Work in Progress

Applications of the Relational Model to Time-Limited Therapy

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Abstract

These papers discuss specific ways a model of healing through connection can be applied in settings where a limited number of sessions is a necessity. The authors summarize several models of session-limited therapy, suggest ways in which clinicians can empower women in these settings, and examine implications of using a relational approach for short-term work with clients from diverse cultures.

A Relational Approach to Short-Term Therapy

Judith V. Jordan, Ph.D.

Although managed care has recently made short-term therapy the therapy of choice for most clients, the practice of time-limited therapy did not begin with managed care, and it is not synonymous with managed care. A study done in 1984 indicated that patients remained in therapy an average of 6-12 sessions, regardless of the setting, the diagnosis, and the motivation (Consumer Reports, 1995). In other words, most patients who come into therapy are in short-term therapy either by design or by chance. While there has not been a great deal of research comparing the merits of short-term versus long-term therapy, there has been much debate about the relative merits of both. A recent *Consumer Reports* article (1995) indicated that the longer the course of therapy, the more improvement occurred. But proponents of time-limited therapy also point out that there have been excesses in the application of long-term therapy. And we are all challenged by the current economic pressures to come up with ways of providing some kind of short-term, limited therapy that is effective and has integrity. We also, however, need to carefully research who can benefit from time-limited therapy and who will not; and then, professionals will need to educate both themselves and insurance companies about these differences. The idea of managed care originally was intended to provide better treatment for more people; problems arise when the profit motive enters the picture and when non-clinicians are shaping clinical policy. These joint papers will explore several different views and applications of time-limited therapy.

Most time-limited therapies hold in common a need to focus on specific objectives. Therapists practicing short-term therapy tend to take an active

role in collaboratively building the therapeutic alliance, in defining problems, in setting goals, in making shifts in behavior, and in trying to stabilize these shifts. Historically, short-term therapy had its inception when Eric Lindemann, who was treating survivors of the Coconut Grove fire in Boston in 1942, found that in such a crisis situation patients improved greatly after six weeks of intervention (Sifneos, 1979). Two of Lindemann's residents, Peter Sifneos and Habib Davenloo, went on to develop something called *anxiety provoking therapy*, one of the primary models of short-term therapy practiced in this country (Sifneos, 1979; Davanloo, 1980). This model can be a rather confrontational, stress-filled therapeutic regimen and this approach is not considered appropriate for many clients. James Mann (1973), who emphasized working with grief and loss, suggested 12 sessions as optimal. In his work, too, there is an emphasis on facing, bearing, and resolving long-standing conflicts. Malan (1979), another leader in short-term therapy, believes that character can be changed in 30 sessions or less if the therapist brings pressure to bear on the experience of affect. And Davenloo's (1980) therapy, called *short-term dynamic psychotherapy*, depends on the provocation of anxiety and challenging defenses. Each of these mainstream models of short-term therapy place heavy emphasis on challenging the client's defenses, producing anxiety, and moving toward separation. There's also a focus on termination from the very onset of the treatment.

Recently, two clinicians have suggested some modifications of the prevailing emphasis on separation and confrontation in short-term therapy. Leigh McCollough Vaillant (1997) frames her work as *anxiety regulating* therapy (in contrast to *anxiety producing therapy*). She emphasizes the importance of connection rather than what she calls "collision" in therapy. Her approach departs dramatically from the confrontational style of many of her predecessors. In addition, Susan Edbril (1994), reflecting on what may be a gender bias in short-term therapy, points out that most time-limited therapies are based on male models of health, which stress the importance of separation. Edbril suggests, instead, that in short-term therapies we need to address the importance of continuity of connection. Both of these women are calling for a different kind of time-limited therapy and both point to the centrality of connection and relationship in the therapeutic process.

Some of the central points that we might look at in thinking about a *relational model of time-limited therapy* are: an emphasis on connection rather than separation; spacing of sessions to promote the development of relationship; promotion of *relational awareness*; and an emphasis on resources of connection. Spacing of sessions should be planned in terms of building a comfortable, working relationship between therapist and client. That may involve utilizing several closely spaced, consecutive sessions at the beginning of therapy to build a sense of connection. After two to four of these weekly sessions, sessions can be spaced farther apart. Rather than calling this time-limited therapy, we might think of it as intermittent therapy which stresses continuity of therapy over time.

To help build *relational awareness* (Jordan, 1995), the therapist and client will pay attention to the relational patterns and images that emerge in the therapy relationship itself, as well as in the current relationships in the client's life. Homework assignments that guide the client to attend to relational patterns would compliment the work done in sessions. Focusing on two or three *core relational issues*, patterns of connection and disconnection in and out of the therapy sessions, would provide a powerful focus for the work. In assisting people to change *their relational images* (Miller & Stiver, 1997), we work on developing moment by moment awareness of the longing for connection as well as the movement toward disconnection, which arises from the terror of connection. The more painful or violating relationships have been for people, the more they will have developed strategies for disconnection in order to maintain a sense of personal safety and integrity. These strategies of disconnection must be honored, and the therapist must acknowledge the underlying longing to connect.

Developing a person's awareness about her or his *resources for connection* is also important. Thus, the therapist will help the client look at her / his patterns of *relational resilience* (Jordan, 1992). As part of this work, the therapist helps the client identify his or her wants and needs and helps find ways to express these needs so that people other than the therapist can be responsive to them. Furthermore, recognition of non-mutual or hurtful relational patterns is encouraged so that the client can appropriately protect herself and make decisions about engagement in relationships. The therapist tries to help the client alter what might be called maladaptive perceptions of self and other, and helps alter relational expectations. In time-limited therapy, this is done in a focused way. A *relational awareness handbook* (Jordan, 1995) assists the clinician and client in tracing relational patterns.

In addition, two group formats have been developed. One, originally called a *self-in-relation group* (Dooley, Kaufmann, & Surrey, personal

communication), is a psycho-educational group meant to be conducted over 8-12 sessions. It introduces participants to some of the core concepts of the Stone Center model. A relational practice manual is currently being written for application to a wide array of group and institutional settings (Jordan & Dooley, in press). Another format called *relational awareness groups* (Jordan, 1995) also includes psycho-educational/conceptual material, a special relational check-in process, ongoing development of awareness of patterns of disconnection and connection, and awareness of relational vulnerabilities and strengths. Relational awareness groups can be tailored to time-limited interventions (8-12 sessions) or can be more open-ended. These groups have been very effective in helping people look at the ways in which they get into relationships that are maladaptive or destructive for them; but, they also help people begin to develop and explore constructive relational resources and begin to alter existing relational patterns. Both these group models have been used in various settings including a women's prison with inmates and guards, a psychiatric inpatient setting, a partial hospital setting, trauma programs, programs for chronically disabled psychiatric patients, a women's housing project, a group of ten-year-old boys, and staff groups in various institutional settings.

Unlike most of the traditional session-limited therapies that emphasize termination from the moment the person walks in the door, a relational approach maintains "an open door policy" and stresses the continuity of relationship, even when therapy sessions are not taking place. Therapist and client do a piece of work together, but it should be clear to the client from the outset that the therapist will be available for future work. This is not a therapy which prescribes a "stand on your own two feet" or a "lone ranger" ethic. Very often people can do a piece of therapy and then come back, possibly six months or a year later or longer, and do another piece of therapy. The relationship that has been built in this initial phase continues in the absence of meetings; it offers the possibility of re-connection when more work is needed. Furthermore, growth-fostering relationships outside of the therapy relationship are encouraged and other relational resources are emphasized and explored.

In summary, a relational approach to session-limited therapy stresses connection not separation, support not confrontation, relational awareness in addition to symptom reduction, and the building of relational strengths and networks that provide support and encouragement for the client when the therapist and client are not having frequent, regular meetings. A relational approach also maintains that it is essential to differentiate when a client can make use of such limited therapeutic contact and when more intensive or long-term work is indicated. And it is imperative that clinicians, not cost-cutting administrators, be in charge of clinical decision making. Furthermore, clinicians have a responsibility to work on an organizational and legislative level to try to get better care for all clients.

The Managed Care Model

Maryellen Handel, Ph.D.

Many relational therapists feel that managed care, with its inherent time limitations, is a barrier to building connections and, therefore, to the healing process. I would like to suggest that a short-term model and the relational model need not be mutually exclusive. I propose that these two approaches can, under optimal circumstances, work hand-in-hand, and, in addition, can provide an opportunity to empower women as they actively participate in the therapeutic process.

This paper makes several assumptions at the outset: 1) that the therapist and client are able to make workable connections with the managed care company; 2) that the managed care company is respectful of the clinician's recommendations; and 3) that the patient has the psychological resources to utilize the model that we are presenting.

It is important to acknowledge the difficulties that disconnections with managed care companies create for therapists and their clients. For instance, communications from managed care companies to carry out treatment for clients in short time frames may lead to disconnections between therapists, clients, and the managed care company. In the service of clients, who depend on managed care company payments, however, it is important to succeed in building good connections with the managed care companies, and thus be to able to carry out the work. For many people, this is their only chance for any therapy at all. Despite the barriers that are present when working with managed care, I have found that the model for treatment presented here can work and can enhance women's growth and connection.

This paper will begin by delineating the basic tenets of this short-term model, then connect these to the relational model as described by Judith Jordan above, and then propose ways in which this combined model can empower women. Clinical material will be used to illustrate the approach.

The Ideal Model of Managed Care

Most clinicians are aware only of the problems and barriers that sometimes exist when working with managed care companies. Yet, there is a positive theoretical basis in the *ideal* model of managed care delivery. The three basic tenets of this ideal model are access, quality, and cost. The concept of access assures that there should be no barriers to care for those who need it. Ideally, networks are established to provide clients with services that are geared to their clinical, cultural, and geographic needs. Quality assures that the treatments used are effective and delivered by qualified clinicians. Finally, cost represents the notion that treatment should be provided at the appropriate intensity or "level of care."

A fourth concept of managed care is "customer focus." This assumes that the client is an active participant in the healing process and in the selection of the clinician who can provide the care. It is a collaborative model and the power disparity of the medical model, i.e., "you are sick and if you do as I say you will be well," is altered.

The managed care model envisages a client / customer at the center with the therapist serving the client's needs according to the client's values, according to the client's customs, and according to the client's level of comfort. Connection is very important throughout this type of work. One must connect rapidly and work in a focused way in fewer sessions. So, how does the managed care construct fit with the relational model?

Weaving Together the Relational and the Managed Care Time-Limited Models:

The work itself, in the context that has been described above, can dovetail with the relational model. The therapist works with the client's strengths and works to ensure connections that are collaborative. In the evaluation, as it focuses both on strengths and problematic areas, the therapist and client select two or three focal relational issues. Together client and therapist can look at patterns of connection and disconnection. They can collaboratively look at the resources for connection and also look within the therapeutic relationship for the issues of connection and disconnection. In addition, the assessment must conclude that the client is a good candidate for this type of short-term, empowering treatment plan.

The next step is to plan, with the client, how this therapy is going to take place. In other words, with these resources and in a limited number of sessions, how are therapist and client together going to help strengthen this client's abilities to make and sustain connections to meet his or her current needs. As mentioned above, one can begin with several sessions close together to support the therapeutic connection. Client and therapist may decide to spread the sessions further apart after the initial connection has been established. For example, the client may say, "I want these sessions to last for six months; so, I'd like to come once a month because I anticipate a problem in September and maybe in October. That is usually a tough time of year for me, so I think I would like to spread these sessions out."

The therapist can also empower the client by encouraging him or her to seek connections within his or her own communities. These connections are important as they can build lifelong bridges and connecting networks that the client can access over an unlimited period of time. The client can be encouraged to seek out support groups, relaxation classes, exercise venues, and the like, on his / her own; therapy encourages and helps repair the client's ability to make connections outside of the therapeutic alliance.

As stated above, the assessment must evaluate the client's resources for connection. Focusing on these attributes empowers the client, helps her or him to establish connections, and reinforces her or his ability to bring strengths to the healing process. It is important to use this collaborative, connected approach in the assessment process. I usually continue the assessment for two sessions. For example, after assessing the connections and disconnections, (assessment of strengths and delineation of problem areas) during the first session, I may use the Beck Depression Scale to help quantify the level of depression if that is an area of concern. Then, I attempt to build a connection with the client, helping to empower her or him through education, to understand symptoms within the context of connections and disconnections. Knowledge and increased clarity regarding the client's subjective discomfort can begin to build strength for the healing process and, in addition, fosters the sense of connection and working relationship with the therapist.

An Example

The client, whom I'll call Mary, was referred by her primary care physician. I work with the client in a two-session evaluation. Mary, as customer, presents her problems requesting that I help her to solve them. She says, "I am anxious and I don't know why. I am not sleeping well. I'm angry and irritable at work. These symptoms have come on in the last month, and

it is very unlike me." We work together to look at past issues, particularly connections and disconnections. We learn that the client was adopted and never thought about looking for her birth mother. She and her husband have been unable to conceive a child and are in the process of a fertility work-up. The client had an abortion when she and her husband were engaged. As she talks, it emerges that this past loss, connected now with the infertility issues, is particularly painful.

The client is not at all connected to her siblings, both the biological and adoptive ones. Her husband and his family are from another culture (they are new immigrants), and she often feels disconnected from them. The client works at night and the husband works during the day—more disconnections.

We establish goals for treatment together. The client says, "I don't want to feel the way I am feeling. I want things to change." We select three issues to work on over time. During the eight sessions, the client: grieves the abortion; sets out her own plans for getting involved with an adoptive children's group; and also works to connect to her own creative energy through craft projects. As a creative project (her "psychological baby"), she starts making flower arrangements, which gives her a good deal of satisfaction. During the therapeutic work, she is able to see that her depression is related to issues of connection and disconnection, and that she has the skills and the resources to find ways to reconnect to the things that are important to her and to grieve the losses that she has had.

Empowerment

Despite the fact that the managed care model as outlined above, has often not been implemented in a way that is faithful to its theoretical construct, it still can work to empower women. For example, the therapist can encourage the client to be active and collaborative in deciding what she needs and how that can be accomplished.

The empowering aspects of managed care and the relational model assume that the client can evaluate the treatment session by session. As a matter of course, I now ask clients at the conclusion of every session, "How was the session today?" If they reply, "It was good," I continue, "Can you tell me what made it good for you today?" and "Which parts of the session didn't work, which parts were particularly helpful?"

This ongoing evaluation and responsiveness on the part of the therapist is very powerful and serves to enhance both the relational and managed care models. First of all, by carrying out this dialogue at every session you are encouraging the connection with the therapist in a collaborative way. You are also helping the sessions to be efficient and focused as you are getting feedback that can help both participants to steer the work toward the most healing and connecting areas. It assumes a mutual respect that is essential in making connections.

Conclusion

In my experience, the managed care model of time-limited therapy can be viewed as fostering connection, empowerment, and a sense of worth and initiative. Both the managed care model and the relational model ideally value the client as a person whose strengths in connection can be known and brought explicitly to the healing process.

Relational Time-Limited Psychotherapy: Developmental and Cross-Cultural Considerations

Margarita Alvarez, Ph.D.

Although time-limited psychotherapy is not a panacea for the solution of all types of psychological problems, it can be effective as an approach when addressing dilemmas that are developmental (i.e., entering into adolescence, graduating from school, moving away from home) and / or transitional in nature (i.e., adjusting to the pressures of a new job; losing a significant support system). Time-limited psychotherapy is helpful with people who are internally resourceful, with flexible meaning-making systems, and with accessible supportive networks. Additionally, this approach might be particularly useful if congruent with the person's world view and meanings regarding their presenting dilemmas, previous help-seeking experiences, and view of helping professionals.

Developmentally related difficulties can be addressed in a time-limited fashion if the focus centers on normative versus pathological processes. Shifting expectations connected to changing roles, contexts, and relationships can be confusing and disorienting. Connecting empathically to clients' grief associated with separating from loved ones, or to their anxiety related to the unknown, as well as with their confusion when experiencing conflicting role expectations, can facilitate reframing these processes as normative. Having a resource-oriented perspective opens up the possibility of exploring options and coping strategies. Shifting from a problem or deficit perspective to a positive meaning-making framework can be liberating and growth promoting (Jordan, 1989; Miller & Stiver, 1995).

A time-limited approach may assuage feelings of

incompetence or family disloyalty if the person's culture and world view are congruent with solving problems on their own and/or within their family or extended network of close friends. Similarly, people concerned with becoming dependent on a therapist benefit from approaches that frame the focus of intervention in a short-term fashion.

This approach can also address therapeutic needs in an efficient fashion if the person seeking help prioritizes her or his needs and commits to working on them expediently because of constraints around money, time availability, and/or energy. Additionally, persons with vulnerable coping skills may fear in-depth exploration of events and affect that may tax their functioning and interfere with meeting commitments. In these situations, a time-limited approach that focuses on facilitating problem solving strategies for their most pressing concerns while respecting defenses might be more appropriate. Considering that psychotherapy has a culture of its own (Rendon, 1996), it can be argued that people not "acculturated" to its benefits, or perhaps with a history of negative experiences with mental health professionals, can shy away from the notion of lengthy treatments, but be more open to a time-limited approach. For many people, shame, despair, and lack of hope are deterrents to engaging in therapy, even more so when they feel they have to bare their souls to a stranger. A time-limited and non-hierarchical therapeutic stance, where client and therapist together share responsibility in elucidating and working towards mutually agreed goals, can help restore a sense of empowerment and control for the client (Jordan, 1986;1989). Lengthy treatments may signify for some people that their problems are too serious and severe, further contributing to a sense of despair and hopelessness. One wonders if this factor contributes to the high rate of attrition in outpatient psychotherapy.

In short, time-limited and "present-oriented" approaches can be effective and appropriate for individuals with pragmatic and "present-oriented" styles; for those dealing with life transitions, including sudden losses and dislocations; for younger populations dealing with developmental shifts and family changes; and even for people with time and financial limitations or with more chronic but stable problems. However, these are assumptions that would need to be verified with each particular individual requesting help.

In the next section, I will discuss some difficulties embedded in developmental and life cycle transitions that often present in clinical practice through the manifestation of "symptoms," where a time-limited approach can be effective.

Developmental and Life Cycle Shifts: From "Symptom" to Context

People usually tend to seek psychotherapeutic services when experiencing internal distress or a disconnection from parts of themselves during times of significant changes, disruptions, or discontinuities in their lives. Growing up, changing physically, adjusting to shifting gender roles, accommodating to shifting internal and/or contrasting external expectations, moving away, leaving behind significant emotional attachments and familiar social contexts which nourished and validated primary identifications, or finding different ways of being in the world, are all examples of normative experiences that can challenge a person's sense of self and continuity. Developmental discontinuities can also be experienced, for example, in children transitioning from elementary to middle school. Moving from a structured, familiar, and supportive setting to one which is less familiar, protected, and nurturing, and where autonomy and emotional independence are emphasized, can derail a youngster's sense of belonging if peer relationships cannot be established soon and a sense of being an outsider prevails. Similarly, the experience of becoming uprooted in order to pursue a new career or job, or to follow a loved one into another culture, faith, life style, or tradition, contributes to an internal sense of disruption due to crossing into new territories (Espin, 1994) where internal maps available to making sense of oneself, others, and the world become incongruent or irrelevant. Discontinuities in the validation received in relationships with significant others as well as in the "average expectable environment" (Hartmann, 1950 cited by Akhtar, 1995) can be emotionally disorganizing and contribute to the appearance of emotional, physical, and/or social difficulties.

Lack of external support or tolerance for the manifestations of emotional pain associated with these developmental transitions can influence the appearance of emotional disconnections with oneself and others, contributing to the appearance of symptoms (Miller,1988). While these can be transient, they can also become chronic and debilitating forces in a person's life if the emotional reactions to the losses experienced are lived in isolation and/or experienced as illegitimate (Miller, 1986).

All these issues can be addressed effectively in a relational, empathic, and validating manner (Miller & Stiver, 1991), especially when symptoms are

understood in light of the person's experiences in context. As Judy described before, the therapist needs to be actively engaged in helping the client access her/his resources for connection. As therapists, we also need to provide information that will enhance the person's access to external resources. A relational time-limited therapy that resonates to the person's culture would attempt to:

- enhance awareness of internal and external resources in light of changes and shifts,
- increase clarity regarding previous functioning,
- increase understanding of a symptom's meta-language as she/he enters a new context with different rules, and
- facilitate relational images that provide comfort and holding while expanding other images that may help in the shifts and transition.

If these goals are met, clients will be more likely to get back on their developmental path and fulfill their optimal potential while adjusting to new shifts and demands.

Non-Normative Transitions

A relational, time-limited approach can also be effective when dealing with the effects of disruptions in peoples' lives that transcend normative life cycle transitions. For example, natural disasters, wars, forced migrations, and immigration contribute to significant emotional, identity, and relational disruptions in peoples' lives due to geographical dislocations and loss of significant relational contexts that previously sustained their cultural identity (Alvarez, 1995). When moving to different places or social contexts because of traumatic circumstances, various forces will inevitably influence how people will function, adjust to changes, and view themselves. The culture of the new place shapes how one experiences and interprets one's experiences through the lens of different ways of being, relating, communicating, and so on. The status of outsider, minority, ethnically different, or marginalized because of language, race, and class, will cast new meanings on previously held identities (Akhtar, 1995). All of these processes influence the emergence of self-doubt and of a devaluing of one's known way of being and interpreting the world. Different behavioral patterns will be tried in order to adjust to new role prescriptions and to new identities, chosen or imposed. If one experiences these processes in isolation, the loss of significant relationships and attachment figures will further contribute to patterns of grief and mourning. Symptoms will most likely emerge if the new culture does not resonate to the emotional expression of these losses (Alvarez, 1995).

Coping Styles as Mobilizers or Inhibitors

Clinical data indicate that people's coping strategies become paralyzed or mobilized around times of anticipated and/or of actual change. However, people get stuck when old coping strategies, that were once functional, become reactivated despite their lack of effectiveness in solving the new challenges at hand.

Old coping patterns become reactivated because people tend to resort to what they know best. It is difficult to let go of what is familiar if there is nothing to replace it. Furthermore, if maintaining old coping patterns preserves a connection with significant others, places, and times, it makes sense that giving them up may trigger a fear of losing a sense of who one is. Loyalty conflicts can also crystallize apparently dysfunctional coping strategies when a person carries an "unsettled account in the family" (Boszormenyi-Nagy & Spark, 1984), usually mobilized by guilt and anxiety. Anniversaries commemorating the loss of significant loved ones tend to reactivate unresolved grief reactions or symptomatic behaviors that serve to connect with the lost loved ones.

Other problems that emerge during developmental and life cycle transitions may relate to peoples' fears of the unknown. Becoming paralyzed or reactivating old coping patterns are ways of responding to the anxiety elicited by the uncertainties about the future or unfamiliarity with the demands at hand. The new maps for interpreting the new territories may not readily describe behavioral patterns that can be easily emulated in order to function effectively according to the norms of the new place. However, other difficulties may arise from the person's interpretation or meaning-making of these events.

Conclusion

In summary, a relational and culturally informed time-limited approach can foster clients' optimal functioning and adjustment to conflicting and shifting demands in times of normative and non-normative transitions. The therapist's non-pathologizing stance can facilitate the client's access to internal and external resources in a growth-promoting and cost effective fashion. This approach can be effective with developmentally and culturally diverse populations.

Short-Term Therapy in a College Counseling Service

Robin Cook-Nobles, Ed.D.

In transitioning from a long-term to a short-term model of psychotherapy, it is important to have a theoretical frame. Theory provides guidance and direction to the work. The focus of this paper is our work at the Stone Center Counseling Service and how we work relationally with students within a limited time frame. We primarily provide short-term counseling, which typically ranges from six to eight sessions. However, there is flexibility around the actual number of sessions per student, which is tailored to the student's individual need(s) and circumstance.

Clients do not exist in isolation, but in relation to the world and their immediate environment. It is important to acknowledge this larger context. Some important questions to consider are whether the environment is supportive and whether other people are available to help provide a supportive network that will complement the work of the therapy. The environment at Wellesley College is supportive. There are a number of resources on campus that can be tapped into to empower the client and the therapy.

Time-limited treatment meets a practical need. It allows us to provide a service while remaining available to the student body at large. Thus, there is no need to maintain a waiting list; we can accommodate a student in crisis, and most students are seen within a week. Students are, therefore, able to get the services they need within a relatively short time period.

The short-term work that we provide is relational. We focus on the connection, working collaboratively, and empowering the client to connect and work with other resources in the community. This is contrary to the belief that short-term work is all about separation and termination. I, therefore, suggest that you consider the larger context in your clinical work. Identify other supports that can be tapped into that can empower the clinical work. It could be the community at large, the family, or grassroot groups.

Practical Considerations

We provide periodic counseling. If a student comes to the Counseling Service and has a good experience, then she knows that the Counseling Service remains available to her and that she can return for support. The mere presence of the Counseling Service on campus provides a holding environment for the student, whether or not she is availing herself of the services at a particular time. She may come back with a related problem, or a completely different problem, in the future. Thus at the end of brief therapy, the relationship has changed, but has not abruptly ended. The student can remain in relation to the Counseling Service and/or the therapist even when she is no longer an active client of the Counseling Service. The Service, therefore, provides continuity for students. It increases the connection and lessens the disruptions and disconnections.

By engaging in short-term work, the client is learning new coping skills and different ways of managing her behavior. The role of the therapist broadens to that of an educator, whose goal is to teach the client new and different ways of managing and coping, which she can internalize and use when other similar situations arise in the future. These new skills may also be transferable to other problems or situations that arise. The client also has the option of coming back later and reengaging in treatment with the same or a different therapist. Thus, one of the important goals of the treatment is for the client to have a positive clinical experience so that she will feel free to reengage in treatment in the future, should the need arise.

In assessing the appropriateness of short-term therapy, one has to assess the client's resources. Margarita Alvarez has already mentioned resilience. It is important to assess the client's survival skills, ego, strength, coping mechanisms, and relational resources. Some important questions to consider are: what has the client gone through before and how did she manage; what made a difference for her at that time; and what shifted things for her. The financial resources of the client can be addressed as well. Such questions help the client become cognizant of her resources and what may have been useful (or not so useful) in the past in getting her through a difficult period. By helping the client identify what worked then, she can begin to explore what might work now.

As previously mentioned, it is important to look at the client's social supports. We have found that students who are connected to other people tend to do much better than students who are isolated. The therapist helps the client to identify her social supports and encourages her to use them. Sometimes, when a support network is lacking, the goal of the therapy is to help the student build a network or expand her social group. Sometimes the focus of the therapy is to help the client develop more mutual supports in which there is balance in the relationship and/or to help the client to learn to relate to people differently.

Short-term therapy does not work for everyone. It is important for clinicians to assess the type of intervention needed and to take into account the needs and wishes of the client. One client might need to be seen for the duration of the academic year, another might need a limited amount of sessions spaced out over a semester or academic year. She or he might need a referral to a private clinician in the community for ongoing psychotherapy or a referral to an agency or hospital might be appropriate. Sometimes a combination of the available services is indicated. It is important to be open to a number of treatment options, and to collaborate with the client in making treatment recommendations.

In providing a thorough assessment, it is important to look at the other stresses that are impacting the client. An academic environment can be quite challenging and other life stresses, such as family history, background, and/or ongoing family problems, may be interacting with academic demands. Given the amount of stress and the degree of distress that the client is experiencing, the therapist may choose not to delve deeply into the presenting concerns, nor attempt to uncover underlying issues. The focus of the clinical work might be to hold, support, contain, and stabilize the client. After the academic year/semester is over, the student may then decide to look more closely at the underlying issues and engage in more intensive psychotherapy.

Clinical Considerations

The appropriateness of short-term therapy may be determined by the presenting concern or the manner in which the client presents or tells her story. For example, a student may present with homesickness, which typically is seen as a reasonable presenting concern for short-term work. However, her presentation may raise concern as to whether there are major loss issues, which may contraindicate putting a time limit on the treatment. For example, the client may talk on and on, and have a hard time ending the session. She may experience the limited number of sessions as an initial rejection and may flee from the treatment rather than connect with the therapist. The homesickness may be the immediate presenting concern, but the long-term issues of loss may be the underlying issue that needs to be the focus of treatment.

Another example of the presenting problem having implications for the treatment modality is the client with a trauma background. One might automatically assume that long-term work is indicated. This is not necessarily the case. If a person is struggling with issues of trauma, but has a lot of other factors impinging upon them at a particular time, long-term intensive treatment might be contraindicated. Instead, it might be more appropriate to focus on safety and stabilization, rather than on the long-term issues. Providing a supportive, safe, holding environment might be the focus of the treatment. Thus, even though the presenting concern is important in determining the appropriateness of short-term work, other factors also need to be considered.

Margarita already talked about the attitudes towards therapy and cultural factors that impinge upon the therapy. I want to reiterate their importance and add that therapy is a culture. People from a certain culture, background, and experience created therapy. As culture shifts and changes, and as people have different cultural experiences, therapists need to remain flexible and open. The rules and techniques of therapy are neither sacred nor static. In some cultures it is appropriate to accept gifts. In some situations the boundaries around the therapy hour and place have to be more flexible (home visits for those unlikely to come to our offices, for example). In connecting with clients from varied cultures, it is important to acknowledge the culture out of which the therapy grew. We should also acknowledge aspects of the training that are helpful to maintain and those which might need to be modified.

Process

Last, it is important to focus on the process. The primary therapeutic ingredient is the relationship and the working alliance between the therapist and the client. Within this relationally focused context, there are three phases of treatment, i.e., assessment, treatment, and what has been called termination. During the assessment phase, the relationship is central and two primary processes are in operation. The therapist and client are establishing a connection, while simultaneously identifying the problem, establishing the goals of the treatment, and devising a contract or plan of how to work together.

In addition, in short-term work, the therapist needs to be active. One cannot let the work unfold as is the case with time-unlimited therapy. Within the first two to three sessions, a decision has to be made as to whether the therapist and client will continue to work together. The time frame has to be decided upon as well. If the problem cannot be addressed fully within the agreed upon time frame, then a smaller piece (focus) of the larger problem might be addressed. Or, the client might feel that she needs

support over an extended period of time and decide to take a referral for long-term treatment. The focus could also be an extended assessment, in which the client gains greater understanding of the problem and what is needed therapeutically. In sum, during the assessment phase of treatment, the therapist and the client decide on a focus and contract for treatment.

The treatment phase follows, in which the client and therapist work together to help resolve the primary concern (focus) and to meet the established goals. The client identifies patterns of behavior that might be counterproductive or destructive, relationships that might be problematic, etc., and develops new ways of coping, and / or makes significant life changes.

During the final phase there is a review and an evaluation of the work, as well as an identification of next steps. Closure on the treatment is gained while also identifying other areas of concern and future treatment options. The therapist and the client clarify options for support in the future, including counselor availability. The relationship remains central throughout the treatment and models mutuality, which hopefully will transfer into other relationships.

The therapist makes creative use of the limited number of sessions. Therapeutic time includes the traditional fifty-minute sessions, half-hour check-in or follow-up sessions, and fifteen-minute telephone calls. Together client and therapist devise a contract or plan which spells out the ways in which the time will be used. The relationship remains key throughout the treatment. It establishes the working alliance, maintains trust and commitment to the treatment, and provides holding and support during time of crisis.

Summary

In sum, short-term therapy is a different way of working, both qualitatively and quantitatively. We believe that it is most effective when the focus is on the relationship, connection, and continuity. The therapy is active and has a specific focus, and the client is empowered as an active participant in the treatment. The client has both voice and choice. This empowerment of the client is important when working across cultures and with disenfranchised groups of our society. Also, short-term therapy can assist the new client in understanding the therapeutic process and how to make use of therapy. Furthermore, in relationally-focused brief treatment, termination is not as final. The connection is central, and the therapeutic door remains open. The client can, therefore, return without the stigma that she has failed.

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