Applications of the Relational Model to Time-Limited Therapy

Judith V. Jordan, Ph.D., Maryellen Handel, Ph.D. Margarita Alvarez, Ph.D., Robin Cook-Nobles, Ed.D.

About the Authors

Judith V. Jordan, Ph.D., is the Co-Director of the Jean Baker Miller Training Institute at the Stone Center, Wellesley College and is an Assistant Professor of Psychology at the Harvard Medical School.

Maryellen Handel, Ph.D., is a Clinical Psychologist who has been in private practice in Newton, Massachusetts and is an Associate Clinical Professor at Tufts University School of Medicine and Clinical Director of Behavior Health Network in Concord, New York.

Margarita Alvarez, Ph.D., is a Clinical Psychologist in private practice at Boston International Psychotherapy and Clinical Instructor at Harvard Medical School through the Latino Mental Health Program at Cambridge Hospital.

Robin Cook-Nobles, Ed.D., is the Director of the Counseling Service at the Stone Center, Wellesley College. She has been working at the Stone Center as a psychologist since 1986. She is also an Adjunct Faculty at Antioch New England Graduate School. She has an interest in diversity, cross-cultural psychotherapy, and brief treatment.

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