This book is dedicated
to Kristina K. Erickson
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Preface

A number of months ago, a middle-aged woman requested a therapy appointment for a long-standing flying phobia. She proclaimed with conviction her belief that "long-term" therapy was necessary. I replied that the therapy would take as long as was needed, noting that for some this meant a few sessions, for others a longer period, and for her "just that amount of time to comfortably make the satisfying changes" she was capable of making. While I assured her that she could continue to elaborate any changes after the therapy was concluded, I also emphasized that any work we might do together would likely be active, experiential, collaborative, and solution-oriented.

As we continued to talk, her initial skepticism about brief therapy gave way to her intense desire for change, and we agreed to a therapy contract consisting of a maximum of 10 sessions, with the primary goal being dissolution of the phobia. Hypnosis was effectively employed during the first several sessions to develop confidence and access resources, so that by the third session we were focusing on which flight she would take as a "test case." When she took a flight with relative comfort during the following week, we were both delighted. During a fourth and final session, we agreed that the therapy contract had been fulfilled, and so no further sessions were scheduled. A later follow-up revealed that several additional flights had been successfully taken, and she considered the problem solved and the therapy successful.

This case illustrates a reality that has slowly been gaining recognition during the past 25 years: Therapy need not be lengthy to be effective. Today, the idea that effective therapy can be brief is central to a growing number of therapists, many of whom are eager to learn more efficient ways of practicing this type of approach. It is thus not too surprising that more than 2,300 therapists attended the Brief Therapy Congress sponsored by the Erickson Foundation in San Francisco on December 7-11, 1988. The Congress brought together the leading authorities in the burgeoning field of brief therapy and provided exposure to the cutting edge of current thought and practice in the field. A rich array of view-
points and methods was presented, each demonstrating a different way of doing effective brief therapy.

This book is a record of the Congress. It contains each of the keynote addresses and the invited presentations. The presentations have been organized around key issues and major themes in contemporary brief therapy. While there is no unquestioned party line for describing, or fixed recipe for doing, brief therapy, the reader will discover that most of the authors harbor a deep confidence in clients' abilities to change, as well as an emphasis on action, resources, pragmatism, solutions, future orientation, context, and therapist flexibility. However, the way in which these values are implemented is surprisingly variable. Some authors advocate conscious change processes, while others favor unconscious processes; some focus on the individual, others on the family; and some think of therapy as a "one-shot" venture, while others suggest thinking of therapy as intermittent throughout the life cycle. Thus, a strength of the book is that it challenges therapists to discover the style of doing brief therapy that is most efficacious for them and their clients.

Taken as a whole, the book constitutes a state-of-the-art report on brief therapy, one that both experienced and novice therapists will benefit from reading. As its title promises, it examines brief therapy's myths, describes its methods, and elucidates its metaphors. Most important, it effectively addresses the key issue in any therapy, namely, how to help people successfully meet the challenges of living.

Stephen G. Gilligan, Ph.D.
Introduction

Contained in this volume are the proceedings of the Fourth International Congress on Ericksonian Approaches to Hypnosis and Psychotherapy, entitled *Brief Therapy: Myths, Methods and Metaphors*, held in San Francisco, California, December 7–11, 1988. Some 2,200 professionals from around the world attended the event. These proceedings consist of the keynote speeches and invited addresses.

**ERICKSONIAN CONGRESSES**

The First International Congress on Ericksonian Approaches to Hypnosis and Psychotherapy was held December 4–8, 1980, in Phoenix, Arizona. Milton H. Erickson, M.D., was a member of the organizing committee of that Congress. One of the purposes of the first meeting was to give him an opportunity to see the impact of his work. He did not have that chance; Dr. Erickson died eight and one-half months prior to the meeting. Doubtless, though, Dr. Erickson would have been pleased by the meeting. Approximately 2,000 professionals interested in his work attended the meeting.

The Second International Congress, also held in Phoenix, helped to broaden and advance Ericksonian methodology. The event was held November 30–December 4, 1983. Attendance at the second meeting surpassed 2,000, probably making it the largest professional meeting held on the topic of hypnosis.

The Third International Congress brought new people to the Erickson movement. About 1,800 people attended, and Dr. Erickson’s psychotherapeutic legacy continued to thrive.

The meeting theme was expanded for the Fourth Congress, and more than 2,200 professionals from the United States and 24 countries met to learn various aspects of Brief Therapy. Dr. Erickson was a strong advocate of brief psychotherapy, and his work is a foundation for many therapists’ work in that direction today.
CONGRESS FORMAT

The program for the Congress was designed so attendees could select from a wide variety of training courses. Registrants picked the format that best suited their needs; there was an academic and experiential component to the meeting.

The academic program consisted of keynote addresses and invited addresses. There were three keynote presentations: Cloé Madanes’ “Strategies and Metaphors of Brief Therapy,” Jay Haley’s “Why Not Long-Term Therapy,” and Arnold Lazarus’ presentation, “Brief Psychotherapy: Tautology or Oxymoron” (with Allen Fay). There were 33 invited addresses. It is the academic portion of the Congress which appears in these proceedings.

The experiential component of the Congress consisted of two-hour workshops and practica, interactive events, and short courses. Fifty-five two-hour workshops were offered, plus small group practica. One of the features created in 1986 was carried over to 1988: Attendees were able to work in small group supervised practicum sessions on various topics of hypnosis and brief therapy. The two-hour small groups were limited to 12 participants and were led by faculty members. The entire faculty consisted of more than 160 members, including moderators, co-presenters, and special faculty.

A format change the third day of the Congress gave attendees an opportunity to witness interactive events. One-hour clinical demonstrations, conversation hours, group discussions, and panels on special topics were featured that day.

Short courses also were presented during the Congress: These one-and-one-half hour miniworkshops covered a wide range of topics on Ericksonian methods, as well as brief therapy.

The evening events at the Congress included a welcome reception and an authors’ hour. A special media program honoring the late Virginia Satir also was featured one evening.

The tone and content of the Congress resulted in a well-received meeting among practitioners of varying schools of psychotherapy.

San Francisco provided a beautiful backdrop to the meeting. Professionals who had attended previous Erickson Congresses missed Phoenix but agreed the City by the Bay was an excellent choice as a meeting site.
The success of a meeting this size is due to the input of a great many individuals. I would like to take this opportunity to thank those people.


Stephen Gilligan shared equally all editorial decisions. This book illustrates the gift Gilligan has as an editor, and his diligence is the reader's reward.

On behalf of the Board of Directors, our heartfelt thanks again go to the distinguished faculty. The work provided by these professionals resulted in one of our most memorable meetings.

The Erickson Foundation staff worked tirelessly to ensure the success of the Congress. Under the direction of Executive Director Linda Carr McThrall, the following staff deserves special recognition: Chris Berger, office assistant; Theresa Cords, administrative assistant; Sylvia Cowen, bookkeeper; Greg Deniger, Congress registrar, computer operations manager; Mary Helen Kelly, executive secretary; Alice McAvoy, office assistant; and Judy Sachs, volunteer coordinator.

Michael Liebman, M.C., director of Clinical Services for the Milton H. Erickson Center for Hypnosis and Psychotherapy, provided additional assistance. His staff also should be specially recognized: William A. Cabianca, Ph.D.; Gordon Cuddeby, Ph.D.; Cari Ellis, R.N., M.S.; Larry Ettkin, Ph.D.; Brent B. Geary, M.S.; Mirta Ghiorzi-Volek, Ph.D.; Craig W. LeCroy, Ph.D.; Gary D. Lovejoy, Ph.D.; Frank C. Noble, Ph.D.; Peter J. Rennick, M.S.; Rebecca Rubin, M.C.; Andrea Scott, Ph.D.; Mark Treegoob, Ph.D.; Marti W. Waller, M.C.; and Neil C. Weiner, Ph.D.

A number of volunteers worked with Foundation staff members both prior to and at the Congress. Special thanks go to Ed Hancock, Phil "Mac" McAvoy, and Jaimie Andes, who provided enormous support throughout the planning stages of the Congress and during the event. Additionally, more than 75 graduate student volunteers served as monitors and staffed the registration and continuing education desks.

Special thanks go to Barry Shephard of SHR Communication Planning and Design of Phoenix. Barry designed the Erickson Foundation logo.

The Fourth International Congress was cosponsored by the Depart-
ments of Psychiatry and Psychology, the Veterans Administration Medical Center, Martinez, California; and the Department of Family Practice, University of California at Davis. Their efforts are gratefully acknowledged.

The Board of Directors provided great support during the planning of the Congress. Many thanks go to Sherron Peters, who worked on early plans prior to her resignation from the Board; Elizabeth M. Erickson; Kristina K. Erickson; and J. Charles Theisen.

JEFFREY K. ZEIG, Ph.D.
Director
The Milton H. Erickson Foundation
Phoenix, Arizona
When I look out the front window of my consulting office, which is attached to my home in Phoenix, Arizona, I see a maturing ironwood tree. Exactly eight years ago that same ironwood tree was in a wicker basket decorated with a purple ribbon. It sat on the stage of Symphony Hall in Phoenix, a much smaller, less mature version of its present self. I introduced that ironwood tree to the Convocation assembled at the December 1980 First International Congress on Ericksonian Approaches to Hypnosis and Psychotherapy.

I envisioned the first congress as a 79th birthday celebration for Milton H. Erickson, M.D. It was to be an opportunity for him to greet old friends and colleagues and to see the impact of his accomplishments on the field of psychotherapy. In my efforts to organize the meeting, a guiding personal vision was to introduce Dr. Erickson to the Congress. When he died less than nine months before the convention, I substituted the ironwood tree.

For those of you who don’t know, Dr. Erickson fancied wood carvings. Toward the end of his life he collected carvings made of ironwood, a hardwood with lavender flowers, so dense it resists floating. These carvings were made by the Seri Indians, the Seris, who live in northwest Mexico in the Sonoran desert. They carved local sea and desert animals using primitive tools, and they stained their work with shoe polish. It seems that modern tools can be used only to initially cut ironwood logs. This wood is best worked slowly and by hand.

The wood utilized by the Seris is scrap. Freshly cut wood is uncarvable. Fallen wood must be used. The fallen wood does not rot. Rather it is cured by the desert climate. The Seris had the foresight to use something that others could not see how to use. And they used it to create art.

At one time, Dr. Erickson had one of the world’s most extensive collections of Seri ironwood. Now that collection has dwindled. A number of pieces are gifts in the possession of colleagues and students, many of whom serve on the faculty of this meeting. My last Christmas gift from Dr. Erickson was an ironwood owl. I told him it was very wise gift indeed.
Now, the ironwood tree that I planted outside my office made a remarkable recovery. It lost all its leaves from the shock of standing on the stage of Symphony Hall at the 1980 meeting. It seemed as if it would never recover, but that was not the case. The leaves grew. The branches developed and continue to spread. The trunk remains solid.

Although it will take a while before there has been enough development, eventually woodworkers will be able to use the limbs from the tree to create sculptures—sculptures that will use modern forms and reflect modern culture. And, remember, it is only from the cured dead wood that the art can be created.

Now Dr. Erickson did get some of the intended honor from the first Congress. At the time he died, 750 people already had registered for the meeting. And this was a time before 750 people had ever previously convened for a "hypnosis meeting."

At the Erickson Foundation we continue a tradition by holding Congresses every three years, 1980, 1983, and 1986. Each of those meetings was attended by 1,800 to 2,000 people. This Brief Therapy meeting, with an attendance of 2,400, is the largest of any of the International Erickson Congresses.

Also, we continue to branch out. In 1985, the Foundation organized the Evolution of Psychotherapy Conference, which assembled 7,000 registrants in an attempt to promote concilience among different schools of therapy. Today’s Congress continues that trend and brings together outstanding practitioners of brief therapy from many different schools. This meeting has been entitled, “Brief Therapy: Myths, Methods, and Metaphors.” The Congress will examine brief therapy’s history (myths), developments in technique (methods), and different models (metaphors).

Dr. Erickson was a man who championed a “utilization” approach to psychotherapy. He advised students to use whatever the patient brings—values, history, and even resistances. I think you will find many things to utilize among the diverse branches of brief therapy represented at this meeting. You might want to use this opportunity to learn from practitioners whose work may be less familiar to you and outside the realm of your preferred approach.

Now I wish I could introduce that ironwood tree to you today. But I can introduce some of the roots, and no tree grows without roots. The strong roots of the Foundation are its staff: Linda Carr McThrall, Executive Director; Theresa Cords, Administrative Assistant and Faculty Coordinator; Greg Deniger, Registrar; Sylvia Cowen, Bookkeeper; Mary Helen Kelly, Administrative Assistant and Institutes Coordinator; Judy Sachs, Volunteer Coordinator; Alice McAvoy, Assistant; Chris Berger, Assistant; and Michael Liebman, Director of the Milton H. Erickson
Center for Hypnosis and Psychotherapy. Some of the strongest roots of the Foundation have been the Erickson family members who have attended and lectured at these Congresses. The Erickson family members in attendance at this meeting are Mrs. Elizabeth Erickson; Kristina K. Erickson, M.D.; Lance Erickson, Ph.D.; Betty Alice Erickson Elliott, M.S.; Roxanna Erickson Klein, R.N., M.S.; and Robert Erickson, M.A.

I hope you have a great time at the meeting and that you acquire some of the knowledge and experience that you have come here for.

JEFFREY K. ZEIG, Ph.D.
"Each person is a unique individual. Hence, psychotherapy should be formulated to meet the uniqueness of the individual's needs, rather than tailoring the person to fit the Procrustean bed of a hypothetical theory of human behavior."

—MILTON H. ERICKSON, M.D.
PART I

Keynote Addresses
Why Not Long-Term Therapy?

Jay Haley

It is curious how few meetings and training programs there are on how to do long-term therapy. Most of the announcements one sees are for seminars and workshops on brief therapy. The implication is that everyone knows how to engage clients in therapy for months or years. Yet long-term therapists are made, not born. Therapists do not have innate skills in committing clients to long-term contracts. Without training, they must learn by trial and error to do interminable therapy when they get into practice.

Often it is thought that long-term therapy occurs because the therapist does not know how to cure a person faster. A more respectful view is that it is a special ability. After all, many people do brief therapy because they lack the skill to keep clients coming for a long time. Little is written about long-term therapy techniques.

One of the few therapists with the courage to discuss how to keep a client in therapy and block him or her from going to someone else was Milton H. Erickson. For example, he proposed that a technique for preventing a client going elsewhere was to listen to him and respond, "I know how difficult it is for you to talk about this. If you had to go over it again with someone else, that would be even more painful." Erickson reported that such simple comments prevent clients from going to other therapists. More complicated techniques developed by Erickson to keep clients in therapy still remain secret.

The length of therapy is one of the most important issues in the field,
and insurance companies now set the limits. Clinicians have some voice in this matter and should consider the issues. The first issue involves the needs of the therapist, and the second the needs of the client.

THE ISSUE FOR THE THERAPIST

Because therapy is both a calling and a business, the topic of how to keep someone in therapy can be embarrassing. The implication can be that the therapist wants to make money by seeing the client longer. It is best if we face facts. A therapist does make more money from a client who stays in therapy for years compared with a client who stays in therapy only a short time. The fact that more money is made should not be a reason to avoid workshops or instruction in long-term techniques.

If we accept the financial problem as something we must live with, what are the merits of long-term therapy for the therapist? Even if some therapists would rather not think about the positive side of interminable therapy, it should be discussed. Like having romantic affairs, many people would rather do it than talk about it at a public meeting.

At one time short-term therapists were on the defensive. Long-term therapists thought of themselves as "deep" and were confident, even arrogant. They liked to imply that brief therapy was a shallow, superficial endeavor. Brief therapists had to quote scientific outcome results to prove their success, pointing out that research did not show any correlation between length of therapy and successful outcome. Long-term therapists easily rejected such data as irrelevant. They pointed out that outcome results do not cause changes in therapy approaches in the field, which change only on the basis of fashion. Short-term therapy was simply condemned as not fashionable and not elegant in practice or theory. Now, with changes in insurance and HMO contracts setting limits on therapy length, the situation is reversed; long-term therapists are becoming defensive and brief therapists are bragging. One day we might even see long-term therapists desperately trying to bring science into the issue.

Young therapists won't recall the Golden Age of long-term therapy and might appreciate an example of a personal encounter to illustrate how it was in those days. I was once dining in a restaurant in Paris and began talking with an American couple who were sitting at the next table. When they asked what I did, I said I directed a therapy institute. The couple knew a lot about therapy since they were from New York. They were pleased to find we had something in common. The husband said he had been in therapy for 12 years, considering psychoanalysis to
be therapy, and his wife had been in therapy for 8 years. Both of them had several sessions a week. I asked if therapy had solved their problems. They looked surprised at the question. "Of course not," said the gentleman, as if thinking the matter over for the first time. "We wouldn't still be going if it had." I asked them if they would recommend therapy to someone else. They said, "Of course we would. Everyone should be in therapy." I could see they had a therapist who knew his business.

In the discussion, I mentioned that 12 years seemed a long time to be in therapy. Rather defensively, the man asked me how long we did therapy at our Institute. I said, "We average about six interviews. With student therapists the average is about nine interviews." The couple looked at me, shocked, as if regretting they had begun this conversation. I found myself saying apologetically, "Well, that's only an average, we see some people a long time." I even added, to fill the silence, "Sometimes people come once a month, and so six sessions can take as long as six months." The couple became rather condescending and polite. The gentleman said that I must see a different class of clients than he was familiar with. I said defensively that we treated every wretch who knocked on our door. He said that I certainly could not be doing therapy with advertising executives like him and his wife. They are required to be in therapy for a long time because they feel so guilty about their work that they have to pay a lot of money to an analyst for years as a kind of penance. I had to agree that our therapy did not meet that special need because we did not have that size advertising industry in our area. The couple lost interest in me and began to look for an Italian to talk to.

I found myself defensive about doing effective therapy even though the people were saying their long-term therapy had not produced results. I also realized that I did not know how the therapists of this couple had kept them coming so many years without any improvement. There are thousands of therapists with that skill in the large cities. If they teach it, they do not do so in public workshops where all of us can learn. Perhaps it is secretly taught during personal therapy. I understand a training analysis in New York now averages seven years. That is quite a bit longer than the few months that Freud recommended. Perhaps the analysands are more obtuse these days and so require a longer analysis, but it might also be that they are being taught more secrets about how to contain people in therapy.

Now that fashions, and funding for therapy, have changed, people are beginning to be defensive about doing long-term therapy. The pendulum is swinging. As we examine therapy today, there have been remarkable changes in the last two decades. No longer do a few therapists deal with a few clients in distress. Therapy has become a major industry. Just as photocopying machines are flooding the world
with paper, the universities are pouring out therapists of every species. There are psychologists, psychiatrists, social workers, educational psychologists, industrial psychologists, hypnotherapists, rational therapists, drug counselors, hospital therapists, marital therapists, family therapists of a dozen schools, and so on. These therapists rush out into offices and agencies everywhere. Part of the reason for this deluge is the publicity given to therapy in the mass media. In TV dramas the characters are in therapy and discuss it as part of life. Talk show hosts discuss their therapy, setting examples for the audience. Women's magazines have columns on the subject. TV and radio psychologists advise everyone to rush off and get therapy. “If only your husband will go into counseling, all will be well” is the cry of the radio psychologist heard by millions.

With therapy such a way of life, is it proper for a therapist to talk about how briefly it can be done? Isn’t that like General Motors bragging about how quickly they can build a Cadillac? Or surgeons bragging about how short a time it takes them to do bypass heart surgery? In the early days of therapy when people were less affluent and there was no insurance, it seemed appropriate to be brief. Now with what it costs to become a therapist, obviously it is only fair to get a return on the investment. Not only is an expensive undergraduate degree necessary, and an expensive graduate degree, but there is postgraduate training. There is also typically the personal therapy expense. It is hoped that a personal therapy will somehow make a therapist more successful. (It is also a way to provide clients for the training staff who might not otherwise have them. Four analysands and four guilty businessmen seen several days a week is all a long-term therapist needs to avoid having to get more referrals for several years.) Besides academic costs, therapists must go to private institutes to learn the therapy skills they were not taught in the university. Seminars and workshops are required to keep up with the continuing education requirements. A therapy practice these days represents a large financial investment, and we must accept that and count it in the fee.

The therapist is not the only person who is being supported by the therapy fee. Just as there are 40 or 50 backup persons to support every soldier who is actually in combat, so the therapist is at the tip of a pyramid of support personnel. There are administrators of training institutes, supervisors, protective service personnel and judges, hospital and prison staffs, public agency case workers, teachers of abnormal psychology, systems theorists, journal editors, publishers, professional organization staff, licensing authorities, constructivists, and so on. Obviously, a therapy case must provide enough money to support not only the therapist and his family, but all the auxiliary personnel employed in the field.
Anxiety reveals different sources of insights. If an individual feels anxious, he or she may be experiencing one or a combination of these fundamental facts of human existence. I present here the use of a paradigm of existential sources of anxiety and dread, differentiating them and integrating six of these sources into the art therapy process. None are psychological problems but, rather, ancient and universal problems of living. They are the anxieties of freedom, individuality, birth, evil, nihilism, and death.

Freedom

This brings us to the matter of freedom and its resulting anxiety. In a 1978 lecture I heard Rollo May describe freedom as the pause that breaks into cause and effect—a phenomenology of total self, not just intellect. In the framework of clinical philosophy the patients and clients learn that with this freedom we construct our world—that the experience of freedom is the experience of consciousness. The experience of consciousness is an infinite backward movement illuminating the world and our freedom to create our own world.

An example of the freedom to constitute our life in the art therapy process is demonstrated when a person makes a scribble with one color and then with other colors brings out the images found therein. The scribble and the art media are symbolic of the amorphous, monochromatic objects which we become aware of some time after conception. The choice of colors and the evolved forms that become the final product symbolize how, with alternative choices and decision making, we gradually constitute a complete three-dimensional world of which we are the sum product.

A diagnosis of loss of access to one's freedom can be made when the client continually uses the same one or two colors, repeatedly draws only on a small part of the page, and restricts his or her use of forms and texture. Therapy for this diagnosis might be that these pictures be saved and later reviewed with the client, thus serving as reminder of how he or she had chosen a particular color, form, and subject. The art therapist could also ask the client to make his or her verbal associations to the product, reminding the client of his or her responsibility for it, perhaps preceded with the words, “I chose to use one color to make this image, and then I chose this form, and I chose to leave the page empty . . .,” and so forth.

My work in a convalescent hospital with geriatric patients who had lost many of their senses is another illustration of the anxiety of freedom, and its treatment, in art therapy. I attempted to get these patients to use any ounce of freedom that they still had. Lila, for example, was 97 years old and confined to a wheelchair. She had very little hearing or vision capability, and her hands lay uselessly in her lap, crippled from arthritis. I would hold up cut-out magazine pictures
from theorizing about the unconscious to turgid discussions of epistemology, aesthetics, constructivism, chaos, and so on. If the theory is heavy, the therapy can be light, particularly when the theories are about what is wrong with people rather than what to do about changing them. Brief therapists are usually stuck with talking about what to do, which does not lead to profound ideological discussions. There is also not much literature on brief therapy compared with the 70,000 books and articles written about psychodynamic theory.

As another issue, brief therapists tend not to have a theory of resistance. They believe one gets what one expects, and such a theory interferes with gaining cooperation from a client. Long-term therapy has a theory of resistance, which excuses therapy being done forever to overcome that resistance. They also have the potent theory that if the client wants to terminate, he is resisting change and has not really improved, obviously needing more therapy. Long-term ideology has the therapist be the one who decides when therapy is over, not the client, so the length of therapy is in safe hands. Therapy does not end until the therapist is satisfied that the client is as near perfect as can be achieved in one lifetime.

One must also not overlook the importance of the therapist's self-image when choosing the type of therapy to be done. The brief therapist tends to have an image of himself or herself as harried and under stress. The long-term therapist has a look of boredom at times, listening so much to so few people. Not even the marital contract requires that much togetherness. Yet the long-term therapist also has a positive image as a wise philosopher, one who could offer the best advice if he chose to, but clients must decide for themselves. In a comfortable chair in a well-decorated office, preferably with a fireplace, the therapist patiently listens like a good friend to the clients who come to him for many years. Sometimes confrontation is necessary, but if so it is gently done, so the person will continue in therapy. The long-term therapist is loved by his clients. Usually the short-term therapist is not. There is not enough time for a romance. This kindly, loving, philosophical image is particularly appealing as a target image for young people coming out of school. Graduates hope for a private practice, though more and more of them must settle for a salary in an agency or hospital where they must do brief therapy.

THE ISSUE FOR THE CLIENT

Besides the merits of long-term therapy for the therapist, there is the question whether the client benefits most from long- or short-term therapy. We must also consider not only the client but also his or her
support personnel in the family network. A scientific case report might clarify the matter.

I recall a woman who became upset when she married. She went into therapy as a result. Eighteen years later she is still in therapy. At that point, she divorced her husband. She also divorced her therapist. The last time I saw her she was considering marriage to another man. She was also thinking of going back into therapy. Can we say that the two decades of therapy had a positive or a negative effect? Would short-term therapy have been preferable in her case? Only intensive research can resolve this question. However, a few ideas are evident. On one side, the woman never had a marriage that was a dyad. She was in a triangle with her husband and her therapist all during her marriage, as many men and women in individual therapy are today. What did the therapy cost her husband? Not only is the expense of therapy over the years a steady drain on a household budget, but what of the personal cost? This husband had a wife whose experiences and ideas, even her intimate thoughts, were more likely to be communicated to another man rather than to him. If communicated to him, it was often after she had spoken to her therapist about it and so it was a twice-told tale with second-hand emotion. Each major event in her life, including childbirth and crises with the children, was shared with her therapist. The husband was labeled as secondary as an advisor to his wife and a parent to the children, while the therapist was the authority and expert on human relations whom she consulted.

For a different perspective on this triangle, we can consider the fact that the husband lived 18 years with a wife while paying another man to listen to her complain. This relieved the husband of that task, which some husbands might consider a positive result and others might not. There was also the agreement, confirmed with each therapy visit, that the wife was defective and the husband was not, since he did not go to a therapist. Therefore, their relationship was defined by an expert as one where the husband was superior and took care of a wife who was not quite adequate. The long-term therapist was, of course, thinking of the wife as fragile and needing his support or he would not have continued with the therapy for so many years. By the act of seeing the wife in therapy, he communicated to the marital couple that the wife was not normal like other people.

How difficult it is to choose brief or long-term therapy in such a case. A positive aspect is that the therapist helped the marriage continue for those many years. An 18-year marriage is an accomplishment in this age of easy divorce. Many wives who get upset after marriage and have brief therapy rather than long-term might break up with their husbands. If the marriage was stabilized by therapy, should that not be considered a
positive effect? One must also consider the fact that some wives and husbands do not seek therapy because they wish to change, but for consolation. Often they feel they must stay married for financial reasons, or for the children. They ask of the therapist only that a miserable marriage be made more tolerable by reframing aspects of it and offering suggestions. Perhaps it is wrong to help people stay in an unhappy marriage, but often they ask for that service. A brief intervention to make a change will not satisfy them.

THE STIGMA ISSUE

One important factor about long-term therapy is that the practitioners do not consider being in therapy a stigma. They consider therapy good for everyone and the fact of being in therapy does not mean one is defective, or inadequate, in the eyes of others. In this framework are the growth therapists, or those who seek to increase human potential. They do not find anything wrong with a client except the human condition, and all human beings can grow and improve. Yet the growth therapist might be aware that the client in therapy should not try to run for president. It is still the popular assumption that “therapy” means that a person is defective and unable to deal with life’s problems like normal people, particularly if therapy goes on and on for years.

Long-term therapy is usually defended with the argument that the client is fragile and needs support in meeting life’s problems. In contrast, the brief therapist tends to have the view that all the person needs to become normal like other people is a few sessions to straighten out some problems. The underlying premise of brief therapy is fundamentally different from the long-term therapy view of the human condition and how people cope with it. A brief therapist, for example, might turn down someone for therapy because the person does not need it. Long-term therapists consider therapy valuable for everyone and no one should be rejected if he or she can afford it.

AUXILIARY PERSONNEL

Only recently has the social context of a client been emphasized by therapists. The effect of the family organization is now more taken for granted. For example, suppose a kindly family member dies and the family becomes unstable. If a family member enters therapy with a kindly therapist, the family is stabilized. A problem only occurs when termination is considered. At that point the family will have to reorganize to adapt to the loss that they had not adjusted to. As the family becomes
unstable, it is the client who will appear agitated, and the therapist will conclude he still has problems and must continue longer in therapy. As the years pass, the therapy has the function of stabilizing the family. Sometimes the same goal is achieved by regularly hospitalizing a family member, usually an expendable adolescent. The auxiliary personnel of the therapist, the hospital staff, and the auxiliary personnel of the client, the family, all benefit from the therapeutic arrangement. The family benefits by stability, the therapist and his auxiliary personnel benefit from the fee. Can we say that is not a proper function of therapy? Short-term therapy does not offer that function. In fact, short-term therapy tends to destabilize a family as part of inducing change. Long-term therapists tend to stabilize the organization the way it is.

There is another aspect of stabilization that involves symmetry in human relations. Just as human beings and other animals are symmetrical, having one eye above each side of the nose, one ear on each side of the head, and so on, there seems to be the same pattern in human interaction. This is called the 4th law of human relations. With a married couple, for example, if one spouse becomes attached to someone outside the family, the other may seek an attachment. That is, if one spouse begins an affair, the other spouse often seeks one also. Or the spouse might become overinvolved with people at work, or goes into therapy and attaches to a therapist. Similarly, if a spouse enters therapy, the other one can become attached to someone else as a way of balancing the symmetry of the family.

Within the family, if a mother becomes attached to her son, the husband is likely to become attached elsewhere, perhaps to his mother or a therapist. Obviously, if families need to balance symmetrically in this way, there must be therapists available to be paid to help correct the symmetry of the family. If the involvement of the family member with someone else is long-term, the spouse must have a long-term therapist to provide the needed stability for the system.

THE NEEDS OF THE INDIVIDUAL

Besides stabilizing an organization, what of the needs of the individual? Does long-term therapy meet those needs better than short-term therapy? Let us consider a basic human need: the need to hypothesize. Social psychologists have proposed for many years, and brain researchers are now suggesting, that a basic need of a person is to make hypotheses about himself and other people. One cannot not hypothesize. Whatever someone does, we must make a hypothesis about why the person did that. As this comment illustrates, we must even make
hypotheses about why we hypothesize. In all our waking hours, if not in our dreams, we explain.

Does short-term therapy help with this need? Obviously it does not because it is not assumed that conversation about a problem will change the problem. Action must be taken. I recall years ago concluding that insight comes after a therapeutic change. When I did a brief intervention and got someone over a symptom, he or she wanted to tell me insightfully about all the functions of the symptom in the past and present. Even if I was not interested, the insight was imposed on me. I now realize that the person was fulfilling the need to hypothesize. People have to have an explanation of why they got over a symptom and so must rethink why they had it. Unaware of the hypothesizing need, I was impatient with them since the problem was over and they should go about their business.

When we examine long-term therapy from this view, obviously its greatest contribution is in the hypothesizing area. Hour after hour, week after week, month after month, year after year, the client has a therapist willing to sit and hypothesize. “I wonder why you are puzzled over what you did?” “Let us examine where that idea came from” or “Isn’t it interesting that you . . .” Every hypothesis about the past and present is explored. The two people enjoy hypothesizing together, and each has needs satisfied. The therapist finds support for a theory that has as its foundation the need to hypothesize and explain. The clients must hypothesize to try to explain why their lives are always such a mess.

THE INTERPRETATION VERSUS THE DIRECTIVE

Long-term therapy primarily focuses on the interpretation, which is the tool of hypothesis making. Short-term therapy focuses on the directive, which is the tool for producing a change. Long-term therapy tends to be educative. Rather than focus on resolving a problem, the task is to help the person understand. With that emphasis, outcome research is not appropriate. There is nothing for the person to get over. In contrast, brief therapy usually focuses on a problem that is to be changed by the interventions. Whether the change occurs or not can more easily be determined. To put the matter in another way, long-term therapy tends to create an elite who have specialized knowledge about themselves that the average person does not have. The client learns to monitor himself and hypothesize why he does what he does within an ideological framework that is only learned in therapy. The short-term client tends to get over a problem and get back to being like other people rather than being special.
Long-term therapy ideas are easier to learn because they are part of the intellectual climate of the time and available in both professional and popular literature. Giving brief interventions, such as arranging an ordeal or a paradox, is more difficult to learn since the specialized techniques are largely confined to the practitioners of therapy and are unknown to intellectuals generally. Perhaps that is why few long-term therapy workshops are needed and many are necessary to learn brief-therapy techniques. They cannot be learned merely by living in an intellectual culture.

**SPECIAL PROBLEMS REQUIRING LONG-TERM THERAPY**

Rather than create an either/or situation for long-term or brief therapy, one might suggest that there are times for long-term therapy and other times for brief interventions. Let us consider some of the situations where long-term therapy seems appropriate.

Besides the need to stabilize a married couple or a family over time, there are special problems. One serious problem is that of sexual or physical abuse where therapy is usually mandated by the court. A brief intervention might stop those illegal or immoral acts. However, how can one be sure the acts have really stopped? The possibility of a relapse is not an academic matter but means a victim will be harmed. There is a need to monitor these clients over time to be sure the positive effect of therapy continues. If one follows the person in a serious way, it becomes long-term therapy and is compelled by the nature of the problems.

Another type of problem usually requiring long-term therapy is the chronic psychotic and his family. With a first episode of psychosis, therapy can be brief since it is focused on getting the person back to normal functioning as quickly as possible. A crisis therapy with the family is designed to get a young person diagnosed schizophrenic off medication and back to work or school. This can be accomplished relatively quickly. However, if a therapist is dealing with a case where the person has been hospitalized a half-dozen times, the need for long-term therapy is apparent. The client is chronic, the family is chronic in that it expects the person to be incurable, and the professionals dealing with the client are in a chronic expectation that medication will be needed forever and custody regularly. To change all the auxiliary personnel in such a situation is obviously not a short-term task.

Another special problem is the long-term therapy that is done reluctantly when a therapist wants to terminate a person and cannot. So the therapy goes on without enthusiasm and even with resentment. In the same way the client can wish to terminate and receives such a reaction
from the therapist that he or she is unable to do so. One analogy in such a case is the addiction framework. Just as a person can become addicted to a lover, this can happen in therapy. The person might be hooked on a particular therapist or just on being in therapy with someone. A therapeutic goal is to successfully get the person free.

Perhaps it is in the nature of therapy that addiction occurs because of the kinds of sequences involved. In a typical addiction pattern there is a promise of feeling good and of intimacy, and this is followed by a rejection, which takes the form of not fulfilling the intimate promise. Yet it might still happen. It is like a mother encouraging her child to seek her out and then not responding because she is too busy. She invites the child and complains if he hangs on her. By the nature of the therapy contract, the situation is a relationship of an intimate nature. Yet the relationship cannot be consummated as an intimate relationship, and rejection is inevitable. The intimate rapport also lasts only as long as the person pays the bill; thus it is a paid friendship and so a rejection of intimacy while implicitly promising that. Often long-term therapists are caught up in such addictive relationships and cannot escape until a third party, such as a supervisor, helps detach them.

There are, of course, situations where long-term therapy is not appropriate and the therapist must work briefly. Therapy that is limited by an insurance company to a certain number of interviews is obviously not long-term, unless client or therapist decides to make a financial sacrifice and to continue the therapy. Another limited situation is the short-term hospitalization paid by insurance companies. The person is hospitalized for a few weeks and discharge will occur when the insurance runs out, no matter what. Usually the therapist who briefly sees the client inside the hospital cannot carry him or her outside and so continue the therapy.

FUTURE FINANCIAL ARRANGEMENTS

As we look over the field today and consider the long and the short of therapy, there are trends for which we must prepare. Obviously therapy is going to become shorter because of the ways it is financed. Just as it was discovered that hospitalization could be more brief when the insurance companies decided that, so therapy will become briefer as insurance companies limit the length of therapy. Certain changes are going to come in the basic financing of the therapy enterprise and so new opportunities arise.

When we look at the history of therapy, the most important decision ever made was to charge for therapy by the hour. Historians will some-
Why Not Long-Term Therapy?

day reveal who thought of this idea. The ideology and practice of therapy was largely determined when therapists chose to sit with a client and be paid for durations of time rather than by results.

When one realizes that charging by the hour was an arbitrary decision, there is no reason why other ways of financing therapy could not be developed. Long-term therapists might continue to use the hourly charge for clients who can personally finance that, but other therapists can consider alternate ways of charging.

**CHARGING BY THE RELIEF OF THE SYMPTOM**

Of the many ways to set a fee, the most obvious is to charge for the cure of a symptom rather than the number of hours sitting in the presence of the client. Each problem can have a designated fee. There is a precedent for this in medicine, where a surgeon charges by an action, in contrast to a pediatrician, who charges by the hour or any portion thereof as an office visit.

In the field of therapy there are also precedents. Masters and Johnson charge a flat fee for sexual problems, with consultation for a period of time afterward. Milton Erickson was known to say to parents who brought in a problem child, “I’ll send you a bill when he is over the problem.”

There are also people charging a fee per phobia rather than charging by the hour. I understand a group is charging $300.00 to cure any phobia. Anticipating quick results, they will continue to see a person for that fee until the phobia is gone. Another way we are already charging by this method is when we accept time-limited therapy by insurance companies. To see a client for only 20 interviews at a set fee is to charge a set price for the relief of a symptom. The difference is that if the therapist resolves the symptom in only three sessions, he or she cannot collect for the remaining 17 hours, as might be done with a flat fee.

What are the problems in setting a fee for the successful relief of a symptom? First, the therapist has to be able to resolve the problem. That is what everyone attending brief therapy workshops is learning to do. If brief therapy can be successfully taught, as the teachers claim, there is no reason that payment cannot be made on the basis of success. There will also be the need to protect both client and therapist with any price arrangement. The client might be offered a choice: payment by the hour into an uncertain future, or a flat fee for getting over a specific problem. The contract would have to be precise in problem and goal. What if there is an ambiguous outcome? One way to protect therapist and client would be to have an escrow account. The fee could be put into it until
the problem is over. On those occasions when client and therapist disagree, an arbitrator can be available.

Such procedures can be worked out since they are simply part of setting up a new system. A more important issue is setting the fee. How much for relieving a depression, if that category is used? How much for solving school avoidance? What is the price to stop an alcoholic from drinking? If a person has several problems, can priorities be listed? There might also be contingency fees for relapses. These are important issues, and resolving them will bring more precision into the therapy field. There will need to be a therapy manual rather different from the current DSM-III, which is irrelevant to therapy. Such a manual would essentially be a price-per-problem listing. One can hope that this arrangement will not lead to price cutting to compete for the insurance dollar. Obviously, the arrangement of payment per symptom will be met with enthusiasm by therapy contractors.

As this pricing system develops, most therapists will first think of correlating outcome with the number of hours to achieve the goal. In time it will be recognized that the issue is types of intervention rather than time. An example is the medication interview of a psychiatrist. Once they charged by the hour, sometimes regretting that they could not see more patients per hour, like other doctors. Then they discovered they could charge the same hourly fee for a medication interview and yet see clients for only 10 minutes. This increased their fee to six times the previous income per hour. Then the medication interview was set for a fee independent of hours. I know of one practitioner who has 60 medication interviews per day, charging what would once have been the fee for 60 hours. This can be a model for brief therapists. They might not achieve that large a number of clients per hour, but they can see clients for 10 or 15 minutes rather than an hour and so increase their incomes by several times.

Obviously there are a variety of ways of charging fees. The problem is complex, but it is solvable. A positive thought is that spontaneous remission is not uncommon and can be as high as 40% to 50%, according to waiting list studies. If that is so, therapists can be rather incompetent and still get a fee in almost half their cases, as they do now.

Once a few therapists have the confidence to charge on the basis of outcome, others will have to follow to stay in business. One important effect will occur in training programs as therapy requires more skill and becomes more brief and precise. It might ultimately be that teachers will be paid by particular therapy techniques successfully taught instead of being paid by the hour or the semester. Just as client fees can be determined by results, so can the fees for training.
At the moment it is the client who risks money and time by going to a therapist with no guarantee of change, with no limit on the length of time of therapy, and no way of knowing the ultimate cost. When a fee is charged for the successful resolution of a problem, it will be the therapist who takes that risk. The therapist must either change someone or continue to see him or her for unpaid interviews while more lucrative clients are waiting. With the past arrangement of pay by the hour, it was the client who could go broke or waste hours, months, or years of his or her time in therapy. With the fee-for-a-problem arrangement, it is the therapist who can go broke or waste time. Is that not something we are willing to risk rather than impose it on clients, since we therapists are kindly and helpful people?
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