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

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

- David Malan

The central therapeutic focus

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

The establishment of, and working within, a core focus is among the most problematic issues which those coming from a psychodynamic background and training face when beginning short-term therapy. This is a result of the need to pay selective attention and use benign neglect in focal therapy. Both are ways of avoiding becoming overwhelmed by the sheer volume and breadth of clinical material. Both challenge orthodox analytic practice, where the therapist enters every session 'without memory or desire' and all material is 'relevant'. In true post-modernist fashion, no material is implicitly more important than any other. This is not the case in time-limited therapy, where material in the realm of the core focus is considered significant, while clinical material falling outside the immediate realm of the focus needs to be jettisoned or considered solely in terms of whether it has any bearing on, or relevance to, the central focus.

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

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

- A developmental stage (such as separation).
- A state (such as grief).
- A conflict (such as writer's block).
- A symptom (such as anxiety).
- A drive (such as sex).
- A life pursuit (such as a job).
- A role (such as being a parent).
- An identity (such as being gay).
As Groves says, the list is relatively endless but will also depend in part on the specific theory of emotional development held by the therapist. The focus is partly determined by the therapist's theoretical approach, which could place differing emphasis on establishing a focus which is either primarily symptomatic, based on a specific issue, or broadly characterological, based on a personality trait. Developmental considerations play a part in considering a core focus – the same event may have a different meaning at different ages and developmental life stages.

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

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

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

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

Dynamic therapists may find this problematic.

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

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

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

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

The active therapist: a contradiction in terms?

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

This active participation between client and therapist does not necessarily come naturally. As early as 1942, Sándor Rado drew attention to the need from the beginning of therapy for the therapist to attempt to 'counteract the patient's tendency to sink himself into a safe comfortable transference neurosis'. A similar danger confronts the therapist less used to working in a time-limited fashion. Alexander, when stressing the need for therapeutic activity, commented on the assumption that a passive therapist 'will solve everything as if by magic' and that this has the effect of 'prolonging many treatments unduly'. He went on to suggest that 'curbing the patient's tendency to procrastinate and to substitute analytic experience for reality... (through careful manipulation of the transference relationship, by timely directives and encouragement)... is one of the most effective means of shortening treatment' (in Barton et al. 1971, p. 40). As we have seen, Alexander's emphasis on the active, engaged therapist rapidly became discredited and, in an effort to shield itself from Alexander's legacy, psychoanalysis retreated behind the belief that anything which was not 'interpretative' was likely to be 'suggestive' or in danger of 'influencing' the patient. Anything that could not be classed as an interpretation was 'not psychoanalysis'.

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

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

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

Therapeutic activity

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

While Freud (1912) advocated a suspension of 'judgement, and [giving] our impartial attention to everything there is to observe
... maintaining the same evenly suspended attention in the face of all one hears', he also, in the case of Little Hans (1909, pp. 1-145), suggested that although ‘it is not in the least our business to understand a case at once', this understanding can be achieved when ‘we have received enough impressions of it'. These 'impressions', which come close to what we have termed contemporary ‘idioms', are what form the focus of the therapy and can be elicited only by the active engagement of the therapist.

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

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

Resistance

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

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

(The patient’s manner of resistance usually has more implications for how that patient interacts with others than the original content he or she was avoiding expressing. The patient’s way of resisting, to a large extent, determines his or her personality style. To escape what is feared, what is being defended against, becomes the person’s characteristic mode of relating, which often leads to the dysfunctional interchanges with others. (Levenson, pp. 188-9)

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

Jason

Jason, a 28-year-old Irishman, had recently arrived in Britain to begin a professional career. He made an appointment with a counsellor at the suggestion of his GP after collapsing in the street with chest pains for which no physical cause was found. This followed a long history of mystery ailments. Jason explained his background of being a ‘worrier’. He was an only child of over-attentive parents who were themselves highly strung, socially withdrawn and prone to stress-related illnesses. Although affable and sociable he had not had any sexual relationships and acknowledged that he was confused ‘about that whole area... I don’t really need a relationship; it’s just another thing to worry about.’ Jason could only worry about one thing at a time. The most striking thing about Jason’s initial consultation was his manner. He was pleasant and courteous, while continually making
reference to the fact that he knew what the problem was, and had been able in the past to conquer his problems by ‘talking myself out of my difficulties’; he knew he was a worrier and that his concerns about his health were ways in which he dealt with other possible worries, but, ‘I don’t want to become like Oprah... no offence to you, but I don’t want counselling to become another thing to worry about.’ Jason’s idiom became apparent quite quickly in the opening meeting, but dealing with his resistance needed some thought – merely confronting it head-on (along the lines ‘You are worried about your body as a way of avoiding worrying about your mind’) would have led to Jason using his characteristic way of dealing with stressful material: a pleasant and polite denial coupled with a statement suggesting that it was a valid hypothesis which he had already thought about but, on reflection, not one that he could subscribe to. Instead the counsellor took up Jason’s statement that he did not want to add counselling to the things he had to worry about by saying that this was exactly what the counsellor thought could be helpful – after all, by worrying about coming to see the counsellor Jason might ‘forget’ about his other worries since, as he had earlier stated, he was the kind of person who ‘could only worry about one thing at a time’. This also had the effect of linking the process of counselling with Jason’s current anxiety about relationships and his parents’ ambivalence about social relationships.

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

Transference interpretations

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

The positions taken in relation to transference interpretations by time-limited therapists tend to differ along conservative and radical lines. Conservatives, believing short-term therapies are more aimed at mild problems of recent onset, as opposed to characterological problems, tend to avoid transference interpretations, since they are viewed as premature unless a transference neurosis has developed. The radical camp, believing that shorter-term therapies can address more severe problems, suggest that transference interpretations, in addition to historical reconstruction, are appropriate and can lead to lasting characterological change. Here again the fault line tends to be between those clients who are able to use transference interpretations and insight-oriented techniques and those who cannot. Increasingly, however, the evidence suggests that therapists may need to be more radical than they imagine. For an interesting account of Malan’s conversion to the radical camp, see Davanloo (1978).

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

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

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

By promptly addressing negative feelings one is likely to be addressing the client’s core idiom as well as the triangles of persons and therapy.
They are inappropriate or unnecessary when:

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

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

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

One development in psychoanalytic theory with regard to transference of direct relevance to short-term therapy is the importance placed on the client's reaction to the interpretation rather than the effect of the interpretation itself. Whether an interpretation is 'right' or 'wrong' is of less importance than the way it is experienced and internalised by the client. The client may have a 'relationship to the interpretation' (Racker 1968) which reveals much about their idiom and the way they are emotionally processing the therapeutic experience. I recently suggested to a client, whose presenting problem was difficulty with her boyfriend, that she appeared hostile to me - in fact, not unlike her description and experience of her partner. She refuted this, saying hostile was the wrong word; angry, yes, but not hostile - 'Hostility is what I feel towards my mother!' It is the emotional response to the interpretation or comment that illuminates rather than the intervention per se.

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

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

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

Claire

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

In the opening session Claire began by appearing thoughtful and reflective, saying interesting and, at times, amusing things about herself and her life, but as the session 'wore on' the therapist became aware of a feeling that it seemed interminable. Glancing at his watch, he was shocked to see that there was a further half an hour of the session left. He had to admit that he was bored. The more bored he felt, the more boring Claire became, her voice frequently trailing off into a desultory murmur. It came as no surprise when Claire eventually asked the therapist 'am I boring you?... I think my previous therapist got bored with me as the therapy just petered out...'. The therapist was now faced with having to metabolise his counter-transference of tedium and languor with Claire's here-and-now transference. This conveyed, through the process of the session, Claire's anticipatory hope and expectation, which eventually became disappointment and annoyance turned against herself. It also gave a graphic account of her relational problem and indicated that however hard she tried, she was inevitably trapped in her family's depressive culture. The therapist felt that it was this here-and-now transference, rather than a there-and-then transference, which needed to be addressed. He did this by reflecting back to Claire the process of the session (that she had begun brightly only to tail off) and that it seemed that Claire's demand on herself to interest others had only the inevitable effect of making her experience herself as boring. The therapist said that he was aware of a stodgy and soporific quality that engulfed the session after the initial enthusiasm, and wondered whether this showed just how problematic Claire found new experiences. This dealt with the transference resistance and the here-and-now therapeutic process, and would provide a focus for the ensuing work. One aspect of the focused work, during which the therapist suggested that perhaps Claire needed to practice being 'more boring' (having established a therapeutic idiom where this form of playfulness was possible) was the recognition that the demand on herself to entertain or interest others was as impossible and absurd as the suggestion that she should be a better bore. This was a therapeutic breakthrough, leading to livelier sessions which was also manifested itself in Claire's increasingly pleasurable daily life.

The concept of working through

A further problematic area for those focal short-term therapists trained in open-ended therapies is the concept of working through. It is another area in which shorter therapies challenge the beliefs implicit in more open-ended therapies. In time-limited therapies there is little of this process which is thought central to longer-term therapies. Working through is in many ways one of the most diffuse psychoanalytic concepts. In open-ended therapies the process of therapeutic internalisation and assimilation—or, less analytically stated, learning—takes time and needs to be approached from very different angles. Personality is complex and time is needed to address the many differing aspects of the client. Working through generally addresses this by pointing out to the patient how the conflict and its defences are manifest in the various aspects of the patient's life both within and outside the transference. This process of repeating and deepening interpretations as the conflict shows itself in many diverse areas is known as working through. (Flegenheimer 1982, p. 11)

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

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

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

Alexander (in Barton 1971) had already drawn much hostility from the orthodox analytic community when suggesting that patients, having learned their therapist's predilections, bring seemingly interesting material to allay the analyst's impatience and give an impression of steady progress and deepening analytic insight. While the analyst may believe they are engaged in a thorough 'working through', in reality the procedure has become a farce. (p. 37)

And Mitchell (1997), postulating that working through is that 'most elusive, murkiest' of all Freud's technical concepts, suggests that it is a process during which the therapist continues to make the same interpretations or similar ones during stagnant periods when nothing seems to be happening in the hope and belief that something useful may happen if the therapist continues with his interpretation(s). (p. 43)

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

In short-term focal therapy the working through begins after the therapy is finished. This may in practice be little different from the more open-ended therapies. The process of working through begins after the last session - we get on with the process of continually having to metabolise our emotional experiences. This is part of daily life rather than a specific aspect of the therapeutic setting.

Finite time or topping-up time?

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

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

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

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

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

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

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

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

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

Termination in short-term therapy

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

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

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

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

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

Summary

In this chapter we have discussed:

* The importance of maintaining a therapeutic focus; this discussion:
  - Distinguished between focal and nuclear conflicts.
  - Stressed the need for 'selective attention' and 'benign neglect'.
  - Defined the major focus in terms of a relational style, or the nature of the client's interpersonal relationships, and suggested that sub-foci are either developmental conflicts or life event difficulties. Both the focus and sub-foci have to be linked in some way to the triangles of persons and therapy.

* The concept of therapeutic activity as it applies to short-term therapy; this has:
  - Shown that therapeutic activity serves to prevent an unhelpful regression and the development of excessive dependence, which can only be addressed in longer-term, open-ended therapy.
  - Explored the difficulties that dynamic psychotherapy has with therapeutic activity.
  - Suggested that therapeutic neutrality, passivity and silence can be as manipulative and counter-therapeutic as inappropriate activity.
  - Discussed how therapeutic activity or passivity have to be linked to the central focus.
  - Underlined the importance of distinguishing therapeutic activity from offering advice, guidance, direction or suggestion.

* The place of transference, and transference interpretations, in focal therapy; this:
Stressed the need for early and prompt interpretation and exploration of any negative transference or resistance.

Discussed the differing approaches between the conservative and radical groups in relation to transference interpretations.

Suggested that the direct use of the transference, and insight-oriented techniques in general, need to be related to the client's capacity and willingness to work in this manner.

Found useful the distinction between a transference neurosis and the everyday-reality, here-and-now transference, in clarifying how helpful transference interventions are likely to be.

Suggested that transference material sometimes needs to be dealt with either metaphorically, in a third-party, 'as-if' fashion, to prevent transference interventions being experienced as persecutory or hostile.

The concept of working through as it applies to short-term focal therapy; this:

- Suggested that while there is little of this process in focal therapy, working through takes place after the termination of therapy as well as during and between sessions.
- Questioned how useful this concept is in its clinical applications.

Time and its relation to circumscribed, or topping-up, time-limited therapy; this:

- Suggested that this issue is linked to the developmental stage of the client and his previous experience of loss.
- Indicated that a balance needs to be struck between a flexible and judicious use of the time frame and the need not to deny or fudge endings.

The issue of termination in focal therapy; the discussion:

- Suggested that termination is more likely to be a central issue in therapy for clients presenting with pre-oedipal problems where issues of separation and loss are likely to be of significance.

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