

C-CTherapy®, The Canadian Psychotherapy, is practiced exclusively at the Center For Counter-Conditioning Therapy®.

©Copyrights to all of these documents are owned by the Center for Counter-Conditioning Therapy®. Non-commercial downloading, re-use, and re-distribution in their entirety with full attribution is permitted.

**A Study of Three Short-Term Psychotherapy Cases
Employing "Counter-Conditioning Therapy®"**

Copyright 1990, Norman A. Gillies

ABSTRACT.

Empirical data emanating from three short-term treatment cases applying "Counter-Conditioning Therapy®" is presented. Each example is selected at random from a clinical pool of 500 short-term therapy patients from 1980 to 1992. These cases are representative of three medical-model diagnostic categories: Anxiety, psychosomatic etiology; Phobia; and, Depressive-reaction, situational. Each case typifies mental health patients receiving treatment from the Center's short-term therapy program, in which the number of sessions range between one and three and in which patients acquire personal skills, thus, producing the foundation for definable emotional change.

The applied treatment design is a unified, non-cognitive psychotherapy. The process of development and field application of the C-CTherapy® treatment design began in 1964 at Weyburn, Saskatchewan. This unified, non-cognitive psychotherapy, "Counter-Conditioning Therapy®", treats the total medical-model diagnostic spectrum of mental health clinical categories, and is practised exclusively at the "Center for Counter-Conditioning Therapy®". The Center as a non-medical, non-disease mental health clinic holds exclusive rights to the treatment modality "Counter-Conditioning Therapy®".

SHORT-TERM THERAPY NEEDS DEFINED.

Short-term psychotherapy, to meet the intent of its treatment mandate, must be short in duration and succinct in its clinical implementation. That is, short-term psychotherapy must be based upon a therapy format designed to produce a short-term treatment experience. "Short-term" implies that a patient will be provided with the mental ability to accomplish some definable degree of emotional change in a short time as a result of the clinical design offered by the therapist. "Short-term" defines a specific design of treatment program created solely to comply with the patient's request for short-term therapy. Short-term therapy is, therefore, a consumer request rather than

a therapist's decision.

Short-term and long-term programs cannot employ identical clinical formats and still remain adequate to the task of tackling their differing treatment mandates. It is not clinically adequate, by re-organizing long-term eclectic therapies, to re-label them as short-term psychotherapy. A therapy, meriting the character and possessing the attributes of short-term treatment, must meet time strictures and be clinically formulated to handle the complexity of the patient's mental upset. As a clinical unit designed for this specialized purpose, short-term therapy must be synonymous with clinical impact. The clinical skill acquired by the patient is the ability to mentally shift from fictitious information to "real-world" information.

Current medical-model therapies are structurally deficient because, in order to comply with the evaluation requirement, the medical-model therapist uses up the allotted time of a short-term program. The evaluation function of traditional clinical modes generally requires 5 - 8 sessions. In order for short-term therapy to qualify as short, the number of sessions must fall within the range of 1 - 3. In this regard, evaluation of the patient, treatment direction and goal, and some treatment implementation is required of the therapist before the end of the first session. The patient-consumer needs to carry away with him from that first session some clinical gain.

The overriding clinical measurement of a truly short-term psychotherapy design is that it be so formulated, that if the patient were never to attend another session, the initial clinical session would be of practical use. Therefore, the therapist's studying of the patient - in order to cure that patient's problem - must, as a clinical procedure, be discarded. A medical-model clinical format is too wasteful of the patient-consumer's time and money.

As a constant theme since 1967, it is my experience that the primary goal of patients - especially of short-term patients - is their desire to take the "mystery" out of what is mentally troubling them. I have never seen patients demonstrate any desire whatever to invest either their time or money on a therapist's evaluation program. They just want direction regarding the source and how to deal with their upset.

When, however, a patient demands more of the short-term treatment program than it is designed to offer (for instance, the wish to operate emotionally differently for the remainder of his life) then, he has made treatment demands which are not related to the structure of a short-term therapy design. The clinical construct of short-term psychotherapy is condensed and consequently inadequate to the needs of long-term therapy goals. The clinical design of "Counter-Conditioning Therapy®" distinguishes between these two program demands.

The most that can be clinically accomplished in short-term therapy is to mentally install a "visually-verifiable" viewpoint which operates on the basis of "real-world" information. A short-term program cannot offer the patient a significant change in emotional mentality (non-volitional), but it can help the patient mentally clean-out perceptions not founded on real-world information; for instance, an electric lamp cannot be physically mistaken for a passenger bus.

A change in operational mentality is possible, however, in C-CTherapy's long-term program. The long-term program provides the patient with sufficient mental building-time to establish an alternative emotional format for countering the negativity of his current one. For, it is the emotional, non-volitional format which is perpetuating the patient's upset; unbeknownst to the patient, the non-volitional division has always played a key role in driving the patient's aberrant behavior. Because of the patient's emotional, non-volitional pattern - in place since childhood - mental pain has been generated for a long-time. The long-term project, therefore, focuses the patient upon acquiring a personal skill, a task which differs from the intent of the short-term program. Short-term treatment requires the patient to institute a routine of mobilizing real-world information.

Like the wheel, "Counter-Conditioning Therapy®", and its non-disease, unified psychotherapy design, is readily adaptable to a variety of mental health treatment demands in various human behavior settings. This innovative clinical format began in 1964, in the out-patient setting of a mental health facility in Weyburn, Saskatchewan, where the author developed effective procedures to meet the treatment needs of his rural population. It is from this 30 year data-base, subjected to field application, that core elements of the short-term therapy program evolved at the "Center for Counter-Conditioning Therapy®".

Functioning like the wheel, C-CTherapy® is the common denominator which drives all of the programs under its treatment umbrella. All programs at the Center--Stress-management, Substance-abuse, Mental trauma intervention, Panic attack programs, and Personnel techniques--draw from the C-CTherapy® design. Likewise, the following key elements from "Counter-Conditioning Therapy®" make the Short-term, "impact-therapy" program possible.

1st---Because "understanding" the etiology of the patient's condition does not meet the requirements for a short-term therapy program, the C-CTherapy® therapist takes from "Counter-Conditioning Therapy®" its procedure for mobilizing real-world information. This enables the patient to methodically de-emphasize fictions held over from the patient's past. The treatment purpose is to mobilize contemporary data in the patient's present. A procedure of differentiation evolves and helps the patient separate-out the informational differences. The clinical goal is achieved, only, when an "application-of-information" change occurs.

2nd---The C-CTherapy® therapist applies the information reported by the patient in the process of establishing an individualized treatment plan.

3rd---All information provided by the patient is accepted by the therapist as truthfully given, throughout the treatment process. Consequently, there is no attempt by the therapist to "fit" the patient into a particular medical-model diagnostic category.

4th---C-CTherapy® introduces a skill-teaching orientation to psychotherapy. In the short-term program, however, the goal of acquiring a personal skill is sacrificed. All that is possible to achieve with a short-term mandate is revision of the patient's out-dated information-bank. Therefore, the change in treatment procedure requires that the therapist's role be re-defined.

5th---The clinical focus is upon the patient acquiring a pragmatic "what to do" approach rather than a philosophical correction regarding "how to think".

6th---The "Counter-Conditioning Therapy®" design is tailored to the specialized needs of a short-term psychotherapy program.

7th---The therapist directs the patient in the methodical application of up-dated information. This methodical procedure interrupts the fictions upon which early patient data is based. It is the emotional hold of this misinformation which fuels and perpetuates the patient's emotional upset.

From a short-term treatment population of 500 patients treated since 1980, the author has selected three diagnostic categories from which to illustrate the out-patient short-term application of C-CTherapy®. These treatment areas are: Anxiety, psychosomatic etiology; Phobia; and, Depressive-reaction, situational. The three

case-examples were randomly drawn from a patient-pool originally referred from social service agencies or private facilities.

CLINICAL SPECIFICS

Medical-model therapists are trained to not totally credit what the patient says. Those therapists view patient commentary through a medical-model grid. C-CTherapy®, however, takes patient commentary as valid reporting and consequently perceives as less suspect the patient's information. Instead of second guessing the patient, this change in listening function allows the C-CTherapy® therapist to put his energy towards formulation of the treatment plan.

Counter-Conditioning Therapy® applies the essentials of the patient's emotional experience, as an active agent, in the treatment process. C-CTherapy® collapses the blend of "study, diagnosis, treatment" into one clinical motion, "treatment".

Counter-Conditioning Therapy® is not a symptom management psychotherapy. Instead, it highlights two spheres of human mental functioning, pin-pointing their dissimilar mentation and concentrating the C-CTherapy® treatment effort solely upon one of them - the emotional, non-volitional sphere. This singular treatment focus introduces the patient to the way in which non-volitional - non-deliberate, emotionally reactive - mental action produces and perpetuates mental "pain".

THIS IS WHAT HAPPENS

The Counter-Conditioning Therapy® clinician, just as does the short-term program therapist, begins the therapy session by asking the patient: "What do you want to talk about?", or, "What kind of thinking has been going on?" The patient recounts what has been "on his mind". Because everyone "thinks", thoughts constantly circulate through the patient's mind. The contents of the verbal exchange between therapist and patient holds sufficient information for the C-CTherapy® clinician to pin-point the source of the patient's mental upset, formulate a treatment plan and supply treatment instruction, all in the first session.

In that first session, the patient's commentary contains sufficient information to give the therapist an overview of the patient's mental mechanics. From this, the therapist is able to extract core subjects and mental themes, "thought-voices" that represent a sampling of the patient's mental "preoccupation". This sampling is an "historical-sketch" of the patient's mentality because the topics illustrate the kinds of human behavior issues which catch the patient's attention. The author has found the above to be so for all patients.

The mental topics that preoccupy the patient represent the sphere of thinking to which the patient listens and are singularly specific to that patient. In structure, the patient's mental system is a unified, rather than a haphazard, mental product. As displayed, the non-volitional system is reactive and emotive in nature. The system makes no sense to the outside observer, because the observer cannot see nor hear the patient's mental workings. Consequently, the medical-model therapist is constantly struck dumb by the activities of the patient's system, for, the activities of the patient's system strike the observer as illogical.

Overall, however, the patient's emotional system is a coherent mental product composed of operant "thoughts" which the patient hears as "voices" continuously "popping" into his mind. Unfortunately, it is from the non-volitional, emotional system, that the emotional problems of all patients originate.

According to the Center's research findings, the non-volitional system is forceful and intrusive, its properties are reactive in quality and emotionally rapacious in character. These intrusive properties dictate the emotional functioning of patients. Patients repeatedly experience the compelling nature of their "voices". These "thought-voices", passing through the patient's head, compel the patient, through habit, to pay close attention to their messages. While the "thought-voices" are mentally "commanding", they are also boringly repetitious. Patients report that, many times in the past, they have heard this mental monologue "playing". In that past, however, the thought-voices were not as forceful as now, because the patient, as he does now, did not interpret them as "commands". The author-therapist has learned from his patients that the messages of the thought-voices, even though low key, were always present. For whatever reason, however, the voices were not forceful enough to affect the patient's daily behavior.

Results from both research at the Center and the author-therapist's field experience dating since 1960, confirm that mobilization of the "voices" invariably requires a triggering event. Whenever the contemporary event or incident happens, it activates negative memories from the patient's non-volitional system.

Consider the patient who experiences an acute depressive reaction because he has not received a hoped-for raise in wages. Whenever such a disappointing incident occurred in the past, this patient responded with a shrug of his shoulders and some degree of annoyance. There is a significant difference between his reaction "then" and his reaction "now". The following commentary is "why the difference!"

WHY THE DIFFERENCE--THEN AND NOW

By nature, the ability of a human being to react to both his physical environment and to the behavior of others is constant and on-going. Any treatment design has to consider the workings of this reactive mental mechanism. The mental mechanism works in a reactive fashion because of its structural place in the non-volitional system. In the non-volitional system, a mental event, once recorded, creates some degree of mental response which always translates into behavior. For example, the patient who shrugged off his disappointment still had the emotional potential to interpret his withheld salary negatively, but didn't. While he was able to shrug off the events in the first incident, in the second - because one cannot not react - he could not because his circumstances had changed. His mental habits were attuned to the negative material of the thought-voices. Thus, he was mentally ripe to respond to the second incident as if it were a "disaster". In this context, the patient's mental reaction paralleled the negative thought-voices which produced his current reaction, "anxiety" and "fear". His reaction was inevitable because no possibility of choosing how to behave exists when it comes to human emotions. This mental condition leaves all patients open to the possibility of being "victimized" by their own emotional system.

For the sake of illustration, let's look at a few case examples of activated non-volitional systems. The following cases illustrate, in addition, the range of clinical categories treated at the Center, how the treatment process proceeds, and the unique role played by the C-CTherapy® clinician in the Center's short-term program.

CASE EXAMPLE #1. ANXIETY--PSYCHOSOMATIC ETIOLOGY

Case History.

