The End is in the Beginning

Pamela Ashurst

Brief psychotherapy is characterized from the beginning by its focus on the end of the therapy. The short time-frame is a potent factor in such therapy. Brief therapy is often denigrated and undervalued, since time is traditionally considered essential if deep and lasting change is to be achieved. This is to misunderstand the nature of change, which is of the instant, and the capacity of the unconscious mind to transcend time. The potential of brief therapies is explored, with clinical illustrations to support the author's experience.

Key words: brief psychotherapy, change, end, short-term groups, time

To choose time is to save time. (Francis Bacon, *Essays*, 1625)

From the beginning brief dynamic psychotherapy has its focus on the end. Time boundaries are important; the limit of each session of therapy is known at the outset, though what might happen within each session will be unknown. Outside therapy, both therapists and patients have real lives, lives with relationships, responsibilities, work, routine. During the brief time which constitutes the therapeutic encounter, real life is suspended yet may paradoxically be experienced, past and present, with unfamiliar urgency, and the primitive anxiety of the unknown emerges.

Future time is unreal, an abstraction about which we can fantasize and speculate. Yet all of time past and time present is contained in time future, and modern theories of the cosmos suggest that all future time is contained in time past. Our experience of time depends so much on circumstance. When we are bored or waiting for important news, time drags or crawls and we experience it as

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passing very slowly. On the other hand, if we are enjoying ourselves time seems to fly. In our dreams both time and place are infinitely flexible, enabling juxtapositions beyond both experience and fantasy. People who have recovered from near-death experiences tell how their lives have flashed before their eyes in minute detail, yet objective evidence suggests that this experience has taken only a fraction of a second. Modern microchip technology enables us to use computers to copy, scan and search, to transmit documents across the world, in less time than it would take to give verbal instructions for such a complex task. All time is relative.

In order to get time in our era and time on earth into perspective, let us consider a short history of the earth. For this purpose we will scale-up units of time by factors of 10 to the power of 8 (100,000,000) to give us 'long years' (100,000,000 years), 'long seconds' and so on. On this reckoning one long second is equivalent to three years, one long hour is 11,400 years and so on. On such a time scale the earth is middle-aged — 46 long years old. When the earth was 27 the first forms of unicellular life appeared; amphibious life, land plants and trees developed when the earth was 44 long years old, and deposits of petroleum oil and natural gas began to accumulate during the last three or four long years. Mammals appeared only during the last 10 long days of the history of the earth (Landsberg, 1975). The psychoanalytic era has been with us for 30 long seconds or so. On the cosmological time scale we are brief indeed!

Can we imagine situations in which the concept of time itself may not be needed? If space travellers move at a high speed relative to the earth, they age less than their earth-bound friends. If they could travel at the speed of light, they could visit earth again and again almost untouched by the ravages of time. A photon, or free packet of light energy, could by reflection between mirrors visit the same place again and again in the same instant of its own time. The concepts of speed, time and space are rendered meaningless, for the passage of light is instantaneous. Space and time only exist in our minds, in consciousness. The very act of observing a light ray defines it in space and time, in the special language which we have developed to describe it.

So it is with our inner cosmos. We have created a special psychological language to describe and explain those phenomena which we experience and observe. But this very language limits our communications with each other and with those who are not privy

to the particular restricted code of psychoanalytic and psychodynamic vocabulary.

As Dick (1993) points out, Sigmund Freud demonstrated the capacity of the unconscious mind to transcend time and place, to have a logic totally alien to that of the conscious mind and to replace external by internal reality. Why then have his followers and descendants in the psychoanalytic tradition perpetuated notions of causality and become slaves to time as if the unconscious could be repackaged and would reveal itself more to the conscious mind, within the time-frame that the conscious mind constructs?

The language and understanding of modern physics has been used in an exploration of group process and an attempt to promote understanding of the limitations of our concept of time and space. One of the great paradoxes of quantum theory is non-locality, which predicts that two quantum objects (like photons), introduced at a common source, can be shot off to opposite ends of a room (or even the universe) and yet remain linked in such a way that a change in one results *instantaneously* in an opposite change in the other. Although Albert Einstein said that non-locality would have to depend on some impossible 'telepathy', this theory was experimentally proven in the 1980s (Gribbin, 1995). Just how it can happen remains a mystery, but it challenges our traditional patterns of thought, requiring us to think in new ways. So too does the prospect of real change, major and enduring, in brief psychotherapeutic encounters, whether in groups or in individual psychotherapy.

The mind, having no mass, 'continuously creates time and space in its moment-by-moment construction of the three-dimensional world' (Powell, 1993). Reflecting on group analysis he writes:

> . . . the group has the capacity for inherent creativity and generativity. Changes can take place suddenly and surprisingly, just as dissipative structures occur in nature. But this needs to be balanced with periods of equilibrium, in which linear time can reassert itself and the consequences of chaos can be usefully assimilated. (Powell, 1993: 462)

Change occurring in individual psychotherapy can similarly be sudden and surprising, although it is generally assumed that change or transformation is effected gradually through the therapeutic process, which aims to promote insight and then consolidate change by 'working through' over a prolonged period.

But change, I suggest, is of the instant. Any change, however slight, will effect changes throughout the system, for a state of

equilibrium is altered. Like the ripples emanating from a pebble in a pond, the implications of modern physics require us to understand that no change is discrete and finite, and that any impact of one person on another, any coming together in a group, has profound and unimaginable consequences for creating something new, for re-creation, for change.

The Swiss analyst Gilliéron (1987), a European leader in brief dynamic psychotherapy, has pointed out that patients always bring their symptoms or problem into the initial consultation, by their very first communication. Dick (1993) may be seen to confirm this view for the group. The challenge for the therapist is to *understand* that communication and to establish rapport — a treatment alliance — by so doing. But alongside his interest in brief therapy Gilliéron experiences a dilemma: is it right to want to shorten psychoanalytic treatment? There are those who believe that the slowness of the therapeutic process is necessary to produce profound psychic change. Can real personality change be achieved despite the limitations of brevity and focalization?

I answer an emphatic 'yes' to both these questions, drawing on some 20 years of clinical experience encompassing a personal caseload of both individual and group therapy, supervising and teaching therapists with a range of clinical and professional backgrounds and experience, and the privileged overview of the outcome of therapeutic endeavours with some 1,000 patients referred to our service in Southampton over a period of 18 years (Ashurst, 1989). This longitudinal perspective allowed me to review the outcome of our group-analytic treatment programme over 10 years, and to determine the pattern of consultation exhibited by our patients and their use of the services offered, particularly in relation to sequential and occasionally concomitant use of therapy.

In his Foulkes Lecture (1992) Lionel Kreeger told how as a young doctor he worked at a large mental hospital on the outskirts of London. The famous psychiatrist William Sargent came to visit, and reviewed the treatment of some depressed patients who had failed to respond. 'Why has this woman not been given ECT?' he demanded. On being assured that she had indeed been given electrical therapy as prescribed, Dr Sargent rejoined 'She has not been given ECT by someone who believes in it' — and he was right.

It is sobering to think that even the application of electric shocks will be ineffective if not accompanied by belief in its efficacy. As

far as brief psychotherapy is concerned, I have no doubt that ambivalence, disdain, lack of interest or sheer disbelief in the treatment modality and denigration of the approach are all powerfully inhibitory of its potency. That must, I think, be true whether the disbelief is in the therapist or in the patient or client.

Psychotherapy should not be undertaken without considering the implications and cost of psychotherapy in relation to real life. Rare and precious items are valued, whereas those things that are common or easily come by are taken for granted, even denigrated. I have often been struck by the fact that analysts and therapists work long and unsocial hours, starting early in the morning and continuing late into the evening, then going off to late professional meetings, and spending weekends and holiday periods with other professional colleagues. Papers are presented or published describing patients with relationship problems, often as poor partners or parents failing to 'pull their weight' in family life, or as workaholics. Have we professionals no insight into our own patterns of behaviour?

Prolonged therapeutic relationships are necessarily intimate — and such intimacy can be a substitute for the intimacy and responsibility of mature relationships in the real world, beyond the couch and the consulting room. There is comfort in meeting colleagues at the ritual round of workshops, lectures and conferences. Measured intimacy, disclosure, brief stimulation: for those who have little satisfaction beyond their work, professional connections may be a substitute for family life and therapeutic work a source of power and self-esteem.

Such a burden of responsibility for gratifying therapists' needs may be too great for our patients to carry. Like the child of a depressed mother, who feels responsible for her mother and needs to take care of her, precocious conformity to the therapist's needs and expectations may be imposed by a slavish adherence to the idea of timelessness, and the belief that change follows a linear developmental pattern; that the patient needs to be a patient patient for a long period.

It is fashionable to denigrate brief psychotherapy and to assume that it is necessarily superficial in its impact and limited in its scope. My clinical experience has supported my enthusiasm for the potential of brief work, not as a substitute for long-term therapy or as a second-best treatment, but in recognition of its potency, applicability, appropriateness and efficacy for many people who

seek help to improve the quality of their lives. Brief therapy respects autonomy, avoids dependent regression, and acknowledges strengths; it seeks to diminish unhelpful defensive patterns but it does not strip naked; it promotes change, recognizing that any change will be dynamic and potentially infinite, not static and finite. It acknowledges that a process begins, and promoting that process will be the beginning of that life phase, and dialogue and change will continue beyond the therapist's intervention. Donald Winnicott reminded us not to overtreat; we should, as in other branches of medicine, be aware of the dangers of overzealous therapy.

The usefulness of brief groups for young people is well recognized. Adolescents, and young adults of 30-going-on-13, make good use of brief groups. The process of growth and change is so rapid in adolescence that a longer time-scale of treatment lacks congruence with the rest of their life experience.

For adult outpatients with a range of neurotic problems over a 15-year period, a standard offer was made of group-analytic psychotherapy in small closed groups running for 18 months, or about 70 once-weekly sessions, conducted by a pair of therapists. The outcome study showed clearly that most people gained significant benefits from their therapy, and that improvement continued after group therapy ceased.

In recent years, in two very different situations, very brief group psychotherapy has been a major weapon in our therapeutic armamentarium, enabling us to offer a service which our over-burdened resources could not have met in any other way, given the level of demand.

In December 1988 the Clapham rail crash killed, injured and bereaved commuters from Wessex, many of the passengers and their families living within our catchment area. Although our local hospitals were not involved in the immediate response since the accident occurred in London, our department spearheaded a major response to the disaster, coordinated by my colleague Carolyn Selley. A few days after the crash I conducted the first group for survivors, who came together to try to make sense of the experience which they had shared. Most who came to the group in the early days had suffered little in the way of physical injury, but the problems of post-traumatic stress disorder, survivor guilt, acute depression and anxiety, and bereavement reactions in families, were disabling and prominent in their lives. Some attended for only one

session, a few for the whole duration of the group, which concluded after the anniversary of the crash, but most for a few sessions, engaging in the brief group therapy appropriate to such a situation. Prolonged therapy focused on such an experience is likely to delay recovery. If deeper underlying issues have been stirred up, requiring longer-term therapy, then these are better dealt with in a heterogeneous group or in individual therapy. The experience of working with the Clapham group was a powerful one for me, since it faced me with issues of control and unpredictability, for example when a number of bereaved relatives arrived at an early group which required me to 'think on my feet' and challenged my tidy notions of group structure.

The other situation which required resourcefulness is the flood of referrals of women who experienced sexual abuse in childhood — some 700 over the past nine years have come to us for help. We believe that for most women, though not all, group psychotherapy is the first-line treatment of choice because it enables women to confront issues of alienation, isolation and secrecy and to address disbelief, family loyalty and responsibility with others who have suffered similar abuse. Individual and couple therapy, psychosexual counselling and other treatments may be additionally provided for some, but group therapy has remained our main therapeutic option. Our service was pioneered by my colleague Zaida Hall, whose extensive research into the use of medical and psychiatric services by women whom she had treated was presented at Heidelberg. Dr Hall offered women 12 sessions in a slow-open group specifically for sexually-abused women, leading the group with a series of male coconductors (Hall, 1992).

Since Dr Hall's retirement the male group analyst, John Sharpe, has provided continuity in our service, and we have experimented with the form of the groups, first with six-month closed groups, and then with a slow-open group which women join with the expectation of attending for six months, but stay for longer if required. This is obviously insufficient as a resource for the large number of women seeking help so in 1992 we offered a six-session group as a first stage, followed by a review and the option of further therapy if required. For many women this has proved to be sufficient, or all they can tolerate at their first attempt to confront their experience. The six sessions have a mid-term break and extend over a two-month period, which also functions as an extended assessment.

Some women never come for therapy even if they have attended an initial consultation and accepted the offer; some drop out at an early stage when they find the resurgence of powerful and long-repressed feelings unbearable. Others find brief therapy sufficient to free themselves of the tyranny of unworked-through material and are able to get on with their lives without being weighed down by past traumas. About 20 per cent of the women who complete the six-week brief groups need to go on to further therapy, either in the slow-open group if the damage is early and severe, or with their partner, or with individual help. Many of the elements of post-traumatic stress disorder are displayed by these survivors, and a prolonged therapeutic focus on the abuses of the past can sometimes hinder their adjustment in the present and diminish their potential for the future, paradoxical as this may seem.

In conclusion I describe just two of the many patients who derived benefit from brief psychotherapy.

John

John was 33 years old when he was referred to me some 16 years ago with depression, panic disorder and major problems in his life. After an assessment consultation he declined my offer of therapy but was later re-referred in spite of the negative transference which had led him to request the Professor to refer him to anyone except Dr Ashurst! He joined an 18-month once-weekly outpatient group, during which time he was found to have high blood pressure, and made great progress; my co-conductor and I voted him our 'star' group member. His life and relationships were greatly improved. A few years later he contacted me in crisis, having developed heart problems; an industrial dispute in the National Health Service was delaying investigations, causing him intense anxiety. He was offered 12 sessions of dynamic psychotherapy with an inexperienced trainee, under my supervision, and he was much helped in the weeks during which he awaited quadruple bypass surgery. Several years later he contacted me again in great distress, with a recurrence of chest pain. He was very frightened that he would die; his partner left him, unable to cope with the strain, and the heart specialists could offer no further intervention.

At that time my work had been greatly influenced by the short-term dynamic psychotherapy of Habib Davanloo. Although I knew John well and felt the situation to be less than ideal, I believed that he had been unable to deal with a deeply repressed anger in his previous therapy. I offered him ten sessions of brief dynamic psychotherapy, which he accepted reluctantly since he feared having a heart attack when engaging in powerfully confronting and emotional therapy. However he used the sessions well and exerted his autonomy by concluding therapy after the ninth session! He has since married and remains well, active and in control of his life.

Ann

Ann is a single woman in her mid-40s, who has been in constant contact with psychiatric services since she entered an adolescent psychiatric residential unit at the age of 14. She waited a long time for an assessment with me, since her very thick case notes, the failure of every type of treatment (from long-term intensive psychotherapy with the analyst of the adolescent unit to electrical therapy, hospital admissions, a full battery of drug treatments and behavioural therapies), and her well-known habit of screaming with frustration if kept waiting did not inspire confidence that I would have anything useful to contribute.

Eventually, after a trial-therapy style consultation, I placed her on my waiting list for treatment, planning to offer her a 40-session therapy. By the time I was able to start treatment my retirement was looming, and I had to offer 16 sessions, which she angrily accepted. I believe that knowing that we had a definite end in view enabled us to work at a depth and with an intensity that long-term interventions would have lacked. She had been disabled by her emotional problems for her entire adult life, and had been made redundant from her part-time clerical post because she was rarely able to work. She lived with her 80-year-old widowed mother in the family home, and was fearful both of the burden of increasing care and of being alone.

The history and symptoms were typical of abuse and abandonment, yet her family were overprotective and loving, though not as sensitive to the needs of their only child as they might have been. Ann had suffered with kidney infections as a very small child and was seriously ill. She recalled many hospital admissions and the 'abuse' of painful catheterization on a trolley under bright lights and the scrutiny of strange adults on several occasions without the support and comfort of her mother. When she began to feel adolescent stirrings of sexuality, she had no voice and no language for it and her anxiety and obsessional behaviour led to admission to the adolescent unit, thus beginning her 'psychiatric career'.

Her progress in brief therapy was epitomized by two cards which she sent me. At Christmas a very diffident tortoise was peeping from its shell, clutching a prickly holly spray in its mouth, the berries blood-red. At Easter the card was unsigned, the tortoise enquiring and perky, with spring flowers blooming around. Ann was angry with me for leaving her, and fearful of being discharged from a lifetime of psychiatric care. But she attended for her final session in a very feminine skirt and pretty blouse instead of her usual trousers. She had been accepted for a university access course and hoped perhaps to train as a speech therapist; she had begun to take driving lessons and to play the cello. She had discontinued all drugs and her long-standing bronchitic problems had resolved (she accepted my interpretation that she had 'got it off her chest'). I suggested that she could choose to attend the Median Group for support, should she feel the need at some future date.

By chance I met Ann some six months after therapy ended. She stopped me in the city, to introduce her fiancé; she had begun a romance with the insurance man who had called regularly at the house, and her college course was going well. What the longer term will hold for her we cannot know. Perhaps my therapy was offered

at a 'pivotal moment' for Ann, but brief therapy had clearly been liberating for her and the agent for change — a new beginning.

Time is not a 'great healer', but haphazard and indifferent. Time sometimes does not heal at all; at other times no healing is necessary, yet time is credited with cure. Poets and physicists understand that time is arbitrary, that there is only a limited value in knowledge derived from experience and that every moment is both new and not new, offering the potential for both change and pain. The emergence of unconscious material is not subject to the passage of time. We do well to consider that such material becomes conscious only when it has lost the power to harm in the unconscious. At birth we are close to death; at conception the seeds of our end are sown. So it is with brief psychotherapy.

> He that will not apply new remedies must expect new evils; for time is the greatest innovator. (Francis Bacon, *Essays*, 1625)

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Pamela Ashurst is a consultant psychotherapist with a particular interest in brief psychotherapy. She retired from the National Health Service in 1993, and now writes, teaches and is in private practice. *Author's Address*: 130 Highfield Lane, Southampton S017 1NR, UK.

Group Therapy Within the NHS III. Should We Invest in Group Psychotherapy? A Personal Account

Arturo Ezquerro

This paper describes the author's experience of introducing group psychotherapy into a State-maintained special school that was becoming 'market orientated'. He concludes that if clinicians persevere, so will the patients . . . and their managers.

Key words: change, child psychiatry, group psychotherapy, special education

Group psychotherapy is a modality of treatment that seems to meet the needs of many patients: it applies to all phases of the human life cycle and recognizes our intrinsic human sociality. Group-analytic psychotherapy can be a lengthy process during which both patients and therapists have to work very hard.

For five years from the late 1980s I worked as a psychiatrist in a maintained special school for 4 to 11-year-olds with emotional, communication and behavioural problems affecting their learning. The school offered weekly boarding and day places. Initially a hospital, it had been founded in the early 1950s and had a strong individually orientated therapeutic tradition; group psychotherapy had never been tried. When I joined the staff team, the institution was going through important structural changes and was becoming locally managed.

Within the school's educational culture, therapy was naturally seen in terms of teaching and learning. Individual sessions were considered best because of their traditional 'one-to-one' nurturing

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