James Mann

Time Limited Psychotherapy

Handbook of Short-Term Dynamic Psychotherapy

Time Limited Psychotherapy

James Mann

from
Handbook of Short-Term Dynamic Psychotherapy

e-Book 2015 International Psychotherapy Institute

From *Handbook of Short-Term Dynamic Psychotherapy* edited by Paul Crits-Christoph & Jacques P. Barber

Contents

ORIGINS AND DEVELOPMENT

SELECTION OF PATIENTS

THE GOAL OF TREATMENT

THEORY OF CHANGE

TECHNIQUES

CASE EXAMPLE

EMPIRICAL SUPPORT

CONCLUSION

References

Time Limited Psychotherapy

ORIGINS AND DEVELOPMENT

In 1962 the outpatient department of the division of psychiatry at the Boston University School of Medicine had too few professional therapists to provide for a growing list of patients awaiting assignment. Because the outpatient department was staffed by psychiatry residents at the time, the problem became mine as director of psychiatric education.

Not unexpectedly, a review disclosed that a significant number of patients were being seen regularly over long periods of time, even for years. Since they were being treated by residents who rotated from one psychiatric service to another every six months their treatment was interrupted twice a year. An examination of the records of some of these long-term patients revealed that, although they apparently related well to their new therapists, they tended to reexamine with each therapist much of what had already been discussed. Further, we noted that these patients did not appear to react strongly to the loss of the previous therapist; thus, we wondered whether transference to the institution and to the outpatient department had become more significant than transference to the therapist. It would seem that patients could go on forever, having their dependent needs well gratified—although their best interests would not be served. Patients awaiting treatment remained at a disadvantage.

In 1950 I had been director of the first outpatient department at Boston State Hospital, where I experimented briefly with time limited group psychotherapy, also under the duress of having a small staff and many patients. Since 1947 I had been working very closely with Elvin Semrad and had come to appreciate not only his unique, intensely penetrating, empathic interview style but also that the resonant chords he always struck in the hearts and minds of his patients played out the invariable theme of separation and loss with the psychotic patients he interviewed. He made apparent their need for a nurturant object of constancy.

Having long believed that the line from so-called normality through neurosis through various mental disorders into psychosis is a continuum along which, given the right toxic circumstances, any of us could descend at almost any time, I came to understand that the repetitive series of separations and losses that every human being endures forms the outline of the self-image that each person constructs.

The significance of time became clear to me in long-term work with psychotic patients, with psychotherapy patients, and with patients in psychoanalysis. No matter how long the treatment lasted, and no matter which therapeutic model, the prospect of the end of treatment was always an unstabilizing experience for the patient and had repercussions in the therapist. The reality of time, with its multiple meanings of separation, loss,

and ultimately death, became of overriding importance in every instance.

Confronted years later with the personnel-patient problem at Boston University, I felt it appropriate to apply my fifteen years of work and thought. I decided to implement a plan in which selected outpatients would be offered twelve sessions of treatment by second- and third-year residents. I thought twelve sessions following an evaluation should be enough in which to pinpoint a significant issue, elaborate it, and work it through to termination. Extant brief therapies did not specify length, although any therapy labeled brief would be expected to have some kind of time limit.

I wrote a fairly detailed description of the model and sent it to each of the residents, along with a memorandum proposing that each try it. I soon realized that I was asking for a drastic change from accepted methods and was not surprised that passive resistance prevailed. I decided that I would begin a seminar in Time Limited Psychotherapy (TLP) and asked the residents to select a patient for me to treat in twelve fifty-minute sessions following the evaluation. I knew that the residents would never choose an "easy" patient for me. Furthermore, as their experienced psychoanalyst mentor, I felt it would be instructive for the residents to see me make mistakes.

At the start the seminar was limited to residents, who observed my

work through a one-way mirror. As we progressed, social workers, psychologists, and psychiatric nurses were invited and we instituted closed-circuit television. In a brief meeting before each session we discussed what had gone on in preceding sessions and speculated on what responses we might anticipate in the upcoming session. After each session we met again for further discussion of the dynamic flow and reactions.

My private practice was primarily psychoanalytic, but as I found that my ideas about separations, losses, and time and their influence on the image of the self were being verified in my seminar and in my supervision of residents engaged in TLP, I began to treat a number of private patients in this mode. I still do. Over a period of some twenty-five years of seminars, supervision, and private practice the elaboration of details, substance, and subtleties substantiated the importance of what I have called the *central issue* as a means of entering immediately into the core of the patient's need for help. The combination of time and the central issue (Mann & Goldman, 1982) is very different from the usual concept of focus in brief psychotherapy. The concept of the central issue incorporating time, affects, and self-image also enables the therapist to glean a remarkable amount of information very quickly from the patient.

SELECTION OF PATIENTS

With the accumulation of experience our early caution about the suitability of patients for TLP has given way to the recognition that a wide variety of patients can be treated by this model. In this connection, the process in TLP is productive of so much information in the first three or four sessions that if a serious diagnostic error has been made and the patient is deemed unsuitable for this treatment, a change to some other kind of treatment may be easily made.

Two generalizations about selection can be made. First, TLP is indicated following a positive assessment of ego strength and its capacity to allow for rapid affective involvement and equally rapid disengagement—a measure of the capacity to tolerate loss. The capacity to tolerate loss is assessed in the evaluative interviews, during which the therapist learns from the patient how the inevitable multiple losses of life have been managed.

Second, in spite of significant defects in mothering and the absence of an early predictable environment, there are many patients who, for reasons not well understood, enjoy a resilience that allows them to emerge with relatively intact egos capable of rapid affective involvement and of tolerating loss. Each patient, regardless of the presenting complaint or early history, should be evaluated on his or her own terms with regard to ego strength, without preconceived theoretical biases. The assessment must be in terms of the relative success revealed in the life history with respect to work and in

relations to others.

These two generalizations aside, there are many neurotic patients with strong dependent longings who may refuse to become involved on any short-term basis, who will attempt to prolong treatment, or who may leave early in anticipation of termination. However, those who are aware of their dependency and have tried to come to grips with prior loss are often eager for help. The time limitation may be a very positive challenge for entry into successful treatment. There are also patients whose dependency may have been fostered by too much treatment with too many therapists. This kind of patient may do very well in TLP.

Patients with narcissistic disorders may tend to consider TLP as far too brief for their important problems and refuse treatment. But those with relatively mild narcissistic difficulties may experience the twelve sessions as a challenge and work effectively. They often require approval and positive feedback from the therapist. They can tolerate loss provided they feel that they have done a good job.

Into the categories of anxiety, hysterical, depressive, and obsessional disorders fall a host of dynamic issues that are amenable to TLP. Patients may present with a variety of symptoms, ranging from anxiety and depression to conversion reactions or obsessions. Under these headings characterological

problems may predominate, such as repetitive unsatisfactory love relationships, problems in work or school adaptation, or difficulty with peers.

Maturational issues arise when an important psychological equilibrium has been broken, for example, when a person suffers a real or symbolic loss or leaves one phase of life and enters a new one. All significant life changes are experienced as losses and will become manifest in the vulnerable person in symptoms or in maladaptive behavior. For example, entering college, leaving home, graduating, choosing a career, changing jobs, getting married, becoming a parent, seeing children leave home, retiring, and growing old are all states of transition and change, and there are many more. All states of transition and change entail giving up something familiar for something that invariably is uncertain—no matter how much preparation is made—and the response is always a reaction to loss.

The contraindications for TLP are quite clear and are most likely those of any kind of brief psychotherapy. Certain diagnostic categories a priori demand indefinite long-term involvement with the patient. Schizophrenia in any of its subtypes, bipolar affective disorder, and schizoid characters are examples. Obsessional characters with major and almost exclusive defenses of isolation and intellectualization have a limited capacity for affective experience, although they may appear otherwise. They may seem to engage rapidly and disengage equally rapidly without any affective concomitants.

Working with them is like writing on water.

My experience with borderline patients has been somewhat different when the patients possess some effective neurotic defenses and are not likely to fall into a transference psychosis. It has been possible to treat them with referral for long-term treatment on completion of TLP. The initial work clears away much of the defensive manipulation that often consumes one or two years of therapeutic groundwork before the patient begins to engage the therapist constructively.

Finally, the psychological elements involved in such conditions as rheumatoid arthritis, ulcerative colitis, regional enteritis, and severe asthma also demand long-term affiliation with the therapist.

THE GOAL OF TREATMENT

The single goal of TLP is to diminish as much as possible the patient's negative self-image. Symptoms that may have brought the patient in for help and that have served to defend against and to obscure the central issue are resolved as a byproduct of the process. Resolution of the central issue leads to the following changes.

1. The patient experiences an expansion of the ego and consequently a greater sense of independence and of self.

2. The always present harsh superego, which had constantly served to reinforce the negative self-image, is softened. The patient comes to regard himself or herself more charitably.

3. The healing process in TLP, as in all psychotherapy, includes the introjection and incorporation by the patient of the good object found in the therapist. A new internal positive reference source becomes available to the patient.

4. The automatic defense mechanisms, which had been used to cope, albeit ineffectively, are replaced by the awareness of choices. The patient learns not to respond in automatically determined, maladaptive ways.

5. Better feelings about the self allow for a broader vision of the patient's relationships with others and facilitate different and better ways of responding.

The experience of TLP is highly emotional, experiential, insightful, and cognitive in its effects. The theoretical underpinnings of TLP, an understanding of the process, and the goals and aims of TLP are all based on traditional psychoanalytic principles. Yet, as in any brief psychotherapy, engagement with the patient is imperative. TLP is not by any stretch of imagination a miniature psychoanalysis, nor does the therapist aim to make conscious what was unconscious. A psychoanalytic understanding of theory, process, aims, and goals makes it possible for the therapist to translate underlying mental processes in terms of the defect the person feels as a

chronically painful part of his or her being and daily existence. TLP requires neither a charismatic therapist nor one with unique skills for certain patients. It requires only the good training that every therapist should have and the empathic sensitivity reinforced by personal psychotherapy or analysis.

THEORY OF CHANGE

TLP exercises its unique influence through the two major points of the treatment proposal, the therapist's statement of the central issue and the setting of the termination date at the start of treatment. The process these points set in motion illuminates the relationship between persistent negative feelings about the self over the lifetime of the patient and the origins of these feelings in the inability to effect separations without suffering undue damage.

It is fair to say that in any form of brief psychotherapy it is not feasible to work slowly through the patient's layers of defense. The central issue as posed by the therapist will, among other things, bypass defenses temporarily, control the patient's anxiety, and stimulate the rapid appearance of a therapeutic or working alliance as well as a positive transference. The result is the rapid evolution of the therapeutic process. For brief psychotherapy, time becomes a major factor in itself.

Time and our concept of time are the means we employ to integrate in our minds and in our feelings what was, what is, and what will be. What was,

often consists of events of significance to us, which we recall as memories. Memories are intimately related in most instances to important people in our lives. It follows that memories cannot be separated from time. As we recall memories, knowledge about ourselves increases little by little because memory and knowledge are the same thing. A good initial psychiatric interview and the work of continuing therapeutic sessions serve to link and to expand time. As we review and pick up threads of the patient's past, present, and future we are also expanding the patient's awareness of what was, what is, and what will be. In all psychological treatment the patient works toward facing up to the past in order to gain some mastery over the present and to be freer in shaping the future.

We are all familiar with the constrictions of time in our daily lives and with the means we employ to escape from its bonds. Relaxation by any method induces a sense of decreased time pressure. Alcohol, marijuana, meditation, and anti-anxiety medications, for example, all induce the feeling that time is moving more slowly—as does simply taking time off from work. In mystic states and in ecstatic states connections between past, present, and future are broken so that time is experienced as unending. By contrast, in fragmented states such as depersonalization, derealization, and acute psychotic decompensation time is without meaning, empty and exquisitely painful. I have written earlier (Mann, 1973) of my experience with “golden memories" in patients in analysis, who derived a sense of great warmth and

familiarity from them but were unable to place them in time or in space. Further analysis revealed early recollections and fantasies about the mother and the wish to be comforted, warmed, and nurtured endlessly.

In states of health one does not feel the passage of time; there is no sense of growing older. On pleasurable occasions time seems to move swiftly and in painful circumstances time moves very slowly. For the therapist, for instance, it is common experience for a session to pass very quickly with a motivated, psychologically minded, hard-working patient but very slowly with a plodding, circumstantial patient who never seems to get to the point.

We think of time in categorical and in existential terms. The categorical is time as noted on clocks and calendars, whereas existential time is lived in and experienced. The development of time sense goes hand in hand with the development of reality sense. Prisoners or hostages in isolation, for example, can maintain reality by keeping an accurate record of the day and date.

With any kind of treatment the patient will have unconscious expectations of some kind of magical cure, of fulfillment, of becoming transformed into what he or she always wished to be. There is an expectation that the therapist will turn back time and will repair what was, to make a new present and ensure a different and better future. I believe this to be true in all treatment, whether it be medical, surgical, psychopharmacological,

behavioral, psychotherapeutic, or psychoanalytic. The greater the ambiguity in regard to the duration of treatment is, the more what I call child time, with its endless expectations of total fulfillment, predominates. Thus we see the regression that invariably occurs in long-term psychotherapy and in psychoanalysis. The structure of these approaches facilitates planned regression so that over the long term there will occur the slow but steady analysis of layers of defense, of varied transference manifestations, and of powerful dependent wishes and demands. The more specific the duration of treatment is, the more rapidly is child time confronted with real time and the work to be done. In this sense, TLP presents a deadline for the patient to meet from the start.

The way a person assesses ongoing lived time is determined by how he or she perceives personal adequacy in the face of some challenging reality. The reality may be outside the person or entirely intrapsychic. In the latter, the ego perceives a situation that it deems important to its well-being, to its needs and aspirations. As a result, an internal question arises of whether and how the person can cope. In other words, intrapsychic reality becomes a challenge to the self. The assessment of our capacity to cope can be made only on the basis of past experience. If we doubt our adequacy or believe that we are in fact inadequate, then tension arises within the ego and is felt as anxiety or depression or both. Anxiety speaks to uncertainties about the future while guilt speaks to the past ("I should have") and to the future ("I should"). The

perception of a potential threat to our adequacy leads to anxiety ("I am in danger and I must mobilize myself to act"). The belief that inadequacy is actual leads to depression and in severe instances means a person is hopeless and helpless and will always be so. In most cases, both anxiety and depression are present and the patient is covertly transmitting doubts about the existence of a future.

TECHNIQUES

The Central Issue

In any form of brief psychotherapy it is essential to get as quickly as possible into the core of a significant problem, perhaps one of a number of problems that the patient presents. It is the entrance into and the establishment of the patient's core problem that I call the central issue; the central issue is very different from the more usual concept of focus of treatment.

The first step in arriving at the central issue is to engage in a way of listening that we may find too unfamiliar. As we take a history we listen attentively to the facts of the case; as the patient relates painful events we discover how the patient reacted to and felt about each of them. But there is a further dimension to listening. As the patient relates many painful incidents

we must ask ourselves this question: *How must this person have felt about himself or herself as he or she was experiencing, living, and enduring the particular incident?* It is not a question that the patient can answer at the time since the complaints or symptoms have served to defend against awareness. Rather it is for the therapist silently to ask and to answer the question, for this question and the answer to it measure the therapist's empathic capacity. It is in the answers to this question, repeated many times, that the therapist will arrive at the central issue. What I look for in the patient's history are recurrent painful events, especially those that, although they may be very different, are experienced and reacted to symbolically as if they were the same. I am looking for the patient's chronic and presently endured pain; this is pain that the patient feels he or she has always had, has now, and expects to have in the future. In the absence of change there is no sense of past, present, or future in the patient's rigidly held conceptions of the self; the patient holds the parallel conviction that nothing about the self can change.

The patient's chronic and presently endured pain can be further defined as being a privately held, affective statement by the patient about how he or she feels and has always felt about himself or herself. The central issue is linked with the patient's time line or history and the various affects associated with it. This affective statement about the self to the self has never been revealed to others and has been allowed to enter consciousness only in fleeting moments, when it has been promptly warded off by automatic

adaptive, coping devices. A simplified but common example is the person who has a profound need for acceptance to verify her own worth but who repeatedly finds rejection and automatically responds with a smile, which effectively keeps the pain out of sight. Although the chronic pain, the negative feeling about the self, is obscured defensively, it remains preconscious and when posed to the patient is experienced as a clarification and not as an interpretation of an unconscious construct never before in consciousness.

The recurrent painful events that feed the sense of a chronic and presently endured pain are also the affective component of the patient's belief that he or she has been victimized. It is difficult to discern any neurotic or emotional conflict in which the patient does not feel unjustly victimized. As children all of us were "victims" inasmuch as all experienced helplessness in the face of parental demands ranging from mild to abusive. The childhood victimization tends to become perpetuated as a guiding fiction in the life of the adult. That is to say, the adult continues to find and to respond to certain events in the same affective way he or she experienced and reacted to them as a child. What was once real in the life of the child continues into adult life as a fiction about the self. The misrepresentation of the self is enhanced by the addition of unconscious fantasies surrounding the painful events from early childhood and from adolescence. A child may feel that he or she is bad when faced with the question why parents no longer live together. The adolescent in the same situation may not only feel that he or she is bad but may also

suffer "bad" sexual fantasies about one parent or the other.

A clinical vignette will illustrate the selection of the central issue. A man in his late forties complains of depression, feeling blocked in his work, and being preoccupied with uncertainty about his future. He is fully aware that he has been successful in his work and equally aware that his work has been recognized by others whose opinions he has valued. Recently he was expecting an appointment to a position offering even greater recognition, but he failed to win it. His history revealed that he was the son of successful and manipulative parents who had impressed him with the need to carry himself in appearance, style, and behavior as though he were not of the immigrant group from which his parents had come. He yielded to the demands, always successfully until the recent failure. Many additional details in the history made clear that as long as he could remember he had carried within him the profound sense of being a phony; at every step of his career he suffered anxiety, which he never understood, in the form of constant terror that he would be found out. The symptoms that brought him for help served to conceal and defend against the awareness and conviction about himself as a phony. He had never pondered or spoken about the sense of being a phony. Rather, there had been only flashes of awareness with immediate defense to remove the discomfort. As he recounted the many painful events of his life and as I asked myself how he must have felt about himself as he endured each particular event, it became possible to tell him that I recognized the nature of

his problem and could express it in terms of his negative image of the self, an image he had carried all his years, carries now, and will carry into the expectable future, along with a sense of despair about ever being able to change the image.

All patients have a conscious and unconscious wish for redress of their grievances. It is conscious in that the patient wishes for appropriate recognition of his or her need in his or her own world. The person's contemporaries have no way of recognizing that need since they are regularly confronted with the person's adaptive devices, which effectively disguise the pain. Unconsciously the patient wishes for reunion with early important persons because the patient believes that those who are held directly responsible for the pain would be the most desirable healers. In this connection the time limit of TLP with its induction of magical expectations facilitates hope that reunion with the original figures will be effected.

Because recurrent painful events and responses are what is significant in this context, it follows that not everything a patient may tell us is important. Time is often wasted in brief psychotherapy listening to circumstances or events that do not have an existence over time; that is, there is no affective connecting link from event to event. Therapists are familiar with the rigid obsessional patient who may wander through a whole session of unrelated minutiae. In TLP the therapist's attention is directed throughout

the twelve sessions to information that is directly or indirectly related to the central issue. Information felt to be unrelated to it should be understood as resistance to further progress. The most fruitful approach to removing the obstacle is to turn it aside by interrupting (many therapists hesitate to interrupt a patient) and suggesting that the patient go back to some specific item from earlier in the session or from the previous week. There are times when an unusually enlightening and difficult session may be followed in the next meeting by the patient's apparent need to take a breather and speak of unimportant details. There will be no objection by the patient if the therapist appreciates the need, allows it for some ten or fifteen minutes, and then helps the patient to resume the important work.

The statement of the central issue in terms of the chronic pain arising out of the negative self-image reverberates from the deepest levels of the unconscious, through the layers of ego defense, and into the patient's conscious experience of self. It spans the patient's experience of time from the remote past through the immediate present into the expectable future. It speaks to the exquisite poignancy with which each person privately endures his or her being.

Components of the Central Issue

The central issue includes time, affects, and the negative image of the

self. A statement is made at the very beginning of treatment that links a profound notion about the self to factors of time (as duration) and intense affect. The ability to tag traumatic events as occurring at a particular moment is less important than the fact that each patient remarks on the "always"—that he has always felt that way about himself. Powerful traumata deeply influence unconscious guilt or narcissistic equilibria or both. They affect relationships back to the primary internal objects, the parents. Since the feelings have their origin in childhood, when the earliest introjections occur, objective time is obliterated as far as the affective experience is concerned, and the felt myth about the self is experienced as always having been there.

The affective result of trauma blurs a person's perception of time, which in turn increases negative affect, which increases the sense of hopelessness. Our patients speak therefore of an impossible past, an unhappy present, and a forbidding future in which the pain of the past and present must be continued. It is the inclusion of these factors that makes the central issue so effective. The formulation is invariably experienced as a powerful empathic statement in which the therapist is experienced as standing both within and alongside the patient. The usefulness of the central issue is further enhanced by the fact that it never includes conflict with important others in the life of the patient. These will emerge soon enough in a setting of trust and positive transference as these are encouraged and stimulated by the central issue.

Since the awareness of this kind of central issue is warded off by the automatic adaptive devices of the patient, it follows that the complaints brought by the patient as the reasons for seeking help will never include the central issue. Rather, we hear the familiar ones—anxiety, depression, symptoms that substitute for depression, difficulties with others, and the like. Conversely, the patient's complaints will never be the central issue in TLP.

Consider the following case. A woman in her late forties consulted with me about her rebellious teenage daughter, who, she said, was driving her crazy. This might appear to be an instance that called for counseling the patient about alternative ways of managing a teenager. Never assuming anything without first taking a careful history, I soon learned that this woman was in fact caring and sensitively attuned to the needs of her daughter and that she had tried a variety of acceptable means to bring reason into their relationship. Her history further revealed that at the ages of three and four the patient, in response to her mother's aspirations, had performed publicly on the stage. She recalled being directed in one scene to enter a frightening dungeon. She was terrified but did it and never forgot the terror. Later she was pressed into ballet and music, always submitting to her mother's ambitions, which also included superior school performance. This remained the story of her developmental years, including the college years, during which she lived at home. She escaped only when she married and moved to another city.

I have highlighted some of the recurrent painful events early in her life; there were many more later. In all of these experiences her automatic response had been obedience. The central issue that was formulated and proposed to be our work for the twelve sessions was as follows: "You are a woman of recognized ability and talent but what troubles you now and always has is your readiness to feel controlled and helpless." The statement elicited an immediate affirmative response; the work of therapy was to learn with her what had happened in the course of her life to lead her to feel this way about herself. We concluded that the rebellious daughter had exercised control over her as only a teenager can, a circumstance that rekindled her own experience of helplessness and consequently distorted her relationship with the girl. Once the mother was relieved of the myth that she was still readily made to feel helpless, she and her daughter became better able to get along with each other.

The varieties of chronic pain out of which arise negative feelings about the self are limited by the finite range of feelings available to all human beings. The limited range may be summarized as glad, sad, mad, frightened, or guilty:

Glad: loving, happy, contented, euphoric, peaceful, feeling wanted

Sad: unhappy, discontented, depressed, feeling unwanted

Mad: irritated, annoyed, irked, angry, raging, furious, feeling like a bad person

Frightened: anxious, nervous, afraid, feeling helpless

Guilty: troubled, uneasy, ashamed, feeling humiliated

Any other feeling is derivative of or within the range of these five. Because the feelings are universal, a negative statement about the self can be identified in everyone regardless of social class, education, cultural background, or economic status, and when identified reinforces the patient's motivation for help. Each life story is unique in the kinds of people involved and in the events that have transpired but each is the same insofar as one or another of the feelings has been experienced by all. There is no person or group who possesses some unique, never previously recorded feeling. Cultural differences may make the expression of complaints different—for example, one person may wail and shriek with minimal pain, another may be spartan; one person may refer all complaints to the body, another to various hexes or spirits—but the painful feelings disguised by the complaints are the ones we all share.

The central issue directly links the past, present, and future that constitute the patient's time line with the affects that accompany memories, regressions, fantasies, developmental arrests, and spurts. All of these emerge as the unspoken, painful, negative self-image. A person evaluates ongoing

lived time in accord with his or her assessment of adequacy; the affective assessment of the self links present circumstances with future outcomes in light of past outcomes in similar (real or symbolic) situations.

Consider another case. A woman in her thirties was depressed, anxious, and sleeping poorly. She had been in psychotherapy for ten years and had developed an intense erotic transference which almost assumed the character of a delusion. When at one point she learned that her therapist had separated from his wife she was certain that he would reach out to her; when he divorced she felt that at last her chance had come. Yet he had never made overt physical moves or suggestions to her. Further, since she had terminated treatment herself some six months earlier she had tried to effect relationships with other men and found herself choosing the wrong kind of person and being frightened by any overtures. Her history disclosed that early on she had been in sharp competition with an older sister for the affection of their father and felt she had succeeded until adolescence, when her father seemed to withdraw from her completely. She recalled being admired by a highly desirable high school classmate and feeling that something must be wrong with the boy because he admired her. She told of other experiences with men who seemed interested in her and then withdrew without warning. The central issue proposed to her was this: "You are a woman who is successful in your work and you also have a number of creative interests. Nevertheless you are troubled now and always have been troubled with the deep sense that

there is something about you that makes you unworthy."

The therapeutic process that followed is familiar to anyone practiced in psychoanalytic psychotherapy—it is similar in content but very different in process. In TLP the process is so accelerated, the dynamic events so telescoped that a major task for the therapist is to keep up, to understand and be prepared to respond to the flow of past and present events within the purview of the central issue. Positive and negative transference, resistance, countertransference, and the ready and evident appearance of all the ego defenses occur as in any psychotherapy. In this particular case, our work around the central issue served to undo the erotic transference and lead her to seek acceptable men. She had been struggling all her life with the feeling of her unworthiness; she had employed various means to cope with it, but the unrelenting pain continued despite her best efforts. She had fought the good fight for her father's attention and admiration and to the degree that she felt she had been successful in competition with her sister, she had felt herself to be worthy. When her father withdrew from her in her adolescence she was correct in her perception but could understand it only in terms of her lack of worth. It never occurred to her, for example, that his withdrawal might have had to do his own discomfort at being confronted by her blooming womanhood.

A degree of helplessness is the lot of every child insofar as control by

adults is inevitable. The pain of separation, with its accompanying feeling of abandonment, is also inevitable because even in the best of circumstances separation is never achieved without pain. Multiple repetitions of separation throughout life are simply a given for everyone. Each separation means a loss, giving up something. Unconsciously separation means giving up nurturance in all its meanings and has ambivalence as a consequence. Each separation brings into the preconscious the sense of leaving and of being left. At the conscious level each separation is experienced in the person's accustomed automatic adaptive mode. Depending on the nature and meaning of the particular person or circumstance the conscious experience may range from ego syntonic sadness to total denial of the separation's significance to counterphobic behavior to overt depression to degrees of psychological disintegration. Further, with each separation and its accompanying sense of loss there is always the possibility of another decrement in the image of the self—of feeling more helpless, more controlled, more unworthy, more unlovable, more inferior, more undeserving, or the like.

Summary

The messages in the central issue are quite clear. First, and very important, there is recognition of the patient's efforts to master the chronic pain. Second, the therapist's statement reveals awareness of how the patient feels and has always felt about the self despite his or her best coping efforts.

In each instance the work of treatment confines itself to learning what events in the life of the patient have led to this kind of conclusion about the self. It is well to note that the central issue as formulated and presented to the patient becomes the paradigm of the transference to follow. Thus, it is to be expected in the termination phase of treatment that the man who feels unwanted, even irrelevant, will feel that treatment comes to an end because the therapist, too, does not want him around. Or the woman who feels stupid and a phony is certain that the therapist finds her so and is pleased to send her away. Or another patient comes to feel that the therapist finds him to be second-rate and unacceptable.

Note again that the central issue includes time, affects, and the negative image of the self; it is formulated by the therapist after having gained sufficient information in the evaluation. It is then presented to the patient as the therapist's view of the problem that brought the patient for help.

The next step is to gain the patient's reaction to the central issue. In my experience, instances in which patients have rejected the statement of the central issue are very rare. An occasional patient has remarked that the stated problem was not why he or she came for help. I ask if there is something more important to examine about himself or herself. The answer has always been no. Some patients respond with such enthusiasm that I am signaled to watch for an adaptive mode; the patient may try too hard to please. Such a mode is

significant in the course of treatment. The patient may need to please so that his or her desirability may be confirmed through the therapist's agreeing to continue treatment indefinitely. There are some patients who hesitantly accept the central issue and express doubt about it but are willing to consider it. Occasionally patients will ask how I found out about them so soon. In any case, each patient is given the opportunity to object and to reject or to accept the formulation.

The question may be asked whether the formulation of the central issue poses difficulties for the learner. I believe that it is fair to say that anyone who chooses to be a psychiatrist or clinical social worker or clinical psychologist possesses a long-cultivated, even if out of consciousness, empathic capacity. I have remarked earlier that the formulation of the central issue is a measure of that capacity. For some therapists the ability to appreciate how this or that patient has always felt about the self comes readily and may need only the confidence that comes with experience. Others are not so ready to allow themselves to feel what the patient feels without becoming lost in identification with the patient. To meet that problem I have used group formulation of the central issue followed by weekly group supervision in the instance of one patient. It is essential that the group be experienced in long-term psychotherapy and enjoy mutual relationships that will allow for constructive supervisory sessions. In group formulation, one member volunteers to present a new case and the group then works together to

formulate out of the data presented the central issue. Slowly there emerges out of the contributions of the members a growing consensus and then agreement on the final formulation as each ponders how the patient must feel about the self in relation to the information available.

It may be helpful to have further illustrations of the central issue as derived from the patient's history.

- To a thirty-six-year-old member of a minority who found himself in a conflictual situation in his field of work and became physically sick followed by depression: "You are a man of ability in your particular field and have done very well in it. Yet you feel and have always felt that there is something about you that makes you feel that you are unwanted, even irrelevant."

- To a forty-two-year-old woman who suffered an acute disorganizing experience which led her to consider divorce: "You have tried hard all your life to be and to do the acceptable things. What hurts you now and always has is the feeling that you are stupid and a phony."

- To a twenty-two-year-old man, a graduate student struggling with the question of staying in or leaving school: "You are a man of high intelligence and you know it. You also know that you can succeed in the work you have begun. However, what bugs you now and always has is the feeling that you are second-rate, unacceptable."

- To a thirty-five-year-old professional man with an acute phobia: "You are a big man [physically and in his field of work] who has achieved successfully and yet when you are alone you feel helpless."

A brief consideration of the evaluative interviews out of which the central issue is formulated is in order. A proper evaluation depends on the experience and skill of the interviewer in promoting the willingness of the patient to speak freely about him or herself. Generally, a one-hour history-taking interview should suffice to warrant a tentative formulation by the therapist of the central issue. A second interview is conducted to clarify or to obtain details about aspects of the patient's history to illuminate still further the central issue. Most often during the third meeting between patient and therapist the therapist offers the central issue as his or her definitive view of the patient's problem. A third preliminary interview may be necessary since some life histories are much more complicated than others. I have found that if a central issue remains elusive after three or four interviews, a severe kind of pathology may be present that in itself warrants as prolonged an evaluation as necessary to establish a clear diagnosis. The claim that evaluative interviews are already part of the treatment process is true to the extent that patient and therapist are sizing each other up and that for the patient the first meeting may well be the ending as well as the beginning of a relationship. Because the central issue as set forth here is so different from what the patient expected to be the therapist's diagnosis and because the

complaints that bring the patient for help are never the central issue, the designated first of the twelve sessions to be offered the patient is the beginning of a novel experience for the patient.

Once the patient has accepted the central issue, the next step is for the therapist to inform the patient of the treatment schedule, the duration of each session, and the date of the final, twelfth session. I have found it most useful to see each patient once each week for forty-five or fifty minutes rather than more often, on the grounds that each session becomes quite stressful for the patient as much painful, affect-laden material pours out. The patient can use the weekly interval to react and to respond alone before the next meeting. Invariably there is much for the patient to digest.

Upon being told of the schedule, the patient is asked to react and respond. The most common question is how I know that twelve meetings will be enough to make progress on the particular issue. I regard this question as real and as an unconscious resistance to the idea of a known date of separation and loss. My usual response is to turn the question back by asking what makes the patient feel that twelve sessions will not be enough. The patient realizes that he or she truly does not know and will have to await the turn of events. Agreement to the twelve sessions follows. There are also unconscious reasons for the acceptance of the treatment proposal. These have to do both with magical expectations of change over a short period of

time and with the unconscious expectation of repair and reunion and the end of loss.

Phases of Treatment

Most cases proceed in a predictable pattern. TLP is unique in that the patient knows exactly when treatment has begun, the precise midpoint of treatment, and the end date of treatment. These become guideposts for the therapist, although they are farther from the patient's awareness. Almost without exception, patients tend to suppress and often repress the end date. As a result they may be consciously unaware, for example, of arriving at the midpoint of treatment at session six. Unconsciously, however, many patients respond to the midpoint with certain behaviors. The same applies as the end of treatment approaches and the patient seems oblivious to the end at hand.

The statement of the central issue invariably stimulates an outpouring of information. Frequently the information consists of associations that corroborate the central issue. During the first three or four sessions the patient brings forth a mass of information about himself or herself, the family, and others, with recollections of painful events that the patient may not have thought about consciously for many years. With the flood of information there is also palpable evidence of the patient's positive transference.

As the sixth session comes or is passed patients often say nothing about

the time left. Instead, what was a positive attitude may become ambivalent. Nothing magical has occurred and the patient is still the same person. There may be complaints that a symptom has become worse or that nothing has changed in any way even though the patient may have spoken gladly about feeling better by the fourth or fifth session. The ambivalence is unconsciously determined by the shadow of the impending separation. The ambivalence that marked earlier separations arises once more within the transference. The patient may remark with evident annoyance that everything that could be said has already been said and that there's nowhere to go. Rather than reacting with anxiety based on uncertainty, the therapist recognizes the meaning of the patient's behavior and encourages further elaboration of the patient's ambivalence so that significant associations to many other separations and the feelings that were experienced are seen as importantly connected with the central issue.

If by the ninth or tenth session the patient has made no reference, direct or indirect, to the approaching end of treatment, the therapist must bring up the subject. One simple method is to ask the patient if he or she knows how many meetings are left. In any case, the end of treatment must be made the subject of discussion for the last three (or four, if the patient brings it up) sessions. The termination phase is invariably painful for the patient and often for the therapist as well.

The central issue is experienced in vivo within the transference and must be resolved as much as possible. I have remarked earlier that there are reasons for the patient's ready acceptance of the limit of twelve sessions. When patients are offered only twelve sessions they may conclude that perhaps they are not doing as poorly as they had thought. As I have mentioned, they unconsciously expect some kind of magical cure. Within the transference the brief treatment means also that relief will come in relation to the important early significant sources of the pain. Further, at the beginning, three months of treatment seem to the patients to be forever. We may think about but not affectively comprehend what we will feel about an event three months hence. Also, the limited duration of treatment suggests that patients will not become tied to the therapist; their independence, however muted, will be preserved. This last factor is of special import to adolescent patients (including patients of college age) who are fearful of the challenge arising out of the conflict between their wish to be fully independent and their desire to remain dependent. The structure of TLP offers from the start a measured dependence with an assured end.

The termination phase is a crucial aspect of the process, as it is in any kind of psychotherapy. The major work of this phase lies in the interpretation of the transference in terms of the patient's feelings about the therapist. By this time, a great deal of evidence has been obtained confirming the patient's repetitive feelings about the therapist in the same terms as experienced with

earlier significant persons. These feelings are also direct affirmations of the origin of the patient's negative self-regard. Interpretations are best made in the familiar triangular configuration—that is, in terms of the therapist, important people in the patient's present situation, and the origins of affects in relation to important persons in the patient's past. If we understand that the central issue is the consequence of a host of unconscious, preconscious, and conscious elements that eventuate in everyone a sense of what one is, it follows that the interpretations made are not about aggressive or libidinal needs and intentions but rather are about derivatives of these expressed in living, existential terms. For example, in any kind of brief treatment, for the therapist to recognize the patient's unconscious fantasy of castration and then to express it in those terms is nonsense. It is meaningless even for the sophisticated patient to speak in such a way. Genuine affective meaning is reflected when the same fantasy is conveyed to the patient through the central issue and therefore in terms of the patient's feeling unmanly or defective or lacking.

A satisfactory termination is one in which the patient leaves treatment feeling sad. Ambivalence, which previously had always led to feelings of anger or depression with concomitant self-derogation, has changed into awareness of positive feelings even in the face of separation and loss. Sadness in place of depression allows for separation without self-injury. The goal of TLP is explicit and single-minded in every case. It is to help patients diminish, to

reduce as much as possible, the negative feelings about the self. Symptoms that patients may have brought among their complaints are addressed, if at all, in terms of the central issue. In most instances, the symptoms are not addressed at all and diminish or disappear as a byproduct of the process. Relief of symptoms is not the goal of treatment.

The Therapist and TLP

Inexperienced therapists may be immediately enthusiastic about doing TLP. The promise of relatively rapid therapeutic returns is enticing. But resistance to TLP among experienced therapists is common and must be understood.

First, most therapists gradually take on a therapeutic stance and process with which they become familiar and comfortable. To be asked to engage in a very different process immediately creates anxiety. Therapists who have established their competence to their own satisfaction may experience the new stance as a threat to their ability as well as to their adaptability.

Second, the time limit raises the hackles of some therapists. We therapists are used to having as much time with our patients as both deem necessary. It is not at all unusual for a patient's dependence to be fortified by the therapist's practice and by a need by both participants to maintain the

dependence.

Third, the argument is often made that the duration of treatment should be negotiated by patient and therapist. In fact, not much surrounding psychotherapy is negotiated these days. Fees are now set at all outpatient departments with little or no leverage for the patient; therapists rarely set fees that are best for the patient. Nor do therapists set the dates and duration of treatment against their own best interest. A colleague once told me that TLP was "money-limited therapy." Perhaps objecting to the time limit can be seen as a rationalization to protect against an even greater resistance.

Setting a termination date at the start of treatment is very difficult for therapists since it is easier to work slowly toward an indeterminate end. Terminations are difficult for both patients and therapists since patients and therapists alike suffer the scars and sometimes the open wounds of separations and losses. To announce what seems like a goodbye at the start resonates in the same way in both patients and therapists. Patients' most ready defense is to suppress or repress the end date as if bargaining to feel better soon. Therapists' defense may be too great a readiness to find patients to be unsuitable for TLP.

Finally, there may arise the very interesting situation in which the central issue proposed to the patient as the work of therapy is a similar issue

for the therapist. Surely few, if any, therapists of any persuasion do not live with some degree of negative self-image. In the best instances negative self-image has been modified in personal therapy. In a few others the therapist's negative feelings may not contaminate the therapeutic process. Certain safeguards can be taken to avoid interference from the therapist's problems. First, TLP is for experienced therapists. Second, a background of sound training and experience in the dynamics of the unconscious, transference, resistance, defense, and countertransference is essential, which means having sufficient exposure to and work with longterm psychotherapy to have learned to bear and to understand patients' anxiety without reacting against them. Finally, a most desirable addition to therapist's training would be personal psychotherapy—or, better, a personal psychoanalysis.

CASE EXAMPLE

A sample case presented in detail will show some aspects of the process from start to finish. The patient was a forty-two-year-old married woman whose family consisted of her husband, one son in high school, and another in the fifth grade. Total obsession with her older son's school grades brought her for help. She would follow every test that he took and would look into his book bag to see what he should be studying. She was aware of nagging him about schoolwork but could not stop herself. Unless he achieved a top grade in any test she could feel herself grow cold toward him, even physically cold.

She dreamed about his grades and was adamant that he get into a prestigious college. She concluded that she was crazy and had better do something about it before her son had to apply to college.

She had been in therapy for about two years as a graduate student. It was “the thing to do," but she really went to find out if she was crazy. Years later she was treated briefly about a problem with her husband. She presented herself as a slender, attractive, neat, and articulate woman. She was physically well and slept well, but in her waking hours she was almost constantly tense and seemed desperate for help.

She was the only child of immigrant parents. Her father held a menial job and both parents could barely speak English, even after years in the United States. She stated that father was "irascible, primitive, always hollering." He had died some years before and the patient was proud that her interventions had resulted in an additional year of life for him. She recalled being embraced by him in his happiness when she was admitted to a competitive high school. Her mother was alive and resided in a distant city. The patient had never gotten along with her, feeling that her mother was snobbish, that she put on airs and felt that everyone she knew was a bad person. The parents continually fought and her father would tend to blame the patient for their battles. She wished her father were still alive because she had come to feel much wiser about him.

She had gone to a state university and then on to graduate school to prepare for a profession. At graduate school she felt her teachers to be poor; she failed in part and left with a master's degree. Three years later she decided to complete her studies and graduated at another university. Married about twenty years, she experienced her husband as more attached emotionally to the children than to her. She described her older son as healthy and a good kid despite her nagging. At one point he had said he hated both his parents and closed himself in his room for almost two days.

She impressed me as an obsessional woman with a need for perfection not realized within herself which she projected onto her son with the unspoken demand that he make her whole by being accomplished intellectually, socially, and in his chosen career. She could then borrow his status as her own and thereby become what she felt she never had been, was not, and never could be by herself. There were other details that clarified the central issue. For example, her graduate school teachers were not in reality poor. In fact, the small class was a select group drawn only from the best universities. It was in that class that she found herself asking, "What am I doing here?" After all, she had come from the family of an uneducated father with his menial work, a pathologically suspicious mother, and very cramped and unattractive living quarters. How must this very intelligent and alert young woman have felt about herself as she observed her father as a model, and how must she have felt about herself having a snobbish mother whose

"superiority" was soon evident as craziness?

The central issue presented to her as our work in the twelve meetings was as follows: "You are a woman of ability and talent. You are aware that you have not capitalized professionally on your ability and talent because what troubles you now and always has is the feeling that you are unworthy, even defective." She agreed that this was so and yet was surprised that I had come up with this statement in the light of the problem that brought her to me. She could readily acknowledge the accuracy of the central issue but wondered whether working on this about herself could be of help to her son. I suggested that we would find out in the course of our work together.

She corroborated the central issue with a number of associations: how she had never had a room of her own, how she had had to be a parent to her parents since she would read and translate letters in English and make out checks and other forms for them. She always behaved well but would be struck with terror when her father glared at her in anger. Sometimes she thought of herself as a witch; sometimes she felt that her parents never understood her needs. I emphasized her feelings of victimization both in her past and then by her son. How much nicer her world could be if he just got good grades and thereby made her feel better about herself, even if only for the moment. Early in treatment she brought a picture of her with her parents taken when she was six or seven. She was surprised to find that they looked

so nice as a family.

As we moved along in the treatment process, she referred to herself as "killer Sue" in recollection of incidents with her mother in which she felt responsible for various of her mother's illnesses, each of which led, in her mind, to the brink of death for her mother. She became aware of the fantasy that her anger could kill and the enormous guilt that followed, with its destructive effects on her image of herself. She saw that nagging her son carried with it clear tones of anger and was followed by guilt and self-denigration. Further along she spoke of the kiss of death when her first therapist said that she was intuitively gifted. She felt that people who wished to know her must have something wrong with them and that I was defective if I was interested in seeing her and in dealing respectfully with her. Positive transference was manifest very early not only in her wondering if I was defective for my interest in her but also in her early questioning whether she could continue to see me at least once a month when the twelve sessions ended. Driving to see me was "like a dream" in that she could hardly believe that I could accept her as not crazy. On the other hand she wanted me not to care too much for her because she thought I would throw her out if she got angry with me.

In the presence of a solid alliance and transference we could now move directly into the problem with her son. I was able to tell her that she made

demands on him in order to repair her own sense of defectiveness but that her expectations could never be fulfilled outside of herself. She said that she had begun to feel less pressure to nag him. At the treatment midpoint, she felt like a "waif," an orphan, and that such thoughts made her tearful. She and her husband meshed well, she said: she gave and he didn't. She told of a recurrent dream in which she is in her parents' bedroom with them. Suddenly she goes out the window into the street. She is not hurt although the room is high above the ground. Actually, during her childhood she had long slept in the same room with her parents; although unconscious sexual aspects of such an arrangement are present in a young girl, I choose to interpret the dream in terms of the central issue. In those terms the dream revealed her feeling that no one cared about what happened to her. The interpretation was followed by a review of her feelings about herself as a little girl who found ways of dealing with her abusive parents by being good but who could not escape her private feelings as one who was bad, a witch, a killer, and crazy.

The shadow of termination was on her mind as she told me that she was almost late for her appointment, although, she added, she was never late for anything. She had met with an old schoolmate who, to the patient's chagrin, was well established professionally and whose son was absolutely destined for Harvard. The patient felt jealous and angry. On her return home she quickly set upon her son with her demands. I remarked on how much the visit with an old friend had activated her own past with feelings about herself as

primitive and unacceptable. Further into the end phase, she related a dream in which she is bleeding to death. She runs to her internist but he is not available and there is no one to help her. In her associations she revealed that the internist was a high school classmate. Again there emerged the feeling that there was never anyone around who would understand her needs. The desire to remain with me was implicit. She made another attempt at continuation by telling me that she was aware of a deep love for her mother but that the idea of closeness was frightening lest she also become crazy.

Her struggle to remain with me became explicit in a repeat of her dream of going out of the parents' bedroom window except that this time the house is mine. In another dream I am lying beside her and she feels I should not be doing that. As she had with her father, she felt that I did not wish to see her, that I would be glad to be rid of her because she was "intractable." It was easy for me to speak to her of her obvious affection for me, like that I had seen in her for her father, from whom she felt she had never gained validation for her womanhood or for her acceptability as a woman. I added that this perceived failure on her part had seriously interfered with her relations with men as well as contributed heavily to the sense of herself as unworthy and defective.

In the last, the twelfth session, she said that she felt that I liked her and she could accept that as well as the idea that she was not crazy. She finally knew that she expected her son to save her, and she felt ready to let him grow

up and away. She felt better about herself and thought she might be ready to become much more active in her profession, even perhaps venturing to publish some of her work. She was sad about leaving me and cried. She asked again if she could call me, and I told her that she should give herself at least six months to digest the work we had done and to experiment further in making changes, that if she felt the need at that point she should feel free to call me.

One year later she asked to see me. She reported feeling so much better about herself that she could hardly believe it. For the first time she had gone away with her husband only and had thoroughly enjoyed it. Her son had done very well on the SATs and life felt very good. Before leaving she asked if she could see me the following April, when college acceptances would be announced. I said yes. At that visit she said she had hoped that her son would have chosen a university in the area; instead he had been waitlisted at several very good universities but had chosen one that was patently not up to the others, not very far from home. She knew very well what her choice would have been but was able to let him make his own and to feel comfortable about it.

One year later she called again. Her son was happy at college, active in sports but not very interested in getting good grades. She chose to see him as a fine boy despite that. She was now enthusiastic about her increased

professional activities, which were providing enormous satisfaction. With considerable pride she announced that she had submitted papers for publication and had already received approval on one of them. I spoke to our mutual appreciation of her wish for her son to do well in whatever he was engaged in but that now she no longer needed his performance as a means of gaining respect for herself. She could do that on her own.

EMPIRICAL SUPPORT

The effectiveness of TLP is known to me and to my colleagues through our experience and through the follow-up interviews that we have done. The preset limit of twelve sessions has become increasingly popular, although the theory and technique of TLP have not been adopted. Unfortunately, there have been no large-scale, carefully organized research projects on the efficacy of TLP. A very large project proposed by the psychology department of a major American university was denied federal funds. At the time TLP may have been regarded as too radical. There is an ongoing, carefully structured research project in TLP being done in Jerusalem. Haim Dasberg and Gaby Shefler of the Ezrat Nashim Mental Health Community Center reported in a presentation (1989): "Our results suggested that Mann's TLP has clear positive outcomes. The outcomes are consistent with the therapy rationale. That is, the changes occur in self esteem, social functioning and target symptoms."

CONCLUSION

TLP provides a model of psychoanalytically based psychotherapy of brief duration that is teachable. The structure is clearly outlined; with some experience the process becomes almost predictably visible. TLP does not require a charismatic therapist; rather it requires being part of or a graduate of a good general training program in psychoanalytic psychotherapy. It requires also a willingness to step out of the traditional mode and a readiness to engage patients actively within the framework of a reasoned approach. It is not a short-term psychoanalysis, but it touches very quickly on what is most important to all people: the self-description that makes our existence either quite bearable or ridden with pain. With its specific time limit and the concept of the central issue, TLP brings to the forefront of the treatment process the major psychological plague all human beings suffer, namely the wish to be close, to be as one with another, to be intimate, the fulfillment of which demands learning how to tolerate separation and loss without undue damage to our feelings about the self.

References

Dasberg, H., & Shefler, G. (1989, June). *A randomized controlled outcome and follow-up study of James Mann's time limited psychotherapy in a Jerusalem community mental health center.* Paper presented at the meeting of the Society for Psychotherapy Research, Toronto.

Mann, J. (1973). *Time limited psychotherapy.* Cambridge, MA: Harvard University Press.

Mann, J., & Goldman, R. (1982). *A casebook in time limited psychotherapy.* New York: McGraw-Hill.