Handbook of Short-term Psychotherapy

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Brief treatment is no newcomer on the psychotherapeutic scene. Chronicled in primitive archives of earliest recorded history, particularly in Egypt and Greece, are accounts of what we may consider species of short-term psychotherapy. In these ancient documents there are transcribed elaborate rituals to heal the afflicted, to solace troubled souls, and to assuage anguish and distress. Among such interventions are tranquilizing nostrums, bodily manipulations, trance incantations, persuasive suggestions, and even rudiments of reinforcement therapy, emotional catharsis, and interpretation of fantasies and dreams. Elaborations of these therapies continue to this day draped in the sophistication of modern theories. Up to the beginning of the twentieth century methods of treatment were short term; even the original Freudian techniques were implemented over a period of a few months. Gradually psychoanalytic methods stretched out in time, and the number of weekly sessions increased as efforts were directed at the task of resolving resistance to unconscious conflict. A few contemporaries of Freud, notably Adler, Ferenczi, Stekel, and Rank, tried heroically to shorten the protracted time of psychoanalysis, but their methods were repudiated by the official analytic establishment. Some Rankian and Stekelian stratagems survived, nevertheless, and have been adapted to fit in with present-day styles and contemporary ideologies.

Psychoanalytic Modifications in Brief Dynamic Therapy

It was Franz Alexander in 1946 who most strikingly challenged the validity of prolonged time as a necessary component of treatment methods directed at reconstructive goals. Reaction to Alexander's unorthodoxy was at first harsh, and although he was accused of abandoning the psychoanalytic ship, it is to his credit that he resisted recanting his convictions. Along with French he published a pioneer work on brief therapy (Alexander & French, 1946) that questioned many of the assumptions of long-term classical psychoanalysis.

In their volume the authors describe experimenting with varying the frequency of interviews, the alternative use of the chair and couch, deliberate interruptions of treatment prior to termination,

strategic playing of studied roles, and combined use of psychotherapy with drug and other treatments. At the time their experiments were considered as daring and innovative. Particularly regarded as aberrant were the emphasis on problem solving and the consideration of therapy as a corrective emotional experience that functioned to break up old reaction patterns. "In some cases," they wrote, "the development of a full- fledged transference neurosis may be desirable; in others it should perhaps be avoided altogether. In some it is imperative that emotional discharge and insight take place gradually; in others, with patients whose ego strength is greater, interviews with great emotional tension may be not only harmless but highly desirable. All this depends upon the needs of the patient in a particular phase of the therapeutic procedure." The modifications suggested were forms of psychoanalysis based on dynamic principles that attempt to secure a more harmonious environmental adjustment with enhanced development of one's capacities.

Frequent interviews over a long-term period, they insisted, had a regressive consequence often gratifying the patient's dependency needs. "The initial soothing effect of the prolonged outlook gradually becomes corruptive, and the therapist, faced with the task of driving the patient from his comfortable infantile position, realizes anew how difficult it is to force anyone to give up acquired rights." It was a fallacy, they contended, to assume that an analysis oriented around regressive material was more thorough than one focused on the immediate life conflict. Indeed, regressive material was usually a sign of neurotic withdrawal from a difficult life situation. It was the duty of the therapist to pert this retreat toward new attempts to solve problems from which the patient had fled in the past. Another disadvantage of too frequent sessions was that transference was not allowed to accumulate, being drained off in small quantities at each session, thus lessening the emotional participation. They advised manipulation of the frequency of sessions to intensify emotional reactions. A focus on the present helped reduce the evolvement of a transference neuroses and the substitution of transference gratifications for real-life experiences. Putting into practice what had been learned in therapy encouraged the bolstering of self-confidence and the overcoming of neurotic impairment. The patient during the course of his experimenting with new patterns was to be forewarned of failures and the need to analyze the reasons for these should they occur, thus turning them to advantage.

With the development of community mental health facilities and the servicing of increasing groups of patients by staffs depleted through shrinking budgets, the necessity of limiting time devoted to

treatment without destroying its effectiveness has rekindled interest in the observations of Alexander and French. Moreover, restriction of payments to a designated number of sessions by insurance companies has forced even those therapists who by training and conviction are dedicated to long-term therapy to modify their tactics and to bring treatment to a halt within the confines of the allotted reimbursement term. Economics has thus had a corrosive effect on ideology, which is probably all to the good in a field where bias and opinion have frozen professionals to postulates that could never have been otherwise thawed out and revised.

The work of Alexander and French provided the foundation for other developing systems of dynamic short-term therapy and inspired a number of analysts who though loyal to the teachings of Freud refused to consider them as pine revelations (Marmor, 1979). While challenging classical analytic concepts, they vouchsafed the validity of the dynamic design. Among the best known of contemporary contributions to dynamic short-term therapy are the writings of Malan, Sifneos, and Mann.

In the study by Malan (1963) at the Tavistock Clinic in London, the patients treated were those who were able to explore their feelings and who gave the impression they could work with interpretive therapy. All of the therapists involved were psychoanalytically oriented and willing to employ an active interpretive technique. Sessions totaled from 10 to 40. It was possible, Malan wrote, under these conditions "to obtain quite far- reaching improvements not merely in symptoms, but also in neurotic behavior patterns in patients with relatively extensive and long standing neuroses." The best results were achieved when (1) the patient was highly motivated, (2) the therapist demonstrated high enthusiasm, (3) transference developed early, especially negative transference, and was interpreted, and (4) grief and anger became important issues as termination approached. The prognosis was also best where the patient and therapist showed a strong willingness to get involved—the former with an intense desire for help through understanding, the latter with sympathy while interacting objectively and not with countertransference. Even deep-seated neurotic behavior patterns could be lastingly changed. The technique if properly used carried few dangers, even where penetrating interpretations were made from dreams, fantasies, and the therapist-parent link of the transference that connected the present with childhood experiences. Malan modestly suggested that a crucial ingredient in change might not be the technique employed, but the nonspecific factor of the analyst applying himself enthusiastically to his technique irrespective of whether it was analytic or non-analytic.

In a later study published in his book *Frontier of Brief Psychotherapy*, Malan (1976) confirmed his previous conclusions regarding the utility of dynamic short-term therapy and described some principles of selection of suitable patients for this form of treatment. In Malan's sample the patients were carefully screened. Chosen were those who appeared "to have the basic strength to stand up to uncovering psychotherapy," "who were responsive to interpretation," and who could help formulate a circumscribed focus around which therapy could be done. Severity of pathology or chronicity were not considered. Of all factors in prognosis, motivation for insight and the ability to focus on significant material seemed to be of primary importance. These were considered to be measures of successful interactions between patient and therapist. Patients who were excluded were alcoholics, homosexuals, drug addicts, those who had at one time made serious suicidal attempts, who had a period of long-term hospitalization, who had more than one course of ECT, who suffered from incapacitating chronic obsessional or phobic symptoms, and who were grossly destructive or self-destructive in acting-out. As was predicted, reasons for rejection were that the patient would have difficulty in making contact, that a great deal of work would be needed to develop proper motivation for therapy, that rigid and deep-seated issues required more work than the limited time could allow, that severe dependence and other unfavorable intense transference feelings would be too obstructive, or that depressive or psychotic disturbances might be precipitated or intensified.

Sifneos (1972), confirming many of Malan's findings, adds some other criteria of selection for this form of dynamic "anxiety-provoking" therapy that lasts from 2 to 12 months. Suitable patients are those who possess five qualities: (1) existence of above-average intelligence, (2) possession of at least one meaningful relationship in the past, (3) ability to interact with the initial interviewer while manifesting appropriate emotions and a degree of flexibility, (4) ability to identify a specific chief complaint, (5) willingness to understand oneself, to work on oneself, to recognize one's symptoms as psychological, to be honest in revealing things about oneself, to participate actively in therapy, and to make reasonable sacrifices (Sifneos, 1978).

For patients who are selected, sessions are held once weekly for 45 minutes in face-to-face interviews. The initial interview deals with history taking, particularly "a judicious confrontation by open-ended and forced-choice type of questions." As areas of conflict and maladaptive reactions open up, the therapist asks questions that will give him a clearer picture of the psychodynamics. He may then be

able to make a connection between the underlying conflicts and the superficial complaints. Before long, transference feelings are apt to emerge. “The therapist must then confront the patient with his transference feelings and use them as the main psychotherapeutic tool.” This facilitates tracing of one’s emotional problems in the past and recognizing how conflicts give rise to one’s symptoms. Sooner or later resistance appears. “The whole tone of the interviews start to change,” silences appear, “the whole interview seems fragmented.” Confrontation and clarification are employed as tools, but a transference neurosis is avoided. The patient must be confronted with his anger and his negative feelings, and these may flair up with the therapist’s anxiety- provoking questions. Interpretations help clarify the patient’s reactions. Awareness of his own countertransference is vital, and the therapist must make sure he is not using the patient to gratify his own needs. Repeatedly demonstrating how the patient deals with his conflicts and the adverse effects on him, the therapist acts as “an unemotionally involved teacher.” Tangible evidence of progress is shown by the patient’s ability to relate what is going on to past sources and by improvement in his interpersonal relationships. The therapist must work uninterruptedly toward termination, handling his countertransference and realizing that “there are certain behavior patterns which cannot be altered by psychotherapy.” At a propitious time termination must be discussed. The patient’s reactions such as anger, depression, and fear must be anticipated and handled.

The following outlines technical processes in Sifneos’s technique:

1. The patient is asked to list in order of urgency the problems that he would like to overcome.

2. It is essential to develop a rapid therapeutic alliance with patient, since the patient’s positive feelings toward therapist constitute a chief therapeutic tool. Agreement must be reached regarding the problem to be solved.

3. The therapist rapidly arrives at a tentative psychodynamics and the underlying emotional conflicts.

4. The focus in therapy is on these conflicts, the object being to help the patient learn new modes of solving difficulties.

5. The therapist must confront patient with anxiety-provoking questions, helping him to face and examine areas of difficulty rather than to avoid them, and enabling him to experience his conflicts and to consolidate new solutions for them.

6. If successful in reaching the goals set forth, the patient should be able to utilize his learning "to deal with the new critical situations in the future."

It must be remembered that the basis of Sifneos' approach was work with a clinic population of self-referred, relatively well-educated young people "who gave freely of their time and were eager to help." While these requirements are ideal, the average therapist will see a good number of less suitable patients urgently demanding symptom relief whose problems are linked to inner conflicts and who do not fulfill the selection requirements of Sifneos. They might still be considered for dynamic therapy, but anxiety-provoking tactics may have to be avoided.

Sifneos has not neglected consideration of other classes of patients not qualified for the anxiety-provoking technique but amenable to an "anxiety-suppressive" form of therapy. Such therapy is designed for patients with weak ego structures who habitually have poor interpersonal relations and are disposed to lifelong emotional difficulties. Here the goal is to dissipate anxiety by such tactics as reassurance, advice giving, emotional catharsis, environmental manipulation, persuasion, hospitalization, or medication. Where the patient has adequate motivation to receive help, recognizes that his symptoms are psychological, is able to maintain a job, and is willing to cooperate with the therapist, he has the best opportunity for relief. Sessions last from a few minutes to an hour and are spaced every week, twice a week, or oftener. Brief crisis supportive therapy lasts up to 2 months and is aimed at overcoming the emotional decompensation. Patients with serious difficulties, however, may require support for a prolonged period.

An interesting form of dynamic brief therapy has been detailed by Mann (1973). A few of the principles were originally described by Rank (1936, 1947). Stressing the subjective and objective meanings of time (e.g., separation, loss, death, etc.) both to the patient and therapist, Mann contends that ambiguity about time limitations of therapy may act as a deterrent to acceptance of reality and the work to be done. Patients, he avows, are bound to "child time," an unconscious yearning for eternity, and must be brought to the acceptance of realistic limited "adult time." He outlines a *fixed* 12 session form of treatment based on psychoanalytic concepts around which he has structured a methodology. "Experience has demonstrated that 12 treatment sessions is probably the minimal time required for a series of dynamic events to develop, flourish, and be available for discussion, examination, and resolution."

The limited interview is concerned with clarifying what the patient seeks from therapy. Two or more sessions may be required here. In the course of this inquiry "a formulation of the central conflict productive of the present manifestations of distress can be made . . . [*the therapist*] telling the patient what is wrong with him." This may or may not accord with the patient's incentive for seeking help. A delineation of other unconscious determinants is attempted by examining past sources of the central conflict. A diagnosis is made, and there is an assessment of the patient's general psychological state. There is then an estimate of how 12 hour sessions should be distributed: 12 full sessions once weekly, 24 half-hour sessions over 24 weeks, or 48 sessions of 15 minutes over 48 weeks. The therapist expresses to the patient his opinion of the patient's chief problem and what he believes should be done. He consults his calendar and announces the exact date of termination. He settles dates and times of appointments and discusses the fee. He assures the patient that if they find the chosen central issue erroneous, they will move on to another issue. The patient is then given the privilege to accept or reject the stated conditions. Assuming that the patient has sufficient ego strength to negotiate a treatment agreement and to tolerate a structured schedule, arrangements for therapy are concluded.

The interviews are conducted on as high an emotional level as possible, moving from adaptive issues to defenses to genetic origins of conflicts. This, of course, requires that the therapist be empathic and that he have a high degree of comprehension of dynamics. The choice of the central issue will vary with the therapist's understanding and experience. Since free association is impractical in short-term therapy, some other form of communication is needed. Mann recommends Felix Deutsch's "associative anamnesis" (Deutsch, 1949) as one way of working.

Even though a number of conflictual themes vary, a common one, "the recurring life crisis of separation-inpiduation is the substantive base upon which the treatment rests." Mastery of separation anxiety serves as a model for overcoming other neurotic anxieties. Among basic universal conflict situations that relate to the separation-inpiduation theme are (1) independence versus dependence, (2) activity versus passivity, (3) self-sufficiency versus inadequate self-esteem, and (4) "unresolved or delayed grief." Mastery of separation-inpiduation influences the mastery of all of the latter conflicts. During termination of therapy the patient will undergo a degree of anxiety reflective of the adequacy of his resolution of the separation-inpiduation phase of his early development. One or another of the four basic universal conflicts will be activated during the termination phase.

Mann advises not to compromise the 12-session time limit by making any promises to continue therapy after the allotted period has ended. In this way a fixed time structure is presented to the patient in which the drama of establishing a dependent relationship and of working through the crisis of separation and achievement of autonomy is repeated in a setting that permits a more satisfactory solution than the inpidual realized in his past early relationships. In other words, we are provided with two themes in therapy: the first, the central issue for which the patient seeks treatment, and the second, the more basic separation-inpiduation theme. The fact that we focus on an agreed area of investigation and that the patient possesses knowledge of imminent termination limits the extent of regression in the transference. The rapid mobilization of a positive transference in the first few sessions will bring symptom relief and an outpouring of material. Although the focus is on the central issue, the adaptive maneuvers of the patient and the genetic roots of the central issue will soon become apparent. The therapist, however, must resist the temptation to deviate from the central theme. At all times, the therapist is active in "supporting, encouraging, and educating the patient." This does not mean giving advice or guidance. About the seventh session the patient will begin to sense disappointment in therapy since he is not allowed to talk about all of the things he wants to bring up and must confine himself to the central issue. At this point negative transference will appear, and ambivalence replaces positive transference. Resistance rears its head, and symptoms may return. Despite these reactions the therapist must work toward termination. This will be difficult for both patient and therapist since the emotions of termination and separation (such as grief and anger) will be disconcerting. The patient will show many defenses against termination that will have to be handled.

Interpretation of the patient's reactions is important as the patient expresses his ambivalent feelings, the therapist enunciating the idea that the patient's responses are understandable since his expectations are not being fulfilled. Data from the patient's past will allow for a relating of the patient's reactions to early experiences with parental figures. The last three sessions at least should be devoted to dealing with the patient's feelings about termination.

As to selection of patients for this type of therapy, according to Mann, most patients are candidates except those with borderline or psychotic problems. Young people in a maturational crisis have difficulties "exquisitely related to the separation-inpiduation process." Regarding therapists who can work with this method, Mann says: "It is evident that this kind of psychotherapy requires a high degree

of skill, knowledge, and experience. Knowledge of the psychoanalytic theories of mental functioning heavily buttressed by experience in the long-term treatment of patients is the first preparation for this treatment plan."

Another system of dynamic short-term therapy is described by Lewin (1970), who, following the lead of Bergler (1949), considers symptoms a consequence of psychic masochism, which is a universal ingredient of neuroses. The need to appease guilt through suffering, he avows, can prevent progress in therapy. "Ideally, the core of the patient's masochism, his bad introject, should be exposed and replaced, along with his sadistic conscience." While this may not always be possible, the least the therapist can do is to confront the patient with his masochism. Assigning all of his problems and symptoms to self-punishment for guilt feelings in relation to parental figures provides the patient with a focus that, according to Lewin, helps shorten the therapeutic process.

Eclectic Systems

Spurred on by community need, by strictures on the number of sessions financed by third-party payments, and by dissatisfaction with the results of long-term treatment, therapists of all denominations have experimented with briefer methods and contributed writings to short-term theory and practice. Some of the techniques are a revival of the methods employed in the preanalytic and early analytic period. Some are replicas of established casework and counseling procedures. Others are more innovative, being influenced by behavior therapy, by the contemporary emphasis on ego functions, by an increasing interest in problem solving as a primary means of enhancing adaptation, as well as by a resurgent flexible eclecticism (Grayson, 1979). Accordingly, a number of models of short-term therapy have been introduced, and some of these will be cited as examples. Other excellent models undoubtedly exist, but they cannot be included because of lack of space. An example of how florid the writings have become in short-term therapy is the annotated bibliography of Wells (1976), who in reviewing the literature up to 1974 details 243 citations covering major journals in psychiatry, psychology, and social work. These articles are categorized into theoretical and review articles, inpidual adult therapy, inpidual therapy of children and adolescents, group therapy, family therapy, marital therapy, and treatment of hospitalized patients.

In 1965 Beliak and Small wrote a book (the second edition of which appeared in 1978) that differentiated emergency from brief psychotherapy. They contend that emergency treatment is a temporary approach utilized in crisis, while brief psychotherapy is a "foreshortened application of traditional psychotherapy, called into being either by the life situation of the patient or by the setting in which treatment is offered." They offer a form of brief psychotherapy that is rooted in orthodox psychoanalytic theory and directed at symptoms or maladaptations, avoiding the reconstitution of personality that may, nevertheless, come about autonomously. Brief psychotherapy may stabilize the inpidual sufficiently so that "he may be enabled to continue with more extensive psychotherapy." The time span allotted for treatment is one to six sessions. A positive transference is fostered, free association avoided, and interpretation tempered, being coupled with other types of intervention like medical, environmental, etc. Brief therapy, they observe, is useful in nearly every kind of emotional disturbance, even psychosis. While extensive restructuring of the character is desired and possible, or where acting-out exists, however, it is not suitable.

A detailed history is essential with a complete exploration of the presenting problem, the precipitating factors, the contemporary life situation, and the developmental history, including family relationships. The object is to understand the present illness "in dynamic terms and related to preceding genetic, developmental, and cultural events." Out of this, some immediate therapeutic help may be rendered that can take the form of a minor interpretation. Psychotherapy is planned "within the framework of what the patient is willing to engage in," in contrast to the position taken by some therapists like Sifneos to the effect that "the patient must fit the treatment chosen for him by the expert." In Beliak and Small's method dreams may be elicited, projective testing like the Thematic Apperception Test used, and hypnosis employed to bring out repressed material. An attempt is made to establish causal factors in relation to precipitating incidents and specific historical events and structures. Judicious use of interpretation to impart insight, reassurance and support when necessary, counseling, guidance, conjoint family therapy, group therapy, drugs, electroconvulsive therapy (as in suicidal depressions), and environmental manipulation will call for a good deal of flexibility, diagnostic acumen, and clinical judgment on the part of the therapist. Emphasis in working-through is upon immediate learning. "The maintenance of the positive relationship," they state, "avoids a sense of rejection in the terminating process and permits the patient to retain the therapist as a benign, introjected figure." Treatment is

ended by informing the patient that the therapist is available in the future when needed.

The literature is replete with descriptions of special techniques vaunted by the authors as uniquely effective for short-term therapy. Their enthusiasm is understandable because therapists become skilled in certain methods to which they are by personality, operational style, and theoretical bias attuned. Lest we become too rhapsodic over any set of methods, however, we must remember that while they may be effective in the hands of some, they may not be useful for all therapists. Matching patient and method is also a challenging problem (Burke et al, 1979). Except for a few syndromes, such as behavior therapy for phobias and pharmacotherapy for psychoses, outcome studies fail to credit any special interventions with global superiority over other approaches. Indeed, statistics indicate equivalent improvement rates for a host of available techniques. Nevertheless, a study of the various modalities in contemporary use is rewarding if no more than to provide us with models that may selectively be useful.

Among the most common techniques, in addition to those previously cited under dynamic therapies, are *interpretive methods* that draw their substance from classical (Freudian) and nonclassical (Adlerian, Stekelian, Rankian, Jungian, and Reichian) psychoanalysis as well as from *behavioral models*. The list that follows includes the more formal modalities currently in use:

1. *Autogenous training* (Crosa, 1967; Luthe, 1963; Schultz & Luthe, 1959).

2. *Behavioral models* (Ayllon & Azrin, 1968; Bandura, 1969; Crowe et al, 1972; Ferber et al, 1974; Ferster, 1964; Franks, 1964; Franks & Wilson, 1975; Ghadirian, 1971; Hand & LaMontagne, 1974; Hofmeister, 1979; Lazarus, 1976; Lick & Bootzin, 1970; Patterson, 1973a, 1973b, 1974; Richardson & Suinn, 1974; Stuart, 1969; Suinn et al, 1970; Wolpe, 1964).

3. *Bioenergetics* (Lowen, 1958; Palmer, 1971).

4. *Biofeedback* (Blanchard & Young, 1974; Glueck & Stroebel, 1975; Stroebel & Glueck, 1973).

5. *Casework therapy* (Kerns, 1970; Upham, 1973; Wattie, 1973; A. Wolberg, 1965).

6. *Cognitive learning* (Bakkar & Bakkar-Rabdau, 1973; Greene, 1975).

7. *Cognitive therapy* (Beck, 1971, 1976; Ellis, 1957, 1965, 1973; Glicken, 1968; Rush, 1978).

8. *Confrontation methods* (G. Adler & Buie, 1974; G. Adler & Myerson, 1973; Garner, 1970a, 1970b; Godbole & Falk, 1972; Kaswan & Love, 1969; Sifneos, 1972).

9. *Counseling methods* (Gross & Deridder, 1966).

10. *Dance and movement therapy* (Smallwood, 1974.)

11. *Decision therapy* (Greenwald, 1974).

12. *Emotional catharsis* (Nichols, 1974).

13. *EST* (Kettle, 1976).

14. *Gestalt therapy* (Peris, 1969; A. C. Smith, 1976).

15. *Goal attainment scaling* (La Ferriere & Calsyn, 1978).

16. *Guided affective imagery* (Koch, 1969).

17. *Hypnosis* (Crasilneck & Hall, 1975; Frankel, 1973; Morra, 1967; Rabkin, 1977; Spiegel, 1970; Spiegel & Spiegel, 1978; Stein, 1972; Wolberg, 1948, 1964, 1965).

18. *Interpretive methods* (K. A. Adler, 1972; Ansbacher, 1972; Barten, 1971; D. Beck, 1968; Davanloo, 1978; Davanloo & Benoit, 1978; Gillman, 1965; M. Moreno, 1967; Small, 1971; Wahl, 1972).

19. *Mediation* (Carrington, 1977; Carrington & Ephron, 1975).

20. *Milieu therapy* (Becker & Goldberg, 1970; Clark, 1972; Goldberg, 1973; Knobloch, 1973; Raskin, 1971; Stainbrook, 1967; Visher & O'Sullivan, 1971; Wilkins, 1963).

21. *Multimodal therapy* (Lazarus, 1976).

22. *Persuasion* (Maltz, 1960).

23. *Primal therapy* (Janov, 1970).

24. *Programmed psychotherapy* (H. Young 1974).

25. *Psychoimagination therapy* (Shorr, 1972).

26. *Psychosynthesis* (Tien, 1972).

27. *Reality therapy* (Glasser, 1965; Glasser & Zunin, 1972).

28. *Relaxation* (Benson et al, 1974).

29. *Scream therapy* (Casriel, 1972).

30. *Sensitivity training* (Quaytman, 1969; Schutz, 1967).

31. *Social therapy* (Bierer, 1948; Fleischl & Wolf, 1967).

32. *Somatic therapy* (Dasberg & Van Praag, 1974; Hayworth, 1973; Hollister, 1970; Kalinowsky & Hippius, 1969; Ostow, 1962).

33. *Structural integration* (Rolf, 1958; Sperber et al, 1969).

34. *Symboldrama* (Leuner, 1969).

35. *Transactional analysis* (Brechenser, 1972; Hollensbe, 1976; Johnson & Chatowsky, 1969; Sharpe, 1976).

36. *Videotape playback* (Alger, 1972; Berger, 1970, 1971; Gonen, 1971; Melnick & Tims, 1974; Silk, 1972).

Less formal therapies have drawn on the following techniques:

1. *Buddhist Salipatthana*, or "*mindfulness meditation*" (Deatherage, 1975).

2. *Communication theory* (Kusnetzoff, 1974; R. C. Martin, 1968).

3. *Dream analysis* (Merrill & Cary, 1975).

4. "*Emotive-reconstructive psychotherapy*" (ERP), which combines the use of imagery with hyperventilation (Fulchiero, 1976; Morrison & Cometa, 1977).

5. "Fischer-Hoffman process (A. C. Smith, 1976).

6. "*Flomp method*" (Hagelin & Lazar, 1973).

7. *Monta therapy* (Reynolds, 1976).

8. *Naikan* (Ishida, 1969).

9. "*Paradoxical intention*" (Frankl, 1965, 1966).

10. *Social skills training* (Argyle et al, 1974).

11. *Social systems approaches* (Clark, 1972).

12. *Story telling* (De La Torre, 1972).

13. *Team systems approaches* (Dressier et al, 1975).

14. *"Therapeutic paradox" technique* (Fulchiero, 1976).

Special techniques have also been recommended for particular syndromes:

1. *Conversion reactions* (Dickes, 1974).

2. *Depressive reactions* (Campbell, 1974; Neu et al, 1978; Regan, 1965; Sokol, 1973).

3. *Hysterical personality disorders* (Seibovich, 1974).

4. *Obsessive-compulsive disorders* (Suess, 1972).

5. *Phobias* (Skynner, 1974).

6. *Psychosomatic conditions* (Mentzel, 1969; Meyer, 1978; Meyer & Beck, 1978).

7. *Sexual problems* (Kaplan, 1974; Levit, 1971; Mears, 1978; Springman, 1978).

8. *Smoking habits* (Marrone et al, 1970; H. Spiegel, 1970).

9. *Unresolved grief* (Volkan, 1971).

10. *Untoward reactions to physical illness* (E. H. Stein et al, 1969; Tuckman, 1970).

11. *War neuroses* (Pruch & Brody, 1946).

Moreover, selected interventions have been advised for specific categories of patients:

1. *Alcoholics* (Krimmel & Falkey, 1962).

2. *Dying patients* (Cramond, 1970).

3. *Geriatric patients* (Godbole et al, 1972; Goldfarb & Turner, 1953).

4. *University students* (Bragan, 1978; Killeen & Jacobs, 1976; Loreto, 1972; W. Miller, 1968).

The use of short-term approaches in primary care and medical settings has been described by Bleeker (1978), Budman et al (1979), Conroe et al (1978), and Kirchner et al (1979). Although not focused directly on short-term therapy, the contributions of Strupp (1972) and Frank (1973) to related aspects of treatment are noteworthy.

Short-Term Therapy in Outpatient Clinics

The urgency in many clinics to alter tactics of psychotherapy in line with the requirements of the patients being treated as well as the disposition of the community has resulted in the shifting from long-term treatment toward eclectic short-term programs. For example, at the Montreal General Hospital in Canada a change in the treatment philosophy away from the long-term objective of personality reconstruction was necessary for practical reasons: (1) because the kind of patient population the clinic dealt with was unable to utilize a prolonged therapeutic relationship and (2) because some of the therapists were not fittingly trained or were unable to spend a sufficiently long time to follow through with appropriate treatment measures (Davanloo, 1978; Straker, 1968). The result was a "high dropout rate or the rapid development of chronic clinic dependency." In addition, waiting lists became so great that acute emotional crises could not receive needed help. A brief psychotherapy program was started in 1961 based on psychodynamic formulations. Patients who did not qualify for the program received supportive kinds of help, pharmacotherapy, social service assistance, ward care, and so on, according to their needs. With this pragmatic change the dropout rate decreased over five times, and staff interest and morale were greatly strengthened. Follow-up studies 2 years after intake revealed that 66 percent of the total case load had benefited sufficiently to need no further therapy. Patients selected for and treated with brief psychotherapy showed an 84 percent remission rate.

Largely through Davanloo's efforts three International Symposia were organized, in 1975, 1976, and 1977, bringing together professionals interested in brief approaches. Davanloo's methods resemble those of Sifneos and Malan. Evaluation criteria for dynamic therapy are, first, the assay of the ability to establish meaningful relationships based on the patient's having had previous emotional ties with other

people. Even in the first interview the patient's capacity to interact with the therapist will be obvious. Second, there is an estimate of the ego's capacity to experience and tolerate anxiety that will be mobilized in the interview. Third, motivation for true change must be differentiated from a desire to satisfy an infantile need in therapy. Fourth, psychological mindedness and capacity for introspection are judged carefully. Fifth, the most crucial criterion is the patient's ability to respond constructively to interpretation during the evaluation interview. Sixth, the degree of intelligence is an important factor in the choice of approach. Seventh, the evaluator must determine the richness and flexibility of available defenses since these correlate with effective utilization of dynamic therapy. Davanloo is wedded to classical analytic formulations, such as the structural hypothesis, and frames his language in these terms. There is general agreement among most therapists with Davanloo's belief that selection of a psychotherapeutic focus is vital in short-term therapy and that "identification and understanding of the psychodynamics and psychological processes underlying the patient's psychological problems is the key issue in the evaluation process."

Other clinics that have remodeled the structure of their services along short-term lines also report an improved remission rate among patients and a heightened staff moral. The number of sessions devoted to treatment is considered arbitrary and has tended to cluster around lower limits, which in some studies have yielded results equal to treatment with numerically higher sessions. Errera et al (1967) compared the results of patients at the Yale-New Haven Medical Center Psychiatric Outpatient Clinic who were in therapy for from 6 to 10 sessions with a similar population who received 21 or more treatment sessions and found that "there was no significant difference in the improvement rates, neither as recorded by the therapists nor evaluated by the raters."

Lingering doubts as to the extent of help patients receive has been all but dissipated by the experience of clinics that have converted their services along short-term lines and conducted follow-up inquiries. At the Boston University Medical Center Psychiatric Clinic, for example, a study was conducted by Haskell et al (1969) as to what happened to patients after 12 weeks in short-term therapy. Significant changes were found in the group as a whole (about 71 percent) on five measures of depression, anxiety, and overall improvement. Even though it was felt "that the type of patient who responds to time-limited therapy differs markedly from the type who responds to long-term therapy," no clear-cut criteria were apparent.

Clinics associated with colleges have also noted excellent results with a small number of sessions (Miller, 1968; Speers, 1962; Whittington, 1962). Because college students are at an age level where problems in identity, resolution of dependency with emergence of autonomy, and firming of sexual role are being worked through, they are, as a group, bound to experience a good deal of stress. The presence of a facility that can offer them crisis- oriented psychological services can be extremely helpful in fostering a better adjustment. Experience indicates that relatively few sessions are necessary for the great majority of students. For example, a review of 3,000 students who applied for help at the City College of San Francisco showed that the average number of contacts was below three (Amada, 1977).

Walk-In Clinics and Crisis Intervention

The growth of community psychiatry has encouraged a multitude of short-term programs organized for purposes of crisis intervention and the dealing with emergencies (Annexton, 1978; Donovan et al, 1979; D. Goldstein, 1978; Robbins, 1978). Walk-in clinics that bring help to virtually thousands of people have sprouted throughout the country. An example is the Intake Reception Service at the Psychiatric Clinic of the Maimonides Medical Service in Brooklyn, N.Y., which functions as a walk-in clinic offering immediate help to anyone applying (Gelb & Allman, 1967). Four to eight inpidual sessions are given. If more therapy is needed, maximal use is made of group and family therapy. Professionals from different disciplines are used, including psychiatrists, psychologists, psychiatric social workers, and psychiatric nurses. An experienced therapist may be accompanied by a therapist in training, who participates as an observer. Thus the session operates as a training tool. Indications for referring a patient to a psychiatrist therapist are any of the following: (1) somatic symptoms, (2) mental illness in a patient who is dangerous to himself or others, (3) a need for medications, (4) history of attempted or threatened suicide, or (5) a special request for a psychiatrist. The approach utilized is dynamically oriented and is not considered, in the words of Gelb and Allman (1967) “an emergency shortcut or a poor substitute for an unattainable ideal but is, in itself, the most effective and human approach to our patients. . . .” Immediate, active, emphatic and accurate confrontation with neurotic functioning is more effective than “years of passive working-through.” Patients who require more help after therapy ends are invited to return “anytime the need arises,” but not on a continuing basis. This approach has resulted in a 60 percent improvement rate within five visits.

This improvement rate, that is about two- thirds of the patients receiving therapy, is substantiated by many other walk-in clinics (Gottschalk et al, 1967; Jacobson & Wilner, 1965). In a large study of over 8,000 patients treated on an emergency basis only 10 percent required continuing long-term therapy (Coleman & Zwerling, 1959). The value of short-term group crisis intervention has also been demonstrated. In a study of 78 cases receiving six group sessions compared with 90 control cases in unlimited groups or inpidual therapy, the short-term group cases demonstrated greater improvement on a 5-point scale of functioning (Trakas & Lloyd, 1971).

Walk-in clinics designed to provide immediate goal-limited help (Beliak, 1964; Coleman & Zwerling, 1959; Jacobson et al, 1965; Normand et al, 1967; Peck et al, 1966) generally concern themselves with crisis intervention and usually restrict the total number of sessions to six or less. Referral for more extended care is provided where necessary. Although the work-up done in different clinics will vary, it generally includes some dynamic formulation of the problem, an assay of existing ego strengths and weaknesses, and an estimate of the degree of pathogenicity of the current environment. Toward this end Normand et al (1967) have described a joint initial interview conducted by a psychiatrist-social worker team. Such a team maximizes the selection of an approach to the existing problem and outlines a blueprint for action. A working hypothesis is formulated attempting to relate intrapsychic and/or environmental aspects to the disturbed behavior or the symptoms, and it is around this hypothesis that choice of interventions is made from a wide range of supportive, educational, and insight-oriented approaches. Should no improvement occur, the working hypothesis is reformulated. This approach has proven itself to be practical "as an aid to providing high quality mental health services for the poor" in the face of even overwhelmingly impossible environmental deprivations. There is a feeling that patients from lower socioeconomic classes do better with short-term crisis intervention therapy than with any other approach (Haskell et al, 1969; Meyer et al, 1967; Sadock et al, 1968.)

Walk-in clinics thus provide a vital need in the practice of community psychiatry by making treatment immediately and easily accessible to all classes of patients. Many problems can be managed through this means that otherwise would go unattended. On the basis of an analysis of many interviews in the psychiatric walk-in clinic of the Massachusetts General Hospital in Boston, which handles about 40 walk-in patients each day (15,000 visits per year), Lazare et al (1972) have listed 14 categories of patients.

1. Patients who want a strong person to protect and control them. (“Please take over.”)

2. Those who need someone who will help them maintain contact with reality. (“Help me know I am real.”)

3. Those who feel so empty they need succorance. (“Care for me.”)

4. Those who need some clinic or person around for security purposes though the contact be occasional. (“Always be there.”)

5. Those ridden with guilt who seek to confess. (“Take away my guilt.”)

6. Those who urgently need to talk things out. (“Let me get it off my chest ”)

7. Those who desire advice on pressing issues. (“Tell me what to do.”)

8. Those who seek to sort out their conflicting ideas. (“Help me put things in perspective.”)

9. Those who truly have a desire for self-understanding and insight into their problems. (“1 want psychotherapy.”)

10. Those who see their discomfort as a medical problem that needs the ministrations of a physician. (“I need a physician.”)

11. Those who really seek some practical help like disability assistance, legal aid, or other intercessions in their life situation. (“I need your legal powers”)

12. Those who credit their difficulty to ongoing current relationships and want the clinic to intercede. (“Do it for me.”)

13. Those who want information as to where to get help to satisfy various needs, actually seeking some community resource. (“Tell me where I can get what I need.”)

14. Nonmotivated or psychotic persons who are brought to the clinic against their will. (“I want nothing.”)

Where the therapist is perceptive enough to recognize the patient’s desire and where he is capable of gratifying or at least acknowledging that he understands the request, he will have been able to start a working relationship. Should he bypass the patient’s immediate plea for help or probe for conflicts and other dynamic forces underlying the request, therapy may never get started. Obviously, fulfilling the

patient's desire alone may not get to the bottom of the patient's troubles, but it will be an avenue through which one will be able to coordinate and utilize the data gathered in the diagnostic evaluating interview. In clinics or private therapy where there is lack of congruence between what the patient seeks and what the therapist decides to provide, the dropout rate after the first interview is as high as 50 percent (Borghi, 1968; Heine & Trosman, 1960).

The claim that short-term treatment accords with superficiality of goals has not been proven, especially where therapy is conducted along even modest dynamic lines. Thus, a type of crisis intervention that aims at more than symptom relief is described by M. R. Harris et al (1963), who treated a group of 43 patients with up to seven sessions with the objective of (1) resolution of the stress factor precipitating the request for help and (2) clarifying and resolving, if not the basic conflict, the secondary derivative conflicts activated by the current stress situation. "Our hypothesis is that such exploration and working through facilitated the establishment of a new adaptive balance." During therapy the motivation for further treatment was also evaluated. Thirty- eight (88 percent) of the patients were helped by brief therapy. Thirteen (30 percent) of the patients continued in long-term treatment. Three patients (7 percent) returned for a second brief series of contacts. During interviewing with this treatment, efforts were made to establish connections between conflicts and the precipitating stress since this enabled the patient to "be better able to cope with his distress and achieve a new psychic equilibrium." Historical material was utilized only when it was spontaneously brought up and related directly to the current difficulty. The authors declare that where long-standing vexations exist, motivation for further treatment "may in fact be increased by the experience of a successful brief therapeutic transaction." Adoption of a psychodynamic stance in crisis intervention can enhance the quality of results, as Louis (1966) and others have pointed out.

Of all devastating stressful experiences, the death of a loved one, or a person on whom the survivor is dependent, is perhaps the most mismanaged. Apart from token consolations, a conspiracy of silence smoulders under the assumption that time itself will heal all wounds. That time fails miserably in this task is evident by the high rate of morbidity and mortality among survivors following the fatal event (Kraus & Lilienfeld, 1959; Rees & Lutkins, 1967; M. Young et al, 1963).

Recognition of these facts has led to some crisis intervention programs to provide short-term help

for the bereaved in the service of both prevention and rehabilitation (Gerber, 1969; Silver et al, 1957; P. R. Silverman, 1967). Success of these programs presages their further development and expansion. Gerber (1969) has described some methods for fostering emancipation from the bondage of grief and readjustment to present realities. These include (1) helping the client to put into words his or her feelings of suffering, pain, guilt, notions of abandonment and anger as well as the nature of the past relationship with the deceased, good and bad; (2) organizing a plan of activities that draws upon available resources and friends; (3) lending a hand in resolving practical difficulties involving housing, economic, legal, and family rearrangements; (4) making essential referrals for medical assistance including prescription of drugs for depression and insomnia and offering future assistance. Service to a bereaved person is often best recommended by the family physician, and such recommendations may be a requirement. An initial home visit by a social worker or other professional or trained paraprofessional may be necessary before the client will accept office visits.

Dealing with Unresponsive Patients

Despite our best efforts to shorten therapy there will be some patients who will need continuing treatment. Clinics only too often become clogged with such chronic patients whose treatment becomes interminable. This can result in long waiting lists and an end to ready access to therapy for even emergency problems. This is not to depreciate the value of prolonged treatment in some long-standing emotional problems. However, from a pragmatic standpoint, for the great majority of chronic patients other modes of management are not only helpful, but actually are more attuned to the continuing needs of these patients. Such alternative methods involve, perhaps for the remainder of a patient's life, occasional short (10- to 15-minute) visits with a professional person on a monthly or bimonthly basis, supervision of drug intake, introduction into a group (therapeutic, social, or rehabilitative), and utilization of appropriate community resources. What the therapist tries to avoid for such a patient is stimulating dependency on himself personally.

An eight-year experiment at an outpatient clinic dedicated to the therapy of the chronically ill at the University of Chicago Hospitals and Clinics is reported by Rada et al (1969). The clinic is open every Thursday afternoon for 2½ hours, patients being seen in order of arrival. Patients are accepted only after a diagnostic evaluation and initial workup by the referral sources to make sure they will be suitable for

the clinic routines. The staffing is by psychiatric residents, medical students, a social worker, receptionist, and two attending staff supervisory psychiatrists, the latter four being the only permanent staff. Upon arrival, the receptionist greets the patient—and if they come, the family—and brings the patient into the waiting room, where light refreshments (cookies and coffee) are served. Patient interactions are encouraged. Inpidual interviews are for 15 to 25 minutes to ascertain the present physical and emotional state, to regulate the drug intake if drugs are taken, to offer recommendations for intervening activities, and to make an appointment for the next time. The patients are then returned to the waiting area for more coffee and socialization. Family and couples therapy are done if necessary. Frequency of visits range from weekly sessions to once every 6 months although patients may return voluntarily if they need help. Should the patient drop out of therapy, he is permitted to return in times of stress without having to go through a readmission procedure. After the clinic hours the staff meets briefly (30 to 45 minutes) to discuss the day's problems. The two attending psychiatrists do not see inpidual patients (except in emergencies); they serve as administrative supervisors and active participants in the waiting area experience and the staff group meetings. Patients see the same therapist (a resident) for 3 months to a year and know that they will be transferred to another professional from time to time. Diagnostic categories vary, approximately half being psychotic, the remainder having severe neuroses and personality disorders. Fees generally support the clinic and are relatively low.

Short-term Hospitalization and Its Alternatives

Shrinking budgets have made it mandatory to take a hard look at costs versus benefits not only in regard to psychotherapy, but also protracted psychiatric hospitalization. Apart from pragmatic disadvantages or impracticalities of cost/benefits, prolonged institutionalization fosters regression and paralyzing dependencies—plus extended separation from community life. These unfortunate contingencies have sponsored shifts from long-term confinement to short-term detention organized around the objective of early discharge. Alternatives to hospitalization have also been explored. For example, in an experimental program Davis et al (1972) demonstrated that a team led by visiting nurses going to the homes of patients to oversee proper medication could prevent hospitalization and improve relationships within the family. Another example is the finding by Zwerling and Wilder (1962) that a day-care treatment facility could often act as an adequate substitute for an inpatient unit. There are,

nevertheless, situations when hospitalization is essential, for example, to provide security for disturbed or suicidal patients or where crisis-oriented therapy is needed and it cannot be done on an outpatient basis. A limited hospital stay may be all that is required. Even in children short-term hospitalization is sometimes considered (Shafii et al, 1979).

That it is possible to reduce the time of hospitalization of patients admitted to an institution through a crisis intervention program utilizing a wide range of treatment modalities has been demonstrated by Decker and Stubblebine (1972) in a 2½ year study of 315 young adults. At the Connecticut Mental Health Center a program of brief (3-day) intensive hospitalization and 30-day outpatient care has been used to deal with patients requiring hospitalization (Weisman et al, 1969). In the hospital, crisis intervention methods are employed toward restoring the patient to the previous level of functioning. On discharge there is a 1-month outpatient period of treatment, which is considered a follow-up measure. An agreement is made in advance as to this limited time arrangement to insure that treatment does not go on indefinitely. "One effect of the time-limited contract is to establish a 'set' which promotes rapid identification of problem areas and requires patients to begin quickly developing new modes of dealing with these problems." The patient is seen each day by several staff members who are usually nurses or aides in order to discharge dependence on the godlike figure of the doctor. To expose patients to different tactics, a fixed style of approach is deliberately not used. Team members also interact with patients in daily group therapy and family therapy. Self- reliance is stressed by focusing on the patient's responsibility, especially in making plans after discharge. While concern and interest are shown, "the staff avoids doing things for the patient which he can be encouraged to do himself." Psychotropic drugs are used to diminish target symptoms. There is early family involvement, and the entire hospital day is structured with activities. As for results, at the end of brief hospitalization of the first 100 patients, 18 percent were transferred for longer inpatient care after the 3-day intensive experience since they required longer term hospitalization. Another 19 percent were rehospitalized within 1 year of discharge. At the 1-year follow-up routine almost two-thirds of all patients had not been rehospitalized or transferred after the 3-day intensive hospital treatment. This compares favorably with rehospitalization rates with longer term therapy.

The function of the usual short-term hospitalization (i.e., 3 to 4 weeks) is, first, to bring about a rapid remission of symptoms and, second, to prepare the patient for, and to see that there is made

available, an adequate aftercare program. The first objective is accomplished by drug therapy and ECT if necessary, inpidual family and group treatment, and milieu, occupational, and rehabilitative therapy, all tailored to the patient's needs. Because of the emphasis on the control of symptoms rather than alterations in the personality structure, crisis-oriented behavioral approaches along eclectic lines are most commonly practiced. Ideally, brief hospitalization should provide psychotherapy to prepare the patient for outpatient care (A. B. Lewis, 1973). The second objective, although most crucial to avoid the revolving door syndrome, is too often neglected. Unless the posthospital environment is regulated, ensuing stress will almost inevitably produce a relapse in symptoms. Among the measures necessary to prevent this are the adjustment of living arrangements so that the least strain is imposed on the patient's coping capacities, the use of halfway houses, facilities providing day and night care, supervised drug management, and rehabilitative, social, health, and recreational programs. The selective use of community outpatient psychotherapy of a not too intensive variety with an empathic therapist can be most helpful.

To safeguard against the fragmentation of an aftercare program, continuity of treatment with one professional person can help prevent treatment degenerating into management of a series of emergencies with inevitable rehospitalization. This person must have established a relationship with the patient and know the history of the latter's illness and something about the dynamics. What causes most patients to return to the hospital is poor aftercare planning with little or no provision for some kind of ongoing inpidual or group psychotherapy, improper monitoring of drug maintenance, failure to utilize emergency measures when needed (such as ECT), stressful living conditions, poor housing and inadequate provision of essential social and rehabilitative services. Where possible, the therapist who has worked with the patient in the hospital should be the one who continues seeing the patient and directing the aftercare program. Sometimes the hospital may provide some of the aftercare services, but the administrators should always strive to integrate the patient into the community as rapidly as possible. This is usually the best course. Where return to a family would be disturbing—for instance, where members are too hostile, demanding, and rejecting—placement in a halfway house and later in a foster home may be advisable.

Short-term hospitalization does not eliminate intermediate-term intensive treatment in a hospital, that is, 130 to 180 days, or for longer periods where the aim is a personality change. However, custodial

care in patients who require continuing management can usually be achieved outside of a hospital facility. Wayne (1976) has appropriately pointed out that what determines the *duration* of hospitalization is not the diagnosis but the persistence of a habitual disruptive life-style, severe family, social, and occupational difficulties, and the presence of a serious physical disability or hypochondriasis. Where the proper environment is made available and aftercare supervision promoted, even chronic psychotic persons can make an adjustment outside of an institution.

There is evidence that short-term family therapy can cut down the need for hospitalization in acute cases of decompensation. To compare the outcome of outpatient family crisis therapy with hospitalization, Flomenhaft et al (1969) treated with the former modality 186 patients in need of admission to a mental hospital. A control group of 150 patients received hospitalization. The outpatients received an average of five office visits, one home visit, and three telephone contacts. The results of outpatient therapy were at least as good as hospitalization, in addition to being more economical and less stigmatizing. In a study by Langsley et al (1969) 75 acute decompensated psychiatric patients were given an average of six sessions of family crisis therapy organized along directive and supportive lines. A control group of 75 received hospitalization and inpatient treatment. In the family therapy group 61 patients were able to avoid hospitalization and only 14 patients required hospitalization within a 6-month period. In the hospitalization group 16 patients required rehospitalization after discharge within a 6-month period. Only an average of 8.1 days were required for improvement in the experimental group as compared to 24.3 days in the hospitalized group. Two years later a similar study was repeated with a larger group of patients. It confirmed that most patients with short-term family therapy could avoid hospitalization (Langsley et al, 1971). At the Eastern Pennsylvania Psychiatric Institute these studies were replicated, indicating the efficiency of short-term family therapy (Rubenstein, 1972). Focal therapy in a day hospital may also be employed as an alternative treatment (Frances et al, 1979).

Short-term Child and Adolescent Therapy

The question is often asked as to whether it period of treatment of the child patient and is possible to do child therapy on a short-term parents is customary. There are some studies basis since it is generally accepted that a long however, that indicate that good results may be obtained with short-term approaches (Cramer, 1974; Kerns, 1970; Martin, 1967; Negele, 1976; Nicol, 1979; Phillips & Johnston,

1954; Rosenthal & Levine, 1970, 1971; Shaw et al, 1968; Skynner, 1974). Other studies verify the utility of short-term group training for parents in managing problems in their children (G. R. Patterson et al, 1973a; Walter & Gilmore, 1973; Wiltz & Patterson, 1974). Many therapists believe that where the child is under 7 years of age the main therapeutic work is with the parents. From ages 7 to 11 the child and parents are seen separately. From 12 on family sessions seem best. Preadolescent children with acute problems have been materially helped by parent groups focused on discussions of child management, power ploys of children, and alternate approaches to problem solving. The children themselves are encouraged to experiment with more mature behavior through better ways of coping with people and situations (Epstein, 1976).

Utilizing a so-called "health" model, Weinberger (1971) describes a form of brief therapy for children "which sees clients basically coping and adapting but experiencing problems caused by ignorance, inappropriate expectations, social surroundings, or other factors which do not implicate the parents as malevolent and pathologically motivated." This is seen as a preferred therapy for the majority of children in contrast to the prevailing model of short-term treatment, which is either a compression of long-term treatment methods or an elongated diagnostic procedure that is appropriate for only 5 to 10 percent of all children sent for help.

As part of the therapeutic process, Weinberger states that it is important to try to ascertain how parents view the child's problem and what their expectations are of the therapist. This leads to the drawing up of a verbal "contract" of what the parents and therapist expect of each other. Usually the goal is the elimination of undesired behavior. The time limit set is 6 weeks during which a maximum of 12 sessions are arranged for the child and other family members. The child generally is ignorant of why he is actually seeing the therapist, has little real notion of his underlying problem, and no motivation to do anything about it. Should the child be aware that he is seeing a "doctor," he may regard this as punishment for his crimes while believing that the "doctor" expects him to change in accord with the wishes of his parents. If, on the other hand, the child is cognizant of his problem, he may rationalize it as a justified consequence of unfair demands and acts by his parents and others. It may be essential in order to secure cooperation with the treatment plan to work with the child until he verbalizes a problem on which he would like to concentrate.

One way of focusing on the problem in the event the child seems ignorant of it is to confront the child with what others say about him and to handle his reactions to the confrontation. Why does he believe he is seeing the therapist? Once the child admits to a behavioral deviation, other ways of reacting are suggested to him. Any distorted way the child conducts himself with the therapist may be an important means of bringing to his attention how he behaves, how other people may be affected by his behavior, and how he himself suffers the consequences of their reactions. These comments are made without anger, disgust, accusation, or threats of recrimination, providing the child with a different experience in relation to an authority figure. Concurrently, the therapist may work with the parents or see the patient together with other members of the family in family therapy. In conference with the parents it is important to alleviate their guilt, to try to clarify what is happening in their relation to the child, to explain unreasonable expectations and developmental norms, and to suggest alternative ways of dealing with the child's behavior. The extent of directiveness of the therapist will vary with the willingness and ability of the parents to make proper decisions on their own.

The plan of action and how it is carried out by the child and parents is monitored by the therapist in the remaining sessions, the plan itself being modified or discarded and a new one substituted depending on the progress that is being made. "A major part of this working through is to help the parents not only recognize and accept their own and their child's limitations, but, to set more realistic goals for themselves as parents, and their child as a child with a unique life style of his own which must be understood, respected, and not enmeshed in their own needs and problems" (Weinberger, 1971). Based on 5 years' experience in the clinic with about 3,000 cases, Weinberger estimates that 50 percent of all children can be handled in brief therapy. More extensive therapy is required by 30 percent, and help other than psychotherapy (special classes, residential placement, etc.) is required by 20 percent.

Short-term Group Approaches

Manpower shortages reinforced by the factor of cost/benefit have accelerated the use of short-term group therapy, both for hospitalized persons and outpatients. Many group programs have accordingly been introduced, utilizing techniques that draw their substance from psychoanalysis, behavior therapy, cognitive therapy, guided imagery or any other theoretical school to which the therapists are dedicated.

1. *Crisis intervention groups* (Berlin, 1970; Crary, 1968; Donovan et al, 1979; Morley & Brown, 1969; Strickler & Allgeyer, 1967; Trakas & Lloyd, 1971).

2. *Experiential groups* (Back, 1972; Burton, 1969; Elmore & Saunders, 1972; Lewis & Mider, 1973; Peris, 1969; Rabin, 1971).

3. *Educational groups* (Druck, 1978).

4. *Behavioral groups* (Aronson, 1974; Fensterheim, 1971; Lazarus, 1968; Liberman, 1970; Meacham & Wiesen, 1969; Suinn et al, 1970; Wolpe, 1964).

5. *Inspirational groups* (Dean, 1970-1971; Greenblatt, 1975; Herschelman & Freundlich, 1972).

6. *Psychodramatic groups* (Corsini, 1966; Moreno, 1966).

7. *Transactional groups* (Berne, 1964; T. Harris, 1967; Karpman, 1972).

8. *Accelerated short-term groups* (Wolf, 1965).

Between 1947 and 1962 over a hundred papers were published on just the last category, (A. Wolf, 1965) and since then more have accumulated.

Short-term groups are usually open-ended and frequently conducted by cotherapists (Goolishian, 1962; Sadock et al, 1968; Shrader et al, 1969; Trakas & Lloyd, 1971. Outcome studies on groups report highly successful results, in some instances being considered as more effective than inpidual therapy (Trakas & Lloyd, 1971). The uses and abuses of groups are described by Imber et al (1979).

Short-term groups with children have been gaining popularity (Graham, 1976; Rosenthal & Levine 1970), some reports claiming successes equal to that in long-term therapy (Rosenthal & Levine, 1971). An example is the study by Burdon and Neely (1966) who treated 55 boys with repeated school failures. A 5-year follow-up showed increased school attendance with 98 percent passing and 73 percent earning promotions. Some useful methods for working with children in groups have been outlined by Rhodes (1973), Epstein (1976), and Levin & Rivelis (1970). Short-term group treatment may also be helpful for maladjusted adolescents (Eisenberg, 1975; Rivera & Battaggia, 1967), during brief inpatient care for adolescents (Chiles & Sanger, 1977; Moser, 1975), for delinquent adolescents (Danner & Gamson, 1968), adolescent drug users (Deeths, 1970), and youthful offenders in a detention unit

(Would & Reed, 1974). The need to distinguish between adolescents whose problems are the product of entanglements related to the developmental process and those whose encounter with adolescence stirs up unresolved conflicts of earlier stages of growth will influence techniques and objectives (Sprince, 1968).

Group work with parents of problem children has also proven rewarding (Epstein, 1970; Maizlish & Hurley, 1963; Tracey, 1970), the training of parents in behavioral methods being especially popular as an effective intervention method (Bijou & Redd, 1975; Ferber et al, 1974; Patterson, 1973a, 1973b, 1974; Walter & Gilmore, 1973). One of the most difficult situations for the therapist is the unmotivated family of children with aggressive behavior disorders. A pilot study at the University of Chicago School of Medicine by Safer (1966) describes work with 29 such parents whose children ranged in age from 4 to 16. Family, conjoint and inpidual sessions produced improvement in most children, and this was maintained in follow-up evaluations after 4 to 16 months. The areas of change brought about by therapy in families with delinquent adolescents has exposed some interesting findings. For example, Parsons and Alexander (1973) discovered that one could utilize in studies four interaction measures that were not a function of extraneous variables.

Marital therapy is also often conducted on a short-term basis both in groups (Leiblum & Rosen, 1979; Wells, 1975) and with inpidual couples (Bellville et al, 1969; Fitzgerald, 1969; Kalina, 1974; P. A. Martin & Bird, 1963; P. A. Martin & Lief, 1973; Sager et al, 1968; Satir, 1965; Simon, 1978; Watzlawick et al, 1967).

An interesting model is described by Verhulst (1975). He has evolved an intensive 3- week approach resembling cognitive learning (Bakker & Bakker-Rabdau, 1973) that emphasizes confrontation and problem solving with the help of active, enthusiastic, facilitative therapists. Other methods are outlined elsewhere (Wolberg, 1977, pp. 733-740).

A number of reports have indicated that short-term marital therapy is at least as effective in dealing with marital conflict as long-term therapy. Gurman (1975) reviewed available data and found that a 76 percent improvement rate was achieved with an average of about 16 sessions. Review studies by Barten (1969), Reid and Epstein (1972); and Reid and Shyne (1969) confirm these positive results. Ratings at

termination and at an average of 2½ years later of 49 couples who were involved in conjoint marital therapy (a comparison of these with reported results of outcome studies on inpidual short-term psychotherapy as well as with another form of conjoint therapy and with psychoanalysis) indicate that the conjoint approach has some technical advantages over and compares favorably with these other types of treatment (Fitzgerald, 1969).

Short-term family therapy continues to grow in popularity. Its techniques are described by Bartoletti (1969a, 1969b), Bloch (1973), Deutsch (1966), Eisler and Herson (1973), Haley and Hoffman (1967), Fangsley and Kaplan (1968), Pittman et al (1966), Satir (1964a), and Watzlawick (1963). The number of sessions that are optimal for family therapy is dealt with in experimental evaluations by Stuart and Tripodi (1973). They randomly assigned 73 families with predelinquent and delinquent adolescents to 15-, 45-, and 90-day behaviorally oriented treatments. Outcome measures showed no difference between the groups. Thus it was concluded that there is no reason to choose longer over shorter family treatments. The idea that brief family therapy yields superficial results is challenged by Haug (1971), who describes a case where ego alteration coincided closely with rapid and persisting alterations in the body image. However, where the adaptive flexibility of parents is blocked by rigid defenses or the conflict in the child is markedly internalized, traditional longer term psychotherapeutic methods are probably more suitable (Haug, 1971).

The combination of group and family therapy appears to possess some advantages, as Kimbro et al (1967) and Durell (1969) have pointed out in their report of a pilot study of time-limited multiple family therapy with disturbed adolescents and their families. Groups of three families met with a therapist for weekly meetings. This design is being utilized more and more and Laqueur (1968, 1972) has written extensively on the rationale and process of bringing problem families from the same background together as a way of expediting treatment.

Massing Therapy Sessions

Attempts have also been made to study the effect of massing therapy sessions by literally immersing the patient in treatment throughout the day. Thus Swenson and Martin (1976) treated patients on a full-time basis for 3 weeks with combinations of different modalities that they considered complemented

each other. Assessing the program on 335 patients at the time of discharge revealed significant improvement in the presenting symptoms, work capacities, interpersonal relationships, and general level of comfort. A follow-up study showed that this improvement was retained.

"Massed time-limit" therapy sessions for as long as 10 hours consecutively have been given (Berenbaum et al, 1969). A form of this therapy—"multiple impact therapy"—that has proven successful is described by MacGregor (1962). Goolishian (1962) employed the technique with 60 families and their problem adolescents. A team consisting of a psychiatrist, a psychologist, and a social worker met three times with the families for all-day sessions. Group and inpidual therapy focused on major dynamics and self-rehabilitation. Results were considered at least comparable to conventional psychotherapy.

Marathon group sessions (Bach, 1966, 1967 a-d; Casriel & Deitch, 1968; Teicher et al, 1974; Vernallis et al, 1970, 1972) while not as popular as in previous years continue to have their advocates.

Conclusion

Somehow, short-term therapy has acquired the reputation of being a substandard approach in which quality of results is sacrificed on the altar of expediency. Superficiality of goals, uncertainty of results, substitution of symptoms, and a general glossing over of effects are said to be inevitable. These ideas have proven grossly inaccurate. There is ample evidence from the reported clinical experiences with short-term therapy that it has a utility not only as an economic expedient, but also as a preferred form of psychiatric treatment. Whatever controlled research studies exist, these substantiate its value in inpidual therapy with adults, adolescents and children, as well as in group, family and marital therapy. A number of models of short-term therapy have evolved from which techniques may selectively be adapted to the working styles of psychotherapists trained in the various theoretical orientations.

The actual models in use are usually conditioned by the experience and theoretical orientation of the practicing professionals and the policies of the agencies, if any, under whose supervision the work is being done. The shortcomings of some of these systems is that they tend to be monolithic, circumventing factors related to the specific complaint and to such elements as the stage of the patient's readiness for

change and preferred learning patterns. Not all persons are capable of utilizing the techniques that are offered. This is not extraordinary since patients generally harmonize with some interventions and not with others. Some do well with a cognitive approach in which they can absorb abstract concepts and insights that help them to alter their singular thinking patterns. Others fail to benefit from such tactics. They do better with behavioral techniques, experimenting with different modes of action, solidifying successful ones though reinforcements. Still others learn by modeling themselves after an admired authority, generally the therapist, bestowing on him virtues he may or may not possess. An effective short-term therapist is one who discerns the needs and learning proclivities of each patient and is flexible enough to alter his methods as he goes along.

Rigid therapists doggedly follow a set agenda into which they wedge all patients with little room for eclectic maneuvering. Yet one hardly ever sees a patient who could not utilize some of the effective interventions of different systems at successive stages of their treatment. Thus a therapist may with the same patient be active at some times and passive at others; he may selectively employ confrontation, reassurance, or suggestive or persuasive techniques. If familiar with the methods, he may utilize role playing, psychodrama, relaxation, hypnosis, family therapy, group therapy, milieu therapy, systematic desensitization, assertive training, and other behavioral techniques when necessary. He may employ psychotropic drugs when symptoms block effective learning. He may utilize the lessons learned from psychoanalysis that help expose and resolve unconscious resistances, particularly transference and acting-out. Obviously for best results the therapist must be highly selective about the modalities he uses so that he does not swamp the patient with unnecessary activity. All therapists cannot be expert in, or even aware of, every available technique that exists. But sufficient flexibility should prevail to prevent a stalemate when the patient fails to respond to the method that the therapist is applying at the moment.

The fact that the various short-term therapies in the hands of competent therapists do bring about relief or cure indicates that the particular techniques and stratagems employed are not the only important elements responsible for improvement. The proposition is inviting that therapeutic maneuvers merely act as a means of communication through which the therapist encourages the emergence of positive, and the resolution of negative, healing elements (Marmor, 1966). If a therapist feels most comfortable with a more active approach than with a less active one, with hypnosis rather than formal interviewing, with behavior therapy rather than analytically oriented therapy, he will probably

be able to help more patients than were he to force himself to use a procedure with which he is not at ease or about which he is not enthusiastic. This is not to depreciate the virtues of any of the existing models and techniques. However, we do tend to overemphasize technical virtuosity while minimizing the vital healing processes that emerge in the course of the helping relationship as a human experience.