talk') are reflections of the individual's core beliefs central to their self-concept and self-

esteem. These core beliefs about the self and the world are in some ways similar to how psychoanalysis views internal objects and part objects. This is how meaning becomes assigned to specific events.

Beck's original cognitive therapy was brief, problem and solution-focused, involving homework, suggested reading ('bibliotherapy') and role play. It challenged negative automatic thoughts and helped practise new behaviour. Initially developed in treating depression, contemporary cognitive behaviour therapy (CBT) is now used to treat a variety of problems including those with high degrees of severity (Hawton *et al.* 1989; Salkovskis 1996; Sanders 1996; Clarke and Fairburn 1997).

CBT is based on a collaborative partnership with between therapist and client. The assumptions of the cognitive model are explained to the client and he is introduced to the ideas of 'automatic thoughts' and 'negative cognitions'. This is very different from psychoanalytic models, where to address the process is to pre-empt experience. Therapy is aimed at training the client to 'correct the idiosyncratic negative thoughts and the underlying negative assumptions' (Beck 1979 pp. 28–9). In recognising when these processes occur and their behavioural and emotional consequences, the client has the possibility of achieving mastery over them. 'Guided discovery' is used as a method of collaborative investigation to explore whether the client's view of a situation is amenable to be seen in a different light. The key technique here is the 'Socratic method' of question and answer, which assists in understanding the client's point of view and considering alternatives. Socratic questioning aims at revealing and clarifying suppressed contradictions. Here, it addresses the underlying belief systems, thus exposing incompatibilities of thoughts, feelings and motives which cause conflicts and tensions (see Mace 1999). The aim of this process is to help the client learn how to question automatic thoughts and core beliefs themselves.

Little emphasis was placed initially on the therapeutic relationship other than to view it as a vehicle for the therapy's stated aim of 'cognitive retraining'. CBT now views the therapeutic relationship as having historical determinants which can become significant in the here-and-now. Contemporary CBT recognises the value of the therapeutic relationship which previously, as

with early Freud, was thought important only in so far as it hindered therapy. While used in a collaborative and explicit way (as opposed to interpreting the therapeutic process), CBT acknowledges the importance of relationship factors in helping or hindering therapy. Increasingly, psychoanalytic insights have been rediscovered by and incorporated into the relational aspects of CBT (Safran and Segal 1990; Safran and McMain 1992). Dysfunctional cognitive interpersonal cycles can be seen to be similar to Bowlby's (1988) concept of 'internal working models' of relationships, which are of central importance in therapy. The therapeutic relationship must avoid a repetition of damaging relational patterns or the exacerbation of negative core assumptions.

The concept of interpersonal 'schemata' was developed in response to criticisms that cognitive therapies were not sufficiently cognisant of non-verbal communication (which maybe derived from the earliest experience), the relational aspects of therapy, or the individual client's highly personal and idiosyncratic relational styles. A result has been the development of 'schema-focused cognitive therapy' (Beck and Freeman 1990; Young 1994). Here, schemata are seen as cognitive structures that function to organise behaviour and experience. Together with core beliefs, they form the 'deepest level of cognition underlying both automatic thoughts and assumptions . . . which are particularly important in structuring perceptions and building up rule-giving behaviours' (Wills and Sanders 1997). They derive from the increasing recognition by CBT that cognitions, behaviour and emotions are influenced by early family experience, and that these schemata might not be conscious. Schemata are ways in which individuals perceive their lives, including interpersonal relationships and self-esteem. Events and experiences are interpreted through the medium of personal schemas. In effect, they function as 'templates' in making sense of the world, and 'tend to be activated when an experience occurs similar to the one earlier incorporated within the range of the template . . . [they] even shape incoming data to conform to [the templates] expectations' (Ross 1999 pp. 75–85). Schemata may be represented by metaphor and 'paradox' (that is, opposites), and while it is sometimes difficult to draw a distinction between them and core beliefs, schemata are thought to consist of the developmentally earliest character struc-

tures. Consequently they are seen to be of importance in treating borderline personality traits. Imagery techniques and dreams are ways that these schemata can be accessed.

As originally conceived, cognitive therapy offered between 10 and 20 sessions if necessary, and while the length may now vary between 10 and 15 sessions, much depends on the conceptualisation of the problem. Schema-focused work is thought to be more appropriate for longer-term, more pervasive difficulties, while symptom/automatic-thought-level problems may be more amenable to a shorter time frame. (For a useful discussion of this see Wills and Sanders 1997.)

Summary

In this chapter we have discussed:

- The cyclical maladaptive pattern (CMP) of the Vanderbilt Group.
- Horowitz's stress response system.
- Interpersonal, developmental and existential therapy (IDE).
- James Mann's time-limited therapy.
- Interpersonal therapy of depression (IPT).
- Cognitive analytic therapy (CAT), which:
 - Offers a model which incorporates both psychoanalytic and cognitive-behavioural theory.
 - Is based on a collaborative therapeutic partnership aimed at understanding patterns of reciprocal roles, behaviour and the feelings associated with them.
 - Is active and uses techniques (diaries, tasks) which avoid regression and utilise the patient's capacity for self-reflection.
 - Offers between 16 and 24 sessions, depending on whether the problem is related to 'borderline personality' characteristics.
- Cognitive behaviour therapy (CBT), which:
 - Highlights the interrelationship between events, cognitions and feelings.

- Places automatic thoughts and core beliefs as central ways of organising experience.
- Involves the therapist collaboratively guiding the client to examine and change negative thoughts and assumptions.
- Means that the developmentally earliest difficulties are addressed through schema-focused therapy.

ECLECTIC TIME-LIMITED THERAPIES

I am above all, an empiricist . . . Ideas are always closely linked with the vicissitudes in the treatment of patients, and by these are either repudiated or confirmed.

– Sandor Ferenczi (letter to Freud, 10 October 1931)

The more eclectic short-term therapies tend to be wide-ranging, drawing from various orientations in framing treatment models. Examples of eclectic short-term psychotherapy include Wolberg (1980), Garfield's (1998) multi-faceted approach to brief therapies and Gustafson's (1986) wide-ranging and theoretically inclusive therapy. As well as using theories from both older and more contemporary psychoanalytic thought, Gustafson's model also incorporates ideas from systemic theories.

Systems theory

Systems theory suggests that symptoms can be seen to be maintained by and for others. Clients may maintain symptoms to protect others or to maintain their existing relationships with them. Gustafson gives an example of a daughter 'needing' to lack confidence so that her mother would feel 'a successful mother [in order] that the daughter could be friends with the father, so (that) the father could tolerate what was missing in his [relationship] with his wife' (p. 263). This is termed 'systemic resistance'. Systems theory, while used extensively by family

therapists, can be incorporated into the practice of counselling individuals. Gustafson's model is based upon finding the missing developmental piece, paying careful attention to identifying and managing resistance (including systemic resistance) and using this to 'resolve and repair' the developmental deficit.

Solution-focused therapy

Systemic thinking helps remind the therapist that the client is part of a wider system which may help or hinder therapeutic change. An associated technique, although having different origins, is the time-limited, 'solution-focused' approach. Rather than focus on pathology, symptoms and problems, this approach looks at how clients solve problems and attempts to generalise these successful strategies to other areas of their lives (de Shazer 1982, 1985; George *et al.* 1990). This model assumes that clients are basically healthy and potentially possess the skills to overcome their problems. The underlying cause of the problem does not need to be established, because change can be brought about without this link. The therapist is active in encouraging a dialogue of 'change talk' rather than 'problem talk' (Walter and Peller 1992). As its name suggests, change talk focuses on viewing the problem positively and working on previously and currently successful patterns of problem-solving. This is achieved by working through stages (see Dziegielewski 1997).

These theories have all had an impact on the practice of time-aware therapy and counselling (Feltham 1997; Dryden and Feltham 1997; Litrell 1998). Egan's (1994, p. 41) influential counselling text includes a three-stage problem-solving model which 'gives helpers the technology of helping'. This moves from identifying current problems including 'unused opportunities' (stage one), through to assisting the client articulate and discover a 'preferred scenario' for the future (stage two), to stage three, which identifies, and supports, the client in implementing, the various strategies to help achieve stage two.

The central tenets of focal therapies are also in evidence in both transactional analysis, associated with the work of Berne (1963, *et al.* 1996), and contemporary existential therapies.

Transactional analysis

Transactional analysis, based on the discrete but related ego states of adult, parent and child, is based upon the notion of a therapeutic contract, which is clear, unambiguous and agreed to by both client and therapist. Included in the contract is consideration of the therapist's contract with the institution which employs him to practice. The notion of cure is clearly defined early in treatment and is based upon what the clients wants rather than what the therapist thinks the client needs. The contract is made when both therapist and client have clearly articulated the answer to the question, 'How will we both know when we have achieved what you are consulting me for?' The aim of the treatment is to 'cure as many patients during the first treatment session as possible' (Berne *et al.* 1996, p. 164).

Existential therapy

Similarly, existential time-limited therapy (Strasser and Strasser 1997) has as its core belief human limitations and the centrality of time. In the belief that there are a certain number of 'givens' associated with the human condition (uncertainty, unpredictability, inconsistency and the fleeting nature of existence), all existential treatments are time-aware. Issues brought to therapy converge around 'givens' and only diverge in the individual client's feelings, attitudes and behaviour towards these givens.

The guiding theme of time-limited treatments is to help the client tease out the distinction between those 'limitations that are imposed upon them by the world and [those they] impose on themselves' (Strasser and Strasser 1997, p. 13). In this model, 12 to 15 sessions, using a modular approach to the timing of the sessions, are offered, with 2 follow-up sessions a month apart. There is less necessity for a discrete focus, because existential therapy assumes many of the client's presenting problems are linked to life's central issues of being and meaning. Treatment is based on the notion that clients develop 'rigid sedimented belief systems' which have both positive and negative connotations and determine their personal values. These 'sedimented outlooks' are similar to core beliefs and can be linked to the central themes of many of the therapeutic orientations described above. Sedi-

mented outlooks are related to four dimensions of the human condition: physical, public, private and spiritual. Treatment consists of looking at the balance between these four dimensions and questioning any 'rigid sediments' which are in evidence. The therapist acts as a guide or catalyst and both prompts or challenges perceptions. Sediments, arising from life experience, can be transformable within the context of the 'givens' existing in a particular client's life.

Heinz Kohut and self psychology

Returning to contemporary psychoanalytic theories, mention needs to be made of the increasingly influential school of self psychology and its relevance to time-limited treatments. Self psychology, associated with the work of Heinz Kohut (1971, 1977), set out to integrate the relational school of psychoanalysis with the drive-structural model. Kohut came to recognise that his patients depended on his active responsiveness to the subtlety of their emotional states. In drawing attention to the actual care offered to the infant, he was implicitly drawing attention to the actual care offered by the therapist to his patients. This required him to modify analytic technique and made his acceptance within the analytic community increasingly problematic. In advocating the need for the therapist to be empathically engaged with his patient rather than passively neutral, it was inevitable that self psychology would become more supportive and experiential than classic analysis would allow. Also inevitable was that Kohut's later work (1984) would show less sensitivity in offending analytic sensibilities.

Kohut (pp. 52–77) suggests that the 'self' develops out of the earliest interpersonal relationships and throughout life mediates between the individual and his 'object world'. What the self requires is 'constancy, resilience and cohesion', which only the relationship with another can provide. The 'others' are termed 'self objects', since in infancy they are not experienced as differentiated from the self. The concept of self object is based upon the infant's earliest experience of the provision of affirmation and recognition by his primary caretakers. Self objects can be people or, later in life, may become more abstract, such as belief systems.

Responsive to the needs of the infant, these self objects provide the basis for the gradual development of the self. They provide a range of psychological functions for another person much as a mother or caretaker provides for her infant. Development consists of the recognition and acceptance that the functions of the self objects will eventually need to be taken over by oneself.

The experiences which are central to the development of the self and are provided by contact with the self objects include:

- ‘Mirroring’ – The infant’s ‘grandiose images’ which the parent affirms and which become related to the child’s self-esteem. Mirroring would include empathy, constancy and basic nurture and is associated with maternal care. It is from mirroring that the eventual feeling that we are understood and cared for by others develops.
- ‘Idealised self objects’ – The infant’s capacity to vicariously enjoy the idealisation of the parent which becomes the basis of the belief that there are things that are greater than ourselves which become the source of comfort and inspiration in adult life. This is associated with the role of the father.

Gradual and inevitable parental failures in both these spheres leads to what Kohut calls a process of ‘transmuting internalisation’. This involves the non-traumatic recognition that self objects are not perfect sources of mirroring or objects for idealisation, and prompts the infant to gradually take on, or incorporate, the functions of the self objects into themselves.

Problems arise through a ‘chronic failure’ of parental empathy, which prevents the healthy development of the child’s sense of self. The development of a cohesive sense of self based upon self-esteem and self-comfort is thus impaired. For Kohut this deficiency or deprivation becomes the basis for destructive or handicapping narcissism.

It follows that in therapy the client will establish a ‘self object transference’ based upon either ‘mirroring’ or ‘idealising’ modes, and this will provide a second chance to rework an earlier faulty ‘transmuting idealisation’. The therapist’s empathic reflection helps provide the missing developmental experiences in a safe and non-traumatic setting. This, of course, will take time as the therapist has to work through stages of empathic mirroring and

idealisation before his inevitable shortcomings, or failures, can be acknowledged and addressed. These deficiencies in therapeutic care (repeating the parental shortcomings) enable the patient to see the therapist in a more realistic light. This assists the patient in becoming less dependent on the therapeutic mirroring and idealisation for his self-esteem, or coherent sense of self, to flourish. The importance placed, in the development of the self, on 'cohesiveness, continuity and integrity' in parental caretaking is reflected in the stance adopted by the therapist. It is the slow exposure to 'optimal frustrations' which is curative, so lengthy treatments are indicated. Therapy consists of the patient gradually working through childhood developmental difficulties in establishing a cohesive sense of self and the movement towards a more mature and less fractured relationship to his self object. While it is apparent that the therapeutic relationship may take a considerable amount of time to develop while the therapist adopts a passive, empathic and 'mirroring' stance, what is of interest in Kohut's work is the importance placed not on the therapeutic relationship itself but rather on the manner in which it is able to be established and maintained, and how it affects the client's sense of self. In this it is crucial to listen for, and validate, *the client's frame of reference* as well as to interpret and focus on any resistance to the establishment of what Kohut terms a 'self-object transference'.

The importance placed by self psychology on ways of relating, and the connection with self-esteem, have led to increasing interest in applying these insights in shorter-term treatments (Baker 1991; Gardner 1991; Lynch 1998.) While shorter-term self-psychological approaches tend to be aimed at supporting and treating current problems, in common with other time-limited approaches, these authors speak of therapy as 'getting something started rather than finished'. It is recognised that working through may take place in significant relationships outside therapy. This literature suggests that self-esteem and a coherent sense of self can be assisted by brief therapeutic relationships. Thus, the client might 'gain some benefit simply from experiencing a self-object transference in relation to their counsellor without needing necessarily to work through experiences of frustration in the context of this relationship' (Lynch 1998, p. 482). It may be enough to be affirmed and heard.

Eclecticism has been frowned upon in psychoanalytic circles, which have tended to view eclectic approaches as promiscuous deviations from pure forms of therapy. Therapeutic eclecticism is however based on what works derived from empirical research. It is increasingly seen as incorporating aspects of proven therapeutic models based upon the needs of the client rather than upon theory-driven professionalism. Advantages of eclectic models include that they tend to be more inclusive in their selection criteria and to assist therapists in focusing on what form of therapy or technique will help the individual client. However, it does assume that therapists are sufficiently flexible to be able to master and implement a variety of techniques, some of which may be at variance with their own therapeutic styles. It also assumes that one can introduce different techniques into the same therapy without changing the therapeutic process. Can one introduce techniques such as homework or diary-keeping halfway through a therapy which has not used such techniques previously, without altering the therapeutic dynamic? Integration of these therapies is not made any easier by the absence of a common language – this despite the fact that, as we have seen, many of the underlying assumptions of therapy are not dissimilar.

What these therapies share is the expectation that the treatment will be short; therapeutic hope; the need for some form of therapeutic focus; and therapist activity. It is perhaps not surprising that interest in short-term therapies has taken brevity to its logical extreme in single-session therapy and the proscription of ‘no therapy’. As we have seen, many of Freud’s early therapeutic successes were single-session treatments. The single four-hour session with Gustav Mahler, mentioned earlier, in which Freud linked the name of Mahler’s wife with that of his mother, was help enough, but it was Donald Winnicott and his concept of the therapeutic consultation which showed how an informed brief contact can lead to major change.

The work of Donald Winnicott

Donald Winnicott, a paediatrician and psychoanalyst, is perhaps not the first person to spring to mind when thinking about short interventions. Considering that he was trained at the

Institute of Psychoanalysis and supervised by Melanie Klein, it is surprising to find many of the fundamentals of time-limited treatment in Winnicott's clinical descriptions. Working as a paediatrician, Winnicott was startled to find that a great many of his patients were helped by the 'full exploitation of the first interview'. This was not what his training had led him to expect.

From this experience emerged what Winnicott termed his 'therapeutic consultations'. His descriptions of these, often consisting of only one session, appear at times to involve a form of magical intuition yet are firmly grounded in developmental theory. As a result, his consultations, predominantly with children, are aimed at removing developmental blocks and ensuring that environmental provision is 'good enough' to facilitate further progress. Hence, consultations 'loosen the knot' and assist development. For Winnicott, each individual session is a treatment in itself. As Groves (1996, p. 447) points out, Winnicott, particularly as he got older 'brought to each session a special type of activity that made every hour count, as if each session would be his last'. This is a helpful approach for time-limited therapists.

Familiar to many contemporary time-limited therapists, Winnicott's technique involved an active engagement with his patients, including the use of both transference and counter-transference, the need for the patient to come to an interpretation themselves with the therapist as a guide, and the importance of therapeutic surprise. He also implied that the more serious the earlier trauma or deprivation the less likely that standard analytic techniques would be applicable and the more the therapist would need to rely on the qualities inherent in the therapeutic relationship. This was, and still is, a challenge to traditional psychoanalytic treatments, where the earlier the deprivation the longer the therapy is likely to be.

Winnicott's therapeutic consultations with children are centred, although not exclusively so, on the 'squiggle game'. The therapist draws a 'squiggle' and the child is encouraged to add to it, in the process of which the child communicates something of himself to the therapist. This makes the consultation 'come alive'. While not relying on an interchange of drawings, Winnicott's consultations with adults are no different from those with children in attempting to facilitate 'communications of a very personal kind'. An

good example of the use of a one-off consultation to facilitate change is given in 'The Case of Mrs X' (Winnicott 1971), his consultation with the mother of a child admitted repeatedly to hospital. Here the timing of the consultation, the active and insightful engagement with her, the use of symbols, and the skilful use of self enabled Winnicott to make immediate contact with the patient's primary concerns. Interestingly, these bore some resemblance to what others have called 'core beliefs' about the self arising from deprived formative experiences. Jerry (1994) attempts to develop therapeutic consultations into a workable technique in brief or single-session therapy that focuses on linking past and present caretaking experiences.

Winnicott was perhaps the first to recognise and work with the 'pre-transference'. In Winnicott's language this was the patient's need to turn him into a 'subjective object'. Struck by the frequency with which patients recalled having dreamt of him the night before the consultation, he found that, to his amusement, he was fitting in with a preconceived notion of what the individual patient subjectively expected him to be. Being this 'subjective object' has great therapeutic possibilities but 'rarely outlasts the first or first few interviews'. It is an early example of the importance which modern time-aware therapists place on the need to recognise the patient's anticipation and expectation, or pre-transference, of therapy. This too is likely to be a reflection of the patient's core beliefs and fundamental anxieties.

For Winnicott the length of a treatment is less important than making contact with his patients. Implicit in his therapeutic consultations is the belief that reaching 'deeper levels of the psyche' is not related to length of treatment; indeed the reverse can be true. Timing and therapeutic surprise can lead to 'a sacred moment' in a consultation which enables the patient to make themselves known. Such moments can 'be used or wasted' and appear to consist of something of the patient's essence being understood by the therapist. This reinforces the patient's belief in the therapeutic value of both therapist and treatment.

'Therapeutic surprise' is important. Winnicott believed that interpretations fail because the patient experiences them as familiar modes of interaction and reacts to them in characteristic and familiar ways. When interpretations work, the patient experiences them as something new, not encountered before, and so

responds to them in a different way. This appears to be not dissimilar from other versions of the need for a 'different' therapeutic experience which we have described previously. Interpretation is not the main feature of the consultation. Indeed, even correct interpretations can be unhelpful, as they can be technically correct but clinically damaging. Winnicott warns against making interpretations, however 'correct', solely for the benefit of the therapist. Dogmatic interpretations are also harmful, because they leave the patient 'with only two alternatives, an acceptance of what I have said as propaganda or a rejection of the interpretation and of me and the whole set up' (1971, p. 10). The issue of how we can avoid 'propaganda' in time-limited therapies is one we return to in a later chapter.

Winnicott alludes to the need to transcend, if not 'unlearn', one's own training in these brief consultations. Aware of the effect that his own analytic training had on him, he states that he found 'that interpretations that seemed right ten years ago and that the patient accepted because of awe turned out in the end to be collusive defences' (1971, p. 10). All snakes might not be penis symbols; rather they might be attempts by the patient to communicate something important about themselves. We return to this theme when we discuss the issue of training for time-limited therapies.

Winnicott believed that this approach was open to almost any level of psychopathology, although he recognised that some patients were too sick and damaged to be helped by brief consultations and needed containment or management. Central to the work is Winnicott's understanding of the individual's emotional development and its relationship to the patient's specific environment. His idiosyncratic style, which Groves (1996) believes should be read like poetry, 'from the heart' rather than the head, makes it appear that his technique is intuitive and difficult to either replicate or grasp. Winnicott appears to recognise this himself when he says that 'the work cannot be copied because the therapist is involved in every case as a person and therefore no two interviews could be alike since they would be carried through by two [different therapists]' (1971, p. 9). This is of little help or comfort to the fledgling therapist attempting to understand and practice therapeutic consultations. Again we shall return to the issue of intuition when we discuss training.

Single-session, and less, treatments

Single-session treatments (in essence an adaptation of Winnicott's therapeutic consultations) and other very brief interventions (for example, Barkham's 2 + 1 model; see Barkham 1989) have tended to be a response to increasing demand for therapeutic services and ways of managing waiting lists. This is very different from the planned use of a minimal number of sessions. The work of Malan *et al.* (1975) at the Tavistock Clinic had already suggested that minimal contact could have positive outcomes. This piece of research followed up patients who were seen for one consultation but did not receive any ongoing treatment. The vast majority of the 45 patients in the research improved to such an extent that Malan initially thought that this was the result of spontaneous remission. However, he eventually came to the conclusion (not without considerable disbelief) that it was the one consultation that led to change; positive outcomes may be extremely widespread following a single session. Profound therapeutic effects may follow from a single interview. Insight can be achieved without therapy. Malan came to believe that what they were seeing was not spontaneous remission (or other non-therapeutic effects such as 'flights into health' and 'transference cures') but rather the outcomes of one-session psychotherapy.

This has led to increasing interest in single-session treatments. Talmon (1993), under the therapeutic maxim of 'Think complex, do simple,' questioned the widely held belief that there is a conflict between brevity and effectiveness. Using techniques such as reframing, linking, making symbolic connections and narrative, Talmon suggested that much can be achieved in a single session. Brunning (1998) gives an account of the successful treatment of a young agoraphobic woman using these techniques. There is growing recognition that there are times when the proscription of no therapy is the (non-) treatment of choice (Frances and Clarkin 1981). While this may appear the logical extension of ever briefer therapies (and an unconscious Freudian death wish for the therapeutic profession!) it does allow for the fact that the clinician's duty is to do 'no further harm'. There may be times when therapy becomes, if not directly harmful, then at least unhelpful. As

Frances and Clarkin suggest, 'the psychotherapies, like drugs, can produce addiction, side-effects, complications and overdoses if prescribed in an unselective fashion' (in Groves 1996, p. 450). They suggest various categories of patients for whom treatment may be harmful, which include not only the psychotic and severely disturbed but also those for whom 'treatment has become a way of life rather than a means to an end'.

The 'no treatment' suggestion may also function as a paradoxical injunction to patients who lack motivation or are passively referred by third parties. By speaking to, and appearing to agree with, the part of the patient that is resisting therapy, the part of the patient that may be wishing to establish a therapeutic alliance is provoked into responding.

A 30-year-old woman, who had recently arrived in this country to pursue a course of further study, sought out therapy. She described herself in a passive and matter-of-fact fashion and was clearly taken aback when the counsellor asked her why she had come for therapy at this stage in her life and enquired as to what she might want from the experience. She had talked at length about herself but without any sense that there was an acute problem that she wished to address. Also absent was any suggestion that there were long-standing issues which needed some attention. The counsellor was faced with the choice of either finding a way of making the counselling 'helpful' for her (in the face of her bemusement as to what it might focus on) or putting responsibility on her to define how counselling could help. He chose the latter course. It turned out that this young woman was the daughter of two psychoanalysts and had been in therapy since she was very small. She had assumed, in line with her parent's beliefs, that therapy was indeed 'a way of life'. Having signed on for her academic courses, paid for her refectory meals for the term, and considered taking recreational drugs she thought she would book in for counselling as it was part and parcel of what students did. She had no particularly enjoyable or rewarding experiences of previous counselling – just thought it 'was something one did'. The suggestion that she might not need therapy as a lifestyle requirement was met with surprise and relief. She left the consultation rather stunned, believing that her 'old compliant self' had been liberated and saying, with more liveliness than had been in evidence throughout the previous forty minutes, that the thought of managing without any therapeutic 'help' was extremely exiting.

This is not dissimilar from the 'research chemist' described by Malan *et al.* (in Groves 1996, pp. 493–4) who, disturbed by the thought of seeing a therapist, was so relieved that his consultation had resulted in the therapist saying he did not need treatment that his symptoms immediately disappeared. Patients can be very relieved that they might not need therapy and gain considerable benefit from the suggestion that they may be able to take more responsibility for their own lives than they believe themselves capable of doing.

Having come to the point of suggesting that some of our clients might not need therapy, we can now move on to a discussion of how to help those that do.

Summary

In this chapter we have discussed the short-term applications of:

- Systems theory.
- Solution-focused therapy.
- Transactional analysis.
- Existential therapy.
- Self psychology and the work of Heinz Kohut.
- The work of Donald Winnicott.
- Single-session treatments.
- The prescription of no treatment as a therapeutic intervention.

IDIOM, THE THERAPEUTIC TRIANGLE AND TRANSFERENCE

If the patient is to fight his way through the normal conflict with the resistances which we have uncovered for him in the analysis, he is in need of a powerful stimulus which will influence the decision in the sense which we desire, leading to recovery . . . At this point what turns the scale in his struggle is not his intellectual insight . . . but simply and solely his relationship to the doctor.

– Freud (1917)

The result of our review of time-limited therapies in previous chapters has been to focus attention on some common themes. Issues which have emerged to be of central importance include:

- The importance of the therapeutic frame work or frame.
- The attention paid to the therapeutic *process*, including the relationship, as distinct from the actual content of sessions.
- The need to link the presenting problem with both the client's history and the here-and-now therapeutic process – what Malan has termed the '*triangle of insight*'.

What has also become apparent are some basic similarities among all the theories discussed in the last chapter. Although very different in their theoretical models and in their clinical applications, all the theories appear to show some fundamental similarities. All appear to moving towards a recognition that it is the quality of, and attention paid to, the therapeutic relationship which is of central importance. In addition, they share a belief in the immediate and active engagement and a demand on both therapist and patient for mutual collaboration. However they also suggest that

there is something in the client's 'way of being in the world', and its immediate clinical manifestations, which is crucial in time-limited therapies.

If we for instance take the following concepts we can see that they are in actual fact addressing a very similar theme:

- Adler's 'faulty beliefs' and 'unstable opinions'.
- Ellis's 'core irrational beliefs'.
- Felix Deutsch's concept of 'associated anamnesis'. Deutsch (1949) drew attention to recurring themes in the client's discourse of which the client may not be fully aware. These may be key words, affects or behaviours.
- Malan's 'repetitive patterns'.
- Weiss and Sampson's (1986) 'pathogenic beliefs', similar to cognitive therapy's maladaptive automatic thoughts.
- Horowitz's 'schematic representations and personal schemas'.
- Strupp's 'cyclical maladaptive patterns'.
- Strupp and Binder's concepts of personal 'maps'.
- Milton Erikson's (1980a) 'organised themes'.
- Budman and Gurman's 'faulty learning' leading to personal 'templates for future behaviour and relationships'.
- Mann's 'chronically endured pain'.
- Cognitive analytic therapy's 'reciprocal relationships' and 'reciprocal role procedures'.
- Beck's 'false cognitions' and 'automatic thoughts'.
- Cognitive behaviour therapy's concepts of 'core beliefs' and individual 'schemas'.
- The 'internal objects' of psychoanalysis which can be seen to be similar, despite differing theoretical assumptions, to 'core beliefs'.
- The 'sedimental values' in existential therapy.
- Kohut's 'self objects' and the importance placed on the client's 'frame of reference'.
- Davanloo's 'subtlety-loaded words'.
- Balint's 'important moments'.
- Winnicott's 'sacred moments'.

Freud in the *Ego and the Id* (1923, pp. 1–66) had referred to 'internal perceptions', 'which arise in the most diverse and deepest strata of the mental apparatus', which can be viewed as a way of

describing a process through which a sense of self, or a personal idiom, is created.

Idiom: towards an integrative model for time-limited therapies

As can be seen, these are all terms which refer to a specific aspect of the client's being in the therapeutic relationship. They all draw attention to the language, behaviour, posture, appearance and belief systems of the individual client. These are ways of being in the world and ways of relating (including the anticipation of encounters with others) which are often evidenced in individual sessions by a recurring word, behaviour or affect. These give clues to the individual's *recurring motifs*, which become central to the therapy. These recurring motifs often centre on feelings and experiences (anger, sadness, betrayal, hope, fear, and so on) and relate to what the individual expects from others and how the individual views himself. They form mental representations of the place of self and others in the world, and include specific expectations in the way the world is perceived and experienced. These can be derived from faulty learning (behaviour therapy) or a result of experiences that lead to a discrete way of 'object-relating' (psychoanalytic and dynamic therapies). Whichever theoretical model is preferred, all are based on the notion that what the individual internalises from his own specific developmental history is a *relational template* which shapes the individual's experience of both himself and others. This is the basis of how the individual relates to others and how he expects others to relate to him. Although these beliefs can arise from real experiences (and symptoms are often failed attempts to master traumatic experiences), they can also result from fantasies, hopes, fears and straightforward misunderstandings.

Clinically recurring motifs can be conveyed by oft-repeated single words (leading to those 'sacred moments'), personal themes and the transference, as well as the client's perception of, and response to, the therapist's verbal and non-verbal communications. They may also represent discrete ways in which the client relates to the therapy itself. Single words or the description of specific experiences or attitudes towards the therapist, can be

important. The particular moment in the session when these appear (in terms of their context and timing) and the feelings and behaviour – frequently expressing disappointment, hurt, rage fear, rejection and so on – associated with them often convey a secret motif that can become the organising theme for the subsequent therapy.

These personal templates are central to time-limited therapies because they speak directly to the client's way of being in the world and his way of approaching and mastering conflicts. The *Oxford English Dictionary* defines 'idiom' variously as

- A form of expression peculiar to a language (and) person.
- The language of a people (and) the specific character of this.
- A group of words established by usage and having a meaning not deducible from those of the individual words.
- A 'characteristic mode of expression' which might be private if not secret.

I would suggest that 'idiom' is a convenient shorthand way of describing these common themes which have emerged from the literature. We can use it to describe these similar, but differently named, concepts which depict the individual's way of being in the world.

Idiom, used in this sense, is similar to the description of a distinctive personal style outlined by Bollas (1992). Bollas considers us to have a range of personal idioms, not all of which we are aware of, that consist of a repertoire of 'ways of being' which are waiting to be called up in our encounters with others: 'without giving it much thought at all we consecrate the world with our own subjectivity, investing people, places, things, and events with a kind of idiomatic significance' (p. 3).

The self is made up of a plurality of idioms waiting to be called up and discovered.

Our idiom is our mystery. We may seek out others to activate dormant idioms (those which Bollas calls 'unthought' but sensed ones). In this way we seek out others to express parts of ourselves. While some objects may have more significant idiomatic meaning for us than others, we seek out and select objects to express different parts of ourselves. The self, or personality, is made up of many idiomatic representations. A person's idiom, 'partly

inherited, partly acquired', actively 'shapes their relational world according to the idiom of their internal world' (p. 50). Idioms come about only through interaction with others, and these interactions (or what Bollas terms the 'collisional dialectic': p. 60) leave a trace on the person. This would imply that we actively seek out those 'objects' that can give expression to discrete notions of our idiom. For Bollas, 'a day is a space for the potential articulation of my idiom' (p. 24). This suggests some degree of choice, albeit unconscious, in the selection of an activity. When deciding whether to read a book, see a friend or see a therapist, we are 'choosing' to bring alive an aspect of our idiom. In this sense the therapist has to be alive to the manifold idioms potentially on offer, while at the same time being aware of his own idiomatic response to his client. It is the neutrality, framework, structure, boundary of the consulting room and therapeutic relationship which enable idioms to appear and thus to become therapeutically meaningful. Whereas Bollas sees idioms as being revealed over time, my contention is that they are immediately apparent. They cannot be hidden: a person's idiom is the one thing they cannot not express.

Tina

Tina shows us the way that idiom can relate to clinical practice.

Tina, a 25-year-old woman, consulted a counsellor, just over a year after the sudden death of her mother. In a frustrated and irascible way she explained that she was becoming listless, irritable and low, feeling reluctant and unable to get up in the mornings. She was aware that she was withdrawing from friendships and social relationships. Without any prompting from the counsellor, Tina somewhat wearily (although indicating that she was complying with an anticipated request from the counsellor) spoke about her background and the events leading up to her mother's death. Her elderly father, originally from continental Europe, had a history of manic depressive illness necessitating numerous hospitalisations, most recently on the anniversary of her mother's death. One of the mother's roles in the family was to support the temperamentally labile father. Tina, the eldest of three daughters, was now taking on this maternal role with little enthusiasm. She told the counsellor that while she supported him as best she could she found his often tearful distress somewhat tiresome. She experienced it as a paternal demand that the daughters should

grieve in the same fashion. Tina felt unable and unwilling to respond in the same way; she did not want to cry with, or could not cry for, him.

Tina's mother had been ill for some time but the family did not think that her frequent bouts of poor health were life-threatening. Tina's maternal grandmother had died some three years previously, after which Tina's mother had developed a range of psychosomatic symptoms which Tina stressed to her counsellor she understood to be her mother's way of dealing with the loss. At this point the counsellor was beginning to experience unease, sensing a certain provocative hostility in the room and puzzled – as well as anxious – about how he was going to be able to make a helpful contribution to the session, since Tina did not appear to welcome or allow any verbal participation in the session from him. He was sensing Tina's dismissive attitude to him but felt a need, out of professional self-respect if nothing else, to comment on the maternal link in patterns of grief. Tina brushed this aside, saying she had already thought of that, which left the counsellor feeling silly for having 'stated the obvious', and summarily dismissed.

Prior to her mother's illness Tina had been working abroad, where she learnt of her mother's hospital admission but thought it unlikely to be serious so had arranged to see her mother on her return in two weeks' time. The following day she was informed by fax that her mother had died. Tina felt numb, and by her own account 'went through the motions'. She had at that time actively dealt with 'what needed dealing with' and having mourned her mother was puzzled as to why she was currently in low spirits. The counsellor who by now was recovering from the earlier dismissal and feeling more comfortable with (and more warmly towards) Tina was beginning to build up a picture of a very competent young woman who, although at times 'listless, irritable and low', 'gets things done'. He was however still aware of a certain anxiety which, when reflected upon, appeared to centre on his lack of verbal contribution and a wish to become more involved in the session. He was nursing a sensation that his silence, and his feeling of being barged out and excluded from the encounter, was instrumental in leading him to feel a certain desperation to become 'involved'. This, combined with a feeling that Tina needed somehow to be appeased and mirrored through support and reassurance, led him to say something about the stages of grief and that people dealt with them in their own idiosyncratic ways. Tina, giving the counsellor a withering and dismissive glance, said she knew all about that – she knew the theory and did not believe in stages anyway – and continued to talk at her counsellor while he retreated to lick

his wounds and consider further lines of approach. He was left wondering about his 'stages of grief' comment, and again felt silly and inane.

Tina went on to talk about her mother and their relationship. They were the 'best of friends', rather than mother and daughter, and this friendship had to be mourned. She would miss the almost sister-like affection. Without her mother she was experiencing herself as boring, something that the counsellor was beginning to feel in relation to Tina – he could only bore her with his 'insights'. Tina felt that she had nothing to talk about with her friends other than her mother. She was so uninterested in other areas of her life that she was 'allowing' her boyfriend to pursue interests in other women. She just did not care. Tina began to talk about having nightmares, at which point the counsellor began to perk up a bit thinking that he might have something to offer here – if he did not have anything to contribute when dreams were being discussed he was surely redundant! One fleeting day-dream which Tina reported was a thought of taking an overdose or throwing herself in the river as a wish to end the pain. At this point the counsellor felt brave enough to comment that these thoughts may symbolise Tina's wish to be reunited with her mother. Tina's withering expression suggested that she had thought of this some months ago; it was literally water off a duck's back.

What was happening here? How are we to understand this therapeutic encounter? One way is to identify and name Tina's predominant idiom. It is by reflecting on the session's *process* rather than *content* that we are able to recognise Tina's *idiom*. Tina's idiom was her self-sufficient competence ('gets things done'). She had dealt successfully with all life's challenges by being busy and successful. Until the death of her mother she saw herself as someone who did not need anybody, and this idiom was brought into the session with her counsellor. The difficulty however, as with all idioms, is that under stress or pressure they may become dysfunctional and part of the problem. Characteristic ways of being are rarely flexible enough to cope with all eventualities.

Tina's expectation of herself was to cure herself of these feelings of sadness and grief without anyone else's assistance. Her counsellor had nothing to say – Tina had covered every angle and thought of everything. She was clearly as uncomfortable in coming to see the counsellor as the counsellor was in her presence; what both Tina and her counsellor felt in these opening minutes pointed to where the real problem lay.

We can see that during the session that certain themes emerged and continuously recurred:

- Efforts at empathy and support were rejected. Tina was dismissive of all the counsellor's verbal interventions.
- Tina was relentlessly counter-suggestible. Her father's suggestion that signs of grief were part of the mourning process was met with dismissal by Tina, who was not going to mourn the same way as him; this was a warning to the counsellor that any prescriptive (or even normative) approach by him was likely to be dealt with in the same fashion.
- Tina's attitude to her low mood and irritability (observable and experienced by the counsellor during the session) was one of frustration and self-reproach – she ought to be able to conquer these feelings herself.
- Tina's attitude to sadness or more specifically tears (as representing her more vulnerable side) was harsh – she was not going to cry like, or for, her father. The statement that she was not going to cry for him was an important transference comment – she was not going to either do what she assumed the counsellor wanted (show her vulnerability in her tears) or 'cry' in front of a man. When Tina said she was not going to cry in front of her father to either please him or grieve in the same way, the fact that her counsellor was male could not but indicate that the same process and dynamic was alive in the session.
- The fact that Tina spoke of her mother as more of a sibling indicated that there were possible conflicts for her around the issue of being mothered and mothering. This was confirmed by both her discomfort and reluctance to 'mother' her father as her mother had done, and by her response to the counsellor's attempts to 'mother' her; for example, Tina's reply to the 'stages of grief comment'. This could be a pointer to why Tina's grief reaction was both delayed and prolonged: Tina harboured considerable unexpressed ambivalence towards her mother's maternal role, and this had been exacerbated by her death. This ambivalence would also be apparent in her attitude to counselling and the counsellor.
- Tina needed to actively control the therapeutic encounter and any suggestion that she became more passive (or

even allow a reciprocal dialogue) with others was dealt with harshly.

- Here was a woman whose personal template led her, in her first meeting with the counsellor, to replicate her characteristic way of approaching problems (and people). She was attempting to cure herself of the consequences of being bereaved just as she had single-mindedly solved previous problems in her life.

These recurring motifs formed Tina's idiom, which became central to the therapy. Apparent in the opening session, Tina's idiom needed to be linked with the therapeutic triangle of history (relationships with parents), current symptom (delayed and resisted grief) and the process relationship with the counsellor.

For this to be done it was important to view the therapeutic process of the session in the context of the therapeutic triangle. The counsellor decided that the first most important element to address was Tina's attitude to counselling, the counsellor, and, by implication, parts of her self. When Tina said, not unsurprisingly, that she did not think regular counselling would be either helpful or indicated, the counsellor, using his experience of being shut out in the session, suggested that this was possibly contributing to the current problem. Tina had worked it all out herself and knew what was going on, but this did not lead her to feeling any better. She knew everything but could not change how she felt with that knowledge. It was the expectation that she placed on herself that was the problem. Her own self-knowledge could not help her, but the expectation she placed on herself (her idiom) was that it should. Could it be that it was this – the way her current symptom challenged her personal idiom – that needed discussing? Perhaps this was what counselling could offer? Tina would treat any form of counselling in much the same way as other demands on the self. During the course of the next eight time-limited sessions other elements of the therapeutic triangle were in evidence and addressed. These included the following questions:

- How was Tina's sense of herself (as someone who needed to solve problems without letting anyone else in) established and maintained?

- How did it manifest itself in the therapeutic relationship?
- Was her response to her own vulnerability gender-related in terms of her father, counsellor and men in general?
- Was this idiom derived from her earliest experiences?

Central importance was attached to the need to address the personal idiom as evidenced in the therapeutic process as soon as possible. Tina shows us how her affects and recurring motifs in the opening session, which represented her idiom, were inter-linked with the therapeutic triangle.

- The *present complaint*: this would include Tina's irritability and self-reproach that she should be able to 'manage' her feelings of loss; the counsellor's fear that he would have nothing to say; and Tina's feeling that she had nothing else to talk about other than the loss of her mother. This needed to be linked with
- the *personal history*: how did family relationships (including both Tina's father's wish that she should grieve in a certain way and 'idioms' of mothering and being mothered) link with the
- the *transference*: this was in relation to what counselling represented in Tina's idiom and internal world as much as to the counsellor as person.

Seen in this light, the therapy could (and indeed did) address all three dimensions of the triangle concurrently via the mechanism of Tina's personal idiom.

Despite being an internal construct or template, an idiom implies that there is always another with whom we are interacting. Idioms are formed and maintained through our relationships with others. They are recurring patterns of interpersonal behaviour which determine how we construct and perceive past, present and future experience. Fantasy plays its part, but it is important to acknowledge and appreciate the impact of real-life experience in the construction of an idiom. It is important however to value the important adaptational aspects of personal idioms, although, as we have seen in the case of Tina, they can at times be maladaptive.

Time-limited therapies pay specific attention to these idiomatic representations as they appear and develop. It is the relationship

between this idiomatic representation and the therapeutic triangle that becomes the central organising focus in time-limited therapies.

The therapeutic triangle

A central organising focus is crucial to time-limited therapies. Ideally, this needs to incorporate various significant aspects of the client's difficulties. These have been conceptualised as triangles.

The important aspect of the triangle of persons (see Figure 1) is to link therapeutic material with all three corners of the triangle. This usually includes the therapist, significant people in the client's current life who impact on the presenting problem, and significant people in the past, including parents, siblings and caretakers.

The triangle of defence, or conflict, illustrates the attempts made to master and manage anxiety (see Figure 2). This is usually associated with one or more of the significant figures in the triangle of persons. An example comes to mind in the writing of this book. Though in the main this has been an enjoyable experience, there have been times when I have felt it was either beyond me or an onerous burden taking me away from more rewarding pursuits. At those times I have felt like giving up or in some way sabotaging the project. This has represented an impulsive response to my concerns. However, these thoughts, rather than leading to relief, have caused me anxiety. A way of managing that

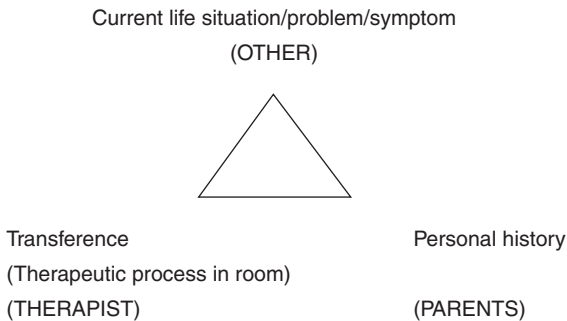


Figure 1 Triangle of persons/insight

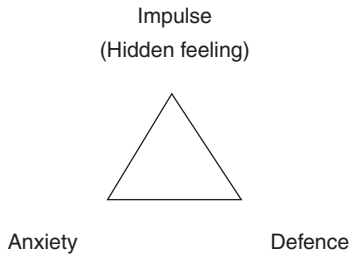


Figure 2 Triangle of defence

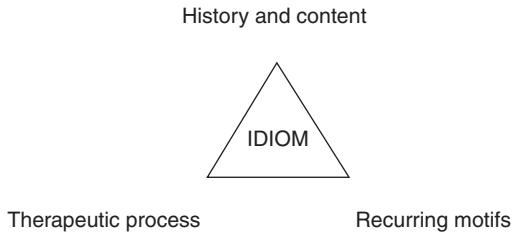


Figure 3 Therapeutic triangle

anxiety (that is, a defence) has been to attempt to read more and more literature on my subject and to take copious notes at the expense of my own thoughtfulness and creativity. This has had the net effect of leaving me extremely confused, irritable and despondent. Such have been the crude ingredients of symptoms despite the attempts of the triangle of defence to prevent their formation.

While this is a fundamental psychoanalytic way of viewing the creation of symptoms, all therapy is an attempt to break the causal links between the three sides of this triangle. Cognitive behavioural therapists would see the triangle more in terms of the interaction between thoughts, emotions and behaviour.

The therapeutic triangle (see Figure 3) provides the framework for learning the client's specific personal idiom, which in turn provides the raw material for making a formulation and treatment plan in time-limited therapy. Anita provides us with an opportunity to attempt to link the material of the first session with the therapeutic triangle.

Anita

Anita, a mature student in her mid-thirties, referred herself for counselling after the long summer vacation, anxious and fearful for the coming academic year, which was to be her final one. She was finding it impossible to concentrate and becoming increasingly agitated and depressed. She had spent most of the summer plucking up courage to come, since she was 'not the kind of person to require counselling'. Last term she had been a welfare officer to other students and had become aware of drug use, which she had reported to the college authorities. They appeared not to take much interest, so, after being assaulted by one of the drug-users, she had informed the police, which had left a great deal of ill-feeling towards her on the part of both fellow-students and the college authorities.

Anita was the eldest of three. She had twin brothers seven years younger than herself. She matter-of-factly described having poor relationships with her censorious parents – although closer enquiry revealed that she meant predominantly her mother – and left home at age 14, abruptly severing contact with her family, to live with her best female friend's family. She lived with them for some time before spending three years travelling. On her return she took a succession of menial jobs during which time she reported that she had been 'quite wild'; by that she meant drugs, alcohol and promiscuity. Eventually, acknowledging her unsuccessful schooldays, she decided to go to college, live independently and 'have fun'. On getting a place at college, Anita's mother became more involved, much to Anita's annoyance – 'She just wants to live off my success.' On her arrival at college she fell out with her best friend and her best friend's family on their discovery that she had had a relationship with their youngest son when still in her teens. While they disapproved of this liaison they still wished to maintain contact, although Anita wanted nothing more to do with them. She then threw herself into her academic work. Soon after her arrival at college she met a fellow student, became engaged and married him four months later. Passing reference was made to a baby which was born towards the end of her second year.

Anita talked at length, looking provocatively directly at the counsellor. She came over as a very 'matter-of-fact' woman, quite adult in her manner, with little evidence of any emotional contact – it felt as if her emotions were under quite firm control. While the counsellor felt able to make a good initial contact with Anita he was aware of a quality of seductiveness on her part which made him cautious and concerned about maintaining boundaries. Reflecting on this subsequently, the counsellor felt Anita may have experienced this as his passivity and withdrawal. He was also struck by his own feel-

ings, which were dominated by a preoccupation with Anita's infant child.

Anita was worried that she would not be able to 'compartmentalise' her work and home life and was perplexed how suddenly she had become a mature student, married and with a family.

Using the therapeutic triangle as a framework for understanding this opening session, we would be seeking to take into account and link the following factors in making a tentative hypothesis.

- *History and content.* We have a narrative account of Anita's progress to becoming a mature student. The precipitating event leading Anita to make a counselling appointment was the long summer holidays and the forthcoming 'final' year. It may well be that this precipitating event can be seen to have an emotional significance in common with Anita's past family history; she left her family before her first major educational examinations.

In addition, and idiomatically important, are:

- Anita's assertion that she 'is not the sort of person to require counselling'. This is made all the more interesting given the knowledge that she had been a welfare officer herself and 'counselled' others.
- Anita's appearing to have made intense attachments which were then abruptly jettisoned – a warning here to the counsellor ?
- Drugs, and Anita's recent experience of reporting drug-users
 - does this have any relevance to her past drug use? By reporting it did Anita believe that responsible adults ought to have taken note of her own previous drug misuse? Were the authorities by 'not taking any notice' reacting in the same way as previous 'responsible adults' in Anita's life? Was this also a warning to the counsellor that Anita needed to be taken notice of?
 - That adults were needed to take the initiative in being authoritatively containing – had that been lacking in Anita's childhood and was she looking for that from the counsellor?
- *Therapeutic process.* Anita did not present as in any way maternal. She appeared cold and somewhat indifferent to her child,

yet described an almost passionate distrust and dislike of her mother who was depicted as appearing to want 'to live off my success'. Was this almost parasitical description a more general comment about Anita's experience of relating to others?

Anita's attachments appeared to take the form of impulsive if somewhat desperate engagement, followed by an equally swift disengagement. A certain reckless impulsivity was also in evidence in Anita's drug-taking and promiscuity and may explain the counsellor's wariness and caution in the face of what at times appeared a provocative seductiveness.

The counsellor's identification with Anita's child is not without interest given Anita's 'adult' presentation. There was very little childlike in Anita's manner, although her wish that the adults (college authorities) would take some responsibility could indicate that Anita herself wanted to be relieved of this 'adult' burden. After her own volatile past, had she gone to the other end of the spectrum and become precociously adult?

- *Recurring motifs.* Linking with the above, was there a wish for her male counsellor to take adult responsibility in a manner absent from her own paternal care? The repeated challenging looks and absence of a potent paternal figure in her childhood could well have represented a wish for just such a figure to save her from an intrusive and damaging mother.

Not to be ignored was the fact that Anita herself had recently become a mother and appeared indifferent to her child. Was this an 'idiom of mothering' that she had experienced from her own mother? In that case this would have transferenceal implications. How competent were the people in positions of responsibility towards others? Were they able to look after others?

Like Tina, Anita appeared to have a complicated relationship to her own vulnerability, but, unlike Tina, dealt with it by impulsive action.

A recurring theme, and one which began and ended the session, was Anita's wish to be able to return to 'compartmentalising' her life. This is the help which Anita was requesting from counselling. This, which could be termed 'splitting', could be seen as a functional 'idiom' which was now in danger of breaking down.

Other themes which were apparent, and could be seen to be in evidence, were Anita's need to escape her mother, the cultivation of an air of unsuccessful self-sufficiency, and some ambivalence about the pain of endings as evidenced by Anita's difficulty in saying goodbye to those closest to her. In this context it is not without interest that she presented for counselling just at the time when she was beginning to have to go through the process of leaving college and sitting her 'final' exams.

From this it is not too difficult to construct Anita's idiom, which then influences the way the problem is formulated and the therapy's frame and plan. Using content, history, process and motif, a therapeutic narrative can be established. What happens in these encounters is that the therapist *attends to the story as it unfolds but pays primary attention to the repetitive motifs through which the client's idiom is rendered intelligible.*

In making a formulation, attention is paid to the precipitating event, or reason, for seeking therapy, and discovering its emotional significance in terms of previous life events or experiences. Tentative hypotheses are made which are based upon the pattern of previous relationships and the developing relationship – or difficulty in establishing one – with the therapist. The therapist then needs to translate his body of knowledge into the client's idiom or private language.

Transference and the therapeutic relationship

One of the most contentious issues in the debate between time-limited and open-ended therapies are the issue of transference and the associated matter of the therapeutic or working alliance. Transference, as classically defined, concerns the totality of the client's attitudes, beliefs and feelings towards the therapist. These are based on previous experiences of relating and can be seen to be incorporated into the client's template or idiom of relating to specific situations or people. As such, transference is more in the realm of fantasy, or a construct of the client's mind, than necessarily based on objective reality. It is interesting to note that in the histories of both psychoanalysis and the more behavioural thera-

pies, transference was initially viewed as a problem. For the early Freud it was something which got in the way of curing the client (clients could not be relied upon to accept the objective reality of their therapist and his interpretations), while for behaviour therapy the therapeutic relationship was seen merely as a vehicle for the delivery of treatment. In psychoanalysis all that changed when Freud (and Breuer) recognised that the 'irrational' responses of their patients – often creating the therapist into something they were not – needed further investigation. Since then, and particularly in the object relation school of therapy, transference has become the central 'tool' of psychodynamic treatments. Similarly, with the advent of schema-focused cognitive behavioural therapy, greater attention has been paid to the need to recognise and use the therapeutic relationship. Transference, which was a problem, is now a major part of the solution. However, the historical legacy, as Langs (1976) has pointed out, has cast an unhelpful shadow over contemporary open-ended psychoanalytic therapies. Patients, according to Langs, are still viewed, 'as the enemy and as resisting . . . [an attitude which still] dominate(s) the analyst's unconscious image while the patient as ally and as curative is still far less appreciated' (in Groves, p. 363). This is not the view of time-limited therapists, who seek the client's active collaboration and agreement at every stage of treatment.

Traditionally, psychoanalytically oriented therapists have tended to view transference as something that is 'subtle[, so] that only through listening and waiting patiently in an atmosphere of stringent therapist neutrality and abstinence will it emerge in a convincing way' (Messer and Warren 1995). Time-limited therapists view the concept of transference as a multifaceted one. A distinction needs to be made between the concept of *transference as ubiquitous* (that it is everywhere, and a normal part of life and social interaction) and the *transference neurosis* (the transfer, both conscious and unconscious, of fantasies, emotions and attitudes from the past onto the therapist, which is a specific illusion of the therapeutic setting). Therapists, despite their frequent protestations, can be quite active (even through their passivity and silence) in encouraging the latter form of transference. Time-aware therapists do not encourage a transference neurosis and do not view the establishment of a neurotic transference as a pre-

requisite for helping their clients. For change to occur it is not necessary to recreate the client's conflicts in the leisurely development of the transference neurosis. Rather, transference

is viewed more modestly as patients' experience of the therapist in ways akin to their view of significant figures, especially from the past . . . clients cannot help but relate to the therapist in accordance with their set patterns, templates or schemas, and it is the therapists job to discern the role relationships into which they are cast, bring them to light, and relate them to other enactments in the present or past. A regressive transference neurosis . . . promotes dependency which may not be resolved in a brief therapy (p. 50) . . . Transference is understood not as a distortion or projection by the patient onto the blank screen of the neutral analyst, but rather as the inevitable expression of the patients' construction of interpersonal reality, shaped and determined by his or her personal experience. (Messer and Warren, 1995, p. 143)

This also applies to the working alliance or therapeutic relationship. Time-limited therapists do not accept that the development of a therapeutic alliance necessarily requires time. They do however view basic trust in the therapeutic process as a positive feature for treatment. This basic trust applies to the therapist as well as to their clients. As will be seen when assessment is discussed, this is reflected in the importance placed on previous meaningful relationships in the client's life. This is also shown by the requirement for therapeutic activity on the part of the therapist, since this can facilitate the establishment of a collaborative and positive working alliance. In order to do this the therapist is always both participant and observer.

This view of transference points to the importance of taking up any transference manifestations, however defined, immediately. These manifestations may well be characteristic ways of relating to people in the client's current life. They demonstrate how they have been used with other people in the past and how dysfunctional or inappropriate they may currently be. The time-limited therapist must not wait for the transference to appear later in therapy as a full-blown resistance, but must be alert to the transference idioms which appear in the first and subsequent sessions. These transference idioms are often in evidence as early manifestations towards the setting, process or frame which needs to be

addressed, since they not only deal with any early anxieties the client has, but also prevent any incipient transference neurosis. Transference in this sense represents aspects of the client's idiom which seeks understanding. It is not always possible or desirable to 'use' or 'work' in the transference; the transference idiom needs to be understood, acknowledged and linked to the central therapeutic focus or triangle.

The client's feelings towards the totality of the therapeutic process are crucial. In time-limited therapy it is frequently more helpful to work with the many 'transference' possibilities which are apparent rather than foster a regressive personal transference to the therapist. *Transference to the setting* in which the therapy occurs maybe extremely important. This can include transference to the therapeutic context such as an educational institution, a hospital, a GP's surgery, and so on. It can also include factors as diverse as transference to one's own development, to what education or medical 'sickness' represents in one's personal idiom, to joining and leaving an institution, the institution itself and what the therapist might represent in the setting in which he practises. This can become the basis for therapeutic encounters – not who the therapist is, or what the client neurotically invests in him or turns him into – but what the setting, and the therapist in that setting, symbolises in the client's idiom. Transference to setting becomes important. This can include feelings about receiving help, limited help, not being encouraged to regress and issues about the ending. These are frequently in evidence from the first session and become predominant themes for therapy. This more multifaceted view of transference implies that therapist needs to adopt a more oblique third-party role, which some may find problematic.

It follows that if transference is ubiquitous then one can even have a transference to time-limited therapy (and a counter-transference of course, too).

These transferences, to the therapeutic process and context, are evidenced by

- The student who comes to counselling expecting the same framework as a lecture, and the same response which he had recently received from a dismissive lecturer.

- The client who is referred to a general practice counsellor feeling 'fobbed off' by their doctor and wishes to continue to view their distress within a medical framework.
- Clients who are either elated or disappointed by the number of sessions offered.
- Clients who view the place of counselling within the institution in a denigratory fashion, perhaps as a repository of vulnerability and shame.
- Clients who experience their need for counselling as a failure on their part.

Many of these 'transferences' can be seen to be anticipatory and in that sense function as a *pre-transference*. The client's initial hopes, fears, expectations and overall presentation both in, and prior to, the first session, can reveal much about the client's idiom and 'transference' to receiving help. What are the client's hopes, fears and expectations from the first appointment? What does he expect to happen? What role does he think the therapist will play? What part will the client play in the process? Is he relieved or disappointed with the first encounter? What are the client's first words or gestures? How the initial appointment is made and kept, as well as the interaction with any other (for example, secretarial or administrative) staff can be very revealing and help in understanding the individual's template in coming for therapy. These however must only be initial tentative impressions, amenable to modification over time, rather than judgements set in concrete. All these 'transferences' are part of the client's subjective idiom and can form the basis of the therapy.

Counter-transference

Comparable considerations also apply to the concept of counter-transference. Having undergone a transformation similar to that of transference in the development of psychoanalysis (from an obstacle to a primary therapeutic tool), its use in time-limited therapies has been further modified. Counter-transference is classically understood as the therapist's feelings and attitudes towards his client, which may result from unresolved issues in

the therapist, as a means of communication of affective states between client and therapist and as a subtle and non-verbal way in which the client seeks to control the therapist. Jacobs (1988) has variously described these counter-transferential manifestations as 'classical' (the therapist's 'transference' to the client), 'neurotic' (the therapist's own unresolved personal issues), 'role' (the therapist's response to the role the client has put him in) and 'complementary' (where the client communicates unconsciously to the therapist his own feelings and experiences). In time-limited therapy, counter-transference is a vehicle for the empathic learning about the client's idiom. Inevitably the therapist will be exposed and drawn in to the client's template or idiom and it is this process (and its link with the therapeutic triangle) which becomes central to the therapy. When and how the therapist becomes so 'unavoidably co-opted' (Levenson 1995) in experiencing what is like to be with the client forms the basis of assessing whether the client's idiom is in any way related to the presenting problem and whether it has historical antecedents. Counter-transference then can shed light on whether the therapeutic relationship represents the client's 'most pervasive and chief problematic style of relating' (Levenson 1995). It frequently assists in adding to the dynamic focus, because the therapist's feelings and actions towards the client will be a microcosm (and parallel) of how the client functions to others, and their reactions to him, in the real world. The therapist uses his response to being invited into the client's idiom (and his experience of being part of it) to facilitate the therapy and help further understanding of how the idiom may or may not help the resolution of the problem.

Understood and used in this fashion, both transference and counter-transference aid the use of the here-and-now therapeutic relationship. While the problems may originate in the past they are maintained in the present, and it is the use of the current therapeutic relationship which provides the most efficacious method of facilitating change in time-limited therapies. The therapeutic relationship provides both client and therapist with a glimpse, and the possible re-enactment, of what gets the client into difficulties in the outside world. It is the interaction between client and therapist and its possible historical antecedents which form the basic building blocks for therapy.

June

June shows how pre-transference, transference, counter-transference and the here-and-now aspects of the therapeutic process can lead to the discovery of a personal idiom. This then can be incorporated into the triangle of past, present and therapeutic process.

June had made two previous appointments to see a counsellor, neither of which were kept. The secretary mentioned that when making these appointments June had seemed anxious and tentative on the telephone. On the second occasion she phoned shortly after the session was due to end saying that she had forgotten but wished to make a further appointment. She arrived a quarter of an hour late for this appointment in the company of a friend who had accompanied (June's word was 'brought') her.

June explained that it had 'been suggested' that she sought counselling after the breakup of a four-year relationship. It subsequently transpired that her friend who had 'brought' her was the boyfriend from whom she had so recently separated. He was concerned at the depth of June's depression and, feeling neither he nor June's other friends could cope with her, had insisted she come to see the counsellor. June's first words were, 'I am not sure I should be here; I don't think you can help.' Here we have aspects of the negative and fearful pre-transference which needed to be addressed before anything else (including getting a history or description of the problem) could be attempted. The acknowledgement of her pre-transference reluctance to come enabled June to explore her fear that counselling (and the counsellor) would in effect 'blame' her for not being able to 'sustain' the relationship and view her as a failure in this as in other areas of her life. It transpired that June was the eldest of four daughters whose parents were continuously at the point of separating and had indeed had a number of temporary separations after violent arguments. Both parents told June that they had to stay together for the sake of their daughters. Consequently June as the eldest always felt responsible for attempting to keep her parents together, although suspecting that in reality relationships were, like the parental one, difficult to 'sustain'. June had also felt responsible for the behaviour and feelings of her younger siblings.

June spent the majority of the first session in tears, evidently in great distress, but continuously apologising to the counsellor for being so 'weak and emotional.' An oft repeated word was 'sorry', frequently followed by the phrase 'you must think I am silly', accompanied by a

tearful and nervous giggle. June said she felt the counsellor would inevitably see her as 'hopeless', and a 'failure' at relationships, not unlike June's perception of her parents. It transpired that these were the reasons which her boyfriend had given for the breakup of the relationship. She believed that the counsellor would only want to get 'rid of' her. This was a not unreasonable assumption, given June's perception that her ex-partner had brought her for counselling for similar reasons, which was subsequently borne out by the fact that he was to have no further contact with June once he knew that she was coming for counselling.

The counsellor felt coopted by June's idiom, not least by the fact that her late arrival had ensured that, since he needed to stick to the time boundary, there was limited time available to contain June's distress and work on enabling June to return for a further session. Her boyfriend, by staying with her until she saw the counsellor (not unlike her parents staying together for the sake of the children) was also adding a further dynamic. All of this led to the counsellor needing to ensure that June did not feel 'dumped' after the opening session, which would have confirmed June's fear that she was unable to 'sustain' relationships.

We can see that June's idiom of feeling weak and emotional, and her 'inability to sustain' relationships, while feeling responsible for others and needing to keep them happy and together, was in evidence from the tortuous route she adopted in approaching counselling. The reasons why she came for counselling at that specific time, the way she presented herself to the counsellor, the counsellor's feelings in the session with her, her current relationships with friends, and the small amount of historical information which initially came to light, all contributed to a tentative hypothesis regarding June's core conflict. It was by linking these in statements which incorporated her pre-transference anxieties, current emotional crisis, real-life concerns, and the process of what happened in the here-and-now of the shortened counselling session, that the counsellor was able to help June return for a further exploratory appointment – without the necessity of being 'brought' by someone else – and to begin the process of a 10-session counselling contract which took as its focus many of the triangular issues which were already in evidence in the first meeting.

Summary

In this chapter we have discussed the following:

- The concept of a personal idiom and how it relates to short-term therapy.
- The triangle of persons.
- The triangle of insight.
- The therapeutic triangle.
- Transference in time-limited therapy, which:
 - Draws a distinction between a transference neurosis and the ubiquitous everyday transference. Time-limited therapies tend to discourage the development of the former while using the latter.
 - Acknowledges that transference need not only be to the therapist but can also be to the setting or treatment.
 - Actively uses the pre-transference.
 - Suggests that all early transference manifestations need to be actively worked with from the beginning of therapy.
- Counter-transference in time-limited therapy, which:
 - Facilitates the empathic discovery of the client's personal idiom or template.
 - Provides a microcosm of the effect that the client has on others on the real world.
 - Assists the here-and-now approach of in vivo experience and learning in therapy.
 - Provides more evidence for formulations within the therapeutic triangle.

Before moving on, we need to look briefly at how both attachment theory and the concept of narrative relate to time-limited therapy.

NARRATIVE AND ATTACHMENT THEORY IN TIME-LIMITED THERAPY

'Absent thee from felicity awile,
And in this harsh world draw thy breath in pain,
To tell my story'

– Hamlet

At first glance it may appear that attachment theory, which places emphasis on the nature of the bond that is established between the infant and his caretaker, poses specific difficulties for the time-limited therapist. Surely, attachment, trust and safety take time to establish? On closer examination, however, the concept of attachment is one that has clinical implications for focal therapies and can be usefully incorporated into a time-limited model. Attachment theory is less an alternative model of therapy rather than a template underlying the practice of all therapies. Bowlby, the originator of the notion of primary attachment, expressed considerable optimism about the potential contribution of attachment theory to brief psychoanalytic psychotherapy.

The work of John Bowlby

Bowlby (1953), drawing on his studies of the newborn infant's dependence and helplessness, drew attention to the nature of the developing bond between mother and infant and suggested that future development and mental health was in some measure

dependent on the constant safety and predictability of this early bonding process. His neo-Darwinist belief that humans will inevitably attempt to bond for survival's sake is very different from the original analytic position, which placed hunger or sex at the basis of the need to attach and 'seek out gratifying objects'. Thus, attachment theory states that the mother 'does not become important because she gratifies . . . she is important from the start' (Greenberg and Mitchell 1983, pp. 184–7).

Attachment theory proposes that the making and breaking of affectional bonds is central to the human condition – it is primary and innate, rather than a secondary response to frustration or absence. This places separation and loss, and the work of grief and mourning, at the centre of our experience. Consequently it is inevitable that this issue in its varied forms will form the basis of most clinical therapy.

Bowlby saw development primarily in terms of the effects of external environmental influence. Genetic endowment, instinctual drives and fantasy are less important than the interactions with others which lead to models of attachment behaviour. For Bowlby the environment was essentially the mother, although towards the end of his life he accepted that this could include the father and other caretakers.

It was these views which led Bowlby to be only ambivalently tolerated by the psychoanalytic community, a position which is gradually changing with the renewed interest in both Bowlby's original work (Bowlby 1953) and contemporary developments in attachment theory (Holmes 1993; Kraemer and Roberts 1996; Holmes 1997). Bowlby had originally hoped and expected that attachment theory would illuminate and strengthen object relations theory – not unreasonably, given the relational core of both approaches – but attachment, and the importance it placed on environment rather than fantasy, was viewed as potentially a threat to, and betrayal of, psychoanalytic theory and practice. (For an interesting discussion of Bowlby's wary relationship with the analytic community see Holmes 1993, pp. 3–9.)

Bowlby suggested that the origins of insecurity occur early in life. His main achievements were to highlight:

- The effects of maternal deprivation.
- The importance of the bond between children and parents.

- The need for a secure base.
- The importance of feeling attached throughout life.
- Loss and its relation to stages of grieving.

Modes of attachment are internalised by the child through ‘internal working models’, templates of early relational experiences, which lead to either a secure or an anxious attachment. Bowlby contrasted the notion of ‘secure attachment’, a result of safe, predictable and continuous (maternal) care, with ‘insecure attachment’. Ainsworth *et al.* (1978) suggested that insecurely attached children fall into two distinct patterns:

- ‘avoidant’ – who appear detached from their parents, showing little protest when separated and ‘hovering nervously near them when reunited’.
- ‘ambivalent’ – who cling desperately to their parents and are unable to be pacified when reunited.

A third group has more recently been added:

- ‘disorganised’ – who show an inconsistent response to separation, ranging from ‘frozen watchfulness’ to behavioural and emotional breakdown.

These patterns of childhood reactions to separation have been linked with various parenting styles (one could call them ‘idioms of parenting’) and are likely to be repeated in any therapeutic relationship. They also ‘carry through into . . . adult life and affect the way we make sense of and ascribe meaning to our world’ (Holmes 1993 Part III). *In other words they assist in the formation of our personal idiom.* Therapeutically significant is the link between attachment styles and what Holmes has termed ‘autobiographical competence’. Secure attachment tends to foster autobiographical competence, which is ‘the ability to talk coherently about oneself and one’s life including painful experiences’. Insecure attachments preclude the achievement of autobiographical competence. The insecurely attached and avoidant tend to be ‘monosyllabically dismissive when talking about their pasts . . . (“can’t remember”, or “fine”).’ Insecurely attached ambivalents are frequently ‘bogged down or enmeshed in past pain, often

weeping inconsolably when asked to recall their early childhood'. (Chapter 8) Alternatively, they may cultivate an air of self-sufficiency when dealing with loss to mask their ambivalence. Initial attachment styles, or idioms, can give some indication of how clients are likely to respond to therapy and what form of containment they may need.

Paul, Philip and Tina

Paul had been abused as a child and his current life was dominated by often violent mood swings, and feeling others had let him down or were hostile to him. His relationships were always unsuccessful, despite his expressed wish for more satisfactory contact with others. In his opening meeting with the therapist, for which he arrived late, he presenting with sullen suspicion and a reluctance to engage in therapy. He was anxious about any form of attachment, fearing that it would inevitably either be abusive or lead to betrayal. Frozen and suspicious, he could be seen as 'disorganisedly' insecurely attached. Attachment theory implies that Paul needed a more supportive, less emotionally intense or interpretative response.

Philip was immediately preoccupied with the therapist's room and personal appearance. Excessively polite and submissive, expressing concern as to the health and well-being of the therapist, minimising his own distress while speaking with excessive warmth about all his friends and family, Philip could be seen as ambivalently attached. It rapidly became apparent that as an only child of fractious and argumentative parents his role had been to pacify them and 'keep them happy' at the cost of his own needs or wishes. He would need a firm, reliable and safe setting in which to begin to experiment with notions of difference in relationships

We have seen how Tina initially exhibited 'avoidant' insecure attachment by minimising her own needs for attachment, partly to avoid rejection. The difficulty she experienced in overcoming the loss of her mother a year after her death speaks to the avoidantly attached need to remain in some, often distant, contact with the person who has rejected them. Close contact with another was associated with pain and possible rejection. Her response to my comments indicated that she experienced them as intrusive attacks on her. She needed a more 'conversational' and flexible therapeutic relationship.

These patterns of attachment may shed light on how the individual approaches intimate relationships in adult life. For an interesting further discussion of the clinical relevance of attach-

ment modes, narrative style, generational transmission and parenting, see Main (1995).

Emotional stability is dependent on the availability of attachment figures. The expectation of available attachment figures is built up over time and is dependent on positive experiences with parents and caretakers. While originally referring to the physical presence of a caretaker, Bowlby, and subsequent attachment theoreticians, have also acknowledged the importance of emotional absences. It has become apparent that it is not the loss *per se* which is necessarily of crucial importance (grief can be successfully mourned), but the nature of the previous attachment and the circumstances following the loss. These are more likely to predispose the person to subsequent depression or psychological problems (Rutter 1985). As we saw with Tina, it is the person's emotional and behavioural response to loss and separation which is of central importance.

Bowlby's work links with modern relational theories because it posits an infant and caretaker who are aware of each other from the start, what Trevarthen (1980) has called 'primary intersubjectivity'. The concept of 'attunement' (Stern 1985) describes how the basis of secure attachment is formed through the 'emotional alignment' of infant and caretaker. It is however the *quality* of this emotional interaction rather than the *quantity* which is important for the future. This is a significant way in which attachment theory informs time-limited therapies which stress the immediate engagement on an emotional level with the client and place the active use of, and 'attunement' in, the therapeutic relationship at the centre of therapy.

Attachment theory has placed separation and loss at the forefront of human experience and thus clinical practice. Since these are the inevitable consequences of being human, they will need to be continually negotiated throughout our lives. Time-limited therapies address this issue directly, not least since the issue of time is apparent in every session. Time-limited therapies are informed by attachment theory in this respect – both ascribe significance to loss and separation (which may be actual or in fantasy), but clinically crucial is how *the loss is emotionally perceived, responded to and resolved by the individual*.

Towards the end of his life Bowlby was advocating a therapeutic approach which suggested that therapy should focus on

current interpersonal relationships and how these are based on previous formative relationships. Implicit in this is the notion that these forms of attachment, or non-attachment, will be in evidence in the here-and-now consulting room. It is highly likely that an idiom of attachment will be evident in all aspects of the therapeutic triangle. This relates to patterns of parental management and handling, which are internalised as internal working models, templates or personal idioms. The idiom of attachment is what Bowlby would call 'transference'. Attachment becomes internalised as a template or working model for all close relationships. Since all therapeutic relationships are essentially ones of attachment and separation (this applies particularly to briefer therapies), attachment theory offers a way of thinking about past, current and future relationships within the context of a finite therapeutic process. In this way attachment theory, including patterns of relating to separation and loss, can assist time-limited therapies, not least in the importance paid in briefer therapies to the therapeutic frame and how it is responded to and used. Attachment theory also sheds light on the struggle to convey both verbal communication and affective states in a setting where time is limited. The therapist must offer a secure and safe base while focusing on real-life experiences, 'at the expense of deep interpretations based on primitive fantasy' (Holmes 1997). In stressing the need for a secure base, attachment theory 'requires . . . reliability, responsiveness and the capacity to process *negative affect*, especially in relation to separation and loss' (p. 122). The key to successful attachment is active and reciprocal interaction. *It is less a question of the amount of time a caretaker (or therapist) spends with the child (client) than the nature and quality of how the time is spent.* These are also the core conditions for time-limited therapies which place emphasis on viewing therapy more like a 'conversation', and where the therapeutic alliance is one of 'companionable interaction' (Heard and Lake 1986), much like the 'playfulness' made possible by a parentally secure base.

Bowlby recognised that attachment can never be entirely reliable; it must sometimes be shared and will inevitably be lost, sometimes prematurely. The capacity to separate from attachment figures and to form relationships with new ones is viewed as a developmental challenge and achievement throughout life; the frames of time-limited therapies speak directly to this.

Time-limited therapies also place emphasis on 'autobiographical competence'; telling one's story facilitates attachment. A dilemma for time-aware therapists is how to allow for substantive attachment and trust to develop without the client becoming too dependant; the notion of 'idioms of attachment' is helpful here. Bowlby's own preferred therapeutic stance assists the development of a non adhesive or dependant attachment:

While some traditional therapists might be described as adopting the stance of 'I know, I'll tell you', the stance I advocate is one of 'You know, you tell me'... the human psyche, like human bones, is strongly inclined towards self-healing. (Bowlby 1988)

It might not take long (or much) to facilitate a process which sets in train the client's ability to heal themselves, provided that the initial attachment is secure and that the therapist is attuned to the client's idiom and to what the client, as opposed to the therapist, wants.

Our idiom of attachment becomes internalised as a 'self narrative'. The way we make ourselves known to others is through our narrative styles, which consist of our personal, and often secret or untold, version of our life stories. Autobiographical competence leads to narrative coherence. Holmes (1993) implies that there is a strong connection between childhood attachment patterns and the kind of narratives that people tell about themselves years later: '[s]ecurely attached children tell coherent stories about their lives, however difficult they may have been, while insecure children have much greater difficulty in narrative competence, either dismissing their past or remaining bogged down in it' (p. 9).

Since attachment experiences are linked to autobiographical competence and narrative coherence, we now need to look at how storytelling can be used in time-limited therapy.

Narrative in time-limited therapy

At one level, narrative in therapy is relatively straightforward. Offering someone the opportunity to tell their story – one perhaps never told before – is helpful and enables them to feel heard and

understood by another. Narratives help to validate our experience and give us a voice. Narratives function as self-revelatory stories which 'help us discover who we are' (Sugarman 1996) and enable our lives to have some form of thematic continuity and direction. Narratives are closely linked to personal development; they give a voice to who we are, where we come from and what we want to become. They link the internal world of the 'me' with the external world of the 'us'. Narrative 'turns experience into a story which is temporal, is coherent and has meaning... it gives a person a sense of ownership of their past and their life' (Holmes 1993).

Narrative is important in time-limited therapy. Having a loosely linear story enables both therapist and client to maintain a focus and link therapeutic material to the emerging narrative. Putting our stories into words, and contextualising their cultural and familial aspects, helps a framework to emerge which is based more on normative, as opposed to pathological, explanations. This non-pathological approach is significant in time-limited therapy, since it enables the client to contextualise his experience rather than blame himself or take a victim or sick role. Being able to tell one's story objectifies experience so that the person is at one remove from it – it becomes a symbol of our personal idiom rather than raw and unprocessed feeling. By converting a series of seemingly unrelated experiences, often painful, into a coherent narrative we are able to use past experience as a vehicle for symbolisation. This can then be reflected upon rather than either acted out or painfully experienced as a series of unrelated misfortunes. Autobiographical competence and narrative coherence enable the emotional processing of painful past events.

Narratives are composed and determined by personal development, life events and time. It is the subtle interaction between personal development, societal norms, life events or experience and one's idiomatic way of managing these phenomena which constitutes our personal narrative. Central to the idea of narrative coherence is the balance between continuity and change. This enables us to feel 'a sense of being the same person [we] have always been – despite the gradual incremental changes associated with ageing – and despite major life disruptions' (Sugarman, p. 291). We struggle to change while remaining the same.

Coherence and making sense of our experience tends to help us have some control over what otherwise may be experienced as random and disassociated events and feelings. Random descriptions make little sense. Since our lives are complex, more than one story can be told; in narrative therapy, client and therapist 'choose' which experiences and events are of significance in the emerging 'plot'. In short-term therapy this is likely to form the core focus. This is helped by the fact that we make sense of our experience when it can be ordered according to recurring themes. 'Emplotment' (Ricoeur 1984), like the development of a plot in a novel, helps us to organise our personal narrative. Narratives can be conveyed in metaphors, images and recurring themes, and through the expression of our personal idioms including those of attachment.

All narratives are personal and idiosyncratic. However, just as in literature, there may only be a limited or finite number of plots in our lives. Elbstree (1982) identified five generic plots which form the basis of all stories. How these plots intersect with the developmental stages of the life cycle influence the construction of our personal narrative. For instance, the acts of, and the feelings associated with, love or betrayal may link with the various developmental stages which can make a significant contribution to our plots. Shafer (1976) suggests that the narrative paradigm, which includes the subjective account of perceptions and feelings in the context of the external environment, may well be as therapeutic as the arousal of transference feelings in successful therapeutic outcomes.

Narratives are inevitably subjective accounts of our experiences. They may bear little relation to factual events. Therapy is concerned with narrative as opposed to historical truth (Spence 1982). Therapists are interested in their clients' subjective accounts not only because they rarely have access to objective and factual information, but also because it is a client's experience of events that shapes their narrative and idiom and it is this which is important in therapy. This links with our discussion of attachment – *it is the subjective emotional content of an event, rather than its factual occurrence, that is therapeutically important*. It is the way, manner and form in which the narrative or story unfolds or is told which are of central significance.

The importance of a story in time-limited therapies

The use of narrative is particularly helpful in time-limited therapies because it incorporates aspects of the triangles of therapy and persons, discussed earlier. As clients discuss their present experiences, and reconstruct past events, the present, including the therapeutic relationship, can be linked with the past. The narrative is not merely the client's story or history; it also throws light on the development and current status of the therapeutic relationship. This is frequently told at one remove in the context of specific metaphors. Therapy then becomes an exercise in 'story repair and reconstruction' which 'encourages the powerless to tell their stories [and confers] a clear and constructive identity on the teller' (Sugarman, p. 304). Clients come to therapy with their own stories which the therapist helps to elaborate, reconstruct or focus.

Short-term therapy can be seen as a short story which

typically focuses on a single theme, a few characters, and [a] slice of life . . . long-term therapy is more akin to a fully developed novel, incorporating plots and subplots, a panoply of characters, and a great variety of situations in which human drama unfolds. (Messer and Warren 1995, p. 211)

Susan

Susan, a pretty and articulate young woman, consulted a therapist in considerable distress, puzzled and worried about panic attacks which seemed to have no meaning or cause: 'They just do not make sense.' They left her 'frightened, confused and scary'. While the attacks had shown some sign of improvement since her doctor had prescribed tranquillisers, Susan was still anxious because she could not understand why they occurred . . . 'I am normally such a relaxed and easy-going person.' She had recently left home to attend university and, having chosen to study law, saw herself as a 'logical, rational' type of person for whom panic attacks just did not make any sense. Susan's mother thought the anxiety might relate to going to university. Anxiety attacks, when the rational cause cannot be identified, are likely to be problematic for people whose personal idiom is one of logic or who, as in Susan's case, view themselves as calm and relaxed. A time-limited narrative approach to Susan's difficulties proved helpful.

- Susan spoke about never 'having had any problems before'. Discussion revealed that aged seven Susan had needed to go

into hospital suddenly for a major operation. The suddenness of the admission 'surprised and confused' her. Having to spend a few days in hospital in unfamiliar surroundings, lacking the familial supports, was 'scary' and 'frightening'. A link was made between this experience and coming to start her university career – she had after all used similar words to describe both going into hospital and her current anxiety attacks. This appeared to make sense to Susan; it was important, given her personal idiom of logic and rationality.

- Susan did not initially want to go to university, preferring to have a gap year to think through what she really wanted. Her mother had linked the symptom with going to university, and discussion revealed that Susan's mother had not been able to go to university herself, needing to attend to her problematic father. Mother had always regretted this and this sense of lost opportunities had dominated Susan's childhood. Susan felt generationally compelled to leave home to study before she was really ready.
- Susan was studying law, 'as I always thought I was temperamentally suited to it'. Allowing Susan to talk and construct her own narrative revealed that her maternal grandfather had spent some time in prison and throughout Susan's childhood it had been impressed on her how unjust and shameful this was. Studying law would correct these wrongs.
- A narrative approach allowed Susan to explore her personal idiom – the kind of person her childhood self had assumed she was – and to begin to consider whether this was actually a realistic picture of herself; perhaps she was more complex, less rational, than her past had led her to imagine?

Susan was able to use the construction of a personal narrative to help her master her panic attacks. However, sometimes life is not as linear and ordered as it seems. On those occasions the narrative needs to be deconstructed.

Happy

Happy, as I shall call him, since he had a name that was both culturally strange and at odds with his demeanour, was a large, ungainly man whose parents were African but who presented himself to his therapist as the essence of a middle-class 'English gent'. Happy had

been 'sent' for therapy by his doctor who could not find any physical cause for Happy's ailment. Happy took a long time to explain that he was preoccupied by a facial skin complaint which, while barely visible to the bewildered therapist, caused Happy much distress and led him to avoid close physical contact with people. He had been attempting to cure himself by attending to his diet but this only had the effect of making him feel 'inauthentic'. People also did not appreciate how tortured he was by his symptom, since others could not see it. His GP had prescribed various medications but none was effective. Happy did not know what to make of his GP's suggestion that he seek counselling – 'For what?'

Happy had a 'wonderful childhood'. Born in the Sudan, he had arrived in Britain when he was three years old, his father, a medical student, having preceded him, leaving the Sudan immediately after his birth. His mother never really settled in Britain and returned to the Sudan when he was seven together with a younger brother. Father remarried when Happy was ten and he had a mixed-race younger sister. Happy had spent the whole of his childhood and young adulthood in the north of Scotland and in an East Anglian village which was 'great'. However he was always worried about his physical appearance and sought various medical treatments, none of which were helpful – in itself not without interest given his father's profession. This was revealed in a matter-of-fact manner with no hesitation, pause for thought or reflection; a coherent, circumscribed, understandable narrative. The only problem was that it lacked any emotional conviction. Narratives need to have some emotional resonance which links with the person's life experience.

Happy's skin was revealing something he would rather conceal. In the same way his narrative, by being so straightforward and seemingly coherent, was hiding something more complex and personal which could not be thought or talked about, but could only be experienced as a physical ailment. Here was a narrative which needed to be deconstructed.

- For Happy any form of self-exposure was problematic, whether it was his skin or his 'authentic' story. His childhood, and particularly his experiences in British schools, had been excessively problematic, but this was defended against by his convincing (at least to himself) narrative. The emotional content of this had to be displaced elsewhere – onto his sensi-

tive skin. We can see clearly here the operation of the triangle of conflict; how feelings are repressed and form symptoms.

- His ambivalent relationship to his father, which could not be voiced, was enacted by his dealings with his various medical advisers, none of whom were experienced as helpful.
- Happy was seeking recognition as 'authentic', but the only way his narrative allowed this to come about was via the treatment of his various physical ailments.

Happy was a very complex and troubled young man but the important point from our perspective is that Happy demonstrates how psychological problems can be evidenced by too coherent a narrative. Narrative theory holds that the self exists only in the telling of our stories. The purpose of telling a story is to reaffirm the self and make a coherent narrative. There are however times, and this is particularly true of psychosomatic problems which tend to reflect the split between the emotional and the physical, when the narrative needs to be broken down so that a different story can emerge.

The importance of surprise in time-limited therapy

Of significance in the construction (or deconstruction) of a therapeutic narrative is surprise. It was Winnicott (1971) who first drew attention to the importance of therapeutic surprise. In describing the use of the 'squiggle game' with nine-year-old Iiro, Winnicott drew attention to a point in the game when Iiro 'had surprised himself' by what he had drawn. The capacity to surprise oneself and be taken unawares by one's own thoughts and feelings can function as potent and significant moments in therapy.

Therapeutic surprise and revelation are important aspects of therapy. Like the best novels, narratives which maintain our curiosity tend to be those which surprise us; discovering alternative scripts with our clients about their lives can be exciting, surprising and helpful. Therapeutic surprise '[is] a very special type of pleasure . . . it opens up, liberating an area like a key fitting a lock' (Bollas 1992, p. 37). Narratives pull together bits of our

stories in the knowledge that other stories are always possible; it is the elucidation and discovery of other possible scripts or stories which inform time-limited therapy. Narrative surprise has the most profound effect when it is coupled with what Enid Balint has called an '*Erlebnis*' in therapy. Roughly translated, this means a new experience in the here-and-now relationship between client and therapist. This assists new ways of being and relating, as well as challenging our existing narratives. Focal therapy needs to be an affective experience as well as a verbal or behavioural interchange. A new understanding is coupled with a new experience. An experience is more important than an explanation, because what is therapeutic is the experiential, emotional tie between the client and his therapist rather than didactic learning through interpretations. A new relational experience with a therapist need not primarily be a 'corrective emotional experience' (Alexander) to repair a 'deficit', but can help the client have a different sense of themselves. Surprise can involve clients having a different experience (hopefully more meaningful and benign) with the therapist than they had with significant people in the past or present. It can also hold out the possibility of the discovery of alternative scripts of their lives. Therapeutic surprise enables the therapist to offer 'not suspicion about the patient's motives and the exposure of a truer meaning known only to the [therapist], but a variety of complementary (and sometimes paradoxical) meanings that open up to new experiential options' (Mitchell 1997).

Therapeutic surprise links with the theory of change in time-limited therapies. While open-ended therapies tend to assume that change comes about only as a result of the working through of as many problematic areas of the personality or fantasy systems as possible, practitioners of time-limited therapies tend to believe that by sticking to the core focal problem a 'ripple effect' will be set in motion. If you change your attitude and feeling in respect of one central issue it is likely to change and affect other areas or parts of your life. This enables clients, by being able to gain some mastery of a central aspect of their emotional lives, to extend and generalise this experience and knowledge to other areas of their lives. A client who works on a core focus of self-reproach and lack of confidence in their therapy may well generalise their experience of therapy to other settings after the therapy

is finished. This is aided by the fact that the core focus is generally a metaphor for various different areas of a client's life.

Lee

Lee exemplifies some of these issues. Surprise, experiential learning and the ripple effect of focal therapy are all in evidence:

Lee, a 32-year-old man from the Far East who had arrived in Britain to study for a professional qualification, consulted a counsellor to express his disappointment with his host country. Lee had arrived with high hopes of discovering a stimulating academic environment and a welcoming community but had found neither. The academic standard of his course was not 'up to much', and he found British people 'inscrutable' – by which Lee meant diffident, closed and unwelcoming. Perhaps, Lee asked, the counsellor could teach him some 'social cues?' The counsellor, unsure he was able to recognise any social cues let alone teach them, offered Lee ten sessions to discuss Lee's adaptation in Britain and his need for social cues. He arrived regularly if frequently late for sessions. A number of issues presented themselves, including Lee's need to escape his country of origin (he had studied abroad for the last six years). It rapidly became apparent that Lee's idiom was one of harbouring high and unattainable expectations of himself and others. The therapist sensed this by experiencing a sense of therapeutic failure in every session. Not surprisingly, Lee thought others saw him as arrogant, although Lee himself was not bothered by this; they were merely jealous of his ability as a scientist to work things, including relationships, out from 'logical first principles'. During the sessions the counsellor, increasingly aware that the core problem lay in the area of Lee's general social manner rather than one of cultural dissonance, was becoming concerned that the day of judgement would soon arrive when Lee would ask the counsellor to come up with some 'social cues'. The counsellor himself felt clumsy and in need of some therapeutic clues. Lee had talked about how enraged, bitter and disappointed he was becoming with his academic institution (a metaphoric reference to the therapeutic relationship) for not giving him what he wanted. This was a contradictory demand for, on the one hand, more guidance and, on the other, more recognition of what a special person he was.

In his sixth session Lee arrived uncharacteristically a few minutes early, and instead of reporting to the receptionist and waiting in the waiting room, went straight up to the counsellor's consulting room, entering without knocking to find the counsellor on the telephone. The counsellor, surprised and aware of his irritation with Lee, asked him

to wait in the waiting room until the agreed time. Lee looked shocked and affronted by this request. The space enabled the counsellor to think about how best to incorporate this action, and the feelings it had elicited, into the impending session. When Lee arrived the counsellor spoke about Lee's strange entrance; the custom in the counselling service, as Lee knew from previous visits, was to check in with the receptionist and wait in the waiting area. Perhaps by ignoring this he was expressing both his dissatisfaction with his counsellor and the customary ways of doing things in the service? When the counsellor explained the rationale for the operation of the service, Lee said it was 'nonsense' – that is, not logical. People knew he was due, the counsellor did not have an engaged sign on his door, and he found it humiliating and degrading to be asked to use the waiting room. This turned out to be the turning point in the therapy. The emotional response to be asked to wait was linked to a discussion of the personal meaning of social cues for Lee. The wish to be taught social cues (which Lee's defensive grandiosity would not allow him to learn) linked with a number of core difficulties in his life. The remaining sessions focused on related issues, including what place logic as opposed to custom and rituals had in Lee's life. For Lee, customs, including how people related to each other, were governed and regulated by logic and could be worked out in a scientific way. It followed of course that Lee was frequently disappointed and annoyed that others did not recognise the superiority of his logic and abide by it. He was then faced with having to adapt to customs and rituals imposed on him from the outside, which was what had made him furious when he was asked to return to the waiting room. The demand that he do so had no basis in logic and led him to feel he was complying and losing any sense of an active subjective self. To conform to ritual and custom was to lose the self. Alternatively, Lee could choose not to adapt to custom or social cues and risk the kind of social, personal anxiety and dissatisfaction that he had originally talked to his counsellor about. Importantly, this was enacted as an *in vivo* experience with the counsellor. The counsellor's feeling that he was going to 'fail' Lee and be 'not good enough' was a reflection of Lee's own fear of failure hidden behind his grandiosity. Lee, at some level, was wishing that his logic would be found wanting, if only because it had condemned him to a peripatetic and migratory existence in his desire to find the illusory relationship which was governed by logic. The counsellor suggested to Lee that adaptation to external rites of passage or customs was a choice he was constantly facing. In making that choice he was losing something of himself. One way of looking at customs or rites of passage is that they are there to help us conform or tame something dangerous in ourselves. This story

surprised Lee, not least since it had considerable emotional resonance as a result of Lee having had an *Erlebnis* of it in the session. The ripple effect of this experience was manifested in the concluding sessions, where Lee's choice of when and how to present himself to the counsellor and the service was significant. It was also in evidence in Lee's experimentation with 'non-logical' interactions with others outside the sessions.

Externalising the therapeutic alliance in time-limited therapy

Transference in psychoanalysis has always had an 'as if' quality. It is not 'as if' the therapist is the client's actual parent, although a transference neurosis might stimulate a regression which leads the client to feel 'as though' the therapist is their parent as opposed to a parental figure. As we see in the next chapter, therapeutic activity on the part of the therapist in time-limited therapy acts to prevent the development of a regressive transference. The use of the therapeutic alliance in time-limited therapy demands a therapeutic stance which not merely maintains an 'as if' position ('you are behaving and feeling towards me as if I were your parent') but also requires the therapist to adopt an oblique third-party role. The exploration of a personal narrative aids this process. A joint exploration is embarked on where both the therapist and the client view the developing narrative 'as if' it was a collaborative story engaged upon by two separate people. To be able to do this also provokes a different form of attachment (an attachment to the narrative) and requires the client to maintain an observing ego. By this I mean the client will be encouraged both to experience what the therapeutic alliance is like and to reflect on its emotional impact in terms of past and present relationships – that is, ones outside the therapy. In this way the therapeutic relationship becomes objectified. This is similar to the concept of the 'externalising conversation' in family therapy (White and Epston 1990), where the therapist 'maps' the effects that the problem has on a client's life, helps them notice the influence the problem has on differing areas of their lives, and then assists the client in 'organising and fighting against' it. Thus, for example, in the case of an encopretic child the problem is given

the name Sneaky Poo' and the family discuss how to get the better of 'Old Sneaky Poo'. This functions, as in time-limited therapy, to put both the symptom/problem as well as the therapeutic relationship at one remove and enlist the 'observing ego' to fight against it: 'How are we going to outsmart Sneaky Poo?' This can equally well apply to any concept – dependence, for instance – which is named and then discussed rather than, as tends to be the case in longer or open-ended therapies, slowly experienced and worked through. Externalising the problem is associated with the narrative approach and helps to:

- Give the problem human characteristics and a will of its own.
- Locate the problem/worry either as part of the self or outside the self so that it becomes less persecutory.
- Plan a strategy to defeat it

This is in many ways similar to Gestalt techniques where parts of the self are placed in an empty chair and spoken to, and helps place the therapeutic relationship in a similar frame. It is something to be named, reflected on, and linked with other experiences outside the consulting room. The fact that both therapist and client maintain an 'observing ego' helps contextualise the therapeutic alliance. The importance of this is borne out by the finding that what helps positive outcomes in focal therapy are the links that are made between the here-and-now – transference – and the there-and-then – parent or significant caretaker (Malan 1976). The transference is externalised and enlisted in the understanding of core relational patterns in both the past and the present.

This 'externalising conversation' has the function of assisting the move from 'people having problems' to the idea of 'problems having people' (Eron and Lund 1996). This enables the person to be 'separated from the problem and helps . . . [the client] marshal their resources against problems' (Eron and Lund 1996, pp. 32–3). Externalising conversations also assist in the construction of alternative stories – and alternative solutions. This speaks to the delicate balancing act in time-limited therapies where the therapist seeks not to become too important (which may in itself be problematic for some therapists). Positioning the therapeutic alliance as an externalised third-party experience and linking it with significant past and current relationships ensures that the

dangers of an intense dependence are kept to a minimum. An example of this is the treatment of a depressed and adhesively dependent young woman whose idiomatic wish/fear of becoming dependent on the therapy was named, thus enabling both her and her therapist to 'work together' to prevent this happening (Coren 1996).

Narrative and the therapeutic process

We have seen how the concept of narrative can refer to two specific areas of the therapeutic process. Primarily it describes the telling, retelling and reconstruction of the client's life story and associated emotional life. However, a narrative also has what Brunner (1986) calls a 'paradigmatic' function; that is, it describes the ongoing, here-and-now therapeutic process. It provides a commentary on the progress or otherwise of the therapeutic relationship. It is a story that is told in therapy but is also, and it is this which gives it its emotive power, experientially enacted in the relationship between client and therapist. It provides a commentary on the day-to-day aspects of the therapy while simultaneously communicating something about the client's core idioms.

More often than not the commentary needs to be decoded, since it is communicated through *metaphors* of the client's life and experience. Metaphors are frequently used to convey aspects of the transference, the treatment alliance and the client's core idioms. Metaphors which are often brought to therapy can be about the client's working or leisure life, sport, literature, popular culture, pastimes and hobbies, the weather and so on. All have some personal or interpersonal resonance. Metaphorical narratives assist in the search for a common language and they provide a vehicle for decoding or reframing the symptom's message.

Time-limited therapy is 'an introduction to a process through which [clients] expand their conscious awareness of the nature of their problem, their role in creating it and the potential to do something about it' (Messer and Warren 1995, p. 27). Time-limited therapies place more emphasis on the here-and-now (including the therapeutic process) of problems as opposed to their origin in the 'there and then'. The question is less about 'What does this

mean?’ than about ‘What is going on here?’ or ‘What are we doing to each other?’ History is used to shed light on the present, rather than the reverse. We have seen that focal therapies which are based on psychoanalytic theories have incorporated concepts and techniques from other orientations and traditions. To the symbolism and relational approach of psychoanalysis has been added the need to challenge attitudes and cognitions from cognitive therapy and the technique of reframing, linking and finding ways of dealing with resistance from more systemic therapies. However, the central point of all time-limited therapies is increasingly the use of the therapeutic relationship; it is here that all approaches are beginning to coalesce. One of the advantages of a degree of eclecticism is that it allows for a broader and more diverse population to be included and to benefit from time-limited therapy. From this it is evident that no single approach is appropriate for all clients, and it is important to *match the therapy to the client rather than vice versa*. Detailed assessment is the crucial element in choice of therapy, and this is discussed in the following chapter.

Summary

In this chapter we have discussed:

- The work of John Bowlby and attachment theory, which has influenced time-limited therapy in the following ways:
 - Separation and loss are central issues to be addressed.
 - There is a need for a secure and understandable therapeutic framework.
 - Attachment styles are linked to autobiographical competence narrative coherence.
 - Internal working models are linked to the concept of a personal idiom.
 - The quality and nature of the attachment is more important than its quantity or length.
 - The concept of secure and insecure forms of attachment is helpful in gauging what form of containment may be necessary as well as the length of any proposed therapy.

- In therapy the subjective nature of experience is as important as objective events or ‘facts’, if not more so.
 - The ‘idioms of attachment’ are evident in all aspects of the therapeutic triangle.
 - The importance of the responsiveness of the caretaker suggests that the therapist needs to be active and engaged from the beginning of therapy.
 - Any negative affect, especially in relation to loss, needs to be acknowledged and addressed as soon as possible.
 - Attachment and separation are developmental achievements which are continually repeated and need to be addressed throughout life. One has never fully worked them through.
- Narratives in time-limited therapy, which can:
 - Contribute to the central organising focus.
 - Enable a normative rather than a pathological therapeutic paradigm to be established.
 - Place emphasis on subjective truth rather than factual objectivity.
 - Lead to a new experience/*Erlebnis* in therapy.
 - Assist therapeutic surprise and aid new ways of viewing old problems.
 - Facilitate a ripple effect, where core focal issues can be both generalised to other areas of people’s lives and experimented on outside therapy.
 - Enable the therapist to take a more third-party facilitating role via the use of ‘externalising conversations’.
 - Be conveyed through metaphors describing aspects of the therapeutic relationship and important aspects of the client’s internal life or idiom.

ASSESSMENT FOR TIME-LIMITED THERAPY

It is as though . . . we have added to the ordinary suffering of biological life the extraordinary suffering of our immortal longings, of our will to permanence. As though our equating of value with duration over time – good relationships, like great art are the ones that last: truths are eternal essences amid the ruinous wastes of time, and so on – straightforwardly turns a blind eye to all the evidence.

– Adam Phillips, *Darwin's Worms*

This chapter discusses the concept of assessment as it applies to focal therapies as well as looking at a number of other clinical differences between open-ended or longer-term therapies and shorter, focal treatments.

The concept of assessment

It has always been a source of bemusement to me that a client's opinion of his therapist is called 'transference', while the therapist's opinion of the client is called 'assessment'. This is a legacy of the history and development of the concept of assessment in psychoanalytic thought. As we have seen, *classical drive theory* was essentially a one-person psychology; the therapist, as 'scientist-observer', stands apart from the therapeutic material and dispassionately assesses the client's problems. Freud originally suggested that assessment consisted of gauging the patient's intelligence, financial situation and moral character. Although this is more palatable than it sounds when viewed from a tem-

poral and cultural perspective, it placed the concept of assessment in a moralistic, if not judgemental, frame which psychoanalysis has found difficult to transcend. Greenson (1981) spoke of the 'requirements' psychoanalysis made of the patient, which included:

- *Motivation* – this included the 'will to be analysed' and the suggestion that the level of 'neurotic misery' should be such that the 'person is able to become a patient'.
- *Capabilities* – which included 'elasticity of character'; the ability to regress and progress and relinquish control; to be able move in and out of reality-testing.
- *Personality traits* – symptoms and pathology.

Already we see here a factor which has been problematic for time-limited focal therapists coming from a psychoanalytic background – the suggestion that the purpose of assessment is to exclude people, rather than include them, from a 'pure' form of treatment. The preoccupation with pathology, motivation and 'character' has over the years ensured that more people were excluded from psychoanalytic treatments than were included. This was not the intention of Freud and his original followers.

Greenson's requirements for the therapist were even more daunting. The therapist needed to:

- Understand the unconscious.
- Show a 'high intelligence and cultural' level.
- Demonstrate skill, theoretical knowledge, character and motivation.
- Possess empathy.
- Be able to communicate to the patient (that is, in a one-way process).

Much of the early discourse on assessment raised the question: is the client capable of 'producing material' or 'working'? This has had the effect that the ethos of 'work' (as opposed to play, for example) has come to dominate the discourse in psychodynamic circles. Therapy can work only if it is seen as 'work'. The early dynamic literature on the subject of assessment reflected the observer-observed quality of psychoanalysis at that time; analy-

sis was not seen as an interactional process. The move to an *object relations framework* led to the recognition that there are two people (at least) in any therapeutic relationship and placed assessment in a more interactional framework, but traces of the early evaluative and judgmental flavours remain. It is part of the generational legacy of psychodynamic practitioners.

Recognition of the interactional nature of the therapeutic dyad has placed the concept of assessment in a more fluid and reciprocal framework (see Mace 1995 for a useful overview of the concept as it applies to various different therapies and settings).

Assessment can be broken down into three main areas:

- *Purpose* – What do we hope to achieve? What is it for?
- *Aim* – Where do client and therapist want to be when the process is completed?
- *Content* – How do client and therapist go about the task? This is determined in no small measure by the answers given to purpose and aim.

The purpose of the assessment process differs according to the context in which it occurs. Both therapist and client may have different hopes, expectations and fears arising from the process. It may function to reassure therapists that they have some indication of (or control over) the nature of the therapeutic task, while clients may experience the process as either reassuring or worry that they are being evaluated and judged.

Tantum (1995) considers the purpose and aim of assessment as being:

- *Establishing rapport* with the client, which forms the basis of any productive therapeutic work.
- *Obtaining information*. This aids:
 - The making of a *formulation*, which includes deciding what form of treatments may be best suited to the client and his difficulties.
 - Assessing the client's *strengths and weaknesses*; can treatment be damaging?

- Determining *why now*? Why has the client sought help at this particular moment in this specific context from this particular person?
- The consideration of the *external and internal variables* in determining how the difficulty has arisen.
- *Giving information* – basic information about the proposed treatment.
- Enabling the client to feel *understood and giving hope*. This would include a coherent narrative. Focal therapy would aim to conceptualise this in the context of the therapeutic triangle.
- Giving the client a *taste of the treatment*. This could involve a trial interpretation (in focal therapy, a linking, triangular comment) as well as the therapist modelling the form the treatment may take.
- Arranging for any *further assessments*. This includes further physical or psychological investigations.
- Ensuring that the *client–therapist mix* is not going to be harmful.
- The making of the *practical arrangements*.

Tantum concludes that a combination of the following should be included in any assessment process:

- Current complaint or predicament.
- Any current habit disorders (eating disorders, substance abuse).
- History of key previous relationships including previous therapeutic relationships.
- Mental or physical illnesses
- Preconceptions of the therapy
- Expectations of the therapist.

It is not without interest that considerable importance is placed on what we have termed the pre-transference – the hopes, expectations and fears that the client has about the therapy and therapist. This suggests that the information-gathering aspect of the assessment process may be less of a priority than many therapists imagine and that equal, if not more, attention needs to be paid to the here-and-now anxieties of the assessment process. This is particularly true in focal therapy, where learning more about the client's idiom is paramount.

A number of additional questions are raised in thinking about the purpose and aim of the assessment and the therapist's contribution to the process:

- Is assessment distinct from treatment or do the two run concurrently?
- Does the therapist place emphasis on history-taking and therefore see assessment as an opportunity to ask questions and take the initiative and control the process? Or does he see it as an opportunity primarily to reflect on the process, so that questions are of less importance than enabling the client to reveal themselves in whichever way the client chooses?
- Is the assessment process one of observer–observed, an interacting dyad, or even a triad as in the case of third-party referrals or where there is an institutional dimension?
- Is assessment the same as diagnosis in medicine?
- What part if any does intuition play?
- Is the emphasis placed on pathology (ego deficits) or on development (the client's strengths)?
- Does assessment take into account the nature of the therapeutic task? (that is, will the client respond more to a reflective as opposed to a more directional approach? Is the client likely to benefit from an interpretative as opposed to a non-interpretative framework? Is the client more comfortable with a compartmentalised approach to his problems or does he gain from linking various different areas of functioning?)
- Is assessment a static or dynamic process? Does it only apply now, or in a week's, a month's, a year's time? Should it be continually part of the process which is built into the therapy?
- If its function is to reassure – who does it reassure, client or therapist?
- Is what we call assessment a way of prematurely controlling material which, however satisfying for the therapist, may over time impede spontaneity and understanding?
- If we as therapists are engaged in something called 'assessment', does that mean that therapeutic progress is being made?

Therapists too can have transferences to concepts, including assessment, that are difficult to relinquish. A balance needs to be struck by the therapist's need, and professional duty, to have some idea of what form of approach and treatment might benefit whom, what individual clients are likely to need or find helpful, and the danger that assessment can be a means by which the therapist defends, or avoids, a real engagement with the client. There is a danger that over-reliance on theories of assessment can give the therapist the illusion of safety, control and predictability and blind them to the values of being open to the therapeutic process as it unfolds in surprising and unexpected ways. Assessment, as a static and diagnostic concept, can merely function to convince the therapist that they know what they are doing. It is then likely to be set in stone and not amenable to change, review or modification over time in the light of clinical material arising during the course of therapy. However, it remains true that a thorough, evidence-led and comprehensive assessment is required in considering suitability for time-limited therapy to ensure that it is the treatment of choice for the individual client.

Open-ended dynamic therapies have highlighted the following areas when considering whether psychodynamic psychotherapy is likely to be indicated:

- Motivation.
- Capacity to form some kind of treatment alliance.
- Capacity for reflection
- Psychological-mindedness.
- Capacity to distance oneself from the immediate emotional experience (that is, the ability to reflect on experience rather than deny or act out)
- Capacity to link symptom or current problem to current relationships or history (a trial interpretation is frequently used to test this out).
- The ability to distinguish between internal and external reality
- Is the client open to, and able to enjoy, introspection?
- Some capacity to recognise internal unconscious life.

What then are the differences between the assessment processes for open-ended and focal, briefer therapies?

Assessment for short-term focal therapy

Assessment and selection are controversial concepts in the field of focal therapies. Freud, who analysed himself and whose own treatments had been brief, had originally suggested that treatment could be shortened for the healthier patient. As a result, many early brief therapists developed stringent selection criteria which suggested that those clients most likely to benefit from briefer treatments were relatively healthy, highly motivated individuals who were able to form successful relationships. In other words, they were indistinguishable from people likely to benefit from any form of therapy.

While there is a wide variation in selection criteria depending on therapeutic orientation, in general time-limited focal therapy has tended to look towards the following as indicators for positive outcomes:

- A circumscribed problem.
- Motivation.
- Psychological-mindedness.
- Intelligence.
- Capacity to form relationships.
- Flexibility of defences.
- Oedipal focus.
- A treatment alliance.
- Capacity to reflect.
- A recognition that problems have an emotional component.
- A certain introspection if not curiosity about oneself.
- A capacity to tolerate frustration or anxiety.

The literature suggests that contra indications for time-limited therapy include the following:

- Severe pre-oedipal problems.
- Exclusively borderline pathology, especially difficulties around the inevitable frustration as a result of the time limit.
- Difficulties with termination because of deep-seated and complex problems in relation to loss.
- Excessive reliance on developmentally primitive defence mechanisms (splitting, projection, denial).
- Acting-out as way of dealing with emotional problems.

What these show is the rule of thumb that oedipal problems are likely to be appropriately dealt with in shorter therapies, while pre-oedipal issues may more effectively be addressed in longer term work. Generally, the earlier developmentally the roots of the difficulty or problem are, the longer it will take to resolve. This holds true in short-term therapy, where a borderline client will need more sessions than a client labelled or diagnosed as neurotic.

However, what can be seen from the above discussion is that the criteria for open-ended or longer-term dynamic psychotherapy are in essence the same, or very similar, to those considered pre-requisites for focal, shorter therapy. It seems that all dynamic therapies are looking for the same clients. Needless to say, such ideal clients are rarely to be found in consulting rooms.

Contemporary theories of assessment and selection for focal therapy are linked more to the populations who present themselves for therapeutic help than they are to static criteria of pathology or health, which have functioned to exclude more people than they include. However, the literature on all focal and short-term therapies tends to suggest that if any of the following criteria are in evidence then extreme caution should be exercised when considering briefer treatments:

- Psychosis, including severe depression.
- Hospitalisation.
- Chaotic acting-out, including severe drug or alcohol abuse.
- The difficulty of establishing a focus.
- The client's unlikelihood of being contained by a time-limited or focal approach.
- The client's not seeking or wanting short-term therapy.

When assessing for short-term therapies a developmental paradigm is likely to be more helpful than one which relies excessively on psychopathology – one is attempting not to 'cure character' but to 'solve problems', although the ripple effect of change suggests that the two are not mutually exclusive. This is similar to what Wiener and Sher (1998) have termed the 'life audit' function of brief therapy.

Narrative coherence and autobiographical competence

From the previous chapter we can see how the concepts of both narrative coherence and autobiographical competence may have a part to play in the assessment process. If clear and coherent stories are told by the securely attached, and muddled, incoherent ones are evidence of the insecurely attached, then 'autobiographical coherence' ('the ability to make meanings out of unstoried life . . . especially out of loss and disappointment' – Holmes 1993, p. 146) is likely to be a good indicator of the length of any prospective therapy. Models of attachment may be linked with the length of treatment. The inability to tell a story may suggest that it may take more time for the individual to construct one. In a similar vein, therapeutic goals could be linked to a client's attachment history. Able storytellers may require less time, as may those people who are able to move comfortably in and out of relationships at transitional points in their lives. This reinforces the importance placed on the quality, as opposed to the quantity, of the client's previous relationships in the assessment process. Of particular significance are any previous therapeutic relationships. These are likely to colour the client's pre-transference and need to be acknowledged and addressed immediately.

Time-limited therapy, because of its selective focus and time constraints, needs, during the assessment process, to address two central issues (Aveline 1995):

- The establishment of an early, positive, *therapeutic alliance*. This is achieved, in part, through therapist activity. Focal therapies place great importance in client selection on an active positive engagement.
- The prompt acknowledgement and addressing of any *negative feelings* evident in first few meetings.

Attention having been paid to the contraindications for focal therapy, a *formulation* of the client's difficulties needs to be arrived at and coupled with a statement as to how therapy might address them. This is based on the triangles of persons and therapy as they affect the following areas:

- Content, including presenting problem.
- Autobiographical competence.
- History, especially of interpersonal relationships.
- Idiom, narrative, personal template.
- Affective expression.
- The context in which therapy takes place.

This takes the form of a working hypothesis which client and therapist use and is amenable to change or redefinition over time. Both client and therapist play with inferential material stemming from the personal history and the affective quality of sessions in order to test out the validity of the dynamic formulation. In this sense, assessment in focal therapy is a dynamic process which lasts throughout the therapy and is interwoven with treatment.

Therapeutic tasks in the assessment process

Bramley (1996a) describes three interlinked stages and therapeutic tasks in the assessment process:

1. *The establishing of a therapeutic alliance* – this includes:
 - The bonding, or attunement, of client and therapist and a joint commitment to work together.
 - Finding a common language, or *idiom*. This is perhaps more important than the concept of psychological-mindedness, which has had the effect of excluding many clients who may have benefited from a short-term dynamic approach.
2. *Making a dynamic formulation* – which would include:
 - Which therapeutic approach might realistically achieve common goals?
 - The recognition of any past therapy.
 - Taking a psycho-social history, including any previous psychiatric involvement.
 - Which internal and external resources are available to the client during the course of what may be an anxiety-provoking (or emotionally ‘churning up’) therapy?

- Attending to the client's anxieties about the therapist or treatment.
3. *Making the contract* – namely, a practical and psychological commitment to work together.

A helpful way of incorporating the different forms of therapeutic material into the formulation is by distinguishing between the *text* (what is said), the *subtext* (what is not said) and the *context* (the setting in which therapy occurs.)

More recently, attention has focused on therapeutic modality rather than client pathology as indicators for focal therapy. The key question is the form of therapy most likely to be helpful for this particular client, rather than necessarily its length. In the final analysis it is likely that the question is less a matter of whether long- or short-term therapy is indicated, than one of what form of therapy (for example, interpretative or non-interpretative, structured or reflective) is likely to be effective. In this, the client's idiom or style – whether concrete or reflective – is likely to be an important consideration. As Malan has pointed out, healthier clients get selected for interpretative work, and sicker ones don't. By the same token, the more disturbed the client the more partial the focus needs to be in time-limited therapy. For less-healthy clients, work in the transference needs to be more indirect – often working exclusively in the 'at-one-remove' metaphor discussed in Chapter 6 – and more reliance needs to be placed on 'ego-building' supportive techniques. Assessment or selection by treatment modality would gauge how supportive, exploratory or interpretive the therapy, or the therapist, needs to be with any individual client, rather than solely looking at aspects of the client's pathology in deciding whether focal treatment is indicated or not. Clients will require differing responses, depending on whether their idioms are reflective or concrete.

Some short-term therapists suggest a period of 'trial therapy' to ascertain whether the client can benefit from a more circumscribed focal approach. Alternatively, the assessment process can take place over a few sessions before the decision to work together is made and an inclusive therapeutic focus identified. It

is less a matter of the client being able to 'work' in the therapist's idiom or orientation than one of assessing what the client's personal idiom may be and being guided by that as to the choice of therapy.

Focal therapies suggest that it is important that the assessment process includes informing the client of the structure, purpose and methods the therapy will employ.

William

William arrived for his first session with a counsellor having been referred by his GP 'to see whether having a chat could help'. He was a worried and anxious young man, of a concrete and practical bent, who had spent some years on antidepressant medication and whose pre-transference to counselling was one of bewilderment. It subsequently transpired that he thought he would be seen for a few minutes and given literature to read, not unlike his experience of consulting his doctor. The counsellor, assuming that an idiom of the counselling process was shared, suggested they meet weekly and 'see where we get to...'. William was bewildered by the next session where the counsellor said little and William, not knowing what was expected of him, even less. The counsellor thought William defensive and hostile, which, had these sessions continued, would have turned into a self-fulfilling prophesy. In supervision, the counsellor was encouraged to explain to William the basic structure and process of how counselling proceeds. William was relieved to be told that they would meet at a specific time weekly for 50 minutes, and that if he arrived late the time could not be made up. The task was to think about William's anxiety and depression (which the counsellor thought had to do with aspects of William's background and current life) and that this would be attempted by William talking about what he considered at the time to be important issues as well as anything which came into his mind. The counsellor would help William think about them by commenting on William's thoughts and by adding some of his own. William was visibly relieved by these guidelines and made substantive progress over the 12 sessions offered.

This elucidation of the focal psychotherapeutic setting and framework shows that the therapist takes the frame, and the client's anxieties about it, seriously but also clarifies for the client what is expected of him (and the therapist) in therapy. Many clients, particularly those referred by third parties, have little concept or idea

of therapy and benefit from the clarification offered by the therapist. This also applies to people from different cultures whose views of therapy and psychological counselling maybe radically different from those of the therapist or counselling agency. Clarification, where appropriate, also helps the client decide whether the form of therapy on offer is what they want. Since the assessment process requires the active participation of two people, clients need to have access to basic information, which assists them in assessing the prospective therapy and therapist. A 'trial therapy' has a similar function in empowering the client. This is a very different approach from that used in longer-term therapy, where the explanation of the frame and possible content of therapy by the therapist is viewed as pre-empting the therapeutic process.

It is becoming increasingly apparent that it is difficult to lay down hard-and-fast criteria that favour one form of therapy over another, let alone between open-ended and focal time-limited therapies. The therapist needs to bring to the assessment process imagination, curiosity and an openness to the use of metaphor and symbols. This is what enables therapeutic conversations to take place irrespective of strict assessment criteria. It is worth noting in passing that this raises the issue of how such things are to be taught. However, in considering assessment the simple rule of thumb remains true: *the earlier the developmental arrest or problem the longer the treatment is likely to be* and, in shorter therapies, the more a circumscribed focus is indicated.

What needs to be guarded against is any unthinking encouragement, on the therapist's part, which may lead the client to become deeply attached to the therapist or therapy and then for this attachment to be suddenly terminated. Therapeutic activity and the maintenance of an agreed, and regularly attended to, focus helps to minimise the risk of this occurring. However, it does bring up the issue of whether or not therapeutic attachments can be regulated. It may well be that different therapeutic styles lead to differing modes of attachment.

Looking at contemporary time-limited therapy, which advocates a high level of activity on the part of the therapist, and a confidence in technique and outcome which is conveyed to the client, where resistances are attacked and challenged directly, and therapeutic material is encouraged, we can see that it is very

similar to the early Freud. However, as psychoanalysis became preoccupied with earlier and more primitive developmental phases and conflicts, therapies became longer and ostensibly more rigorous in order to treat these conditions. The current challenge for focal and time-limited therapies – and one could say for all therapies – is to examine whether they have anything to offer those clients who are considered borderline characters or, more simply, difficult. It is here that a careful assessment is especially important.

Focal therapies and the ‘difficult’ client

As we have seen, the early brief therapists thought that focal therapies had little to offer those clients who presented with what are termed ‘pre-oedipal problems’. By definition these included people with the most complex and often long-standing problems, who were also less likely to be able to enter into or sustain a therapeutic alliance. These clients were thought to be contraindicated for briefer therapies, often on the basis that they lacked ‘motivation’. Motivation, however, has always been a problematic concept in psychotherapy:

Until the late 1970s I . . . considered motivation an important criterion; but since then my position has changed totally based on my research. I consider motivation a criterion created by therapists who cannot treat highly resistant, complex patients . . . Until 1980 I considered a fragile character a contraindication . . . but our research data . . . shows that they are the best candidates and that we can bring about major structural character changes. (Davanloo 1994, p. 378)

Clients perceived as ‘difficult’ (although the term presupposes that others are ‘easy’, which is debatable since any client is likely to pose a therapeutic challenge at some point during therapy) may be those deemed unsuitable for a specific therapy or therapist. However, there is evidence that certain clients present specific difficulties whatever the therapeutic approach attempted, but particularly one which seeks to be briefer and more focal.

Whatever assessment criterion is used, the reality is that, particularly in public sector settings, many clients are included in

focal therapies who might on reflection not be the most suitable candidates for short-term therapy. Economic concerns should not lead to the belief that time-limited therapy is necessarily the treatment of choice for every client. This is a concern that we discuss in more detail in Chapter 9.

However, it remains the case that borderline clients pose specific difficulties for any therapist under any conditions. The nature of the problems presented in many therapeutic settings is increasingly having the effect of encouraging the consideration of how shorter focal therapies can address the multifaceted difficulties which are brought by the borderline, or difficult, client. This is not to be discouraged, since many of the advances in psychotherapy have been made when learning from clients initially considered not suitable for a specific therapy; as Messer and Warren (1995 p. 249) point out, 'Today's difficult patient is tomorrow's new conceptual and clinical vista.'

The concept of borderline

'Borderline' is a difficult concept to define, and some would say it is a category devised by the therapeutic profession to describe people it would rather not treat. In that sense it has acquired somewhat moralistic overtones. However, descriptively it can be a helpful term which identifies certain character traits, behaviour, actions, affects and states of mind which are likely to have a central bearing on any prospective therapy. The phrase describes difficulties which lie on the frontier between neurotic and psychotic states of mind; in that sense, everyone has the capacity, under pressure, to swing in and out of borderline states of mind. However, the concept does suggest that there are certain characterological traits which, when concurrently in evidence, contribute to a way of functioning, or being, that (because of their complex, disconcerting and challenging presentation) require specific therapeutic attention. These include:

- Labile and unstable mood swings, which are particularly sensitive to slights, real or imagined.
- Fragile boundaries between the self and others.

- A wish for closeness (fusion or merger), coexisting with a fear of engulfment. This can frequently lead to fierce oscillations between the hope for, and dread of, intimacy.
- Low tolerance of frustration and angry outbursts.
- Faulty reality-testing.
- Unstable interpersonal relationships which are dominated by oscillations between idealisation and denigration. Relationships which tend to be dominated by demanding, distrustful, envious and rivalrous feelings and behaviour.
- Self-harming behaviour, including drug and alcohol abuse.
- Pervasive feelings of emptiness, meaninglessness and boredom.
- Identity diffusion and confusion; these manifest as basic conflicts around ego integration and object constancy, where the normal differentiation between self and other either has not occurred or else has not been sustained.

These characteristics potentially present major challenges to the establishment of a working therapeutic alliance. Since borderline character traits involve, on the one hand, a dread of closeness and engulfment, while concurrently yearning for intimacy and attempting to seek it, this dynamic will be constantly enacted in the therapeutic relationship:

These people experience the harrowing dilemma of extreme dependence coupled with an intense fear of closeness. They believe that closeness to the other person will be mutually destructive. The true danger arises not so much from their aggression as from the more tragic fact that their love is destructive. They feel that to give love is to impoverish oneself and to love the other person is to drain him. (Model 1968)

Fonagy (1991) has described this form of presentation as one of 'stable instability', which accurately sums up the constant, if variable, difficulties these clients experience. Many of these people will have had unstable and neglectful childhoods which may have included emotional, physical or sexual abuse. It follows that these clients may be problematic to engage in any reflective therapy, and once engaged pose considerable challenges to orthodox therapeutic approaches:

The therapist is . . . used as a receptacle for the patient's feelings, and may be filled with anger, confusion, fear and disgust in a way that, for the inexperienced, is unexpected and difficult to tolerate. The patient treats therapy in a very concrete way, and may become highly dependent on the therapist, seeking comfort in fusion with a rescuing object who is, at other times, felt to be sadistic and rejecting. These latter aspects emerge especially at times of breaks, or when the therapist lets the patient down, as inevitably he will . . . (Holmes 1993)

Assessment and the borderline personality

Caution needs to be exercised when considering such clients for focal, time-limited therapy. These clients often evidence traumatic losses, which makes problematic any treatment approach that places a high premium on termination. Similarly, narcissistic clients who exhibit fragile self-esteem may find short-term therapy problematic, seeing it as evidence of the therapist's rejection of their importance or neediness. Borderline clients tend to present with diffuse and global problems, which make the clarification of a clear focus more difficult. Excessive reliance on idealisation, splitting and denigration ensures that their perception of the therapist changes in rapid and unpredictable ways. The capacity for symbol formation or the use of metaphor may be impaired, making the use of language, including interpretation and clarification, more problematic. Profound anxieties over dependence and separation ensure that these clients split off and minimise experiences of abandonment, intrusion or neglect, or act them out outside the therapeutic frame. Rigid character defences, often in evidence in psychosomatic complaints, make a time-limited approach more complex and challenging. Modifications in therapeutic technique may be necessary for this group of clients. The conundrum is how short-term dynamic therapists can modify their therapeutic approach while still achieving something of psychodynamic value with these more difficult clients. This applies particularly to clients with whom it is difficult to make emotional contact as a result of their defensive structures described above.

Messer and Warren (1995) suggest the following criteria to be borne in mind when offering focal or brief therapy to a borderline client:

- Capacity for engagement with the therapist in some meaningful way.
- Capacity to disengage at termination; with those clients who have not satisfactorily disengaged from their 'primary objects' or have suffered traumatic losses from primary relationships, the therapist must avoid recapitulating the loss at termination.
- The need for some degree of focality in the client's difficulties; for some clients (for example, adolescents), the lack of a focus, may become the developmentally appropriate focus, while for others, any combination of this lack with excessive borderline functioning may make short-term work difficult.
- The client's capacity to tolerate emotional requirements of therapy; this will vary between clinical models and therapists, but all short-term therapies would make some demands on the client's ego strengths and take into consideration the availability of environmental and personal supports.

While it is true that people with severe borderline personality disorders tend not to be treated by time-limited models, there is an increasing literature suggesting that, with some precautions, a modified form of focal therapy may benefit some of them (Magnavita 1997). As with selection criteria in general, a premium is placed on a client's interpersonal relationships and history when considering focal therapy for a member of this group.

In Chapter 3 we have discussed how cognitive analytic therapy (Ryle 1998) has specifically set out a time-limited treatment for borderline or difficult-to-treat clients which offers up to 24 sessions, focusing on the client's awareness of self and other states of mind. Rather than the length of treatment, central importance is given to the consistent, reliable therapeutic response from both setting and therapist. The therapist needs to track and remain attuned to the client's emotional state and be alert to the constant invitation to repeat current or previous traumatic experiences of intimacy which the client has come to expect, and may, albeit unconsciously, seek to re-enact.

The work of Miguel Leibovich

Leibovich (1996) presents a comprehensive rationale and framework for time-limited therapy with borderline clients. Client and therapist choose a single recurring personality trait as a focus (low frustration level, overvaluing or devaluing relationships, narcissistic slights), while the client's tendency to become diffuse is discouraged. The fact that therapy is short is emphasised from the beginning, which places central emphasis on separation and ensures that it is linked in some way to the central focus. Because borderline clients are sensitive to real or imagined rejections, 'planned abandonment makes it less devastating', p. 438, The time frame gives clients a sense of purpose, which is frequently lacking in borderline functioning, while the actual fact of having persisted with a therapeutic task and relationship can be experienced as a considerable achievement. Leibovich suggests that since the therapeutic task and focus are clearly articulated they can be more easily understood by more concrete borderline clients than longer-term, open-ended therapy, which places a premium on growth and personality change – diffuse concepts which may have little resonance with these clients. Through his active, empathic but structured stance the therapist conveys a message that therapy is a task which can be ordered and problems solved; behaviour is not entirely effected by the past, so it is possible to create an anticipation that shifts can occur in a limited time. Therapeutic activity ensures that the therapist speaks to the danger that silence and passivity can be experienced as threatening and intolerable to the borderline client. It also assists the client's 'self-definition, differentness and separateness by demarcating and accentuating the boundary between two individuals'. p. 440 The therapist maintains a presence as a real person, drawing attention to attempts by the client to merge or fuse as well as disengage, and linking them with relationships outside the therapy. Short-term work, by limiting and making explicit the therapeutic relationship, enables the client to feel less threatened by fears of fusion and engulfment.

Therapeutic passivity leading to symbiosis is avoided, while the borderline client's need for his immediate and concrete needs to be met are continually reality-tested in sessions by stressing the client's determination to directly face and address his problems

with all possible haste. Achievements, however minor, in the areas of self-assertion, competence and individuation are reinforced in order to address the client's impaired sense of autonomy or active agency. Minute examination of the emotional impact of the sessions is linked to the client's fear of being overwhelmed and completely at the mercy of their own labile moods. Since the therapeutic relationship is viewed as an experience of reality rather than transference, and the emphasis is on current conflicts and the here-and-now experience, the borderline client's frequently defective capacity to test reality is helped by correcting any distortions or misperceptions as they arise; in the 'more nebulous framework of some long term therapies . . . the patient's grip on their own reality . . . [is impaired] . . . engendering panic, insecurity, confusion and disorganisation' (Leibovich, p. 444). The structure and predictability of sessions provides a containing environment which speaks to the borderline client's poor impulse control.

Focal activity, and the encouragement of the client's active participation in the therapeutic alliance, assists the client's realistic expectations of what the therapy can achieve. Small, gradual achievements in the area of the focus assists the development of self-esteem, which 'neutralizes the rage so typical of the borderline and avoids the primitive transference so frequently the cause of therapeutic impasses'. p. 441 While a short-term therapy which is structured, stable, consistent, empathic and focus-oriented may be helpful for some borderline clients, it needs to be pointed out that Leibovich suggests that a framework of between 36 and 52 sessions is indicated. This in many contemporary therapeutic contexts would be viewed as extremely long-term therapy! However, it does indicate that a focal way of thinking can assist in treating a diverse and complex group of clients.

Tony

Tony, a 40-year-old middle manager in a computer software company, was referred for counselling after the breakup, with no explanation, of a brief (three-week) relationship with Sue, a younger woman. This had precipitated loss of concentration and interest, antidepressant medication, bouts of heavy drinking and an intention of stalking his former friend to 'show her how much I am suffering . . . I do not deserve to be treated like this'. One the one occasion that he insisted on meeting

with Sue, in the company of a third party, she had subsequently become alarmed and contacted the police, saying Tony was harassing her. Tony reacted to this action with barely controlled rage. He had come up against a brick wall – ‘What should I do?’

Tony had grown up in an expatriate family and returned to Britain with his mother on the parental separation when he was seven. After living alone with his morose and uncommunicative mother he was sent to boarding school at 11, where he had an ‘uneventful’ time. He had a number of relatively short-lived relationships which ended because he thought none of his partners were quite good enough for him. This was what made the current situation unbearable – the knowledge that Sue was ‘perfect’ for him. They got on very well, both were ‘unemotional’ and ambitious, and she had a high-status occupation, which made Tony feel they were equals.

A plausible narrative could be sketched which linked his current devastation with the loss of his father, his tense and eventually abandoned relationship with his mother, the need to distance himself from the emotional impact of his family’s upheavals, and his own ambitions for himself. However Tony did not want to know any of this, beginning every session with a detailed (and monotonously repetitive) account of his weeks ruminations, and the injustice of Sue’s actions. He was so angry that he wanted to punish her and attempted this by avoiding going into work, or when there, sitting still, disconsolately refusing to begin his scheduled tasks – ‘That will show her just what she is doing to me.’

During the initial three assessment meetings Tony became increasingly annoyed with Sue, bewildered and frustrated at his own inability to manage himself in response to her departure, and threatening to harm himself as a way of communicating his distress to her, and by implication the therapist. The therapist was by this time feeling irritated and annoyed with Tony. He was aware of a feeling of dislike towards him which manifested itself in the hope that Tony would not come to appointments. In supervision the therapist recognised this counter-transference rejection as something Tony was unconsciously seeking to bring about. It was also clearly linked with the acute here-and-now difficulty Tony was experiencing. In response to this the therapist suggested to Tony the following focus for sessions: Given just what a turbulent effect Sue’s action was having on Tony’s life, therapy would monitor the day-to-day emotional repercussions of such a profound rejection, which was made worse by the fact that no reason was given for Sue’s actions. Since Tony had some experience of not being given reasons for events that affected him – his parents’ separation for instance – we needed to ensure that therapeutic reasons

were given for everything that occurred in sessions. Tony could assist in this task by thinking about how he had managed to deal with previous separations and even noting how he was managing the time between the weekly sessions. Tony agreed that this might help – it would also give meaning and structure to his week – but wanted to be reassured that he would not have ‘to come forever’. What were his associations to the thought of coming forever? Tony replied – ‘It would kill me,’ which subsequently provided a useful ancillary focus: What was it about contact with others that could be so (self-) destructive?

Tony also provides an interesting example of the use of metaphor discussed in the previous chapter. During the course of treatment Tony talked about being ‘dropped’ by the football team that he played for; this was extremely unfair, as he had trained all season only to be displaced by someone who was more friendly with the captain. Football, and the emotions it could provoke in Tony’s life, was to become a central theme of sessions which could be clearly linked with the feelings evoked by Sue’s departure. The fear of being ‘dropped’ was pervasive, but, said Tony hopefully (without any obvious malice and referring to his own future development rather than a yearning for retribution) in his last session, ‘We need to remind ourselves it is a game of two halves!’

In working with borderline clients a more supportive (as opposed to emotionally expressive) approach may be called for. Less attention is given to interpretation, confrontation or insight and more importance is placed on containment, improving self-esteem and a decrease in anxiety through the experience of being with a benign therapist whose boundaries and framework are clear and safe. The focus may need to be circumscribed to the client’s immediate here-and-now situation, and it is only this aspect of the therapeutic triangle that is available to be directly addressed. This does not mean that negligible therapeutic benefit can result, merely that there is greater reliance, and respect for, the ripple effect in the therapy. Significant others may need to be enlisted in the treatment, or a care network be set up to maintain a safe therapeutic structure and contain acting-out.

When working with these clients, greater attention may need to be paid to the therapist’s counter-transference. The time limitation and the clinical demandingness of these clients may elicit more negative counter-transference feelings. It is these negative, sometimes hostile interactions with borderline clients that the therapist needs to process, since they tend to be central to the

client's relational problems. If unrecognised they are in danger of being acted out in the therapy by the therapist in destructive and untherapeutic ways.

The therapist needs to be able to acknowledge and deal with any excessive therapeutic zeal ('I can cure this impossible person') as well as to avoid 'therapeutic nihilism' along the lines that 'it doesn't matter what one does, the patient is too disturbed to be helped' (Messer and Warren 1995, p. 274). These can be counter-transference responses which parallel the client's oscillation between grandiosity and self-denigration. Messer and Warren note that the therapist's own self-esteem and their need to feel effective and competent are likely to be challenged when working in a focal fashion with borderline clients since, unlike in open-ended therapies where this can be postponed into an indefinite future, the sorrow of recognising the limitations of the therapy is more immediate. Both therapist and client are made painfully aware of the limitations of therapy and what cannot be achieved from the outset of treatment. Therapist and client need to recognise the value of 'partial solutions, compromises, [and] ambiguous outcomes' (pp. 43–61), however difficult this may be for them. Therapist guilt, always in danger of arising in short-term therapies but pervasive with borderline clients, at not having done or helped enough – and the associated belief that if only more time was available the outcome would be better – can also be a reflection of the therapist's defence against an imperfect if realistic outcome.

Summary

In this chapter we have discussed:

- The concept of assessment.
 - Assessment and selection are governed by purpose, aim, function and context.
 - This dictates whether assessment involves taking a detailed history (and viewing assessment as distinct from treatment) or whether more importance is placed on viewing assessment as part of the therapeutic process.

- Assessment should be seen as a two-way process; therapist and client are ‘selecting’ each other.
 - Focal short-term therapies are more likely to be thought suitable for oedipal problems.
 - Pre-oedipal difficulties are likely to take longer to treat, although they may still be amenable to a time-limited frame.
 - Current and past relational history is of central importance when assessing for focal therapy.
- The concept of borderline.
 - There are specific borderline character traits which, when concurrently in evidence, require specific therapeutic attention.
 - Evidence of traumatic loss, early deprivation or abuse, fragile boundaries between self and others, excessive sensitivity to slights, and fluctuating and inconsistent mood swings all present specific difficulties for time-limited therapy.
 - Borderline character problems are likely to need modifications in technique, with less emphasis on interpretation and the facilitation of affects and more on support, monitoring of emotional states, and increasing self-esteem.
 - These clients frequently present with diffuse and global problems, making the establishment of a core focus problematic.
 - Using the framework outlined, borderline pathology can be treated within a time-limited model.

DIFFERENCES IN THERAPEUTIC TECHNIQUE BETWEEN OPEN-ENDED AND TIME-LIMITED THERAPIES

... being under sentence of termination do the most marvelously concentrate the material

– David Malan

The central therapeutic focus

Short-term therapies are distinguished by their relative brevity, the careful attention which is paid to assessment and selection, therapeutic activity, and clinical focus. French (1952) introduced the concepts of the *focal* and the *nuclear* conflicts. Focal conflicts are 'preconscious, close to the surface' and 'explain most clinical material in a given session'. They are derivative of earlier, developmental nuclear conflicts, which lead to focal conflicts. Thus 'nuclear' conflicts would incorporate early history and traumatic experiences, previous difficulties and their precipitating events, family constellations and the repetitive patterns associated with all three.

The establishment of, and working within, a core focus is among the most problematic issues which those coming from a psychodynamic background and training face when beginning short-term therapy. This is a result of the need to pay *selective*

attention and use *benign neglect* in focal therapy. Both are ways of avoiding becoming overwhelmed by the sheer volume and breadth of clinical material. Both challenge orthodox analytic practice, where the therapist enters every session 'without memory or desire' and all material is 'relevant'. In true post-modernist fashion, no material is implicitly more important than any other. This is not the case in time-limited therapy, where material in the realm of the core focus is considered significant, while clinical material falling outside the immediate realm of the focus needs to be jettisoned or considered solely in terms of whether it has any bearing on, or relevance to, the central focus.

The focus serves to protect both therapist and client from becoming overwhelmed by clinical material which neither party can make sense of; it is a case of being able to see the trees through the wood. Since it is mutually agreed near the beginning of therapy and constantly borne in mind thereafter, the danger of the therapist imposing a therapeutic focus on a bemused and unsuspecting client is reduced. The focus is not imposed or rigid, and can change over time. It is inevitably initially tentative and incomplete; it 'does not explain everything 'it is a map, not the territory itself' (Schacht *et al.* 1984) The focus enables a sense of narrative coherence to be maintained; it provides the central theme which weaves together sessions which may appear unrelated, and helps organise therapeutic experience. The risk of therapeutic drift, as evidenced in many open-ended therapies, is also avoided.

The central, umbrella focus is generally in the area of the client's *recurrent interpersonal patterns*, and how they are created, developed and maintained in the client's current life. More specific 'sub-foci' are given by Groves (1996). They may reflect:

- A developmental stage (such as separation).
- A state (such as grief).
- A conflict (such as writer's block).
- A symptom (such as anxiety).
- A drive (such as sex).
- A life pursuit (such as a job).
- A role (such as being a parent).
- An identity (such as being gay).

As Groves says, the list is relatively endless but will also depend in part on the specific theory of emotional development held by the therapist. The focus is partly determined by the therapist's theoretical approach, which could place differing emphasis on establishing a focus which is either primarily symptomatic, based on a specific issue, or broadly characterological, based on a personality trait. Developmental considerations play a part in considering a core focus – the same event may have a different meaning at different ages and developmental life stages.

What unites dynamic therapists is that the factor underlying the major focus is in the area of the client's significant relationships, including the therapeutic alliance. How the discrete sub-foci link with the core relational conflict will inform the therapy. The therapeutic triangle provides the structure for the focus to be addressed. Many sub-foci, since they are not mutually exclusive, can be in evidence concurrently.

Generally, short-term therapy reformulates the discrete presenting symptom or complaint in relational terms, while returning to it when the therapy, or session, is in danger of becoming diffuse. Friedman and Fanger (1991) advise beginning with the metaphoric function of the symptom, which becomes a focus, then planning a course of therapy with the client, which, while couched in in positive language, isolates issues that are 'central to the client, are therapeutically possible, and are congruent with the client's idiom and culture'.

The formulation of a focus in itself poses problems for the analytic short-term therapist:

Formulating a focus . . . demands a high degree of sensitive observation, a good knowledge of psychoanalytic theory, *freedom from compulsive ways of thinking about psychopathology* and above all, *resisting the attraction of well worn psychoanalytical phrases*. (Enid Balint in Balint *et al.* 1972, my italics)

Dynamic therapists may find this problematic.

It is important for the central focus to remain relatively fluid. Formulating a specific one too early runs the risk of getting it wrong and, in neglecting other material, ensuring that the therapy proceeds up the wrong path. However, clients, as active participants in the therapeutic process, tend to point this out

when it happens. Leaving it too late runs the risk that the therapy may be almost over before the therapist knows how to proceed and intervene. A useful guide to the timing of the focus is when the therapist has some inkling and knowledge of the client's idiom and relational functioning. This can generally be identified relatively early in therapy. Enid Balint calls this the 'Aha' experience, where the focus 'arrives in a flash', while Malan views the focus as something that crystallises between therapist and client relatively early on in therapy. 'In a certain sense', states Groves, 'once the two people sit down together and begin their relationship . . . the focus chooses itself growing naturally out of the subjective space between the two' (p. 99). In general the focus arises out of the meeting of the client's presenting complaint and narrative, affective contact with therapist and the therapist's philosophy of cure and treatment. The client's idiom meets that of the therapist.

The important aspect of the core focus is that most relevant clinical material can be linked with it. This needs to be incorporated into the triangles of insight/persons and therapy described in Chapter 5. The client's idiom, narrative and presenting complaint as they apply to the past and the present, as well as the here-and-now therapeutic relationship, become the focus of the therapy. It follows from this that when the focus cannot be determined (or if it is vague or diffuse) then short-term therapy is contraindicated. Vague, chronic difficulties as well as clients who fluctuate between several different problem areas, without the wish to settle one focal area, are less likely to benefit from short-term therapy. Therapists need however to guard against the danger of assuming that no focal area exists when it is their own theoretical assumptions that prevent them discovering one. Not all foci need be oedipal in nature. Clients whose predominant idiom suggests they are struggling with issues to do with separation-individuation and basic trust-mistrust may not lend themselves to discrete foci and may, as we have seen, require a more supportive holding environment, where the focus consists of the continuous and ongoing recognition of the client's use of the therapist to monitor and regulate internal affects and states of mind. For others, a partial focus may be more appropriate.

An exception would be adolescence, where vagueness and con-

fusion might be developmentally appropriate and the termination of therapy indicated when a focus has been gleaned or achieved (see Coren 1997). Failure to generate a focus may also be as informative as eliciting one; the process of the difficulty of yielding a focus may reveal a lot about the client's idiom and whether short-term therapy is likely to be helpful.

The ability to discover and articulate a core focus necessarily depends on the active participation of the therapist. This is a further challenge to psychodynamic short-term therapists.

The active therapist: a contradiction in terms?

Therapeutic activity contrasts with the more passive, exploratory and leisurely model of time-unlimited therapies. Many clients in their pre-transference will expect a more conversational model of interaction, and are puzzled when this is absent without explanation. In focal time-limited therapy, an active therapist serves to maintain the focus and limit dependence as well as keeping the emotional tension high. This helps to link all material with the issue to be dealt with and prevents regression, which may be untherapeutic and may complicate the termination of therapy. The therapist models a therapeutic manner which, by its active engagement, indicates both therapeutic interest and hope as well as the expectation that the client will be similarly active in the attempt to master their problems or difficulty.

This active participation between client and therapist does not necessarily come naturally. As early as 1942, Sandor Rado drew attention to the need from the beginning of therapy for the therapist to attempt to 'counteract the patient's tendency to sink himself into a safe comfortable transference neurosis'. A similar danger confronts the therapist less used to working in a time-limited fashion. Alexander, when stressing the need for therapeutic activity, commented on the assumption that a passive therapist 'will solve everything as if by magic' and that this has the effect of 'prolonging many treatments unduly'. He went on to suggest that 'curbing the patient's tendency to procrastinate and to substitute analytic experience for reality... (through careful manipulation of the transference relationship, by timely

directives and encouragement) . . . is one of the most effective means of shortening treatment' (in Barton *et al.* 1971, p. 40). As we have seen, Alexander's emphasis on the active, engaged therapist rapidly became discredited and, in an effort to shield itself from Alexander's legacy, psychoanalysis retreated behind the belief that anything which was not 'interpretative' was likely to be 'suggestive' or in danger of 'influencing' the patient. Anything that could not be classed as an interpretation was 'not psychoanalysis'.

Freud had himself suggested that in the treatment of some cases (for example, phobias) at some point the analyst will have to encourage the patient to engage in activities that he was avoiding. Therapy in this sense must be in the service of life, not the other way around. Freud was also aware of the problem of 'suggestion', although there were times when the analyst had to serve as 'mentor and guide'. However, the use of words like 'encouragement', 'manipulation' and 'direction' ensured that therapeutic activity came to be viewed with the utmost suspicion; at worst the client was going to be coerced, influenced and managed. Psychoanalytic suspicion of anything that approximates to 'influence and suggestion' can be traced back to its roots. In an effort to distance itself from the Freud of hypnosis and catharsis, psychoanalysis, and dynamic therapies more generally, went to the other end of the spectrum – the concept of neutrality and 'free-floating attention'. At times it seemed as though any intervention by the therapist was intrusive and, when not interpreting the transference neurosis directly, a failure on the part of the therapist. This was a reflection of the determination of psychoanalysis to define itself as a science with the therapist as a 'detached observer'. This led to psychoanalysis remaining non-interactional and 'non-suggestive', so that the patient's inner world could emerge in an uncontaminated and pure form. The worst that could happen to an analyst was to effect a 'transference cure' – that is, a cure by the 'personality' of the therapist. In passing, it is worth questioning whether there are any other forms of 'cure' in the dynamic therapies other than those achieved via the therapeutic engagement of the personalities of the therapist and the client. This is especially true of short-term therapy.

Therapeutic neutrality

The myth of therapeutic neutrality and the therapist's 'non-influential' posture has been challenged by, among others, Mitchell (1997). Talking from an open-ended, as opposed to a short-term, framework, Mitchell makes the point that it is not so much the interpretations in the analytic setting which are mutative as the patient's discovery of 'a different kind of experience [in therapy] . . . than they encountered in their childhood'. This is very similar to the notion of 'therapeutic surprise' discussed earlier. Since this is a central facet of therapy, Mitchell implies that the therapist should seek to provide it more actively than analytic notions of 'neutrality' or 'abstinence' allow. There has been a belief, still widely held in therapeutic circles, that only therapeutic neutrality, passivity and abstinence can guard against intrusion, influence and suggestion. Mitchell makes the point however that a passive analytic stance can be experienced very differently by the client and be perceived in various differing ways by different clients. A therapist may think, through their non-intrusive passivity, that they are being neutral, while his client may experience him as being withholding, sadistic or seductive. Even silence is a participation – Mitchell sees silence as being manipulative if its consequences remain unexplored in the ensuing therapy. It is, as Gill (1994) says, 'not the content of what the analyst does that makes it analytic; it is the curiosity and openness to explore the impact of one's own participation' (Mitchell 1997, p. 17). Seen in this light, therapeutic silence or reticence is just as potentially manipulative as activity – more so in the sense that it is rarely acknowledged or examined. Frustration is just as much a manipulation of the transference as activity or 'gratification'. Mitchell tells an amusing anecdote to illustrate how therapeutic passivity can actually impede the progress of therapy. A patient, who was in therapy with an analyst who adopted a 'withholding, blank-screen' stance, became aware that after certain material the therapist's chair would squeak. In the absence of any explicit acknowledgement of this she decided, believing that this 'betrayed some form of discomfort on his part, to use the squeaks to guide her contributions' (p. 13). The squeak, perhaps the most significant therapeutic material, was never analysed. This was, says Mitchell,

ironic and tragic. The analyst was apparently convinced that he was protecting the patient's autonomy by not interacting, while yet that very denial created a secret, bizarre interaction that likely included some actual features of what the analyst thought and felt, expressed in an unintended fashion. (p. 13)

Neutrality, silence and passivity do not deal with the problems of influence and suggestion. They are likely, if not acknowledged, to be as potentially coercive as therapeutic activity. The important point, whatever therapeutic stance is taken, is for it to be acknowledged, voiced and placed in the service of the client's therapy. Nevertheless, therapeutic activity is still a problematic concept for many dynamic therapists in short-term therapy, not least since psychodynamic trainings still tend to be profoundly ambivalent and suspicious about departing from the classic analytic stance.

Therapeutic activity

In focal therapy the therapist and his contributions are there to be thought and talked about in relation to the client's core focal conflict. In time-limited focal therapies silence can impede therapeutic progress by encouraging therapeutic drift away from the focus and, not infrequently, especially with more concrete and borderline clients, raising anxiety to the extent that it threatens the therapeutic alliance. Silence or activity, inasmuch as they are interventions as any other, need to be used cautiously. All therapeutic interventions, including silence, need to be viewed in terms of how they answer the following question: How necessary is this intervention in the maintenance of the focus and how does it relate to the client's relational difficulty? Therapeutic activity also means taking charge of the therapeutic frame and its boundaries. *Therapeutic activity must not be confused with advice-giving, confrontation, or directiveness.* It does not mean coercing or influencing the client in directions more favoured by the therapist. The client needs to be heard rather than overwhelmed by the therapist's insights and suggestions.

While Freud (1912) advocated a suspension of 'judgement, and [giving] our impartial attention to everything there is to observe

... maintaining the same evenly suspended attention in the face of all one hears', he also, in the case of Little Hans (1909, pp. 1–145), suggested that although 'it is not in the least our business to understand a case at once', this understanding can be achieved when 'we have received enough impressions of it'. These 'impressions', which come close to what we have termed contemporary 'idioms', are what form the focus of the therapy and can be elicited only by the active engagement of the therapist.

Resistance, the function of interpretations, and the therapeutic alliance in focal therapy

Therapeutic activity aids the formation of an early therapeutic alliance. The creation of a stable, safe environment, the establishment of a focus early in therapy, and a balance between responsiveness and directness all help engage the client in the joint undertaking in short-term therapy.

Resistance

As we have seen in previous chapters, focal therapy can succeed only if any resistance, or negative feeling however muted or disguised, is taken up promptly. Traditionally, resistance is viewed as that 'which keeps the unconscious unconscious' (Levenson 1995). Ideas and sensations which are potentially unpleasant are excluded from awareness via repression. This is a different perspective from that adopted by the short-term focal therapist, who views resistance less as a rejection of awareness of some problematic or painful aspect of mental life and more as a response to the person of the therapist and what he may represent in the client's mind. For some reason, therapy, or the therapist, may be seen as threatening by the client, and it is this which must be understood. In all probability it will form part of the client's idiom, the understanding of which will contribute to the core focus.

Neophyte therapists tend to have clinical difficulty with the concept of resistance, and negative transference in general, fearing either that if the negative is acknowledged the client

will not return or, conversely, that resistance is a stubborn refusal on the client's part, to accept the truth of their situation and the therapist's insight. Focal therapy teaches us that unless negative feelings are acknowledged and worked with from the beginning the client will not return. Confrontation, or denial, is less helpful than attempting to understand what the negative transference – or pre-transference – may represent in the context of the emerging focus:

[T]he patient's manner of resistance usually has more implications for how that patient interacts with others than the original content he or she was avoiding expressing. The patient's way of resisting, to a large extent, determines his or her personality style. To escape what is feared, what is being defended against, becomes the person's characteristic mode of relating, which often leads to the dysfunctional interchanges with others. (Levenson, pp. 188–9)

Challenging and naming negative feelings and resistance in the first session can foster a stronger therapeutic alliance, not least since the client can see that you are not afraid to broach more difficult or painful subjects which they may be attempting to avoid. It also suggests that the therapy can safely incorporate difference, hostility and ambivalence, possibly unlike the client's other relationships. Resistance and the negative transference may, like other material in focal therapy, need to be approached from an 'at-one-remove', metaphorical level.

Jason

Jason, a 28-year-old Irishman, had recently arrived in Britain to begin a professional career. He made an appointment with a counsellor at the suggestion of his GP after collapsing in the street with chest pains for which no physical cause was found. This followed a long history of mystery ailments. Jason explained his background of being a 'worrier'. He was an only child of over-attentive parents who were themselves highly strung, socially withdrawn and prone to stress-related illnesses. Although affable and sociable he had not had any sexual relationships and acknowledged that he was confused 'about that whole area . . . I don't really need a relationship; it's just another thing to worry about.' Jason could only worry about one thing at a time. The most striking thing about Jason's initial consultation was his manner. He was pleasant and courteous, while continually making

reference to the fact that he knew what the problem was, and had been able in the past to conquer his problems by 'talking myself out of my difficulties'; he knew he was a worrier and that his concerns about his health were ways in which he dealt with other possible worries, but, 'I don't want to become like Oprah . . . no offence to you, but I don't want counselling to become another thing to worry about.' Jason's idiom became apparent quite quickly in the opening meeting, but dealing with his resistance needed some thought – merely confronting it head-on (along the lines 'You are worried about your body as a way of avoiding worrying about your mind') would have led to Jason using his characteristic way of dealing with stressful material: a pleasant and polite denial coupled with a statement suggesting that it was a valid hypothesis which he had already thought about but, on reflection, not one that he could subscribe to. Instead the counsellor took up Jason's statement that he did not want to add counselling to the things he had to worry about by saying that this was exactly what the counsellor thought could be helpful – after all, by worrying about coming to see the counsellor Jason might 'forget' about his other worries since, as he had earlier stated, he was the kind of person who 'could only worry about one thing at a time'. This also had the effect of linking the process of counselling with Jason's current anxiety about relationships and his parents' ambivalence about social relationships.

By promptly addressing negative feelings one is likely to be addressing the client's core idiom as well as the triangles of persons and therapy.

Transference interpretations

Similar modifications of technique are needed when thinking about transference interpretations. While the personal transference is traditionally seen as the sole curative factor in analysis, dynamic focal therapies tend to differ in the extent to which it needs to be directly interpreted, as opposed to the necessity to address here-and-now transference manifestations.

The positions taken in relation to transference interpretations by time-limited therapists tend to differ along conservative and radical lines. Conservatives, believing short-term therapies are more aimed at mild problems of recent onset, as opposed to characterological problems, tend to avoid transference interpretations, since they are viewed as premature unless a transference

neurosis has developed. The radical camp, believing that shorter-term therapies can address more severe problems, suggest that transference interpretations, in addition to historical reconstruction, are appropriate and can lead to lasting characterological change. Here again the fault line tends to be between those clients who are able to use transference interpretations and insight-orientated techniques and those who cannot. Increasingly, however, the evidence suggests that therapists may need to be more radical than they imagine. For an interesting account of Malan's conversion to the radical camp, see Davanloo (1978).

The emphasis in contemporary short-term therapy is less on the achievement of insight than on using the transference actively in the service of the core focus. It views interpretations as aiding the development of the dynamic focal hypothesis and helping a reformulation of the problem, rather than seeing interpretations as leading to insight leading to cure. Indeed, in short-term therapy, insight, or any change in perception, can occur during sessions, between sessions or a considerable time after therapy has finished and, although a welcome aspect of treatment, is not seen as solely responsible for any progress.

Interpretations in the area of transference, particularly ones that link feelings about the therapist with significant – current or past – others tend to be most successful. While many clients who can benefit from short-term, focal psychodynamic therapies do not need transference interpretations, Frances and Perry (1983) suggests that transference interpretations are appropriate in the following circumstances:

- Transference feelings have become 'a point of urgency and/or a major resistance'.
- Transference 'distortions have disrupted the therapeutic alliance and interpretations are necessary to strengthen the alliance'.
- Conflicts in the transference 'directly reflect conflicts responsible for the presenting problem or maladaptive character traits'.
- The client is able to 'observe, understand or tolerate' transference interpretations.
- Where the 'length of the remaining treatment will allow sufficient exploration of whatever transference interpretations are made'.

They are inappropriate or unnecessary when:

- Transference distortions do not develop.
- '[T]he point of emotional urgency and the related conflicts are fixed on current events and relationships outside the treatment situation.'
- a fragile therapeutic alliance will be further jeopardised by a distressing and unacceptable transference interpretation.
- The client is unable to 'observe, understand, tolerate or use transference interpretations'.
- Transference distortions are not clearly related to the presenting problem or 'significant maladaptive character traits'.
- The remaining time available is too limited to attempt 'even a partial analysis of transference material' (in Groves 1996, pp. 256–7).

A helpful distinction is the one mentioned earlier between the classical transference neurosis and the here-and-now, everyday, more relational transference. The latter needs to be regularly interpreted in the area of the therapeutic triangle, while caution needs to be exercised in developing and interpreting the former. It needs to be remembered that many clients will hear transference interpretations as either a reproach or a form of criticism. This applies particularly to the more vulnerable, difficult or borderline client.

We have seen that focal therapy demands that the opportunities for developing a transference neurosis are kept to a minimum. This is in keeping with Freud's warning about the dangers of transference gratification when the patient's experience of the transference replaces the desire to be cured. Paradoxically one way of preventing the development of a transference neurosis is to interpret the transference very early in therapy. This alerts the client to the dangers of regression and links transference material with the relational focus.

One development in psychoanalytic theory with regard to transference of direct relevance to short-term therapy is the importance placed on the client's reaction to the interpretation rather than the effect of the interpretation itself. Whether an interpretation is 'right' or 'wrong' is of less importance than the way it is experienced and internalised by the client. The client may

have a 'relationship to the interpretation' (Racker 1968) which reveals much about their idiom and the way they are emotionally processing the therapeutic experience. I recently suggested to a client, whose presenting problem was difficulty with her boyfriend, that she appeared hostile to me – in fact, not unlike her description and experience of her partner. She refuted this, saying hostile was the wrong word; angry, yes, but not hostile – 'Hostility is what I feel towards my mother!' It is the emotional response to the interpretation or comment that illuminates rather than the intervention *per se*.

Focal therapy sees what happens in the transference relationship as running in parallel to life experience outside the consulting room. The transference relationship is used by the client in the service of real life; it is less a repetition (although it is likely to be a recapitulation) of previous relationships than a rehearsal for future ones. Interpretations then are more in the area of what Levenson (1995) has called possibilities based upon what the client has said or done or rather than reductive truths 'known only by the therapist'.

It may well be that the emphasis which psychoanalysis has placed on what is seen to be the 'correct interpretation' has served to obscure what is centrally important in therapeutic change. A transference interpretation can be technically correct but clinically inept. Focal therapy teases out transference patterns based on the client's experiences in therapy which are then concretely named, thus avoiding the danger of premature interpretations which are likely to be met with the client's hostility or confusion.

As with the topic of resistance, the importance placed by analytic orthodoxy on interpretations which are based upon the transference neurosis makes it more difficult for time-limited therapists coming from psychodynamic backgrounds to relinquish 'deep' interpretations. It is, says Mitchell, not unlike the old joke about the narcissist who suddenly says to his conversational captive, 'Enough about me. Tell me about yourself. What do you think of me?' In a similar vein the therapist who can only oscillate between silence and transference comments is saying, "'Enough of me making interpretative statements about what is going on in your mind. Lets talk about my mind. Here's what you think is happening in my mind'" (Mitchell 1997, p. 133).

Focal therapy demands that transference manifestations and feelings are responded to creatively.

Claire

Claire consulted a therapist, having recently started a new job in a new town. She felt friendless, depressed and experienced herself as boring, unable to keep a conversation going with potential new friends without slipping into talking about her own problems. Claire thought she 'started off all right' in company but found it difficult to maintain the interest of others. She had two years of therapy some years previously, which had helped, but felt she was 'trapped' in the family myth that relationships outside the family were likely to be difficult and that family members were prone to low spirits. Claire, her parents and her elder brother were all quiet and tended towards introspection. She felt she could not 'sparkle' and, as a consequence, was not interested in going out with others. She had to be lively, charming and vivacious if she was going to be with others. If she could not capture their attention and interest she would stay at home rather than be perceived as 'boring and depressed'.

In the opening session Claire began by appearing thoughtful and reflective, saying interesting and, at times, amusing things about herself and her life, but as the session 'wore on' the therapist became aware of a feeling that it seemed interminable. Glancing at his watch, he was shocked to see that there was a further half an hour of the session left. He had to admit that he was bored. The more bored he felt, the more boring Claire became, her voice frequently trailing off into a desultory murmur. It came as no surprise when Claire eventually asked the therapist 'I'm not boring you am I? . . . I think my previous therapist got bored with me as the therapy just petered out towards the end . . .' The therapist was now faced with having to metabolise his counter-transference of tedium and languor with Claire's here-and-now transference. This conveyed, through the process of the session, Claire's anticipatory hope and expectation, which eventually became disappointment and annoyance turned against herself. It also gave a graphic account of her relational problem and indicated that however hard she tried, she was inevitably trapped in her family's depressive culture. The therapist felt that it was this here-and-now transference, rather than a there-and-then transference, which needed to be addressed. He did this by reflecting back to Claire the process of the session (that she had begun brightly only to tail off) and that it seemed that Claire's demand on herself to interest others had only the inevitable effect of making her experience herself as boring. The therapist said that he was aware of a stodgy and soporific

quality that engulfed the session after the initial enthusiasm, and wondered whether this showed just how problematic Claire found new experiences. This dealt with the transference resistance and the here-and-now therapeutic process, and would provide a focus for the ensuing work. One aspect of the focused work, during which the therapist suggested that perhaps Claire needed to practise being 'more boring' (having established a therapeutic idiom where this form of playfulness was possible) was the recognition that the demand on herself to entertain or interest others was as impossible and absurd as the suggestion that she should be a better bore. This was a therapeutic breakthrough, leading to livelier sessions which was also manifested itself in Claire's increasingly pleasurable daily life.

The concept of working through

A further problematic area for those focal short-term therapists trained in open-ended therapies is the concept of working through. It is another area in which shorter therapies challenge the beliefs implicit in more open-ended therapies. In time-limited therapies there is little of this process which is thought central to longer-term therapies. Working through is in many ways one of the most diffuse psychoanalytic concepts. In open-ended therapies the process of therapeutic internalisation and assimilation – or, less analytically stated, learning – takes time and needs to be approached from very different angles. Personality is complex and time is needed to address the many differing aspects of the client. Working through generally addresses this by

pointing out to the patient how the conflict and its defences are manifested in the various aspects of the patient's life both within and outside the transference. This process of repeating and deepening interpretations as the conflict shows itself in many diverse areas is known as working through. (Flegenheimer 1982, p. 11)

The triangles of insight, persons and therapy ensure that focal therapy attempts to address as broad an area of the client's life as possible. However it does not involve the constant transference repetition and interpretation which working through implies. One area where working through takes place in focal therapy is during and after its relational enactment in sessions with the

therapist. This is the affective component of therapy which ensures that it is not merely an intellectual exercise.

In keeping with the tenor of focal therapy, and the importance it places on its relational stance and the client's self-determination, the client is encouraged to continue working on the conflict after therapy is finished. An associated message that this implies is that it is not necessary or appropriate for the client to become too dependant on the person of the therapist or the process of therapy. It is also assumed that the ripple effect of therapy means that small changes brought about by a limited amount of therapy can lead to the positive feedback, which in turn opens up the possibility of more major changes occurring. Since symptoms tend to be overdetermined and interrelated, a shift in one area can lead to changes in another. In this sense, short-term therapies set in motion a process which is continued beyond the consulting room.

Alexander (in Barton 1971) had already drawn much hostility from the orthodox analytic community when suggesting that patients,

having learned their therapist's predilections, bring seemingly interesting material to allay the analyst's impatience and give an impression of steady progress and deepening analytic insight. While the analyst may believe they are engaged in a thorough '*working through*', in reality the procedure has become a farce. (p. 37)

And Mitchell (1997), postulating that working through is that 'most elusive, murkiest' of all Freud's technical concepts, suggests that it is a process during which the therapist continues

to make the same interpretations or similar ones during stagnant periods when nothing seems to be happening in the hope and belief that something useful may happen if the therapist continues with his interpretation(s). (p. 43)

It may be that rather than mourning its absence in focal short-term therapy, the concept of working through and its clinical application would benefit from further review in more open-ended therapies.

In short-term focal therapy the working through begins after the therapy is finished. This may in practice be little different from

the more open-ended therapies. The process of working through begins after the last session – we get on with the process of continually having to metabolise our emotional experiences. This is part of daily life rather than a specific aspect of the therapeutic setting.

Finite time or topping-up time?

A contentious area among time-limited therapists is whether the clinical contract allows for the client to return, for 'topping up' sessions, or whether the time framework set for the treatment is such a central part of the process that it should not be evaded. What most orientations agree on is that the suggestion 'Let's meet for X weeks and see where we get to' should be avoided (since it conveys such ambiguity about the nature of the work and its likely future), although personally I find 'Let's meet X times and review' a useful approach to adopt, particularly with clients who are profoundly ambivalent or for whom it is unclear at the outset whether short-term therapy is likely to be indicated.

The argument against allowing for a future review or topping-up after the main course of therapy has ended is most forcibly put by those (for example, Mann 1973) who believe that to offer a further session, or sessions, is to fudge or deny the reality of the ending, thus making the work of termination less effective. Many time-limited therapists will defuse the issue somewhat by offering the client the opportunity to return on an 'as-required' basis at the end of their contracted sessions. If one is offering intermittent treatment, says Mann, then the issue of termination does not arise and is consequently avoided. This might be as much a denial or evasion on the part of the therapist as on that of the client. It may also imply that offering follow-up, or topping-up, sessions suggests some doubt on the part of the therapist as to the current therapy's likely efficacy. Equally, and less charitably, clients who return could be seen to be 'relapsing' or needing longer-term therapy which, in the competitive atmosphere of the current therapeutic environment, may not be welcomed by the more zealous brief therapists.

One way of approaching this dilemma is to offer a finite number of sessions with the client choosing when to have them.

Kutek (1999) describes a particularly inventive use of this method when talking about counselling in an employment assistance programme for a large bank where the client chose to have a specified number of sessions immediately and 'bank' the rest for future use! Alternatively, the scheduling of intermittent sessions over a prolonged period, rather than being a denial of the ending, may be particularly helpful for clients who have experienced traumatic losses or suffered from extensive emotional neglect.

However, development across the lifespan suggests that returning for a further course of time-limited therapy, or follow-ups and top-ups, can be a manifestation that the client has experienced the initial therapy as helpful and wishes to address an associated or linked issue. This form of more intermittent focal therapy appears to be becoming more popular, although some concern needs to be expressed that this might be a reflection of the managed care environments in which more therapists are having to work, rather than a result of clinical evidence or therapeutic choice.

Donald

Donald consulted a therapist shortly after his eighteenth birthday, concerned about his relationship with his girlfriend. Donald could not bear her smoking and his 'having to inhale such noxious fumes'. He showed an adolescent intolerance with the foibles and vulnerabilities of others and found his girlfriend's behaviour 'thoroughly objectionable and selfish'. The therapist saw Donald for six sessions, focusing on Donald's fear of the contagion of others and the projection of his own vulnerability into others which he could then safely denigrate.

Donald returned to the same therapist three years later having separated from his (the same) girlfriend some weeks previously. To his surprise he found himself missing her, unable to concentrate or sleep, and noticing that 'I just start crying in the presence of other women'. The ostensible reason for their separation was that he did not think she was 'good enough for him'. It turned out that Donald had become frightened when his girlfriend had started talking about a more serious commitment and, as a way of dealing with this fear, had convinced himself that she was not good enough for him. Relationships did not matter, said Donald, since most significant historical figures who had left their mark on history had poor or non-existent personal lives. Donald might be the same.

He was an idealist and was increasingly aware that most things in his life fell short of his expectations. He thought that by splitting up from his girlfriend he 'could play the field', but to his dismay no one came close to her in his estimation, and he was left tearful and morose wondering whether she had found someone else. Donald was seen for a further ten sessions and the focus, building on their previous work together, looked at his fear of intimacy, his defensive grandiosity and how he protected himself against feelings of loss.

Donald sought therapy on two further occasions. Once was for four sessions, shortly before his marriage to a woman he had met some months previously and then for a total of 12 sessions prior to the birth of his first son. The foci in all the work with Donald was cumulative and developmental. While on the last two occasions Donald was seen by a different therapist, Donald himself outlined previous foci. Had he not, the clinic's notes were available which included brief notes as to the nature of the past work and focus.

This is an example of how a topping-up model can be linked to the various developmental stages of life; in Donald's case leaving home and psychosexual confusion, issues surrounding intimacy versus autonomy, and getting married and becoming a parent. During these years of intermittent therapy the focus was progressively modified and developed to the extent that it formed a historical narrative which was 'held' by these therapeutic conversations.

The judicious use of time is not unlike any other intervention in short-term focal therapy. It needs to be considered and applied in a thoughtful and flexible manner rather than in a rigid and unquestioning fashion. It may be that topping-up models are more helpful for some clients in some contexts than others. Quite which clients in what contexts are likely to benefit from one method rather than another is closely linked to the issue of termination in focal therapy.

Termination in short-term therapy

Focal short-term therapy revolves around the issue of termination and loss. The manner in which clients deal with endings is a reflection of previous separations and the therapeutic response to termination needs to be sensitive to these issues. Given the inter-

personal nature of short-term focal therapy, issues of loss and separation need to be interwoven in all phases of the therapy, rather than merely worked on as the treatment nears its conclusion. It forms part of the ongoing narrative rather than being necessarily a specific phase of treatment, although clearly more attention may need to be paid to it as the end draws closer. We have seen that the client's transference to the limited time available is likely to be linked to their personal idiom, and by definition included, however peripherally, in the core focus. The therapist too must feel comfortable with separation issues, since his idiom of separation will communicate itself to the client. The neophyte therapist may find any number of reasons for prolonging therapy which have more to do with his anxiety than any possible difficulty that the client has about ending. (See Levenson 1995, p. 217 for more discussion of the therapist's resistance to terminate.)

Since issues involving separation are often related to the central focus, some therapists find it helpful to summarise the content and issues worked on at the end of each session, which not only gives it structure but also has the effect of addressing endings and separations on a session-by-session basis. In that sense the end of every session is a microcosm of the impending separation and keeps the issue of the time limitation on the agenda.

While many therapists differ on criteria for termination and techniques used in the ending of therapy, it can be said that where loss has been a significant issue in the therapeutic triangle and focus this will be repeated in the therapy and require active attention as termination issues are addressed. This is more likely with clients struggling with pre-oedipal issues. Where the focus has been more oedipal in nature, loss and separation may be less pressing issues, and consequently need less therapeutic attention. For these clients, endings may not be experienced as painful losses, with the associated feelings of abandonment and anger (see Marx and Gelso 1987). Termination then becomes one of a number of possible variables which may relate to the core focus.

Whether termination is a central part of the core focus or not, short-term therapy by its very nature places time, and its limitations, in the centre of the therapeutic frame. The ending is anticipated from the beginning.

In the next chapter we look at the efficacy of short-term treatments before turning to discussing the place of time-limited focal therapies in the rapidly changing contemporary world.

Summary

In this chapter we have discussed:

- The importance of maintaining a therapeutic focus; this discussion:
 - Distinguished between focal and nuclear conflicts.
 - Stressed the need for 'selective attention' and 'benign neglect'.
 - Defined the major focus in terms of a relational style, or the nature of the client's interpersonal relationships, and suggested that sub-foci are either developmental conflicts or life event difficulties. Both the focus and sub-foci have to be linked in some way to the triangles of persons and therapy.
- The concept of therapeutic activity as it applies to short-term therapy; this has:
 - Shown that therapeutic activity serves to prevent an unhelpful regression and the development of excessive dependence, which can only be addressed in longer-term, open-ended therapy.
 - Explored the difficulties that dynamic psychotherapy has with therapeutic activity.
 - Suggested that therapeutic neutrality, passivity and silence can be as manipulative and counter-therapeutic as inappropriate activity.
 - Discussed how therapeutic activity or passivity have to be linked to the central focus.
 - Underlined the importance of distinguishing therapeutic activity from offering advice, guidance, direction or suggestion.
- The place of transference, and transference interpretations, in focal therapy; this:

- Stressed the need for early and prompt interpretation and exploration of any negative transference or resistance.
- Discussed the differing approaches between the conservative and radical groups in relation to transference interpretations.
- Suggested that the direct use of the transference, and insight-oriented techniques in general, need to be related to the client's capacity and willingness to work in this manner.
- Found useful the distinction between a transference neurosis and the everyday-reality, here-and-now transference, in clarifying how helpful transference interventions are likely to be.
- Suggested that transference material sometimes needs to be dealt with either metaphorically, in a third-party, 'as-if' fashion, to prevent transference interventions being experienced as persecutory or hostile.
- The concept of working through as it applies to short-term focal therapy; this:
 - Suggested that while there is little of this process in focal therapy, working through takes place after the termination of therapy as well as during and between sessions.
 - Questioned how useful this concept is in its clinical applications.
- Time and its relation to circumscribed, or topping-up, time-limited therapy; this:
 - Suggested that this issue is linked to the developmental stage of the client and his previous experience of loss.
 - Indicated that a balance needs to be struck between a flexible and judicious use of the time frame and the need not to deny or fudge endings.
- The issue of termination in focal therapy; the discussion:
 - Suggested that termination is more likely to be a central issue in therapy for clients presenting with pre-oedipal problems where issues of separation and loss are likely to be of significance.

- Indicated that this is less likely to be the case for clients presenting with oedipal problems, where the ending may not be central to the therapy and core focus.
- Suggested that therapist resistance to ending can be a major factor in termination difficulties.

THERAPEUTIC OUTCOME AND THE EFFECT OF MANAGED CARE ON TIME-LIMITED THERAPY AND ITS PRACTITIONERS

Does it work? Outcome in focal psychotherapy

Since the time of Freud, dynamic psychotherapy has struggled with the twin issues of treatment outcome and evaluation. At one level it is relatively straightforward: you ask the client whether they feel better after a course of treatment and their answer tells you the success or failure of your treatment. Unfortunately, however, it is not that simple. Are successful outcomes linked to symptom relief, personal development or life 'domains', such as the quality of life or the ability to cope with certain previously stressful events? Should one measure the process of treatment, or merely focus on the end result? How can one control for therapist (and client) variables and limit the concern that any research tool may interfere with the process of the therapy? This last factor in particular has bedevilled research in dynamic psychotherapy. Psychodynamic therapists have in the past been emotionally dependent on (and defensive of) single, process-led case-studies, and resistant to objective, verifiable and replicable evidence of therapeutic outcomes. This position has been reinforced by the belief that open-ended dynamic psychotherapy seeks different, more diffuse ends which may include self-exploration or personal development and growth (although it could be argued that this is a hoped-for consequence of time-limited therapies as well) and

that these do not lend themselves to easily quantifiable research. In an age of evidence-based practice, where the purchasers of counselling and mental health services want proof that a treatment works before committing funds to it, the onus is placed on specific treatments to show evidence of their efficacy.

Roth and Fonagy (1996) have looked at the effectiveness of psychological treatments across the field of mental health. While they have provided welcome evidence that psychological treatments do help, their survey does not specifically look at time-limited or brief interventions. Before this researches into brief treatments were deeply flawed in both their sampling and control methods. The short-term clients included in the studies did not receive *planned* short-term therapy, but were often people who terminated what were intended to be longer-term treatments. The short-term treatments were frequently carried out by people with little or no training in briefer methods of therapy, who often used truncated techniques borrowed from the long-term therapies.

Allowing for the difficulties of controlling for client and therapist variables, there is currently a great deal of research into short-term treatment. The increasing popularity of manualled therapies, particularly in the United States, where the therapist is guided through the stages of therapy with the aid of a manual, has made more rigorous evaluation possible as well as focusing more closely on the client-therapist dyad via audio and video taping of sessions.

Considerable research in the field of briefer therapies is suggesting that various forms of short-term therapy are efficacious with specific client populations (Koss and Shiang 1994). All research suggests that most therapeutic benefits occur early in treatment for the majority of clients (Smith *et al.* 1980; Howard *et al.* 1986; Lambert *et al.* 1986). For up to 75 per cent of clients the law of diminishing returns applies. However, for a small number of clients with specific problems, longer-term therapy, although not necessarily open-ended, is likely to be more helpful.

Research evidence points to planned short-term therapy as being most successful with the less severe problems. Clients presenting as depressed or anxious are likely to improve faster than those considered to be borderline. More severe problems (personality disorders or borderline personalities, psychosis and sub-

stance abuse) may need more time and find a more flexible use of the time frame, including 'intermittent' therapy, more helpful. It will come as no surprise that clients who come to address circumscribed problems (loss, interpersonal relationships, depression, anxiety) do best and that one of the main values in short-term treatments is that they help accelerate positive change. Given the more structured nature of focal therapies, they are likely to avoid the dangers highlighted by Roth and Fonagy (1996) in their review of the differential effectiveness of various therapies. They suggest that non-specific, poorly structured treatments such as generic counselling, non-focused psychodynamic psychotherapy and a variety of experiential therapies are likely to become less effective the more severe the client's presentation and problem appear to be.

Comparative studies of short and time-unlimited therapies show no significant difference in results between the two in outcome, although research here is hampered by the lack of well-designed evaluation research for open-ended therapies. In general, it can be said that briefer therapies do as well as the longer-term therapies with which they are compared (Koss and Shiang 1994; Garfield 1998). Given the time and resource implications, this is a not insignificant finding. There is some evidence to suggest that premature terminations, or drop-out rates, are reduced when clients were offered a circumscribed time-limited therapy (Sledge *et al.* 1990)

While previous research has focused on either process or outcome of therapy, current findings point heavily to the therapeutic alliance as the single most predictive measure of a successful outcome (Hartley and Strupp 1983; Frieswyk *et al.* 1986; Crits-Cristoph *et al.* 1988; Gaston 1990; Koss and Shiang 1994). This non-specific factor appears more crucial than either theoretical orientation or clinical technique (Frances and Perry 1983). The discrete fit, and interaction, between clients and their therapists, will affect, positively or negatively, the process and outcome of therapy. The therapeutic relationship, rather than the theoretical model or style of therapy, will have the major impact on the success of the therapy. This holds true across varying therapeutic orientations and aids the belief that common factors in therapy, rather than the specific techniques or clinical approaches of each therapy, are the ones most helpful to clients. This is welcome news

for those who believe the relational style of both client and therapist is at the centre of the therapeutic project, but also suggests that specific attention needs to be paid early in therapy to the working alliance, particularly where it appears not to be working. These findings have helped the debate over outcomes to move on from the fraught and sterile question, 'Does this therapy work?', to the more clinically helpful, 'What factors make this treatment model succeed or fail?' (see Messer and Warren 1995 for more discussion on this issue).

There is now a substantive body of research into short-term psychodynamic therapy which supports its efficacy and suggests that the changes last over time (Gelso and Johnson 1983; Lambert *et al.* 1986). Further research is still needed in the area of 'What works for whom?' in time-limited treatments (Barber 1994). There is however the danger, in the rush to 'prove' the efficacy of brief treatments, that these will be tailored to the wishes of the purchasers of therapeutic services rather than the wishes and needs of their clients.

Managed care – or does the piper call the tune?

It currently remains unclear whether the interest in short-term focal therapies represents a breakthrough, particularly for psychodynamically based therapies, in therapeutic techniques and efficacy, or whether it heralds the beginning of the disappearance of concepts such as clinical autonomy and professionalism. In an age where fiscal imperatives push for shorter treatments there is enormous pressure to prove the efficacy of one treatment over another and for therapies to compete for public and private funding on grounds which owe much to financial audit rather than clinical need. There is considerable incentive for therapies not only to compete with one another but also to assert their potency by making claims as to their efficacy which suggest that treatment can be successfully completed in the shortest possible time using the minimum of resources. Therapy is in danger of becoming a commodity or product, much like any other, rather than a discrete form of relationship which may not readily lend itself to the discipline of the market.

While it has been the norm that the individual clinician – or

clinical service – has, together with his client, decided on the duration, goals, and methods of treatment, contemporary developments are leading to these decisions being taken by health service managers or insurance administrators. The American ‘managed-care’ industry, beginning to be evidenced in Britain by, among others, employee assistance programmes and insurance-driven health care, whereby industry or insurance companies pay for or reimburse the cost of therapy, has meant that they, rather than clinical need or opinion, define which (and what forms of) problems are treated and how long that treatment should last. Often this leads to a specific number of sessions allocated to all problems irrespective of any clinical assessment and to the growth of telephone or computer ‘counselling’. Invariably this therapy tends to be time-limited and frequently managed and evaluated by non-clinicians (Kutek 1999). Whether this can be called planned short-term focused psychotherapy, based upon therapeutic ethics and values and taking its lead from the needs of the client, is debatable.

Managed care demands that clinicians demonstrate that their treatments are both necessary and effective. Concrete and identifiable gains need to be seen to be achieved in the shortest possible time, with minimum financial outlay and with the minimum of professional support. This favours highly structured, brief forms of therapy with goals that are tightly circumscribed, easily measurable and observable. At best these can be seen to speak to the needs of the client rather than the preference of the therapist. Clinical preference on the part of the therapist has, in the absence of consideration of other therapeutic alternatives, frequently been unhelpful for clients and an indulgence on behalf of the therapist. Vague attempts to help ‘clients feel better’, idiosyncratic or amorphous clinical judgements based more on subjective feelings on the part of the therapist than objective evidence, and therapists who know rather better than their clients what their clinical material represents and when clients are ‘cured’, are becoming endangered species. At worst, however, brief managed-care interventions, which are manual-led and highly technical in their execution, can fail to acknowledge subtle differences between seemingly similar client groups, and represent a bureaucratic form of social control, a crushing of clinical freedom, and a means of denying psychic pain and emotional distress. All this is very

different from the forms of short-term focal therapy we have been discussing.

Therapy as a corporate commodity

Short-term therapies are in danger of becoming, willingly or otherwise, part of what has been described as the 'corporatization of psychotherapy' (Pington 1997). This entails the disappearance of psychotherapy's libertarian, questioning or radical potential at the expense of a therapy based on the use of technology, techniques which can be easily learnt by lay people, and aimed at the rapid adjustment to the mores of society as interpreted by employer, insurance company or provider of health care. The danger exists that short-term therapies which allow themselves to be incorporated into the managed-care industry without any clinical safeguards become mere means of social control – attempts to change behaviour which an employer, say, finds difficult. In that context it can become an alternative to good management, with 'difficult' employees told to seek counselling to 'correct' their attitude or increase their productivity to the organisation. Psychotherapy, which at best is about personal growth and empowerment, is in danger of becoming a 'cost-effective treatment for individuals with socially disruptive behaviours' (Kutek 1999). A further effect of this corporatization is the tendency to discriminate between different problems or ailments; alcoholism may qualify for treatment, while personal alienation or confusion may not. Additionally, clients may need to be defined as 'ill' to become eligible for treatment. Managed care, in many parts of America, demands that the client be given a DSM number based upon a psychiatric definition in the *Diagnostic and Statistical Manual of the American Psychiatric Association* where each DSM number is authorised a fixed number of sessions, independently of the client's individual needs. Managed care, and fiscal prioritised resource management, can also represent a form of 'invisible rationing of treatment' in the absence of any more open public debate in the wider community (as well as by clients of any particular service) as to what the underlying philosophy of therapeutic help and its aims may or should be.

Pingitore sees corporatization as leading increasingly to the non-clinical management of psychotherapy where the therapist's 'jurisdiction over diagnosis [and] treatment is under attack by health care administrators and entrepreneurs'. The risks are that all treatments will require standardisation and be heavily dependant on rigid diagnosis and outcome evaluation research. Resources will follow the most recent research findings. If ten sessions of a specific therapy are found helpful in the latest outcome evaluation then everyone will be funded for ten sessions of that treatment, irrespective of the problem or the wish of the patient. Since health insurance tends to place a limit on the number of sessions they are willing to reimburse, this will lead to attempts to ensure that therapy will not continue beyond what the administrators think is the minimum necessary length. One of the outcomes of this will be the need for more technical flexibility on the part of clinicians. This may prove increasingly problematic for those trained in 'pure' models of therapy with no experience of, or exposure to, alternative therapeutic methods. The therapeutic relationship will be influenced by the fact that there will always be third parties in the room, be they funding bodies or non-professional 'review personnel'. The net effect is that therapy is potentially in the service of the employer or insurance company as much as, if not more than, that of the client.

Since the aim of therapy under managed care, and increasingly in the public health care system, is not personal growth or fundamental shifts in personality, but 'symptom reduction and behaviour adjustment' (Kutek 1999, p. 21), the psychodynamic therapist's professional autonomy and skill base is immediately challenged. Since corporate applied therapy tends to be symptom- and goal-orientated, an insidious effect of this is that the more reflective, explorative, personal developmental therapy is sidelined at the cost of the more functional-adaptive-coping-strategies model. In this scenario the therapist, feeling unable to influence the course of his professional work and whose judgement is always under scrutiny, potentially becomes more and more deskilled, if not disaffected. Ethical problems may arise if the clinician thinks his client needs longer treatment while the funding body does not (Small and Barnhill 1998). As the content and length of treatments is increasingly dictated by third-party service providers, clinicians – and psychotherapies in general –

face a number of difficult ethical, clinical and political questions (for fuller discussion of these issues see Kupers 1981; Messer and Warren 1995 p. 330). A consequence may be a growing cynicism over the use of short-term treatments on the part of the clinician, which may give scope for the therapist to act out his discomfort with funding decisions in the therapeutic relationship, to the detriment of his client.

'Making a virtue out of necessity'

The danger exists that in this climate many therapists may be asked to use time-limited focal therapy as a result of institutional resource limitations, poor line management in organisations, and lengthy public health sector waiting lists. The industrialisation of forms of psychotherapy, often combined with a wary and increasingly cynical clinician's belief that he has 'to make a virtue out of necessity' and practise 'brief therapy', is a reflection of the dangers inherent in a system where fiscal and administrative necessity are given pre-eminence over clinical discourse or research based upon psychological theories of personality and human development.

The pressure will mount for focal therapy to be offered to inappropriate clients. Our discussion of assessment has shown that some clients are likely to benefit more than others from time-limited therapy; it is incumbent for therapists and their employers, or those paying for clinical services, to recognise this. It would be extremely unfortunate, and bring all therapies into disrepute, if more and more clients were offered short-term therapy because of resource limitations and a vague hope that 'it is better than nothing' and 'may help' as a result of there being little other therapeutic help on offer. Focal short-term therapy needs to be part (albeit an important one) of a continuum of provision, rather than something that is offered to all as an administrative or fiscal convenience. Time-limited short-term therapy should never be the only therapeutic option. Difficult clinical decisions will still need to be made to avoid clients being offered short-term therapy inappropriately. Time, as we have seen in focal therapy, needs to be used flexibly on the basis of the clinical needs of the client; a blanket provision of, say, ten sessions for everyone will not speak

to the need to carefully tease out how many sessions are required for any individual client.

Additional problems are likely to arise because funding decisions based on over-prescriptive purchasing or reimbursement policies by health service managers and insurance companies may well stifle clinical innovation and development. Few clinicians will feel safe to innovate in the absence of any encouragement from funding bodies. If funding is available only for tried and tested therapies, where will clinical innovation and development come from? (See Roth and Fonagy 1996 for further discussion of how genuine evidence-based practice may be delayed as a result of administrative funding decisions.) Similar concerns affect clinical trainings; who will take responsibility for trainings if those funding services decide that only one narrow form of treatment is to be made available?

Whither exploratory psychotherapy?

An unhelpful dichotomy has been drawn between open-ended psychotherapy, which is believed to be leisurely, reflective, exploratory and discursive, and time limited therapy, which is thought to be hurried, superficial, and open to didactic or authoritarian tendencies. While, as we have seen, this polarity is both unhelpful and untrue of both forms of therapy, its hold on at least the clinician's imagination is perhaps a reflection of how far the emphasis in contemporary culture and society on active agency, speed and immediacy goes against the grain of many of the central tenets of the more exploratory psychotherapies (Shipton and Smith 1998). There appears at times to be a devaluing of the relational in contemporary society, so that goods are more important than people and there is a preoccupation with the peripheral and fleeting, accompanied by a constant wish for new and exiting experiences with the attendant low attention span, all of which adds to the concerns that certain forms of 'brief therapy' merely mirror the less attractive or thoughtful aspects of contemporary culture. Although, as we have seen, focal therapy is both thoughtful and reflective (and open-ended therapies can be both active and focused) these stereotypes are difficult to relinquish. This poses problems for the profession of psychotherapy

and counselling. Short-term therapists in particular need to be aware that they are practising focal therapy for the right clinical reasons.

At times it appears that the debate has become clouded by an inability to distinguish between clinical necessity and administrative or fiscal demands. Health service administrators will always be more informed by financial imperatives than theories of personality and human development. The reverse will be true of clinicians. In language, these two worlds are difficult to reconcile, yet attempts to do so must be encouraged.

The retreat into grandiosity

Hubris, in the trumpeting of the efficacy of brief therapies in the hope of favourable funding, is likely to be short-lived, because there will always be a minority of clients for whom focal therapy is contraindicated. It is also reminiscent of the founding fathers – and mothers – of psychoanalysis who argued vociferously in favour of psychoanalysis as the cure for many of the world's ills. Those that claim that short-term therapy can help everyone can be seen as retreating into a form of grandiosity. The opposite of grandiosity, denigration, is also in evidence in contemporary therapeutic debates. A stigma is attached to weakness and vulnerability, which are traits to be hidden or placed in others and then denigrated or disparaged. Therapists too can denigrate what it is they are offering (brief therapy, say) as a way of defensively avoiding the effective active engagement with both their client and their employing agency.

In a world that puts a premium on competence, effectiveness, efficiency and control, the idea that every problem has a rational and immediate solution is particularly attractive, however erroneous it maybe. Contemporary culture has great difficulty with aspects of existence that are beyond our control and imply human limitation. There appears to be little place in society for helplessness, weakness and dependency. It would be tragic if focal short-term therapy, which has so much to offer to so many, were to be coopted into a corporate vision of life which seeks to deny, or minimise, the existence of emotional suffering.

These are very real difficulties for the short-term therapist to

consider, but one effect of living in the real external world means that some accommodation needs to be found between clinical autonomy and professional (and lay) accountability. Even without these external constraints there are other professional dilemmas which the short-term therapist faces.

Is clinical rigour being replaced by administrative sadism?

As we have seen, the danger exists of fitting all clients into a narrow range of therapeutic modalities. This is made more acute since in many areas it is increasingly difficult for short-term therapists to refer on those clients who require longer-term treatment, since these resources are either not available or have long waiting lists. Only having one treatment modality available runs the risk of reinforcing the belief among clinicians that it is not the best that they can offer and less than the client needs. The emphasis then becomes more on technique than on exploration or reflection. Looking at some of the more prescriptive brief therapies, one is struck by the technical onslaught against resistance employed by some clinicians; these have the flavour of indoctrination rather than therapeutic 'play'. Indoctrination leads to compliance; clients can incorporate their therapists in a manner analogous to pets resembling their owners. Arguably this is as much a danger in open-ended therapies, but the premium placed on therapeutic activity and focal attention in short-term therapy makes it more vulnerable to accusations that it can lead to a submissive compliance. However, it is the case that some short-term therapies have aroused discomfort out of a sense that their therapeutic techniques appear to be at best insensitive, at worst sadistic. This is particularly true of the more analytic drive-structural approaches employed by, among others, Davanloo and Sifneos, who have been accused of an authoritarianism akin to religious fundamentalism, where only compliance with the therapist's view of reality is acceptable (Messer and Warren 1995 p. 109). These critics suggest that there is little of reflective exploration or open and spontaneous dialogue in these therapies – merely compliance to the therapist and his view of reality. Therapeutic process is pre-empted by therapeutic zeal, while it is the provocative stance of

the therapist which arouses the client's intense feelings and anger rather than historical transferences. The therapist elicits affect rather than observes affects, while resistances are battered down rather than respected.

One consequence of this is that clients may not be heard. Psychotherapists hear only what they are able to hear. All clients will pick up ways in which their therapists can or cannot tolerate or hear their pain. 'Brief' clients may not feel free or safe to tell the whole story. They too may feel the need to select their contributions on the basis of what they feel comfortable telling a therapist from whom they may shortly separate. 'Brief' clients may tell 'brief' stories in the same way that focal therapists may only hear stories that can be related to the focus. In this way, the concept of time will affect (and potentially limit) the process. The pressure on the therapist to 'cure quickly' will parallel the pressure on the client to 'get better' quickly. The dangers of selective material and compliance are all too obvious. A focal therapist needs to be aware of the danger of never hearing of, or never encouraging their client to reveal, the full extent of the client's suffering. This is also an area where therapeutic sadism might be in evidence. The therapist may avoid, or not respond to, painful or difficult material. The focus in short-term therapy needs to be in the area of the client's most painful conflict – it must never function to exclude painful or problematic clinical material.

A further objection to focal short-term therapy is that, unlike open-ended analytic therapies, which because of their intensity and rigour are 'deep', so that the results are profound and long-lasting, time-limited therapy can only be superficial and the results temporary. According to this school of thought, the depth of therapy is proportional to its length; open-ended intensive analytic psychotherapy can reach parts of the personality which other therapies cannot. Associated with this is the belief that the true nature of any individual's problems will only be discoverable over time. This is what Wolberg (1980) has termed the 'prejudices of depth'. While it is true that short-term therapies are more modest in their aspirations than long-term psychotherapy, there is little empirical evidence to back up the claim that some therapies are deeper than others or that it takes a long time to ascertain the true nature of a client's difficulties. It would appear that these claims are related to the need to justify more intensive

and long-term therapies on the basis of their rigour. There is increasing evidence that core conflictual relational themes can be observed very early in therapy (Silberschatz and Curtis 1986; Crits-Cristoph *et al.* 1988). The equation of length of treatment with depth and rigour is one that many clinicians have questioned. Ferenczi (Stanton 1990, p. 33) is quoted as saying that therapeutic progress is not related to the depth of either an interpretation or the patient's insight. Alexander believed that daily sessions, rather than making therapy more intensive and therefore rigorous, merely made therapy more routine and superficial, while Winnicott thought depth unrelated to intensity or length of treatment.

Rigour and depth are problematic and diffuse concepts for the psychodynamic therapist.

Beverley

Beverley, a 30-year-old woman, had been seen for some five years employing a 'topping-up' model of focal therapy. She was first seen on her arrival in this country and sessions focused on aspects of cultural dissonance, familial conflicts and her own professional and relational aspirations. These had been reflective and explorative sessions during which the therapist felt they had come to know each other quite well and had a positive therapeutic alliance; he believed he had a firm understanding of her and her concerns. The therapist was surprised when, during his fifth year of seeing her, (and during a period when she had become depressed after the failure of a professional venture) she asked him whether they could engage in some 'short-term' cognitive work, since 'although our work together has really been helpful it has not really addressed the innermost me'. She now needed 'something deep which could affect the way I think and behave'. The implication was that their work together (stretching over a number of years and focused on transitions, relationships, family and culture) although helpful, had in some respects been 'shallow'. What was 'deep' was her cognitive thought processes, and she wondered whether they might be able to be accessed over a shorter time.

Clients may be able to define what is deep and what is superficial for their therapists, and these definitions may bear little relationship to the therapist's fantasies of what constitutes rigour and depth. Issues of depth versus superficiality are historical legacies of the disputes within the psychoanalytic profession. 'Superficial'

has served to determine all that is 'not psychoanalysis' or intensive psychotherapy and has become a term of abuse. Similarly, brief therapy has been dismissively termed a 'band-aid' or 'plaster', but this may be exactly what is required when some one is hurt – as Messer and Warren suggest, it provides the 'antiseptic protection to enable healing to take place'.

However, the focal therapist must ensure that therapy is not carried out in a crudely mechanistic and unempathic manner. This could be a danger, given the sheer numbers of clients that might be seen in short-term therapy.

Short-term therapy: the easy option?

It has been said that short-term therapy, because it is brief, is less demanding than more open-ended therapies. These beliefs still linger in the mind of therapists partly as a result of the harsh psychoanalytic super ego, with its equation of intensity, length and rigour. Therapists who have been trained in psychodynamic open-ended therapies and then practise (or are placed under pressure to adopt) a more time-limited model are likely to have an ambivalent transference to short-term therapy. They are likely to view focal therapy as an abbreviated and superficial (and therefore less demanding) form of psychoanalysis and to view the undertaking as second best as a result of the hierarchy that exists in dynamic psychotherapy as reported by Flegenhimer (1982) 'Psychoanalysis is the best form of treatment available, long term psychotherapy has merit if psychoanalysis is not possible, and lesser forms of therapy are makeshift at best.' This is made more acute if therapists are made to undertake time-limited therapy by their employers and leads to the combination of professional ambivalence and practical cynicism felt by psychoanalytic practitioners towards focal therapies. All this fosters the belief that brief therapy is easier (that is, less intense or demanding) than longer, open-ended therapies.

The need to work within a short-term framework places the therapist under a great deal of pressure. In some ways it is as intense as open-ended therapies, if not more so. The therapeutic demand of constantly dealing with beginnings and endings (with little of the more leisurely middle bit in between), the high

activity level and the need to be constantly actively present in every minute of every session all ensure that focal therapy is emotionally very demanding for the therapist. One of the difficulties is the seemingly promiscuous nature of short-term work; seeing so many people in such a short space of time imposes its own discipline and demands. In researching this book I was struck by how, in many clinical vignettes in the short-term therapy literature, clients are not given a name, merely a function or symptom (for example, 'The Case of the Man with the Headache' or 'The Case of the Masochistic Statistician'). It may be that this is a reflection of the short-term therapist's need to defend against any personal or more intimate therapeutic contact with their clients, given the sheer numbers they are being asked to treat.

One of the consequences of the more cost-effective nature of short-term therapies is that clinicians will come under pressure from their employers to see more and more people, with a consequent danger of clinical fatigue or burnout. It is important for short-term therapists to have access to regular supervision and support, as well as for their employers to recognise the stresses inherent in the high turnover of clients.

These are also issues which should inform counselling and psychotherapeutic trainings.

Summary

In this chapter we have discussed various topics:

- *Outcome studies* – we have seen that these provide ground for optimism for short-term therapy. They suggest that short-term therapy is most successful with the less severe problems, while suggesting that more severe or chronic difficulties may need a more flexible time frame. The nature and quality of the therapeutic alliance is the single most important factor in time-limited therapy, as it is in most therapies.
- *Managed care* – we have explored how the advent of third-party funding of therapeutic services is likely to provide a challenge to the therapeutic profession, especially in the area of clinical autonomy. Corporatization, or therapy as a commodity, can

lead to a much more functional, goal-oriented (as opposed to developmental) approach to therapy. We have questioned whether the increasing preoccupation with the technique and mechanics of therapy in these approaches can really be described as short-term dynamic psychotherapy.

- *'Making a virtue out of necessity'* – we have discussed the specific difficulties for the clinician of doing this in practising short-term therapy. Psychodynamic practitioners will inevitably be vulnerable to feelings that this is second best when asked to practise time-limited therapy because of administrative diktat or resource limitations. In this climate there is a danger that short-term therapy will be offered inappropriately and that the need for continued diversity of therapeutic provision will be threatened. Planned short-term therapy must never be offered solely because of resource limitations.
- *Society's denigration of the relational* – we have seen how, together with the preoccupation with 'quick fixes', this can lead to a denial, or a wish not to hear, emotional or psychological pain.
- *Grandiosity, denigration and authoritarianism* – it has been shown that the short-term therapist is in danger of drifting into these as a result of the premium placed on increasingly technical and mechanical therapeutic modalities.
- *The debate over depth versus superficiality* – the discussion has shown how this has served to hamper attempts to formulate short-term psychodynamic approaches.

TRAINING AND SUPERVISION

Training matters

The central tenets of short-term focal therapy – brevity, activity, focus, selective attention, benign neglect – pose problems for psychodynamic therapists, because they run counter to the fundamental assumptions of many psychodynamic-orientated trainings. In a sense, the psychodynamic therapist who is interested in short-term work has to transcend, or unlearn, many of the theoretical and clinical values and approaches of his training.

Freud recognised that psychodynamic treatments might need to be made more available and accessible for a larger section of the population. In 1919, at the Fifth International Psychoanalytic Conference in Budapest, the heavy demand on psychoanalysis was discussed and it was suggested that Ferenczi's active technique was a possible way for psychoanalysis to develop to meet the anticipated large-scale requests for treatment. This was before the Ferenczi–Freud split. Freud, however, aware of the danger of psychoanalysis becoming a treatment for the privileged few, had talked of having psychoanalytically based outpatient clinics and making treatment free of charge. Few, though, took up this challenge.

At the same Budapest conference, Freud made his famous statement that 'It is very probable, too, that large-scale application of our therapy will compel us to alloy the pure gold of psychoanalysis freely with the copper of direct suggestion' (Freud 1919). While Freud was not suggesting that briefer therapies were 'copper' and thus less valuable (he was referring to his old hypnosis and catharsis methods), his words have subsequently been

misinterpreted to suggest that the 'applied psychoanalysis' of short-term therapy was less valuable, and a second choice after 'pure' psychoanalysis. This has bedevilled attempts to develop short-term treatments based upon psychoanalytic principles ever since. Freud, in the same paper, went on to say, 'but whatever form this psychoanalysis for the people may take, whatever the elements out of which it is compounded, its most effective and important ingredients will assuredly remain those borrowed from strict and untendentious psychoanalysis.' Freud was throwing down the gauntlet for others to devise a form of briefer therapy, based on psychoanalytic principles, which could be made widely available, effective and accessible. However, he had also, perhaps inadvertently, given rise to the belief that whatever form of therapy this might entail it was likely to be second-best to the 'pure gold' of psychoanalysis. Balint *et al.* (1972), in discussing why the initial focal workshop at the Tavistock Clinic failed, gives a graphic example of the threat that psychoanalytically trained practitioners felt at the suggestion of briefer and therefore less 'rigorous' treatments. To this day, trainings in psychodynamic therapy and counselling are hampered by this belief, and it represents a major hurdle in the training of psychodynamic short-term therapists.

Contemporary issues in the training of time-limited therapists

One of the problems is the belief that short-term therapy is just a modified and compressed form of psychoanalysis. We have seen in previous chapters how short-term dynamic therapy, although selectively using psychoanalytic insights and their clinical applications, is very different from psychoanalysis. Short-term dynamic therapy cannot be a concentrated version of psychoanalysis. Short-term dynamic therapy is increasingly developing a knowledge base of its own, for which psychoanalytic theory provides the foundation. Its clinical application is, as we have seen, very different from psychoanalytic methods and requires of the clinician different skills and a flexible, more pluralistic, mindset or framework.

If time-limited therapy is to be the treatment of choice for certain clients then it has to be the choice of treatments for the therapist. A treatment with which the therapist does not feel comfortable is unlikely to be very helpful for the client. Resistance on the part of the neophyte therapist is a major difficulty in trainings. If, a client says, 'Can I be helped in such a short space of time?', and the therapist for whatever reason shares this ambivalence, then the prognosis will be bleak (Flegenheimer 1982). Trainings need to address this ambivalence towards short-term therapies, which is unconsciously fostered by the trainings themselves and then internalised by the trainee therapist.

While there are trainings, and trainees, wary of seeing their clients forever, there are many negative attitudes and resistances that confront those teaching and learning short-term psychodynamic therapy. Among these are some we have already come across and some we have not mentioned: the guilt at not offering the client enough, including feelings that the therapist is rejecting or abandoning the client; anger at 'the system' for not allowing enough to be provided; the difficulty of accepting limitations and conveying the therapist's feeling that focal therapy is second-rate, leading to the danger that the client enacts the therapist's ambivalence, and the therapist's need to mourn not being wanted. Many of these difficulties stem from the value systems of open-ended trainings and reflect the ambivalence that psychoanalysis has always felt towards short-term approaches. Longer-term therapists are often slow to adapt to the philosophy of briefer therapies – transference to a body of knowledge can be a major problem – and may find themselves drifting into old habits of attending to everything that comes up in a session without sticking to the focus. Therapeutic activity and structure may require them to have to replace the ideal of entering each session without 'memory or desire' with the need to prepare for sessions by reading up last week's case notes to ensure that the narrative themes are remembered for the ensuing session. Conversely, those with little experience of longer-term work are likely to miss metaphors, idioms, the subtleties of the therapeutic process, and unconscious communications.

These issues have led to a lively debate in training circles over whether, to learn short-term therapy, the trainee needs an initial

experience in open-ended, longer-term therapy or whether, given the amount of unlearning that the therapist has to do after his open-ended training to become comfortable with more focal approaches, trainees would be better advised to train in briefer methods from the beginning of their trainings. This would address the difficulty of having to modify, adapt or change the skills and beliefs inherent in longer-term, open-ended treatments. The former view suggests that in order for therapists to be able to properly assess for short-term treatments, and to feel comfortable with metaphors, unconscious communications and transference manifestations, they require the in-depth knowledge and experience that open-ended, long-term psychodynamic work provides. To discern, and keep to, the focus may require knowledge, sensitivity and ease on the part of the therapist with regard to psychoanalytic theory and its clinical applications. Mann and Goldman (1994) advise that

Time limited therapy is not for the beginning therapist. The best preparation for it is extensive experience in long term psychotherapy so that one can gain full appreciation for the unconscious functioning of the mind, the ego defences, transferences and resistance.

Others believe that the preconceptions fostered by long-term treatments (for instance that it is impossible to be both brief and deep, active and not influencing) are such that it is preferable to train therapists in short-term therapy without them having learnt and internalised the 'bad habits' of long-term therapies. Sifneos at one point abandoned training experienced therapists in short-term work because he experienced considerable resistance with therapists who had trained only in long-term therapy, and concentrated on the training of volunteers or people early in their training who were less likely to be set in their clinically rigid ways. Habitual ways of thinking are difficult to modify or adapt. In this sense, 'the novice comes to [short-term psychodynamic therapy] with fewer preconceived ideas about what constitutes good practice and with enthusiasm and high motivation that are great assets for learning' (Messer and Warren 1995, pp. 54–5). Budman and Gurman (1983) have suggested that the value systems and goals of the long-term and short-term therapist are different. This is encapsulated in the 'state of mind of the thera-

pist and patient' rather than specifically in the length of treatment or number of sessions. Among these differences are the suggestions that short-term therapists tend to be more pragmatic and less preoccupied with notions of 'cure', believing more in developmental change (as opposed to static pathological descriptions), and that psychological change can occur outside, or after, therapy. Many therapists, trained in long-term work, see short-term therapy as a prelude to getting the client into longer-term therapies, rather than an end in itself. The danger exists that this preoccupation about further treatment may blind the therapist to the here-and-now focus of short-term work and can function as a defensive avoidance on the part of the therapist. (For more discussion about the differing value systems which may lead psychoanalytic practitioners to have difficulty practising short-term therapy, see Hoyt 1985; Levenson *et al.* 1995.)

This point of view is expressed most forcibly by those short-term therapies which lend themselves to either manual-led or explicitly technical approaches and tend to assume that the therapist can slip in and out of therapeutic modalities almost at will. They tend to place minor emphasis on the use of self as a therapeutic vehicle and thus differ from the more dynamic approaches which place more emphasis on counter-transference. The danger with the more manual-led short-term therapies is that the therapist becomes technically competent but the therapy becomes somewhat mechanical in its application and lacking in sensitivity.

Both points of view express valid differences in approach. However, there is currently little in longer, open-ended dynamic trainings that is necessarily helpful for the short-term therapist – this despite the fact that models of focal therapies which form the basis of this book are heavily reliant on psychodynamic insights and their applications. The danger exists that open-ended therapists will either lack the specific skills required for short-term approaches, or possess frames of mind that preclude the ability to use them, or both. This is of some concern, since at present most therapists practising short-term dynamic therapy have had little training in this modality and allow their core training to dictate how they work as time aware therapists.

To overcome this difficulty, Messer and Warren suggest that

trainings need to recognise the differences between the novice therapist, who needs to learn the clinical skills required for short-term therapy, and the psychodynamically experienced therapist, who needs more attention paid to emotional resistances and intellectual preconceptions. (Messer and Warren 1995 provide interesting training blueprints for both groups on pp. 54–8.)

Negative attitudes to short-term therapy and its value systems need to be addressed in trainings for psychodynamic therapists practising short-term therapies and parallel the central importance in the therapy of working actively with the client's negative feelings early in the treatment. Preconceived beliefs are unhelpful for trainees learning focal therapies. If psychoanalytically informed short-term therapy is to have any future, ways must be found for trainings to incorporate the teaching of time limited treatments in a manner which prevents the assimilation of long-term treatments as the norm from which short-term therapy can only deviate. Short-term values and a focal mindset must be assimilated without losing that which is fundamental to psychodynamic thinking. This is assuming greater contemporary importance, not least since trainings need to prepare their students for the workplace which is increasingly focal in character. Trainings which prepare their students to become 'pure' open-ended psychotherapists and counsellors are unlikely to have much to offer public sector clinical services. Roth and Fonagy (1996) have pointed both to the importance of training, which they state becomes increasingly important the more severe or chronic the problem presented is, and also to the fact that a therapist is more likely to achieve a better outcome the more they are able to adapt their technique to match the client's problem, which may mean a more flexible approach to treatment modality.

However, given that it is now widely accepted that time-limited therapy is a specialised form of treatment requiring its own methodology and clinical application, specific trainings in short-term psychodynamic therapy are needed. At present a great deal of short-term therapy is being done, but on the basis of very little training. The crucial problem faced by trainings in psychodynamic short-term therapy is how to preserve that which is essentially psychodynamic (knowledge of unconscious processes, transference and counter-transference, the symbolic nature of

much therapeutic communication), and is the cornerstone of the idiomatic form of short-term therapy described in this book, while at the same time ensuring that the clinician maintains the flexible and open mindset to recognise the values of the more plural and active clinical modality which focal therapy entails. Flegenheimer (1982), believing that prejudices about length of treatment and method need to be put aside, has suggested that the preferred trainees for short-term psychotherapy are those who have some grounding and background in psychodynamic theory but are 'not yet habituated to the particular techniques of long-term therapy'. This would suggest that a psychodynamic-oriented training which seeks to incorporate shorter-term treatments needs at some point, perhaps in its second or third year, to ensure that its trainees are expected to treat at least one client using a short-term, focal approach. Similarly, when working within an institution it is often suggested that the therapist has at least one long-term client in treatment. This ensures that the therapist is in touch with the issues which arise in more open-ended treatments but carries the danger that this client will be over-valued at the expense of other, more short-term, clients. It forms the baseline from which time-limited work may be judged rather than being viewed as something similar but very different. Short-term treatment modalities need to be placed on a par with the more open-ended approaches, not added merely as an after-thought as the trainee reaches the end of their course and faces the world of paid clinical work.

In the same vein, clinical supervision of time-limited therapy needs to recognise that this is a different modality from the supervision of open-ended treatment, not merely an adjunct to it or a modified and concentrated version of dynamic psychotherapy.

Support and supervision

Time-limited therapies are stressful for the therapist. The discipline involved in making and ending therapeutic relationships, the high turnover of clients, sticking to the focus, and the need for therapeutic activity are emotionally draining. Therapists have to continually deal with their own separation anxiety; they have to continually separate from people with whom they have been

quite intimate. Focal therapists need to be well supported if they are to remain sensitive to the individual client's problems. There are dangers in becoming either overly technical or vulnerable to burnout as a result of the demands of working in such an active and time limited fashion. There is some evidence that without regular supervision, short-term therapists are likely to become mechanical and authoritarian (Henry *et al.* 1993).

Supervision

Access to regular high-quality supervision is imperative. Although individual supervision is helpful, short-term work is well suited to group supervision. Malan (1963) recommended team supervision and case conferences where members can support each other in formulating a focus, dealing with therapeutic anxiety or guilt, and diminishing the chances of therapeutic drift. Without adequate supervision, planned short-term therapy is likely to be unsuccessful because the therapist is likely to become unfocused, anxious or confused and the client more likely to drop out.

The functions of regular clinical supervision include support, guidance, both positive and negative feedback, and suggestion. Additional tasks are the articulation of alternative views and the continuing stimulation of professional curiosity and learning for both supervisor and supervisee. In short, supervision provides a secure base from which learning and clinical practice can develop. This holds true for both short-term and open-ended therapies.

What form supervision takes is in some measure dependent on the particular orientation of the short-term therapist. The more manual-led therapies rely more on direct guidance, while others use audio and video tapes. There is considerable evidence that technical strategies and therapeutic tactics, which have a place in short-term therapy, can be effectively taught via these methods (Binder 1993; Henry *et al.* 1993).

This differs, however, from psychodynamic supervision, which involves the observation of, and reflection on, the therapeutic process as it unfolds. Traditionally, psychodynamic supervision has been heavily reliant on the process recording (that is, the recording of the verbatim exchange between client and therapist)

of each session, which is then discussed in detail in supervision. Psychodynamic supervision has sought to incorporate the twin roles of 'the supervisor as educator', a reflection of the one-person, drive-structural model of psychoanalysis, and 'the supervisor as therapeutic facilitator', who, among other things, can point out the supervisee's blind spots. The latter form of supervision is linked more with the relational, object-relations model of therapy. Integrating these two differing paradigms, as in other areas of dynamic psychotherapy, has not been easy. Binder and Strupp (1997) propose a paradigm for psychotherapy supervision which distinguishes between 'declarative' knowledge (theories, principles, concepts and facts), which can be directly taught, and 'procedural' knowledge (when and how to implement and apply declarative knowledge). This is a useful distinction in the supervision of idiomatic short-term work, which lends itself to both the more didactic skills-based supervision and the use of intuition, based on the therapeutic process, in making short-term, focus-related interventions. These different forms of learning can then be incorporated into clinical supervision, leading to what Schon (1987) has termed 'reflection in action' – the ability to intuitively improvise where standard principles may not apply. The reflective practitioner is able to reflect internally on his practice by holding on to what Casement (1991) has termed the 'internal supervisor'. The supervisory relationship needs to be sufficiently internalised for the therapist to be able to go on from there to arrive at a distinctive personal style of practice based on both declarative and procedural knowledge. This provides the foundation of reflective practice that only good supervision can provide.

Current supervision theory suggests that a form of parallel process is at work in any supervisory relationship (Ekstein and Wallerstein 1958; Jacobs 1996; Bramley 1996b). This proposes that in any discussion of clinical process and material, important issues from the treatment relationship are enacted in the supervisory relationship. While it would be unwise to hold this as a hard-and-fast rule, it is a useful way of thinking about the supervision of short-term therapy where the demands of the treatment modality may well be a reflection of the supervisory relationship, or acted out in it.

As in short-term focal therapy, short-term therapeutic supervision requires a modification of the traditional supervisory relationship. While short-term supervision aims, like open-ended supervision, at the benign internalisation of the supervisor (Casement 1991) or supervisory relationship, there are a number of significant differences between open-ended and short-term supervision. In focal supervision, there can be little of the free association to the client's material or discursive reflections on the therapeutic process. While all good supervisory relationships should allow the supervisee the safety to 'play', an aspect of the parallel process is that short-term supervision needs to be framed in a manner similar to short-term focal treatments:

- The supervisory relationship needs to model the central tenets of short-term work – activity, focus, brevity and curiosity. Included in this is the discovery of the idiom of both supervisor and supervisee.
- Prompt attention needs to be paid to the early manifestations of the therapeutic process. The initial counter-transference may point to aspects of the time-limited intervention which may be problematic for the therapist. The supervisee's anticipatory hopes, fears and expectations need to be voiced.
- The supervisor needs to model an active agency and confidence that something of value can be achieved in a short space of time. This is particularly important because it is likely that at some stage in the treatment the supervisee will doubt the efficacy of their work. The ripple effect of short-term work may take some time to be evidenced, and the neophyte therapist may become despondent. The supervisor needs to hold on to therapeutic hope as well as modelling for the supervisee a specific therapeutic stance of speed and decisiveness.
- The supervisor needs to keep a close eye on the meaning of any statement like 'this client needs long-term work', particularly if it appears early in therapy. Unless it is stating what will probably have been evident anyway at the assessment stage, it is likely to represent either anxiety or guilt on the part of the supervisee.

- The briefer the therapy, the more structured the supervisory relationship needs to become. Specific idiomatic relational patterns, as manifested in client–therapist interactions, need to be highlighted, rather than non-specific intrapsychic dynamics. Attention needs to be paid to the temptation for the therapeutic and supervisory dyad to drift away from the focus. Holding the therapist to the task in hand is a major supervisory function.
- The selection and tracking of a focal theme throughout the therapy (and by definition in the supervision) needs to be encouraged.
- Feedback, whether negative or positive, needs to be specific rather than framed in generalities. Supervisory feedback needs to be concise, succinct and promptly formulated.
- Careful preparation for the next sessions needs to be encouraged.
- The supervisor needs to be aware of the possibility of therapeutic collusion whereby the therapist will, albeit unconsciously, indicate to the client that long-term work would be more enjoyable and useful for both parties, making termination more problematic. This can be helped by the careful monitoring of transference and counter-transference.
- The timing and spacing of supervision (although not its framework or boundaries) can be flexible, reflecting what happens clinically. It need not be weekly or individual – group supervision can offer a diversity of views and the group can be mobilised in helping supervisees to stick to the focus.
- The need to establish a speedy therapeutic alliance with a client is mirrored in supervision. Any negative feelings towards, or ambivalence about, time-limited work needs to be actively acknowledged and worked through. Both supervisor and supervisee may have pre-transferences to short-term work which need to be aired. These may be reflections of what is happening in the therapy.
- Didactic teaching and clinical practice can and should be combined in the supervisory relationship. It may appear paradoxical, but some process-led, idiomatic short-term therapy can be taught (for example, how to respond to and use metaphors, and the linking of apparently diffuse narratives.)

- Given that a positive therapeutic alliance is heavily related to treatment outcome, the relational skills of the therapist need to be addressed, particularly if there are early signs of difficulty in this area.
- There is an urgency about short-term work that needs to be reflected in the supervision – one has to think and respond inventively, since time is limited.
- Supervising short-term therapy is ‘like watching people travel up an escalator; they are on and off in a flash and you catch no more than a glimpse of them’ (Mander 1998). Both supervisor and supervisee might find not knowing what happens next frustrating. The need for mourning on the part of the supervisee may need to be articulated.
- The supervisor needs to be constantly aware of the developmental sequence of short-term therapy and to assist the supervisee to bear in mind that therapy is always in one of three stages – beginning, middle or end. The differing stages require different supervisory – and clinical – input, and failure to recognise this can lead to unsatisfactory outcomes. In recognition of this, Mander (2000) suggests a three-stage supervisory input. The supervision moves from the beginning of treatment where a focus is formulated and strategies planned; through a middle phase where anxieties about attachment and separation are in evidence and an interim assessment of what has and has not been achieved can be made; to a final stage before the last session where a review of the therapy can be made, and thought given to whether a follow-up is indicated.
- The externalising of ‘third-party blame’ (‘if only the uncaring employing agency would allow a few more sessions’) needs to be discouraged. While there is room for allowing space for the meaning of the clinician’s frustration as it may affect their clinical work, a preoccupation with any third party’s shortcomings functions to take the supervision outside the room and to defensively avoid the need to attend to the task at hand. This is true of the supervisory as well as the therapeutic relationship.
- Finally, it may be that not every therapist is temperamentally suited to practise time-limited focal therapy and this will require sensitive handling on the part of the supervisor.

Intuition in short-term therapy

Before leaving supervision, a word is due about *intuition*, that most elusive quality that can lead to the therapist's most helpful and liberating insights. Does it have a place in time-limited therapy, or is it merely a vehicle for unprocessed self-indulgence? In short-term idiomatic therapy the therapist must allow himself an imaginative inner play. Intuition, derived from the Latin for 'to look', is essentially a way of looking and seeing. As defined by Webster, it is 'the direct knowing or learning of something without the conscious use of reasoning, immediate apprehension or understanding'. In short-term therapy, intuition, while appearing as 'immediate knowing' and consequently in its unprocessed form potentially unhelpful, serves to direct attention to areas that may not be logical but may have idiomatic significance. The dynamic short-term therapist requires an intuitive sense of 'where to look, what to look at and how to look at it' (Bollas 1992 pp. 89–93). Bollas views intuition as form of desire on the part of the clinician which, when successful, allows the clinician to explore 'lines of investigation that would meet with incredulous disapproval' if subjected to the laws of evidence or logic. It follows that intuition cannot be taught, but results from respecting the vagaries of transference, and most especially counter-transference, as manifested in sessions and brought to supervision. Without some sense of intuitive response, the time-limited idiomatic therapist is left not knowing 'where and how to look'. Ideas, feelings and hunches need to be used to gauge their idiomatic and focal significance. Clients can always disagree if our intuition is wrong, but it is surprising how often an initial intuitive response leads to something of significance.

The reflective practitioner

The concept of the reflective practitioner implies that the skilled therapist will make use of therapeutic intuition. Using counter-transference and supervision can assist in intuitive responses to the client's material that can form tentative hypotheses, which can then be tested out. The therapist has the freedom to get it wrong

and models a form of speculative intelligence to the client. In this way the essential foundations for practice and supervision (thinking, feeling and intuition) can be combined. Psychological intuition, defined as 'the ability to process evidence before it has properly manifested itself in the session . . . that second sight that therapists must innately possess' (Bramley 1996b), differs from empathy. The therapist must learn to maintain some emotional distance from the client, and not to be overwhelmed or identified by the client's pain, in order to be able to allow intuition to play its part.

It follows from this that experienced clinicians are likely to be able to make more direct use of their intuitive responses to their clients than are practitioners starting out on their short-term therapy careers. Perhaps the last word on the subject of the relationship between technique and intuition should be left to Winnicott (1971, p. 6):

It cannot be avoided that changes . . . [in] my work do occur in the course of time and on account of experience. One could compare my position with that of a cellist who first slogs away at *technique* and then actually becomes able to play *music*, taking technique for granted. I am aware of doing this work more easily and with more success than I was able to do it thirty years ago . . . and my wish is to communicate with those who are still slogging away at technique, at the same time giving them the hope that will one day come from playing music.

Intuition can be a valuable tool for the time-limited therapist when it is harnessed to the central beliefs which underpin focal treatments; developmental theory derived from psychoanalytic observation, and the concept of lifespan development. These are brought to bear on every clinical encounter. They provide a means of understanding complex problems in a non-pathologising manner and enable difficulties to be viewed as developmental challenges rather than enduring personality characteristics which have their origins in childhood. It follows from this that problems which may have their origin in the past and are maintained in the present are able to be addressed in a wide variety of therapeutic contexts.

We now address the clinical implications of using a short-term dynamic model in various clinical settings.

Summary

In this chapter we have discussed:

- The stressful nature of time-limited therapy. Short-term therapy is stressful for a number of reasons, not least the large number of people that time-limited therapists are asked to treat. The need to maintain therapeutic activity and focus adds to the pressure of practising short-term therapy.
- The central importance of training in time-limited therapy. Training needs to accept that short-term therapy is not merely a concentrated version of psychoanalysis or dynamic psychotherapy but, despite drawing on psychodynamic theory, has its own methodology and clinical application. We have looked at the debate between those that believe that short-term therapy can only be practised after some experience of open-ended therapy and those that contend that the ambivalence and resistance likely to be apparent after a training in long-term therapy leads to rigidity and hampers training in shorter-term, more focal, therapies.
- Models of the supervisory relationship, and how they differ in short-term work. The supervision of focal work mirrors the process of short-term dynamic therapy and poses its own discipline on supervisor and supervisee.
- The place of intuition and various forms of knowledge (declarative and procedural) involved in the training of the reflective short-term practitioner.

TIME-LIMITED THERAPY IN DIFFERENT CONTEXTS

It is the contention of this book that short-term focal therapy is applicable to a wide range of clinical settings. Furthermore, that the insights and clinical skills of psychoanalysis and psychodynamic psychotherapy can be applied to briefer therapies. Open-ended dynamic psychotherapy is a costly undertaking and inappropriate for many clients. Therapists working in public and institutional or corporate sectors are increasingly recognising the need and potential benefits of working within a more limited time frame. A useful distinction can be made between settings where topping-up or intermittent-mode short-term interventions are appropriate and those more suited to a strict adherence to a circumscribed time limit. Closed institutions (for example, educational organisations), where people are likely to be part of the organisation for some time and experience a number of developmental transitions during the course of their membership, may lend themselves to an intermittent model, while others (for example, general practice or bereavement counselling settings) may benefit from a more circumscribed time limit.

Primary care

General practitioners, recognising the high levels of psychological and emotional problems with which their patients are presenting, are increasingly using counselling skills or employing counsellors to respond to these patients. The Balints' pioneering work in this area (Balint, M. 1955, 1964; Balint, E. 1973) has

enabled many to recognise what can be achieved with minimal interventions and has shown how optimum use can be made of the doctor–patient relationship. The Balints assisted the recognition that it was not necessarily the doctor’s prescription that was helpful, but the clinical relationship offered by the doctor himself. More recent work (Burton 1998; Wiener and Sher 1998) has also helped define the nature of the therapeutic interventions which are applicable to primary care settings. Close collaboration between the doctor and the therapist underpins all therapeutic work in these settings. This is not without problems, and issues such as confidentiality, competition and the split transferences to GP and therapist need careful attention and management. Patients tend to have long-term transferences to their GP or health centre practice, which, in a paradoxical fashion, facilitate the fleeting transferences required for short-term therapy. The specific difficulties, often in evidence in these settings, which surround those clients who are recommended or sent for therapy or counselling are particularly amenable to the approaches described in this book, which place a premium on the active engagement with ambivalence and resistance. It is in this area that one is likely to locate, and work with, the client’s specific idiom.

Counselling in business and industrial contexts

Similar considerations apply to the burgeoning field of employee assistance programmes (EAPs). As we have seen (Chapter 9), many of these bear little resemblance to dynamic therapeutic treatments. The therapeutic model is frequently dictated by the employer, and a debate exists as to whether or not they are merely aimed at patching people up to return to the workforce, helping people feel better about losing their jobs or an excuse for poor management. While issues of boundaries, contracts and confidentiality need particularly close attention, much creative short-term work can be achieved in this setting (Mander 2000).

Forms of crisis intervention and the treatment of post-traumatic stress disorder, while perhaps more in the nature of debriefing than therapeutic process-led counselling, have always lent themselves to the discipline of a more focused approach (Bisbey and Bisbey 1998).

Education

Similarly, adolescents, young adults and those in education are likely to benefit from short-term active interventions which stress the necessity of being aware of the developmental context of psychotherapy with these client groups (Coren 1997, 1998). Identity formation, the task of separation, and areas of sexuality and competition are crucial developmental obstacles at this stage of life and are influential in personality formation. Intervention at this time offers the possibility of a much more profound outcome over and above the number of sessions offered. In education, short-term therapy captures the developmental fluidity of the process of being a student and parallels the student's experience of learning. This is also true for young adults. Many young people, at a time in their lives when they need to go out and actively master the world are – unless open-ended therapy is specifically indicated – unlikely to be helped by a regressive relationship in long-term therapy. Ambivalent about intimacy, adolescents (traditionally difficult to engage in all forms of psychotherapy) and young adults are likely to experience the third-party, oblique role of the therapist in focal therapy as more helpful. Similarly, the developmental process is helpful in working, using a short-term model, with children where brief interventions can remove developmental obstacles. With all these groups short-term therapy, because of the importance of developmental progression, is unlikely to be merely superficial, but able to influence the course of development in a more substantive fashion.

Bereavement and the elderly

At the other end of the lifespan, short-term work with the elderly is also becoming more recognised, and models appropriate to this population are being articulated (Hildebrandt 1995; Terry 1997; Gorsuch 1998). Recognising that there are special issues, both symbolic and real, in relation to loss, and that limited time has a special meaning for older clients, the idea of a therapeutic time frame has a powerful impact in work with older people. Mortality, loss, the absence of meaning and the creation of a new, or modified, narrative all provide foci for the elderly client. Time is literally running out, so

the time limit in psychotherapy is a vehicle for the work that must be done . . . therapy becomes a microcosm, a symbolic space in which certain experiences are made possible and certain affects can be borne . . . the time limit represents the therapist's faith that something of value can happen within the frame, *within this moment* . . . (Messer and Warren, p. 319)

Affirmation and mirroring may be of particular importance to the elderly client, thus lending weight to short-term approaches which adopt a self-psychological framework (Lazarus 1988). Similarly, bereavement lends itself to a short-term approach, particularly to phase-oriented treatment models with specific goals and tasks for each stage which run parallel with the different aspects of a grief reaction. However, as we noted with Tina in Chapter 3, particular attention needs to be paid to the client's idiom when considering phase-linked treatment models. There is increasing evidence that when working with the medically or terminally ill and HIV-positive clients a time-flexible, focused approach is helpful (Guthrie 1993; Levenson and Hales 1993; Levenson 1995; Pollin and Kanaan 1995; Eimer and Freeman 1998, pp. 222–31). An increasing literature is appearing on the use of short-term therapy in community mental health provision (Brech and Agulnick 1996, 1998) and adult psychiatry (Macdonald 1997) which highlights the importance of client assessment and therapist training in the practice of short-term therapies.

The conversational model of therapy in mental health settings

Hobson's (1982) conversational model of therapy, which places emphasis on the nature of the therapeutic relationship, or the way attempts at forming that relationship are negotiated, has provided the framework for working within a time limit with clients with severe and chronic difficulties who have had considerable experience of unsuccessful previous treatments (Guthrie *et al.* 1998). Believing that engagement tends to be taken for granted in many therapies, this model of interpersonal short-term therapy places the issue of trust at the centre of working with very damaged people. The relationship is entered into with a particular focus on

issues of intimacy and trust and, using the model of conversational therapy, attempts to understand how a conversation is developed rather than the content of what is discussed. With these very damaged and suspicious clients, being able to hold a conversation at all, be it verbal or emotional (or even of regular attendance), is a major therapeutic advance.

Short-term therapy may also be more acceptable to ethnic, social or cultural minorities than more traditional, open-ended, psychodynamically informed interventions. Western philosophical and cultural tradition, which emphasises forms of introspection, including the capacity to reflect, may well be alien to those from other cultures and backgrounds, making open-ended, longer-term reflective psychotherapy less amenable or appropriate to these clinical populations (Coren 1997, ch. 5).

Therapeutic activity, focus, careful selection and assessment, together with the client's idiom and relational past and present, form the fundamental beliefs of short-term focal therapy. These beliefs are to some extent irrespective of the setting or context in which the therapy occurs. A general rule of thumb would be that the shorter the therapy the more the therapeutic variables need to be kept to a minimum. Changes of room during therapy, a less than secure framework and therapeutic boundary, the distinction (and referral) between the assessor and the clinician who will carry out the therapy, and an ambivalent therapist or clinical setting, are likely to add to the variables that may make treatments less brief. In addition, in contrast to the open-ended psychodynamic tradition, the short-term therapist needs to explain the treatment to the client to avoid false expectations and to ensure that the client shares responsibility for the therapy.

Organisational aspects of time limited therapy

Institutional factors are also likely to play a part in the satisfactory practice of short-term therapy (Towler 1997). The context, history, assumptions and societal meaning of the institution from which the therapy is practised will all impact on the therapeutic process. Professional and administrative staff in the agency should be committed to short-term therapy. The implementation of a time-limited policy on a therapeutic service which has not

offered this in the past is likely to provoke administrative and professional ambivalence. Anxiety about change will coexist with a hopeful anticipation for service development and individual therapist growth. Institutions which adopt a short-term approach as a result of fiscal restraints or administrative diktats are likely to need to ensure that the feelings and issues which are evoked by having to work in this fashion are not enacted in the treatment or between individuals in the team. Equally, services which operate brief therapy under these conditions are more likely to adopt an 'us-and-them' approach – the tendency to project hostile or negative feelings onto administrators or budget holders, which can have the effect of a halfhearted or ambivalent approach to short-term clinical work. This is frequently evidenced by claims that administrators do not recognise how disturbed or needy the service's population is, so that as a result they are cruelly preventing these clients getting the longer-term or open-ended treatment which they need. The result is a grudging and reluctant implementation of a short-term framework by therapists, who are at best ambivalent about working briefly and often have little specific training in more short-term approaches. In these situations the unconscious (or subconscious) wish that the short-term treatment should fail, proving the clinician's initial doubts correct, is generally in evidence.

Clinical examples

Henrietta and Dinah are examples of clients from general practice and education; they show how a short-term framework can apply to diverse clinical settings.

Henrietta

Henrietta was a 50-year-old married woman who, depressed and 'trapped' in a loveless marriage, was referred by her general practitioner for counselling to 'find out why I have put up with the situation for so long and what to do about it'.

Henrietta was increasingly desperate about her 28-year-old marriage. Overweight, suffering from high blood pressure and chest pains, and prone to bouts of hyperventilation, she had suffered from poor physical and mental health for some time. She had a number of admissions to psychiatric hospitals, when her concern about being able to

cope with her four children as well as looking after her own elderly and sickly mother and brother had precipitated severe depressions leading to suicidal thoughts and behaviour.

Henrietta's husband, described by her as solitary and anti-social, was not one to discuss problems. He did not appear to acknowledge any problem, although Henrietta subsequently acknowledged that she did not confide in him, 'since I know he will ignore me'. He was very close to his elderly mother and there appeared to be some competition between Henrietta and her mother-in-law over who was better able to 'mother' him. She was at the point of applying for teacher training, now that her own children were older, and her main source of concern was that her husband would not agree to this step towards independence and would consequently refuse to help finance her studies. This was a reflection of her perception of the lack of concern that he showed towards her.

Henrietta came from a small, tightly knit rural community 'where people stay married'. Her father became disabled as a result of a farming accident when Henrietta was aged 12 and died after a slow and degenerative illness when she was 15. She had helped nurse her increasingly irritable and volatile father and 'knew what it is like to be in a one-parent family'. Her mother had struggled after the death of her father and would not hear of Henrietta's thoughts about leaving her husband.

This all poured out disinhibitedly in the assessment session. It was not too difficult to ascertain why Henrietta 'had put up with the situation for so long'. Her own background and experience as a member of a one-parent family ensured that separation or divorce was not seen as a realistic option. Using the therapeutic triangle and Henrietta's idiom of being trapped in a situation which was beyond her control, doubting whether men would want to (or could) care for her, and her need to mother others (reflected in the assessment session by anxious enquiries as to the therapist's robustness in relation to Henrietta's anxious and breathless presentation), a formulation was made along the following lines.

Henrietta did not want to leave her husband. This was partly a result of her experience in her family of origin but also because she did actually care for him. How else could one understand the extent of her anger at his seeming lack of affection or attention? In the absence of any evidence she was, however, unsure of whether he cared for her, although it was pointed out that it was difficult to know what evidence Henrietta would require, as she did not want to speak with him, 'knowing' what his response would be. Her experience of looking after her ailing father with her mother was currently replicated

by the competition between Henrietta and her mother-in-law in mothering her husband. It was very important for Henrietta to be able to give and mother others, as evidenced in the therapeutic process; Henrietta would begin and end every session enquiring as to the therapist's welfare. This limited the ability of the therapist to 'nurture' Henrietta. It also reflected Henrietta's ambivalent response to allowing her husband to show any nurturing qualities towards her – witness Henrietta's refusal to talk to him about her problems or resentments.

These issues formed the focus of the six sessions. They incorporated the present complaint, the historical antecedents and the here-and-now process. The central organising metaphor for the treatment was the issue of offering and accepting nurture. What evidence would one need to know that someone cared? Central to this was whether Henrietta's husband would accept her wish to train as a teacher and contribute to her course fees. Since Henrietta remained determined not to approach her husband with her grievances, wanting to silently nurture them as it appeared she had done with her dying father, this issue had to be approached in a roundabout way. Henrietta mentioned that her eldest daughter was both aware and concerned at the lack of communication between her parents but had been sworn to secrecy by Henrietta. Eventually Henrietta acknowledged that this might not be helpful for all concerned, not least her daughter, and gave the girl permission to talk to her father about how she felt about life at home. In the penultimate session Henrietta revealed that, without discussing it with her, her husband had signed a cheque for her first year's course fees. This was some evidence of his affection and suggested that Henrietta's reluctance to speak to him was a reflection of her own ambivalence about her own independence. This could be seen as a reflection of Henrietta's uneasy identification with her mother, whose independence was compromised by devoting all her life to her husband and family.

This intervention cannot be said to have cured Henrietta's vulnerability to depression or her problematic marriage. It did however give her a framework for understanding her difficulties, through narrative and metaphor, made sense out of her previously random and irrational feelings, and helped her to discover ways of recognising and dealing with situations where her self-esteem was under threat. It also enabled her, without confrontation, to see the ways in which, because of her own unresolved issues, she was instrumental in contributing to situations which she experienced both as painful and as originating from outside herself. In this way she was able to regain some control over her life.

Dinah

Dinah was a 26-year-old graduate student training to be a teacher. She reluctantly came to see a counsellor, having acknowledged a similar behavioural pattern repeating itself. She would embark on projects but then convince herself that she was not up to them and find ways of 'sabotaging' herself. On this occasion she was tempted to 'run away' from the course and 'throw everything up'. In these opening statements we already can see how a personal idiom was being articulated; it was highly likely that attempts would be made to 'sabotage' the project of counselling, possibly via an attempt to 'throw everything up' on the grounds of not being able to metabolise the counselling experience. It would be important for the therapeutic framework to incorporate and use this idiom.

Dinah's family background and idiom of being mothered confirmed this view. She came from a farming family where mystery surrounded her mother, who was not available to her as a small child. Dinah believed that her mother was in hospital during this period, 'suffering from a form of epilepsy', but this was never spoken about either at the time or subsequently. Her parents separated when Dinah was aged six and her father, with whom she lived, remarried soon after. This liaison brought two other children into the family, which Dinah found difficult, since 'I was Daddy's little girl.' Sharing became difficult for her and it was through her undoubted – if personally brittle – academic success that she learnt that she did not have to share. She hated boarding school, having been 'sent' there aged 11 and by her account spent most of her time there in tears (as she did in the opening session). On reflection, though, Dinah speculated whether it wasn't home rather than school which had been 'so awful'. Dinah's mother now worked locally and they saw each other frequently – 'She seems fine now but at times gets very hyper.' Dinah said that nothing of any importance from the past – or present – was ever discussed in these meetings.

Dinah was offered five sessions focussing on her tearful wish to run away from things that she might succeed at or enjoy. Within a personal idiom of 'sabotage' and lack of ability to complete projects (although they were generally completed, it did not lead to a personal feeling of 'completeness') we can see how, using Dinah's own phrases and language, the therapeutic triangle could be addressed simultaneously. The experience of teaching had touched on her own childhood experiences and was forcing Dinah to review her assumptions, or narrative, about her past. An idiom of parenting and being parented (alive in the counselling relationship), her functioning *in loco parentis* in relation to the small children in her class, and her experience in her family of

origin, all contributed to her need to 'sabotage' herself. There were two parts of her: the 'on paper' confident and successful woman and the 'sabotaging' little girl. Who were these two and where did they come from? How did the person who was confident and excited about new projects turn into the one who sabotaged things and wanted to run away? Could they be related to aspects of the therapeutic triangle?

Dinah was a thoughtful and introspective person who studied diligently at school with considerable success. She worried that she could not teach since she was preoccupied with the 'naughty children' whom she felt she had nothing to offer, although they held a strange fascination for her. For Dinah it was as though being naughty was very brave. Dinah identified with these 'naughty' children, since she wished as a child that she had been able to 'rebel and be heard'. No one had noticed her distress but perhaps, despite the solitary tears, Dinah had not been 'brave enough' to acknowledge her misery to others. She did not like sharing 'things' with others, since 'it just makes me angry'. Personal confidences to others merely underlined the fact that her mother was absent, mirroring her reconstituted family of origin. A maternal presence had not been available, and contributed to Dinah's doubting whether she was able to succeed or see things through. Her father's praise was suspect, since he needed to 'make up for the fact that my mother was not there'. Indeed, his praise just made her weep – angry tears – since it reinforced the continued absence of her mother, the one person whom she felt could confirm her worth. Dinah speculated that she might be like her mother; she too could get very excited about a project, but all that dissipated when the project needed to be worked at and completed. Dinah did not have confidence in herself to see it through. Amid this was considerable anger – how could she expect to feel confident and good about oneself when her mother was 'mysteriously' absent?

Dinah completed her course of study not without a great deal of soul-searching. She also completed her short-term therapy, which had faced her with the temptation to 'throw it all up'. Her yearning for some form of maternal approbation, defended against because it seemed disloyal to her father who had brought her up, led her to entertain the thought of talking to her mother about both the past and the 'sabotaging' present. In short, this narrative of a missing attachment and its sequel provided Dinah with hope for the future and a framework within which she could begin to think – and feel – differently about herself.

Much psychoanalytic theory was generated from private practice. This needs to be modified in order to be applied to diverse con-

temporary institutional settings. Since institutional structures and organisational goals are apparent in consulting rooms, they need to be both worked with and addressed by time-limited dynamic therapists. Time-limited therapy practised from an institutional base, or paid for by a company, implies that there is always a third presence in the room. The challenge for short-term therapy is to harness this third presence to facilitate creative therapeutic change.

Summary

In this chapter we have discussed:

- The varied clinical and institutional contexts in which short-term therapy is practised. These include:
 - Primary care
 - Mental health services.
 - Business and industry, employee assistance programmes.
 - Education.
 - Therapeutic work with the elderly and the bereaved
- The influence of the employing institution on the practice of short-term therapy.

CONCLUDING REMARKS

Joan (pages 1–2)

In thinking about Joan's difficulties and how to respond therapeutically to them I would be alert to her particular idiom and the triangle of presenting problem/current life situation, transference/therapeutic process, and personal history. I would be aware of the idiomatic significance of an almost cowed and frustrated attitude to her own development and self-determination as it was represented in her history, the reason she sought help, and her presentation to the therapist. This led Joan to an impotent feeling of being trapped.

In terms of her past, Joan had lived in the shadow first of her siblings and then lately of her husband. Her own frustrated development as a child was being replicated both in the marriage and in the difficulty she was having to negotiate – or be in the middle – of threesomes; between her parents and siblings as a child and currently between her family and husband. A complementary theme can be seen in Joan's having to choose between her husband's and children's views in seeking therapy. Her over-solicitous attitude to her children, and their independent welfare, could be seen as the repetition and reversal of a childhood frustration – the barriers which she experienced her parents placing on her individual development. In wanting to be different from her mother, was she in danger of becoming the same – by her fretful attitude to her children was she hampering their autonomy? It was not without interest that Joan's mother, like her daughter, was an artist, and perhaps the link between maternal emotional expression and cruelty would be significant. Joan's failed attempts to cheer her mother up were alive in the present; she had married a man with whom she was attempting to fulfil a similar task. Her husband, in his benign emotional distance and denigration of therapy, could be seen to share some traits with her father, while Joan's seeking help had, as we have seen, placed her in a position similar to the one she experienced in her family – of having to be in the middle, or being presented with conflicting choices.

In her present life, and as it appeared in her past and the immediate transference, Joan felt trapped. Coming to therapy was experienced as betraying her husband (much as she had betrayed her family of origin by marrying her husband) and led to feelings of having failed as a mother. These in turn led to her remembering incidents of her own mother's shortcomings. By enquiring about the therapist's qualifications, was she needing reassurance that her children's views were correct in that she should seek help, or was she sharing her husband's scepticism? Equally, was she saying something about her original choice of her husband's qualifications to be her partner? Had her family been right after all – after all these years of marriage had her husband not been the right one? What lay behind the issue of people being qualified, anyway?

We can also see the beginning of an important counter-transference. The triangular constellation of Joan, therapist and GP meant not only were there three people in the room in the here-and-now, but also that what was being recreated was a replication of earlier triangles in Joan's life where threesomes needed to be negotiated. This returns us to Joan's presenting problem, and the one that she had had to address throughout her life. On the basis of this formulation Joan could be offered a time-limited contract which took threesomes and the demands of others as its focus.

Trevor (pages 2–3)

Trevor's idiom was one of withdrawal and suspicion of his active agency. For Trevor, not being noticed, having no opinions was preferable to risking being spontaneous or active. We could see how his history, particularly parental separation, could have led him to be passively and anxiously identified with his son, which defensively manifested itself as indifference. To be active or spontaneous in the present would risk his marriage, as it had the parental marriage; far better to withdraw into software where one could feel safe. The result was an uneasy compromise: family life was safe but dull. Trevor's suspicion of others, and the world of emotions, could be linked with memories of his relaxed and emotional mother (which masked a significant depression) and his emotionally withdrawn father. His yearning for the safety of the life prior to the parental separation led him to withdraw into the world of objects, which were more under his control than people – who could suddenly, without warning, separate and cause such turmoil. Despite, or perhaps because, of his indifference, Trevor appeared sad and lost in relation to his present and past families as well as in the encounter with the therapist. He had never got round to living and had no sense of active mastery; this was also in

evidence in the triangle of his family of origin, his current family and the session. His passivity ensured that no one actually cared what he did, which fuelled his belief that others were not interested in him. The process in the session added to this impression – here was a man appearing not interested in therapy but wanting via technology to escape contact with the therapist in a fashion similar to past attempts to escape from the world of relationships, which were experienced as too painful or uncertain. He had however turned up for the session of his own volition; was he perhaps more ambivalent about receiving help than his resistant manner implied?

In Trevor's case more sessions might be required given his suspicion of, and lack of trust in, the value of relationships. What would need to be addressed initially was the lack of motivation – his idiom of passivity – as it manifested itself in the therapy. The sad and lost little boy behind the indifference needed to be spoken to, understood and acknowledged. Trevor's therapy – like his life – needed meaning and direction. By focusing on, and where appropriate challenging, Trevor's passivity and withdrawal and what it represented, a time-limited intervention could address the central conflicts in Trevor's past and present life via the microcosm of the therapeutic process.

We can see that for both Trevor and Joan a dynamic formulation could be made which incorporates the past, the present – including the reason for seeking help – and the here-and-now process, or transference. These factors, combined with Joan and Trevor's personal idioms, could be linked to understand their difficulties and to identify a therapeutic focus which the therapist can share and discuss with them; dynamic focal therapy is nothing if not collaborative. This, then, becomes central to a – time limited – conversation.

Psychoanalysis began as a short-term therapy. We have seen how dynamic therapies gradually became longer and open-ended. Describing the various time-aware contemporary therapies has enabled us to highlight the common features of each. From this a model of short-term psychodynamic therapy has been articulated and its application discussed. The challenges this poses to counsellors and therapists trained in open-ended therapies have been addressed. Attention has been drawn to specific difficulties associated with short-term therapies in contemporary society, with the premium society places on the quick fix.

Rather than promising miracle cures in unrealistically few

sessions, time-limited dynamic therapies need to articulate models of treatment which are applicable to a large number of people in various different settings. Central to this is the ability to differentiate those that can be helped by short-term focal interventions from those who cannot. I hope this book has contributed to this process. For many years, to stand any chance of success, psychodynamic psychotherapy was viewed as a long-term undertaking. Short-term therapy was seen as essentially short and superficial. As short-term psychotherapy has become more acceptable, these views are being challenged, and briefer approaches are being seen as treatments in their own right, rather than as modifications or diluted versions of the real thing. Time-aware short-term treatments can be the treatments of choice for many psychological problems. While some people may wish to enter into open-ended, time-unlimited therapies, many do not. Despite being the preference of many therapists trained in open-ended models, long-term therapy is more costly, requires a great investment of time, and has not been demonstrated to be superior in outcome to shorter forms of therapy. Time-limited therapy proposes that people continue to grow throughout their lives and that limited interventions can assist this development. Its focus is on the obstacles to development rather than disease or deficits. In this way it can assist even those deemed to be severely damaged. However, it remains the case that not everyone can be helped by focal interventions. What is required is a plurality of provision based on the thorough assessment of an individual's needs.

For psychodynamic therapists, the difficulty has been how to preserve that which is unique and of value in psychoanalytic theory and clinical practice. What makes the therapeutic conversations described in this book psychodynamic? I would contend that the central paradigm of time-limited therapy is the use and understanding of the therapeutic relationship. The awareness of unconscious processes in the transference and countertransference and how these can be identified and utilised in the use of symbols, metaphors and personal idioms within the treatment relationship, together with knowledge of developmental theory, all make these brief encounters possible and productive. Many time-aware therapies are focusing increasingly on the therapeutic alliance and relationship. Psychodynamic short-term therapies place importance on the here-and-now therapeutic

process, as this is evidenced in the consulting room and how it is understood in relation to the client's past and present experiences. This might not be psychoanalysis but it is psychoanalytic. The debate is not about whether short-term dynamic therapy is better or worse than longer-term psychotherapy, but about the difference between these two models.

People in distress lose track of who they are and wish to be. At best, time-aware conversations, offering alternative scripts and constructions of the client's problems, can help both therapist and client unravel the mystery of how the problem has originated and is currently maintained. It offers an active relationship with the therapist, the discovery of a shared narrative and a way of overcoming problems (Holmes 1993).

There are dangers, however. Since time-limited therapies appear to sit comfortably with contemporary market forces, are they in danger of losing that which is distinctively therapeutic and libertarian? Or are they the best form of commodity currently on the therapeutic market? Does focal, time-limited therapy comply with our culture, or is it the best product of our culture since, in contemporary life, time is both limited and valuable? In a curious way this returns to the fundamental rule of psychoanalysis: free association. Does it inevitably lead to therapeutic drift? Is it the means or the obstacle to cure? For psychodynamic therapists the jury is still out, yet time-limited dynamic therapy offers the profession a means of creatively harnessing the profound insights of psychoanalysis with the contemporary demand for empirically driven treatments. In this it may realise Freud's wish that psychoanalytically informed therapy can become a therapy for the people.

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