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Psychotherapy: Selection, Assessment, and Focus

For some of those seeking therapy, experiences that are a normal part of life, such as bereavement, pregnancy and childbirth, changing jobs, difficulties in personal relationships, marriage, or divorce, have served to reveal the limits or precariousness of their previous ways of going about their lives. Such patients are best treated while the crisis is recent or current, support being combined with therapy aimed at correcting the faulty assumptions or strategies that led to the difficulty. For others, the decision to seek therapy is based on the recognition that their physical symptoms are psychologically caused, or follows their experience of prolonged or repeated depression and anxiety, or the recognition of their inability to control aspects of their lives. Others, again, may feel more generally that life in some important way is not proceeding well, or that something is missing.

It is the responsibility of the professionals to whom such people go to be sure that the patient who asks for therapy is an appropriate case for it, and, if he is, to offer the best available kind. In suitable cases, decisions must be made whether to treat the individual on his own, in his natural group (couple or family), or in a therapeutic group. Only individual therapy is being considered in this book. Approaches to group therapy and to marital therapy are reviewed in Ryle (1976 and 1979c). If individual therapy is indicated, it is an unfortunate fact that the type of treatment offered will depend much more upon the predilections of the professional than upon the nature of the patient's problems. In an ideal world this would not be the case, and the period of assessment would be devoted to deciding upon the method most appropriate for the particular case. In the integrated approach being described in this book, which aims to get closer to this ideal, the decision whether to offer therapy and, if so, in what form, is usually left to the end of the two-to-four sessions of the assessment period.

SELECTION FOR PSYCHOTHERAPY

The first purpose of assessment is to exclude from treatment people too well to need help, people able to get enough help from the assessment period to proceed on their own, and people suffering from conditions not amenable to therapy. This last group may include those suffering from organic illnesses producing psychological symptoms, such as thyroid disorders, as well as those too emotionally disturbed to be able to make use of therapy. The second purpose of assessment is to determine what kind of help to offer, given the available resources and the nature of the patient's difficulties.

The process of excluding unsuitable patients is, unfortunately, less easy than it might appear, because some patients with severe difficulty can make good use of therapy, while others with quite minor problems can prove very difficult to help. It is, however, certain that the risk of harming the patient (and of exhausting the therapist) is far greater where the patient has extensive difficulties, where his current relationships with others are markedly impoverished, or where there is no history of any remembered good figures from childhood or of any sustained good relationships since. In addition, patients with serious addictions or with personalities marked by much envy and destructiveness are difficult to help. The magical dependency, or the disappointed fury, provoked by psychotherapy in unsuitable cases of this sort can destroy what capacity the individual may have achieved for managing some kind of life in the world. Drug therapy, institutional care, and other forms of management may enable some of these sicker patients to use therapy later, and a few can make use of therapy that is very carefully limited, both in scope and duration. Only a few intrepid workers attempt psychotherapy with schizophrenics; in manic depression, on the other hand, psychotherapy may be helpful, although it is not possible during markedly depressed or manic phases.

STARTING THERAPY

As far as possible, patients should be seen in a reasonably comfortable room that is free from interruption, and the seating arrangement for patient and therapist should be at the same height, the most comfortable angle between the chairs being about 45°, which avoids both eyeball-to-eyeball confrontation and parallel staring into space; that is to say, it leaves eye contact possible but not compulsory. At the first meeting, the time and duration of future appointments should be spelt out clearly. If one has prior knowledge of the patient from the referring source, this should be indicated at the start of the first session. Initial meetings will be for assessment, and this too should be made clear on the understanding that discussion will take place about plans at the end of this period. The therapist working privately will spell out his expectations about fees at this point, and patients may indicate the extent of their insurance cover or other resources. If individual therapy is offered and accepted after assessment, further discussion will then take place which will outline

the proposed approach, agree on a list of target issues, and will either set a termination date or arrange to consider that date at some agreed point. The therapist may also at this time tell the patient about any anticipated breaks in treatment. If patients need treatment other than individual work, then arrangements for referral will be made. Any changes in practical arrangements should be communicated in a businesslike way, in the recognition that, if an important transference relationship develops, such changes may be felt as conveying meanings that will need to be discussed.

Most patients know, or discover for themselves, the way to use the sessions but, initially, some need encouragement. If the therapist is a doctor, the patient's assumptions may be formed by his experience with doctors treating him for physical disorders and he could expect the interviews to be highly structured. If the therapist is seeing a patient who has not been assessed psychiatrically, he will need to obtain an adequately full account of the patient's history and present psychiatric status. To get this history without setting up the medical interviewing stereotype, especially when patients have been referred for therapy and are probably suitable, one can begin with unstructured interviewing, in which the patient is encouraged to give his own account of his troubles, history, and expectations for treatment with minimal prompting. This account can then be supplemented by direct questioning in those areas not covered. In the course of this unstructured interviewing, the therapist can both observe the patient's style and begin to shape the conversation towards a concern with meanings and feelings as well as facts, and towards the acknowledgement of mixed feelings, a process that will be aided by his conveying a non-critical acceptance of what is said. The general instruction to "say whatever comes into you mind" seems of little value to me, and even in intensive psychoanalytic treatment it must be honoured more in the breach than in the observance. However, by attending to hesitancies or non-sequitors, by noting connections between apparently disjointed communications, and by inviting the patient to pause and think more about the meanings and implications of particular statements, the therapist can enable the patient to realize the value of such associative thinking.

In the course of the assessment period, the therapist needs to form a preliminary hypothesis about the patient's difficulties, and to offer a problem-oriented account of them to the patient. During these first sessions, the patient is declaring his troubles and the therapist is offering a sample of his wares. At the end of the assessment period both should be in a position to agree about what might be attempted together. This discussion will, I believe, be clearer where the therapist shares his assumptions and methods explicitly with the patient. There can be no universal strategy for these meetings but, for the most part, the therapist should leave the patient to talk in his own terms, intervening only to prompt or clarify and only occasionally making his own contribution. This contribution is, however, very important; it has one aim: to make of what the patient has said something useful, that is to say, something that the patient did not know (or did not know that he

knew). If the therapist can do this, and if the patient can hear what he says and see that it is of value, then therapy can usually proceed.

During these sessions, and those that may follow, the therapist will not, however, be solely dependent upon his ability to get things right. A great deal of his impact is due to the situation and is common to therapists of many different attitudes and beliefs, and doubtless also to witch-doctors, solicitors, clergymen, and many others. The experience of being carefully attended to by someone regarded as an expert produces, in the patient, a renewal of hope, an increase in self-esteem, a sense of being permitted, and often relief from loneliness and the sense of failure and shame. These effects, often called non-specific yet in reality specific but common to many approaches, are of genuine help, offering containment to the patient which relieves his disabling anxiety and enables him to think more clearly about his difficulties. They are the result of any attention that is genuine (people will soon see through ritual gestures, however) and to some extent they continue to operate throughout therapy , but they may include elements of magical hope and the hidden wish to hand over responsibility and control to the therapist, which must be countered if regressive dependency is to be avoided.

By the end of the assessment sessions, the therapist will have discerned how far his patient has realistic hopes of, and a genuine motivation for, the process which he can provide.

GOALS OF THERAPY: GENERAL AND SPECIFIC

The general goals of interpretive psychotherapy can be summarized as follows.

(a) That the patient should know the meaning of his life and his history accurately, as opposed to accepting the attributions or versions of others, as opposed to denying his own feelings and intentions or to translating them into symptoms, and as opposed to states of numbness or confusion.

(b) The patient should have satisfactory control over his acts, as opposed to feeling powerless or to repeatedly acting contrary to his intentions.

(c) The patient should have realistic and appropriate beliefs about himself and his social reality, as opposed to negative or inaccurate beliefs or assumptions.

(d) The patient should take realistic responsibility for himself, as opposed to disclaiming responsibility on the one hand, or omnipotently claiming it on the other.

(e) In his emotionally significant relationships with others, the patient should be capable of mutuality and openness, as opposed to being limited by, or feeling preoccupied with, questions of control or defensiveness.

(f) The patient should be able to live his life according to his desires and intentions rather than by evasions, restrictions, or compulsions.

The achievement of these goals involves both "destructuring" and the elaboration of new procedures. Destructuring involves the questioning and abandonment of ineffective understandings and strategies of living, and must precede the

development of new and more satisfactory modes. It is accompanied by anxiety and confusion, and can only be faced if the patient can sense that the therapist, as a person and through the understandings he conveys, is with him. Restructuring demands the acquisition, in the context of this human experience, of new understandings and new ways of acting. Psychoanalytic approaches have paid most attention to the destructuring process, while behavioural and cognitive approaches have emphasized restructuring. The focused, active, integrated therapy proposed here, which may be labelled, after its origins, cognitive-analytic therapy, attempts to combine the strengths of both.

While the general goals discussed above serve to indicate the direction of change that is desirable, in formulating the detailed goals of an individual therapy one is more concerned with the identification and eradication of the *obstacles* to these general goals. We do not usually have to tell our patients how to live, although to indicate that perhaps they might live more fully is helpful; but we are always concerned to help them overcome the ways in which they are currently stopping themselves from living. The individual goals drawn up at the end of the assessment of a patient need to describe the aims of therapy in terms of these obstacles, and to define the obstacles as far as possible in ways indicating possible alternatives or necessary changes. The aims of therapy will, therefore, include overcoming blocks or distortions on perception or understanding, assisting fuller access to feelings and personal meanings, changing negative self-referrant assumptions and judgements, describing self-identity and strategic scripts of which the patient is not aware, and identifying traps, dilemmas, and snags. In discussing therapy in these terms with the patient, one is explicitly offering him access to the model of his difficulty which one is using in the conduct of the therapy; this reinforces his self-understanding and his self-control, and diminishes the likelihood that he will seek to hand over all responsibility to the therapist. It is usually helpful to discuss explicitly both the aims and the model at an appropriate level of detail, and I personally prefer to write the goals down.

Target problems described in this way provide a conceptual framework for therapy and also serve as a basis for rating progress at intervals. Formulated in this way, they point emphatically to the ways in which the patient's patterns of belief, conceptualization, and action are responsible for his difficulties, and they show him that, to lose symptoms and to alter his experiences and increase his control, he must revise his underlying procedures. Such revisions may be encouraged by many different means, including explanation, instruction, confrontation, the encouragement of different forms of behaviour, teaching forms of self-observation and self-control, and the interpretation of the transference. In addition to these methods, I believe that the act of sharing the concepts and the model with the patient is itself therapeutic. Kuhn (1962), by describing how scientific progress is held up because of the reluctance of scientists to discard old, familiar, but restrictive paradigms, offered to scientists a chance to become more aware of, and to guard against, this reluctance, which reflects the universal human need to maintain a more or less stable representation of the world, and an understandable unwillingness to discard understandings which have served in the past. By formulating the general goals of therapy in terms of changing assumptions and strategies, the psychotherapist can, in the same way, free his patients from their restrictive paradigms and help them elaborate more adequate ones.

The task of making sense in this way of the patient's account of his difficulties and of reformulating them varies in complexity. The recognition of negative assumptions or of a conditional or precarious sense of self-esteem is usually quite evident from the patient's story and also from his demeanour during the early sessions, although patients will often present themselves in these respects as if they were describing their personalities rather than their difficulties, and the therapist may need to identify these aspects of self-description as problematic and potentially changeable. Difficulties over experiencing and expressing feelings, and defensive strategies, may or may not be easy to detect; attention must be paid to what is not said and done as much as to what is, and much will depend upon the human style and sensitivity of the therapist. A full discussion of which treatment method to use, and how to combine them, is deferred to Chapter 10, by which time different therapeutic procedures will have been described.

THE INFLUENCE OF THE SETTING

The decision about what method of treatment to use cannot be taken solely in terms of the patient's problems; it must also take into account the therapist's skills and setting. In a formal psychotherapeutic situation, this will be relatively simple, but much valuable counselling and therapy takes place in other contexts with professional workers whose roles are more general. General practitioners and social workers are easily accessible to troubled people, and they are therefore frequently their first resource. Many of them accept counselling and therapy in some form as being an aspect of their work. Traditionally, the main response has been a supportive one, through the provision of a friendly ear and the offer of encouragement through difficult times. In many situations this is an appropriate and adequate response but it is not always helpful. Just as the long-term use of tranquillizers and anti-depressants to treat symptoms of emotional stress is, I believe, harmful, in that it provides a pseudo-medical label for life problems, so in some cases the provision of long-term supportive care can be equally habit-forming and equally irrelevant to the solution of the patient's problems. Most doctors and social workers will, of course, carry a few patients in their care whose lives are so troubled and whose personalities are so fragmented that long-term supportive care is appropriate; but, even for some of these, and certainly for the far more numerous ordinary troubled or moderately neurotic people, and for those struggling to adjust to everyday losses and stresses, I believe a brief, more explicit psychological intervention, aimed at extending the patient's skills and capacities, would often be preferable.

Such an approach involves the setting aside of enough time to make a proper

initial assessment; but the understandings so gained allow later interviews to be brief and focused. The form of explanatory framework offered in this book, describing problems in terms of aims, procedures, assumptions, defences, traps, dilemmas, and snags, is a suitable one for work in these contexts, although the focus of the intervention will often be more restricted than would be the case in a formal psychotherapeutic situation. For example, if psychotropic drugs are being prescribed to control symptoms such as anxiety attacks or depression, the patient can also be given written instructions on self-monitoring his mood changes (see next chapter). This procedure aids diagnosis by adding information about the circumstances of the attacks, and it can also increase control of symptoms. Other symptoms or problems may respond to simple behavioural methods, and many people, given clear descriptions of their problems in terms of the concepts of traps, dilemmas, or snags, can manage their lives better without much further support being needed.

A more problematic question arises in respect of the transference, and the use of transference interpretations as a means of therapy (see Chapter 9). If strong feelings develop in the patient's or client's relationship with a doctor or social worker (and this can happen where long-term support is given) or if such transference feelings are made the main focus of treatment, then it is very difficult to provide general medical care or to carry out statutory social work responsibility, because the real and the metaphoric aspects of the relationship will become inextricably entangled. For doctors, moreover, the possibility of highly emotional and sexual feelings developing in the transference would make physical examination of the patient inappropriate. An understanding of how transference may be manifest is therefore of importance to all professionals, not least because it can occur in situations other than a psychotherapeutic one; but therapy based upon its encouragement and interpretation should only be carried out in an explicit and exclusive contract, which means that other forms of care must be carried out by somebody else.

CASE HISTORY EXAMPLES

Both David and Anne were given written instructions in the form of the "personal therapy file" (see Chapter 14), which consists of descriptions of how to consider and list symptoms, how to recognize unwanted beliefs and behaviours, how to monitor unhelpful thought patterns and how to recognize traps, dilemmas and snags. Anne and David had also done repertory grid tests (see Appendix); these will not be further discussed here, but the completion of them and the discussion of the analysis of their grids probably served to heighten their awareness of patterns in their relationships. At the end of this assessment period, their thoughts, as provoked by these procedures and the first sessions, and as recorded by them in their personal therapy file, and mine, as formed in the course of the sessions and from the results of the test procedures, were the basis upon which we drew up a list of treatment goals. These goals were recorded and formed the basis of rating scales, as follows. Each problem or issue, as it was at the time of the first consultation, constituted the mid-point of a vertical visual analogue rating scale. Subsequently, at points indicating the date, deterioration or improvement were recorded by making marks on a ±20 mm vertical line, labelled at the bottom "worse", and at the top with the treatment aim. These goals are described succinctly in terms of symptoms, beliefs or assumptions, traps, dilemmas, and snags.

David

David's list of problems read as follows:

1. Depressed mood; aim, to be normally cheerful and energetic.
2. Not feeling in control of my life; aim, to have a sense of appropriate control over my life.
3. Not able to work; aim, able to work effectively.
4. Sadness and anger over Patricia; aim, to complete the mourning process.
5. Trap (a version of the placation trap): self-uncertainty, leading to adoption of a helpful, placatory role, leading to a sense of my own needs being unmet, leading to resentment or childish reactions, leading to feeling bad about myself; aim, to assert my own needs while recognizing those of others.
6. Dilemma: *either* guilty and submissive *or* amiably controlling in relation to others; aim, more mutual terms.
7. Dilemma: *if* dependent, *then* not in control; aim, able to control by adequate autonomy and mutuality, while risking some dependence on others.
8. Dilemma: *if* submitting to others, *then* not cross; aim, able to assert own needs and defend them if necessary.
9. Snag: diminishing my own life *as if* needing to expiate for my parents' divorce and father's depression; aim, able to take control over life without guilt.

In the session at which this problem list was assembled and discussed, the last point, already raised in the second session, as reported in Chapter 4, and discussed at other times, was discussed once more, as follows.

> AR: About the snag, I felt that operating very strongly when you were talking about your work. I had the feeling that you were giving away in advance any chance of a good degree, which didn't seem a realistic prediction of the effects of one term's impaired work. It seemed to me to be a way of saying, "I'm not going to claim that", which implies the possibility that you would feel guilty of things seemed to be going well. Now, I know it's very hard, if you don't sort of immediately feel that's right, to know whether it is.
>
> DAVID: Well, I've actually thought along lines like those before, especially recently, but before too. I mean, trying to work out why something's gone wrong, when the capability was there to make it go completely right, and I wanted to know why.
>
> AR: Maybe the "why" was because you arranged it that way?"
>
> DAVID: Well, once these sort of pitfalls started becoming apparent time after time after time, you are bound to think like that.

Anne

Anne's list of target problems was as follows:

1. Preoccupied with the fear of nervous breakdown; aim, to be no longer scared.
2. Suffering from depression and hopelessness at times; aim, a normally hopeful mood (this description was unsatisfactory, for at the first rating she felt that she was feeling her depression *more*, while feeling *less* hopeless).
3. Inability to trust others; aim, able to trust appropriately.
4. Compulsive caretaking; aim, to be able also to be dependent in a mutual way.
5. Unhelpful thought cycles with depressive origins and depressive outcomes; aim, control over depressive thinking.
6. Social isolation trap: being self-isolating, keeping distance from others, leading to perception of others as being unfriendly, leading to further self-isolation; aim, to be able to extend friendships and social contacts.
7. Trap: self-deprivation maintained as a means of relieving inappropriate guilt; aim, proper self-care and self-permission.
8. Dilemma: *if* feeling helpful and effective, *then* imagining the future death of one or other parent, with the responsibility for the survivor, leading to guilt and depression; aim, a more realistic view of responsibility for parents.
9. Dilemma: *either* helpful and controlling (the preferred role for self) *or* dependent and potentially crazy; aim, mutuality in relationships.
10. Dilemma: *if* loved, *then* feeling trapped and guilty; aim, able to accept love and care without feeling the loss of freedom or guilt.
11. Dilemma: *if* striving for perfection, *then* stressed; *if* not striving, *then* guilty; aim, to be able to work from interest, ambition, pleasure, and for realistic ends.
12. Snag: avoiding fully achieving, enjoying, claiming, or having, a life, as if own life is at the cost of my mother's; aim, to be able to claim my life.

The role of guilt and guilt relief evident in Nos. 7, 10, and 12, was described by Anne on her therapy file as follows.

> I feel guilty and I feel I do not deserve love and affection when everything seems to be going well; when I have all, or any, or these I destroy it and feel miserable, unloved, alone, and that everything is going badly, but I feel comforted that I have got what I deserved, and feel my guilt disappearing.

These lists of aims for David and Anne represent bald summaries of the work of the first sessions, work consisting essentially of elaborating on their presenting symptoms and transforming them into descriptions that identify the underlying assumptions, patterns of action, traps, dilemmas, and snags. We can now consider how these translations are related to the basic model of the procedural script, and how they provided the basis for planning treatment.

David

In David's case, his depressed mood and work difficulty were linked together, constituting one potentially self-maintaining process, whereby negative assumptions, negative predictions, and negative retrospective evaluations of his performance had led to his giving up trying, with the development of catastrophic

predictions about the future effects of this state. When he was first seen, he had already missed some weeks of work, and he had failed one assessment exercise, so there was a serious issue in reality. This was tackled from the first interview by:

(a) arranging to write to his tutors. The discussion of this revealed some aspects of David's self-deprecation; he had dismissed his past good grades as undeserved, he was reluctant to expose his weakness to them, and he felt that my certificate of impairment would constitute an unfair advantage. However, after discussion, the offer was accepted;

(b) he was encouraged to plan a work programme which was initially minimal, and to record his progress on this, increasing the requirements only when he had achieved the set tasks appropriately;

(c) he was encouraged to visit tutors and plan with them the best use of his limited current capacity;

(d) I argued with him that his estimation of the long-term effects of his present state was unrealistically gloomy.

These steps were intended to forestall and reduce any possible negative reactions from tutors, and to help him plan tasks which he could achieve, and from which therefore he could begin to rebuild some positive evaluation of his capacity, and meanwhile help him deal realistically with the implications of his current state.

The issue of being in control of his life was far-reaching in its implications. In relation to this one, he had written as follows, in his personal therapy file.

> I do not control my own life as much as some people appear to control theirs; basically, I don't care about that, though, the point here is that by my own standards I don't consider what I do enough. I don't believe in myself enough to do it. I don't often get angry with myself, though, but I usually end up by feeling sad about it. I don't mean just now, I mean always. I tend to think that I have to have a reason for doing things. If there isn't a sufficient reason, I won't do them, or find it very difficult. I won't have my heart in it. I tend to think that, unless I can benefit others by what I do, whatever I do is less valuable; I doubt, and I think I have always doubted, myself so strongly. If the only person who will benefit from an action is me, then I doubt the value of it.

From this account, it is clear that David's procedural scripts were based upon negative self-judgements, and upon eliciting validation from his relationship with others.

His sadness and anger over Patricia's loss was, in part, an appropriate response to a loss, and to the unkind way in which it had occurred. The sense of it having "happened to him" increased his depressive passivity, although he also recognized, with hindsight and self-blame, that he had contributed to the event. The depth of his response suggested that the implications were wider; it was seen as being linked with his general dependence on others for his self-definitions and this, in turn, led to a consideration of the possible implication of his separation, at the age of four, from his mother. It was as if he had assumed, from that first experience, that "if you depend on others, they will leave you". This prediction was confirmed when his first important relationship ended, but he had rapidly replaced that one with

Patricia. At the strategic level of his relationship scripts, David recognized how the options open to him in relationships were limited to those summarized in the dilemmas listed as Nos. 6, 7 and 8. As regards No. 7 in particular, he felt very unhappy at being incompetent and needy, and he had not been able to seek the support of any of his close friends, although for many of them he had, in the past, been a helpful person.

In planning David's treatment, the control of the depression in the way described above was clearly the first priority. The other issues were more extensive in their implications, but the formulations made of them served to link together the two issues which brought him into treatment: the problem of not being in control of his life, and the problem of his extreme reaction to Patricia's departure. A treatment plan was made on the basis of his early formulations, determined also by the fact that only a limited amount of time was available for him to see me. A contract was made for that period (under 4 months), during which he was offered appointments at fortnightly intervals. These intervals were determined in part by my availability but reflected also my feeling that David needed to experience coping on his own. It was hoped that this treatment plan would enable David to control his depression, to resume work, and to start some exploration of the wider issues. In view of the extent, and long-term nature, of these, I also suggested that he should subsequently join a therapeutic group. In the event, he did not do this, and I saw him individually for a few spaced-out sessions after a gap of 5 months.

Anne

Anne sought help with two problems: a fear of a nervous breakdown and depression. She used self-monitoring to understand and control her depressive thinking, with good effect. She had not realized before the extent and exaggerated nature of many of the thoughts which accompanied her lapses into anxiety or depression. The following are examples of such thoughts listed in her personal therapy file; they were collected over a period of one week.

1. I get sudden, or sometimes continuous, physical symptoms to do with anxiety, usually these are located in my right temple; as tension develops, I feel that my brain is disintegrating and splitting up, being hammered or beaten. This develops into feeling that I am having a nervous breakdown. I associate these moods with my mother's breakdown; this thought then leads to more fears and the feeling of actually having a breakdown.
2. When I haven't felt any tension for a while, I wonder if I can still remember what it's like. This produces a mood change and I get some comfort out of this, because I feel worried if I go for periods without the tension, feeling I am undergoing some other physiological change, which is also symptomatic of a nervous breakdown. That makes me depressed because it indicates how pervasive and time-consuming my fear is; then I think I'm a hopeless case, and I wonder how I'll survive life if I continue in this fashion.

3. Any thoughts about my family produce a mood change.
4. I feel a bump on my head and I imagine it's cancer and feel tense.
5. Feeling tired, I tell myself I should go to bed. The thought of sleep makes me think of mother's last breakdown, which occurred in the night.
6. I hear an ambulance and immediately think of mother being taken off to hospital.
7. I clean my teeth and look at myself in the mirror and I wonder if I look strained and old and think about myself.
8. Often, watching a film on television, I can become depressed or anxious; usually where the people are free and happy and everything is marvellous, I feel lonely and scared that I can never be like that.
9. Quite often, having thoughts like this leads me to think that to think in such a distorted way is to lead to a nervous breakdown, therefore I cannot win.

Anne's difficulty in trusting and its manifestations in therapy have already been discussed in Chapter 3, and was related also to the social isolation trap (problem 6). The description of her compulsive caretaking represents my summary of her preferred role; it describes an inferred, restrictive relationship script. The dilemmas listed as problems 9 and 10 refer to the same issue. Basically, Anne preferred giving to receiving because, in her terms, to receive implied powerlessness and guilt. In terms of the PSM, her repertoire of available means was limited to dichotomized role alternatives. Problem No. 11, her perfectionist work attitudes, describes a characteristic which she herself had regarded in the past as normal and virtuous or, at least, necessary, but which I saw as being related to the effects of an unduly harsh and critical self-judging script. The description of her snag (No. 12) and of the associated dilemma (No. 7) gave her an explicit understanding of her guilt and negative actions which she had not had previously.

As in the case of David, therefore, the work of the early sessions had converted a passive state of suffering into a preliminary understanding of the underlying issues. Anne's relatively severe distress and her clear ability to work effectively in therapy made her a suitable case for treatment, and she was offered weekly sessions for a period of about 8 months, the extent and exact duration being left for later discussion. In the event, after a 5 month gap, a second period of treatment was given.

The emphasis in this chapter, and throughout the book is on focused therapy, with goals or aims agreed between therapist and patient, after initial assessment interviews. I believe this to be a suitable model for most therapies, particularly for brief ones. It is clearly an improvement on the totally undirected approach caricatured in the comparison made between psychoanalysis and Columbus's voyage to America: namely, when he left he did not know where he was going; when he got there he did not know where he was; when he returned he did not know where he had been; but he knew he had had an experience. However, it must be said at this point that, for some people, the need is for just such an uncharted voyage, and for them the premature imposition of focal aims would be inappropriate. I am not certain whether I can describe clearly how one can recognize these patients.

although in practice I usually find it obvious during the first hour or so of contact. I think there are two factors here: the patients themselves are usually people who feel incomplete in some way, out of touch with, but aware of, something valuable in themselves, perhaps as the result of a failure to mourn for the loss of an important person, perhaps from some early sense of having "gone underground" due to not being recognized for what they were. The second factor is in the way they use the early sessions, and is a transference or transference/countertransference manifestation (see Chapter 9). These patients seem to understand right away the metaphoric possibilities of the situation. All they want is to be allowed to *be*, in relation to the therapist, in ways that include the lost or submerged aspects of their natures; they want to be known so that they can know themselves. This process of getting in touch with the self is, to some degree, an aspect of most therapies, but for this group of patients it is the only one, and an emphasis upon "doing", which is implied by a problem-oriented approach, would be unsuitable.

DISCUSSION

Selection

There is no clear agreement about the criteria of suitability for brief psychotherapy. Sifneos (1972) quotes the following positive factors about the patient.

> His capacity to recognise the psychological nature of his symptoms, his ability to introspect honestly about emotional difficulties, his curiosity about himself, his willingness to change himself, his realistic expectations of therapy, and his willingness to make reasonable sacrifices of time or money for fees.

In my view, this represents a somewhat ideal list, at least for an unsophisticated patient at first presentation, although a good therapist would hope to achieve most of those criteria in his patients by the end of the assessment period. Malan (1976a) quotes the following as excluding criteria.

> A history of suicide bid, drug addiction, convinced homosexuality, long-term hospitalisation, more than one course of electroconvulsive therapy, chronic alcoholism, incapacitating phobic or obsessional states, destructive or self-destructive acting-out.

This list seems a somewhat mixed bag and unduly excluding in some respects. In my own view, treatment with the proposed integrated approach might well be offered to some people in all those groups apart from the drug-addicted or alcoholic, although additional treatment methods might be required. Suicidal behaviour and destructive acting-out are both commonplace problems in psychiatric practice, and while drug therapy may have some part to play in such cases, most could be helped by some psychotherapy; the choice will usually be between brief psychotherapy and none at all. In my experience, focused, active methods can be effective in such cases, even though subsequent long-term work, either group or individual, may be the ideal.

Some of the fifteen cases described in a recent paper (Ryle, 1980), concerning the

application of focused, integrated, active therapy, would be excluded on Malan's criteria but were, in fact, helped by brief therapy. Two cases of anorexia with binge–vomit cycles (Cases 3 and 9), one case of repeated self-injury (Case 8), and one case with powerful suicidal urges (Case 11) showed definite gains from brief therapy. The exclusion of homosexuals, except where the treatment is directed at changing sex-orientation, seems quite unnecessary. Severe phobic and obsessional cases may need to be treated behaviourally in the first instance, but the majority will need, and be suitable for, brief interpretive therapy thereafter.

I remain personally unclear about the criteria distinguishing those who need a long and intensive treatment as opposed to brief psychotherapy. Some patients with major difficulties do very well with brief therapy, and some less ill patients do rather badly in long-term and intensive therapy. As the latter is, in any case, beyond the financial means of most patients or services, an initial period of brief focused therapy would seem to provide the best option; on the experience of this a proportion may well proceed to further individual or group therapy.

Therapists of the cognitive and behavioural schools pay remarkably little attention to diagnosis and selection, as a sympathetic reviewer (Kovacs, 1979) points out in discussing treatments for depressive disorders. In the case of the more extreme behaviourists, a reluctance to consider issues of self other than as a "mediating process" does not encourage attention to issues of personality structure and integration. This simple approach engenders a certain therapeutic optimism, however, and does at least lead to attention being paid to what may be capable of modification.

The focus of treatment

Behavioural therapists restrict their therapeutic endeavours to observable behaviours, and plan their therapies in terms of explicit programmes, leading to discrete goals. The definition of a focus for treatment is therefore an essential element in such therapies. For therapists of the psychoanalytic persuasion, on the other hand, the preference for time-unlimited, open-ended therapy has only slowly yielded to the idea of time-limited, focused work, even though there is by now a long tradition of heresy (see Wolberg, 1965). More recent authors (reviewed by Malan, 1976b) show some agreement about the nature of the focus, although there are still areas of dispute. Mann (1973) instituted a rigorous 12-session limit on all therapies; he put emphasis, from the beginning, on the relationship of the patient's problems to issues of independence–dependence, activity–inactivity, self-esteem and unresolved grief as provoked in the transference by the time limit. This single emphasis seems unduly restricted.* Sifneos (1972) uses a confronting anxiety-arousing technique, emphasizing the interpretation of ambivalence and resistance in the transference and its relation to past history, especially to oedipal issues. His

* But Mann, J. and Goldman, R. in "A Casebook in Time-limited Psychotherapy" (McGraw-Hill, 1982) describe clearly the definition of "central theory".

approach (see Davanloo 1980) can seem confronting to the point of provocation. For Malan (1976a and 1976b) the focus represents the therapist's choice of a psychodynamic theme. Such themes may represent a nuclear conflict of deep significance, or a less central issue. The therapist maintains the patient's involvement with this theme by selectively attending to, and interpreting, only those issues related to it. Malan reports that the patient's willingness to work with this kind of interpretation, the therapist's ability to maintain a focal approach in this way, and the linking of feelings about parents with the transference in relation to these focal themes were the three factors associated with successful outcomes in the cases treated with brief psychoanalytic therapy by him and his colleagues. It should be noted, I think, that these themes are clearly the ones with which they would have been most comfortable in view of their theoretical predilections.

The process of agreeing explicit goals, described in this chapter (and in Ryle, 1979a and Ryle, 1980) is similar to the cognitive/behavioural approach in so far as goals are spelt out very clearly. However, target problems, dilemmas, traps, and snags represent a more complex description of mental and behavioural processes and assumptions than do the target symptoms and behaviours of cognitive/behavioural therapists. In the emphasis on cognitive issues — assumptions, beliefs, and processes — these goals are referring to "dynamic" issues of the sort described in different terms by psychoanalytic therapists. They represent, in effect, hypotheses about the sources of difficulty, described in terms of "current procedures" although often informed by historical material. They may include, but are not exclusively concerned with, aims and beliefs and procedures of which the patient is not, or has not been, aware. Their accuracy and relevance will be tested out in subsequent therapy and the application of the ideas in the patient's life. The explicit sharing of these concepts at this stage distinguishes the approach I propose from psychoanalytic methods, the patient being given an idea of the therapist's model and of its application to his problems. He is in this way invited to be his own problem-solver, and the use of any particular procedures will be understood by him in the context of this general picture. The inclusion in these hypotheses of descriptions of procedures that are inflexible and no longer relevant, but are not necessarily the result of dynamically repressed issues, is another point of differentiation from the focus as described by Malan. Where the limitations of time or the extent of the patient's difficulties are such that only some issues can be dealt with, a decision as to which to attend to will be made in terms of the overall understanding and of the accessibility to change of the different problems. These strategic decisions will be more fully discussed in Chapter 10, after other therapeutic methods have been considered.

8

Active Methods in Therapy

As we have seen, the diagnostic and exploratory focus of the assessment phase of therapy does not rule out the introduction of comments and procedures designed to initiate change. In the same way, the emphasis upon change during the active process of therapy does not imply that the explanatory concepts formulated in the early stages may not be modified and extended. In time-limited therapy, however, it is important to identify the main goals early and to proceed primarily along the lines determined by those goals. In every case there will be continued discussion of the central issues, namely the adequacy of the patient's grasp of the reality of his experience, his maladaptive beliefs and assumptions, the nature and possible restrictiveness of his self-identity and strategic scripts, and the blocks on his changing—described in terms of traps, dilemmas, and snags. The understandings encapsulated in these ways can be applied to the patient's history, to his current life situation, and to his relation to the therapist. For many patients, this process of grasping and using new ways of looking at their problems is all that is required, and the therapist's role is to hold him to this task, to be alert to the ways in which older patterns of thinking continue to be manifest, and to help him form realistic evaluations of his progress. Beyond this, however, patients may be helped by two rather different methods: on the one hand by various active specific procedures, and on the other through the experience of the developing relationship with the therapist. In this chapter, we shall consider the use of active techniques, leaving the question of the relationship with the therapist to be discussed fully in the next chapter.

In using active methods, the therapist is attempting to modify, by instruction, encouragement and guided experience, the self-monitoring, self-judging, and self-control exercised by the patient (PSM Stages 4 and 6) and to extend his skills (PSM Stage 3), so that he can learn to recognize and name his feelings more accurately, to understand and control his symptoms, to alter his unwanted patterns of behaviour, and to modify unhelpful ways of thinking (PSM Stages 7, 1, and 2). Behavioural and