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

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 it's 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.

Mrs C. suffers from heart palpitations. She has suffered from this condition since the birth of her first child five years ago. Physical medicine evaluated her condition a year later, but found nothing unusual.

At the time of her second pregnancy two years ago, she again experienced heart palpitations, and again, physical examination proved negative. When she again experienced, for the third time, a recurrence of these puzzling symptoms, she came to see me.

The author suspected that in addition to a long-term anxiety condition, a marital problem may be the current exacerbating item. I asked her a standard opening question employed by all C-CTherapy® therapists: "What thoughts do you hear constantly running through your head?"

She reported to the author that the stream of thoughts usually contained a "fear" theme. For instance, when she was away from the house, she would hear: "Am I going to be okay?" "Are the kids safe?" I gave her a homework assignment. "Pay attention to the contents of your thought-voices", I told her. Over the next week, she was able to hear those voices and identify them. She was able to differentiate between circumstances in which she had fearful thoughts from those in which she heard "safe" thoughts. She discovered that she always had safe thoughts when she was in her safe place - her home. Only when she was away from the "safety" of her house did she hear scary thoughts.

She wanted to know why this kind of thinking happened to her. She didn't like having to tolerate it because her scary thoughts always produced upset. For this sort of patient, C-CTherapy® is designed to provide a practical view.

Counter-Conditioning Therapy® Commentary on Case #1.

I identified for her where the mental action was coming from, that is, "her non-volitional mentality". I assured her that the emotional aspect of her mental system was working normally and without her deliberate intent. Unfortunately, her pattern, supported by illogical information, promoted mental agitation instead of mental tranquility. I intentionally pinpointed the source of her troubling thoughts, the normal workings of her reactive pattern, instead of affixing an "abnormal connotation" as does medical-model therapies. I was introducing her to a human behavior model of psychotherapy.

I also explained to her that our mutual goal was to associate the upsetting thoughts with normal function, albeit disturbing. By focussing upon the source of her trouble, the non-volitional, emotional division, the therapist resolves the emotional mystery and introduces the patient to the automated character of the non-volitional system. The therapist emphasizes that the patient participates only unintentionally in the production of mental "pain". In short, the patient is not "choosing" to be "crazy".

All of the verbal direction and interpretation which I imparted to Mrs C. originated from a non-disease data-base. In this unique approach, the therapist steers away from clinically stereotyping a patient and "fitting" that patient into a medical-model, disease formulated diagnostic slot. Unlike the medical-model, the C-CTherapy® format does not advance theoretical conclusions based upon assumptions about a patient's condition. Mrs C. did not decide to manufacture a state of anxiety for herself. Without choosing to do so, the workings of her non-volitional system dictated her mental processing. From her mental processing came the kind of behavior which Mrs C. did not like, anxiety.

Unfortunately, as her therapist, I was clinically in competition with those thought-voices that perpetuated anxiety: "Am I okay? Are the kids safe?" Although she had acknowledged the messages as illogical, they were,

nevertheless, dictating her behavior. That is, her non-volitional pattern was the culprit in the production of her "anxiety". The non-volitional division of her functioning mentality cancelled-out thinking based upon logic and reason that represented "real world" information. Consequently, as the therapist, I would be wasting her treatment time if I were to begin reasoning with her - using logic and reason to talk her out of the "crazy-making voices". In this instance, it would be clinically counterproductive to "joust" with her skewed interpretation of "real information". Her mental habit of listening to the pattern's interpretation of her human, physical environment triggered her state of panic. Consequently, to challenge the "logic" of the illogical material in her non-volitional pattern would only "ignite" her tendency to hang-on more tightly to her illogical interpretations. Indeed, her chronic emotional pattern is forceful enough to drown-out my words. Consequently, she would not be able to hear me.

Instead of talking against her "thought-voices", or trying to dissuade her from listening to them, the therapist orients the patient with information about the source of her emotional upset, those "thought-voices". C-CTherapy® turns the therapy session into a learning opportunity. In this way, the author-therapist makes it possible for the patient to move away from her subject-fixation and to direct her attention to the pursuit of self-education. Thus, what she initially thought strange, that her "crazy" thought-voices produced upsetting behavior, she begins to tolerate with some ease. Additionally, she gains emotional relief from knowing the source of her crazy thoughts.

Meanwhile, we both acknowledge that the "thought-voices" do not make "logical" sense. My patient recognized, also, that the information she possessed (that they were only "crazy" thoughts) was not in itself intrusive enough to mentally overthrow the invalid thought-voices of her illogical thinking. It was here that she realized the need for both herself and the C-CTherapy® therapist to "counter-act" the forcefulness of the non-volitional pattern.

CASE EXAMPLE #2--PHOBIA

Case History.

Another diagnosis which cannot be resolved by the application of logic or reasoning is "phobia". Because the C-CTherapy® therapist does not employ a medical-model treatment approach, he does not begin the treatment process by "understanding" what particular phobic subject is bothering the patient. Nor does he enter into pursuing an "understanding" of the rationale behind the variety of subjects which overwhelms the patient's common, everyday information-bank. People who are not ruled by their anxieties do not experience the "barrage" of harried "thinking" which governs the phobic.

In his 30 years of clinical experience, the author has found that the genesis of phobic reactions - no matter the precipitating behavior - is always from the same source: "fear of, and anger with people". This common denominator is the "engine" propelling phobia. Unlike medical-model therapies, the Center views the patient's presenting symptoms only of academic interest. According to the Center's findings, presenting symptoms are short-lived. Historically, once one symptom disappears another takes its place.

Research findings at the Center bear-out the irrelevance of basing the treatment on the presenting symptoms. The level of sophistication of the patient's mental upset and the nature of symptom formation will vary in accordance with the complexity and history of the condition. At the Center, the patient's portrayed symptoms are not allowed to determine the treatment format.

Case #2 portrays the C-CTherapy® clinical approach regarding a Phobia diagnosis.

The typical phobic retreats from all people and adopts a generalized negative reaction towards them. The author's patient, Mr D., displays the usual "phobic" washing of hands but avoided only certain people and situations. He was even able to tolerate some people in close proximity, such as in public transportation. In fact, phobic-aversion is a progressive condition, and my patient's aversion to people had not yet advanced to an incapacitating degree.

My patient provided information from which it was possible to pin-point his chronic state of "mad" at people. He attributed his emotions of "mad and fear" to his early reactions to his father. The patient's "thought-voices" centered around this preoccupation. The patient accused his father of imposing rules and making demands at random in "a dictatorial" fashion. His grievance system is illustrative of a common cause of later problems in a child's development, namely, parental inconsistency. Those parents tolerate behavior on some occasions which they don't tolerate at other times. Consequently, an atmosphere of unpredictability germinates on the "home grounds"; the child never knows the actual "boundaries". This case vividly illustrates a child as the "victim" of parental inconsistency.

The author asked the patient to recall which of the "tall" people around him, when he was a child, were nervous and judgmental of other people's behavior? This C-CTherapy® question prompts the patient to link likenesses in his own emotional pattern to those which he copied (not imitated). As the patient becomes adept at identifying who he copied, the C-CTherapy® therapist emphasizes the fact that those parents, in turn, also copied their own parents. This mechanism has prevailed throughout the genealogy of the extended family. In this manner, the C-CTherapy® therapist introduces the patient to the phenomenon of "how come" we behave in a fashion similar, but not identical, to other family members.

The C-CTherapy® therapist is introducing the patient to a universal phenomenon, "copying" emotional items from members in the patient's childhood environment. Copying (not imitating) the mental mannerisms from the previous generation is a universal feature of mental development - "mental osmosis". Mental osmosis is the core element that builds our emotional, non-volitional mentality from childhood. The therapist orients the patient to make sense out of the illogical "thought-voices" which spontaneously "pop" into his mind. Making sense of his reactive system - its non-volitional characteristics - emotionally liberates the patient. His ability to pin-point the mental source of negative mental data helps reduce, markedly, the level of his anxiety. Additionally, the C-CTherapy® therapist informs the patient that the development of the non-volitional pattern follows a process of mental maturation, and consequently, is not the product of a haphazard process. As the C-CTherapy® therapist places no negative association upon this process of mental development, the result is a further reduction in the level of the patient's anxiety. Co-incidentally, my phobic patient was able to recall that, while he was growing up, both of his parents had mental patterns of a nervous, anxious variety.

Coupling my patient's mental problem with his description of his own parents' mental manner, it was easy to visualize Mr D. as being the "kid" of those parents. The author is able to visualize the patient as the "kid" of those parents because kids copy the emotional structures portrayed by their parents. To become a mental health patient, therefore, one must have copied aberrant emotional behavior from a line of forebearers.

While my patient copied generalized anxiety from his parents, that does not translate into his being anxious about the same events, thoughts, issues, etc, as were his parents. His parents, in short, did not cause him to be phobic. The Center's research reinforces the observation that the child is not an emotional clone of the parent.

Formerly, my patient had been a staunch church-goer, but he became disinterested and disillusioned because the church did not make his life meaningful, according to his definition. Like all those who seek immediate solutions, he temperamentally demanded that the church answer his mental needs; he demanded tranquility from

a benign, established religious environment. Inevitably, that environment could not measure-up to his personal bidding. His disaffection provided him with an emotional "mad" which helped him justify his decision to "abandon" his membership. In addition, his "mad" at the church fueled his opinion that church-goers are hypocritical and fail to measure up to his definition of "moral integrity". His "holier than thou" reasoning was necessary because "dropping" the church, with its attendant mental security, was a scary and difficult decision.

Additionally, my patient was harboring a "mad" towards his brother who, in my patient's view, had arbitrarily taken their father's side in matters my patient considered to be none of his brother's business.

During Mr D.'s short-term treatment contract of three sessions, his mother and brother were very interested in what was going on therapeutically. Mainly, they were "surprised" by his rapid rate of improvement, and, in their telephone calls to me, questioned this feature of the therapy. They were suspicious of the author's treatment design, despite the patient's improved condition. Their suspicion was understandable given the fact that until his work with C-CTherapy® the patient's behavior had not been improved by medical-model design therapies.

The Center's therapists have noticed, repeatedly, that family members are often compelled to tell them of their past struggles with the patient, that is , their own side of the story. Their "complaining" about the patient's past behavior is predominantly a "smoke-screen" masking their effort to determine if the patient has been "telling lies about them". The tendency of various family members to absolve themselves from any possibility of being made the "scapegoat" appears - at least from the author's experience - to be a common item in mental health cases. Family members want "everyone" around them to: "Understand absolutely..." that they did not cause any of the patient's problems.

Counter-Conditioning Therapy® Commentary on Case #2.

During the first session, the author assigned a mental exercise designed to identify the repetitive qualities of the patient's "thought-voices". As the patient gains practise with the "identifying" exercise, he begins to hear the unremitting action of the "thought-voices" with its negative quality. By systematically practising the exercise, the patient notes a gradual diminution in the emotional level of his thought activity; consequently, he becomes less intimidated. Gradually the repetitive thoughts become progressively connected in the patient's mind with mental "garbage" - instead of commands to be obeyed. Because the thought-voices are so forceful and disruptive, the patient must methodically oppose them. C-CTherapy®'s short-term program goal is for the patient to routinely attach a response of "irrelevant" to those voices.

Instead of responding to the thoughts in his former intimidated fashion, therefore, my patient begins to hear, in a more neutral manner, the "mad" thoughts directed at his "father". Another treatment goal is that he respond benignly to the thought-voices. This change in mental associations enables my patient to eventually shift from his previous state of serious listening to that of paying little or no heed to the past commands. His compulsion in this matter of "obeying" will gradually diminish in intensity.

According to the previously outlined short-term therapy requirements, the C-CTherapy® therapist is mandated to move the patient from mental pain to less mental pain as quickly as possible. This is why the C-CTherapy® therapist constantly intercedes, keeping the therapy goal in front of the patient at all times. The patient is repeatedly apprised by the C-CTherapy® therapist that his recovery is dependent upon practising the assigned exercises.

Had the patient been involved in a medical-model approach, he would not have known that certain items of emotional thought foster the production of mental upset. In their therapy, medical-model therapists do not

"implement" the connection between the "thoughts-voices" and the production of emotional "pain".

By reiterating throughout the first session that recovery is dependent upon practising the exercises, a C-CTherapy® treatment imprint is established at the outset. Practising C-CTherapy® exercises allows the patient to confront his negative conditioning early on in the treatment process. Because the short-term program restricts the quantity of areas covered, short-term requires an early start to the process of counteracting the disruptive nature of the non-volitional pattern. The C-CTherapy® therapist is obligated to pursue the efficient use of the available treatment time.

The C-CTherapy® therapy design works well on phobic cases. It does so because phobic activity is nothing other than repetitious "voices" circulating in the patient's mind. It was the previous absence of a method for counteracting these thoughts which left patients without a means for coping. The florid mental activity in the thought processes of phobics makes it operationally critical for the patient to possess a methodical program for "personal disruption" of this chronic "pain" producer.

All phobics produce abundant mental activity which, in turn, develops an abundance of physical tension. One aspect of the short-term program concentrates directly on physical tension release. The author instructs patients to employ a physical "ventilation" exercise, the purpose being the simple release of tension. I tell the patient to punch a punching-bag or a pillow. Throwing rocks into the sea or a lake is another inexpensive method of relieving tension. The goal, here, is to drain-off mentally produced "steam" which is manufactured daily by the workings of the thought-voices (worried thinking).

CASE EXAMPLE #3. DEPRESSIVE REACTION; A SITUATIONAL MATTER PROMPTED BY A SEXUAL-PREFERENCE ISSUE

Case History.

Mrs J. came into my office to tell me that her son had "become a homosexual".

"Whoa, just a minute Mrs J., people don't just become homosexuals. What we're dealing with here is an issue of sexual preference."

She listened and thought a moment.

"You mean to say that is all it is? But my church says a different thing about this whole business of homosexuality. My church says its unnatural."

"Not only does your church maintain that this particular kind of sexual preference is unnatural", I said, "but society at large agrees with your church".

Everything she had been conditioned to believe in, and thus cherish, caused her to reach a traditional conclusion, that homosexuality is bad and doesn't equate with behavior which church dogma would support.

I acknowledged her shock and upset, but mentioned a characteristic germane to human beings. I told her: "Consider a universal feature of the human equation and that is, human beings don't like to cope with unusual behavior, physical or mental in origin". Then I said, "Let's look at it from a what-is-real perspective", what issue are we dealing with here?" In order to answer that question, I told her the C-CTherapy® view of personal sexual

preferences.

From a Counter-Conditioning Therapy® clinical view, homosexuality is divided into the two categories of: "sexual preference" and the "politics of sexuality". I told her: "if you lose your perspective regarding the" personal preference" aspect of the sexual preferences issue, it's easy to create confusion for yourself and lump the sexual preference part with the political aspect. And because this is an emotional subject, it's very easy for one to be regulated by the emotionality which the subject generates".

"Now let's consider this matter of perspective, both yours and mine, Mrs J. First off, we're dealing with the matter of your emotional shock over the life-style of your son. Next, we're confronted with your worry that his lifestyle will compromise his future and quash your hopes that his life be less of a struggle than was yours. Finally, we're dealing with a shock to your social and moral sensibilities."

Then she told me of another worry, a wider, more intrusive issue. She found out about her son's sexual orientation because of a "vengeful lover" who had been rejected by her son and phoned her at 3:00 AM. "He woke me out of a sound sleep to tell me that my son made love to boys. Obviously, I didn't want this sort of harassment to continue, both for myself, or my son's sake." She confided: "Other members of the family might find out about this situation. My guess is that they will reject him and his behavior because they're not tolerant people".

This final case example demonstrates application of "real-world" information, a core C-CTherapy® procedure, in all C-CTherapy® treatment programs. No matter the presenting problem, C-CTherapy® focuses upon effecting a change in the non-volitional mental operation of the patient rather than instructing the patient "to think differently". As "thinking differently" is not a C-CTherapy® goal, the treatment design does not focus upon removal of any of the patient's biases or long-held attitudes (this is the subject arena of volitional mentality). While thinking is a function that the patient is able to perform on his own, not so the patient's ability to create a method for neutralizing chronic pain production. The patient's lack of a methodology for managing pain creation will continue, if not neutralized, to victimize him. By acquiring some features of a personal mental health skill, namely, mobilization of real-world data, the patient begins building the means to not victimize himself.

Maintaining a working therapeutic climate is a challenge in Case #3. Emotionally-charged subjects, such as sexual preference, are rife with hear-say and myth and sometimes assume a quasi, "scientific" morality in the mental health professions. Also, the abundance of misinformation on this subject contaminates the patient's information bank. By adhering to a "real world" information base, the C-CTherapy® clinician works from an unambiguous clinical stance to confront rampant misinformation.

The C-CTherapy® treatment procedure is precise and uncluttered, fortified by the therapist's articulation of what the treatment plan is to be. This allows the process of treatment to advance along a measured therapeutic pathway. By applying a systematic format, the therapist ensures that speculative activity on the patient's part will be treated only as that -- an exercise in speculation. In the C-CTherapy® treatment process, no energy is expended on philosophical musings.

The therapist, by actively intervening during the session, instils a sense of purpose and clinical direction. The C-CTherapy® therapist establishes a precise framework for the patient to follow, unlike eclectic treatment programs. A treatment oriented to working with "real" information weans the patient away from a tendency to wax philosophical, dramatize or sensationalize behavior. The titillation potential of certain issues of human behavior, such as sexual preference, if allowed to govern the treatment plan, would obscure the clinical goal. C-

CTherapy®'s only treatment goal is a diminution in the degree of pain which the patient is experiencing.

Homosexuality is not considered by the Center to be a disease. The Center maintains this clinical position because no identifiable pathogen has yet been revealed. The Center treats this subject, therefore, as a human behavior matter involving the issue of sexual preferences - no more and no less. The Center's clinical approach to homosexuality cuts through all the myth and misinformation fuelling medical-model treatment therapies. The C-CTherapy® patient adopts a much more practical and workable posture towards sensational issues.

SUMMARY

In the above material, the author presents a picture of the Center's short-term therapy program. The three presented cases were randomly selected from a general pool of mental health cases treated at the Center since 1980. These cases illustrated:

(1.) Application of patient-generated information in the innovative clinical context of "Counter-Conditioning Therapy®";

(2.) The treatment time consumed by "understanding" the background of the patient's problem was discarded;

(3.) No use of theoretical concepts was allowed to enter into the treatment process, so that all clinical planning was based upon actual patient experiences.

This treatment design meets the requirements of the short-term therapy mandate outlined by the author. A medical-model treatment format was not employed because it does not meet the time demands of a short-term mandate, nor does its theoretical approach take the "mystery" out of what is mentally happening for the patient. Consequently, the medical-model design does not offer the patient workable solutions and fails to meet the explicit demands of a short-term therapy program -- a rapid reduction in the patient's level of mental upset.

All mental health patients suffer, to some degree, from being victimized by the workings of their emotional, non-volitional system. They need to acquire, therefore, some knowledge about how that system is sustaining their state of chronic upset and a method for correcting that problem. In the C-CTherapy® short-term therapy program, patients develop the beginnings for interrupting negative items in their system of mental/emotional pain production.

As well as providing the patient with a unique way of responding to the thought-voices, the C-CTherapy® design lays the foundation for an efficacious mental perspective. The combination of a change in mental response and an up-dated mental perspective produces a renovation in mental structure - and thus content - from the current non-volitional system. For, it is the original system which produced the patient's upset. In essence, provides patients with a practical, workable way of managing immediate upset (short-term program), and actually managing (long-term program) their emotional, non-volitional pattern.

How will they achieve the goal of mental pain reduction? They will achieve pain reduction only from a clinical design which works with the patient's non-volitional system. Failure to neutralize the intrusive nature of the non-volitional pattern places the patient in a position of having to face a future composed of chronic emotional upset. Any short-term program, therefore, must be able to direct the patient to take what he learned and assemble the material into a package for mental self-management. In sum, a short-term program has to be unfettered by

current traditional medical-model theories which misapply the disease-design of physical disease to a mental health, human behavior problem.

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