... the laws of nature appear simple when expressed in higher dimensional space (Kaku, 1994, p. 37).

In the mental health professions, we all have some kind of niche with some kind of procedure that is useful. I am thinking of psychology and psychiatric social work and nursing and mental health workers, with procedures of cognitive-behavior therapy and solution-focused therapy and psychodynamic therapy, and I am thinking of psychiatry with psychopharmacology. If we had a chance to add one step to what we already do, what would this step look like?

It has been my job to give this chance to trainees and staff in psychiatry, psychology, and social work at the University of Wisconsin, Department of Psychiatry for over 30 years. Since the mid-1990s, the medical school has required every patient seen by a trainee to be seen also by an attending, and I have had to practice giving this chance, most of the time, in 10 minutes. This is the time frame, the window of opportunity, for either the patient or the trainee to ask one question. Additionally I can take 20 minutes if the question is about a dream, and once a week I can take an hour in my brief psychotherapy clinic to do a videotaped interview about a case of particular interest that is stuck and needs my opinion about how to get unstuck. But the usual chance is taken in 10 minutes, and that is very brief psychotherapy.

Many colleagues have been loud in their sympathy for me that I get so little time to be of help. Surely, I must only have time to write a little note and sign it. I tell them that this is quite enough time, and they are amazed, or disbelieve me. There is a simple reason why this is enough time: human beings are astoundingly repetitive or redundant. If they take a single step,
say being subservient, they tend to repeat this step endlessly, and it will make for a trajectory, and the trajectory is circular. Thus, I say to the patient and the therapist that we can start anywhere they choose, for everything comes around a million times. Any one circle will show a microcosm of the whole picture.

Consider our most common case. This is a person being taken advantage of and getting a bad exchange with the world. This builds up rage, which erupts and frightens the patient back into compliance. I call this "the exploding doormat problem" (Gustafson, 1995a, 1995b, 1999). In the psychoanalytic literature, it is called "moral masochism" (Brenman, 1952). The masochism, or arranged suffering, is moral rather than sexual, and its shadow side is moral sadism which terrifies the patient more than the moral masochism. Thus, the patient circulates between two untenable horns of a dilemma (Gustafson, 1995a, 1995b), the step of claiming too little, and the step of claiming too much. Stevenson described it most memorably as the single case of the modern world in *The Strange Case of Dr. Jekyll and Mr. Hyde* (1886/1985). In our clinic it is more common as Mrs. Jekyll and Mrs. Hyde.

Thus, I am continually asked by patient or trainee how to get out of this perpetual bog (Gustafson, 1986/1997a, chap. 6; Reich, 1949)? For example, a young woman complained to us of being criticized unmercifully by her husband at every turn. She would take it and take it, and then lose it in rage and feel very guilty. In her guilt, she would review all of her past mistakes in suffering this same cycle with her parents and then again with her childhood boyfriend. What did I recommend? I simply asked her if she ever felt free of it with this husband? She didn't know. I asked her to consider it longer. Gazing off to her left she suddenly brightened and exclaimed, "Yesterday, I told him, 'You may not talk to me like that,' and walked out of the room." That, I said, is how you get out of this bog (Gustafson, 1986/1997a, chap. 6). That is the single step, if repeated, which will lead into a different world, of equality in a relationship, rather than subservience, or overpowering (Gustafson, 1992).

Of course, the working through (Freud, 1914/1975e) is a further matter, for such a start on a new trajectory will slip back into the old trajectory. Also, a new beginning (Balint, 1952, 1968; Gustafson, 1986/1997a, chap. 8) in one domain, as with the husband, will have to be transferred into the other domains of her life for a complete working through of her developmental impasse.

The beauty of this way of looking at it is that a departure can be clearly sighted from the usual circularity, in any of its million episodes in any 10-minute window of opportunity. In chaos theory
(Gleick, 1988) this is called “sensitive dependence on initial conditions.” Two steps which look about the same, but are slightly different, end up in completely different places when repeated a million times. This is the meaning of Frost’s (1916/1969) poem, “The Road Not Taken,” where he writes: And both that morning equally lay/In leaves no step had trodden black.

So Very Brief Psychotherapy is about grasping, like this, the implications of a single different step. It works on this infinitesimal level (i, or i’ or i”), by which I mean the smallest possible unit of difference, quite as in the calculus (Berlinski, 1995).

For example, returning to our single case in the clinic, the single step of giving and not getting leads by redundancy into the moral bog. The patient who compensates herself with a moral claim of taking or forcing her due, leads by redundancy into guilt, for which the punishment is giving up the claim. The second and compensatory step thus brings the trajectory full circle.

The most common variant of this attempt at service is the attempt at control. The controlling step becomes a program, by repetition, and forces its isolated will upon everything. Our patient’s husband is forcing his ideal upon her, in continual criticism. Of course, it only gets her bowing lower and lower until she explodes. Then he compensates himself by withdrawal, feeling sorry for himself, and going away, as a ploy to arouse her fear of abandonment and her guilt. Thus, she is pulled back in and the game starts over, but, repeated a million times, gradually drives the two apart into a cold distance of “parallel lives” (Gustafson, 1992, chap. 8; Rose, 1984).

Thus, the entire pathology of the clinic is built upon wrong steps of exchange, either controlling, or being controlled (serving), or like Dr. Jekyll himself, a mixture of controlling and serving. Of course, there is organic medical pathology which needs to be ruled out, as discussed in the introduction to part I.

I also appreciate that there are many cases, as of gradual onset schizophrenia, or of semicriminal mania, or of elaborate obsessive compulsive disorder (OCD), which act as if they are hard-wired medical conditions, and respond only to strict medical regimens. In this sense, DSM-IV correctly distinguishes one illness from another, and builds up an evidence-based medicine to contain them (American Psychiatric Association, 1994).

I also appreciate that there is a synergy between brain and psychology and environment, as discussed in the exchange of letters between myself and Dr. Ronald Pies in The Psychiatric Times (Pies & Gustafson, 2004). Improvements in the containment of anxiety and depression and their...
compensations can build a platform from which psychological steps, as discussed in this book, can step forth from, and these together, psychotropic and psychological, can alter the course of the relatedness in love and work. After all, that is the basic premise of biopsychosocial psychiatry announced by Engel in 1980. The reverse is surely the case, when steps taken in relatedness of work and love, and psychologically, alter brain chemistry as well.

Nevertheless, almost all of our patients seem to have this simple isolated will (Tate, 1934/1999), in which control is the single idea. Listen to the exchanges in your clinic with the doctors, and I bet you will hear this word control handed back and forth as the main business. It is a kind of romance, namely, the romance of science, or of “technique.” There is a technique for everything and it will control the outcome. This is what our trainees tell the patients who complain of lack of control, and, of course, they learned it from us!

This book proposes something other than the usual list of techniques for our 400 conditions of DSM-IV. It says that the flow of the case circularly, downhill, is very simply constructed by the repetition of the first step, and it says that the flow of the case to a different outcome is very simply constructed by the repetition of a significantly different first step. That is, for lack of control, forcing control in compensation is not a significant difference, but only comes full circle if a little more exhausted and resigned.

I propose four kinds of different first steps which make such a significant difference in outcome. I have to perform each of these within a 10-minute window, and you are free to do the same. I notice our residents and psychology fellows doing just this, as they spend more time with me. Their trajectories are changing hour by hour.

The first different step concerns what I call containment and is the subject of part I of this book. Because the isolated will to control (or control by serving) keeps getting pushed farther and farther, faster and faster, it eventually crosses a line after which the tension is unbearable. Essentially, the remainder of the body pushed along in this project joins in the conversation, unconsciously. It takes the form of rage, or anxiety about rage, or collapse into defeat. In other words, there is a discontinuous jump into anxiety and/or rage, or collapse and depression (Gustafson & Meyer, 2004).

If you are not going to get dropped, from your job, or school, or even by your spouse or children, in a society like ours in which functioning is imperative, you must keep up functioning. Thus, the emergence of anxiety and depression means that you become nonfunctional and can go rapidly down a steep slope into social disaster. Also, all the compensatory steps
which arise in a highly anxious or depressed patient (person), such as histrionics, avoidance, alcohol dependence, and antisocial acting out, only threaten the niche further (Gustafson, 1999). Thus, the containment of anxiety and depression and compensatory acting out is our first subject for a different step. Anxiety must be reduced, and depression must be reduced, and compensatory acting out must be reduced, if the patient is not to go straight downhill. Of course, psychotropic medications are an immense help with this, but so are measures which address the psychological mechanism of anxiety, depression, and compensation. It is extremely simple and it involves an address of the isolated will which has become too one-sided in its forcing of control. If the isolated will can step back from attempting too much, the tension in the system drops back within a bearable range. Thus, the 60-hour day is brought back to 50, and the 20 projects of the weekend reduced to 10. This is the kind of difference that makes a huge difference in containing the emergency, and is part 1 of this book, “Containment.”

The second step I propose is to help the patient sight, first in retrospect, and then prospectively, how he or she walks right into this nonlinear eruption or collapse. Almost invariably our patients have no idea how they got into the mess. It almost always seems to come “out of the blue” as they tell us. Of course, this is because isolated will is a kind of hypnotic trance (Freud, 1921/1975j) in which the patient is in a kind of sleepwalk! He is not looking ahead and that is called “selective inattention” (Sullivan, 1956; Gustafson, 1986/1997a, chap. 6). Thus, we back things up by returning to the point at which the patient was relatively fine, and then see what he did to bring these things to this pass. It is always one of these control operations, taken too far, with no eye out for where it is leading. This step toward a significant difference is simply to keep an eye out for where his steps lead and is part II of this book, “Selective Inattention Revised.”

The third step I propose is to ask the patient to consider an opposing step, which leads to an opposing current to the usual one of disaster, as I got our patient with the criticizing husband to come up with on her own. Of course, opposing steps, and currents run different risks, and that is our subject at part III of this book, “The Opposing Current Navigated,” namely, how to step in a different direction and be ready for its dangers. For example, yesterday a patient of mine after 2 years of grief from the death of her husband began to be a little bold at her dance class and invited a pleasant man out for coffee afterwards. He was glad to unburden himself, as he too had lost a spouse. However, at the next dance class he seemed very remote, and my patient was crushed. She simply wasn’t ready for the ambivalence to be expected in such a prospective partner. Next
week she will step into such bold forwardness with a better eye for the mixed results altogether likely in a lonely man.

Finally, the fourth step I propose is an extension of the third, for it is one thing to see that a prospective partner is not completely open to one's advances, but has an ambivalent reality of his own about engagement, while it is another to see that the world, in general, is not one's egg! We all like to think it is our egg and this is what Freud called the dream as "wish-fulfillment" (1900/1975a): I will have my way, and get just what I want. Now, that is a childish position which is very intransigent in the human being and is very difficult to get past. Balint (1952, 1968; Gustafson, 1986/1997a, chap. 8) followed Melanie Klein in calling it "the depressive position," which it truly is, because holding out for one's ideal world is always a setup to collapse, and is the very mechanism of depression (Bibring, 1953). A more primitive version he followed Klein in calling "the paranoid position," because the world is felt not only to be indifferent, and thus depressing, but downright hostile, and thus highly suspicious.

Ironically, the step out of such intransigence is to have a perspective from above or below one's field of action, to yield a "double description" (Bateson, 1972; Gustafson, 1986/1997a, chap. 15), so one can see both one's own dream of conquering the world, and the world's own game which is not so fitting after all, for one's dearest plans. Thus, the Cheshire Cat in Alice (Carroll, 1865/1985; Gustafson, 1986/1997a, chap. 19) continually comments to Alice from above about her fortunes in the game of Queen's Croquet, to wit, that the Queen calls "Off with her (his) head" for anything that does not suit her own winning. Such a moment is what I am talking about as a step out of the developmental impasse of being stuck in the contradiction between what I dream of doing, and what the world itself calls for. Every such moment is a step on the path of growing up.

It will not suffice to control oneself to suit the Queen, for the eruption and collapse will follow from this one-sidedness, nor will it suffice to hold onto one's ideal of having one's own way altogether, for an eruption and collapse will follow from this one-sidedness just as badly. Only a balanced step will read my claim and the world's reply equally. This is the subject of part IV of this book, "Impasse Surmounted," of the key first steps, whose difference makes a huge difference in the life of the patient.

In what sense then is this a book of very brief psychotherapy? In several, after all: First, it is about what can be done in very brief windows of opportunity like 5 or 10 minutes! As the English general practitioners found out (Balint & Norell, 1973), there is such a thing as long brief therapy (Gustafson, 1986/1997a), where the time spent is 6 minutes on the average, but the duration may be years or even a lifetime. A few days ago, I saw
a woman in the clinic for another 5 or 10 minutes, 3 years down the road, who finally said no to her son in prison that she would not take up his burden of getting himself out. That key step of going out the back door of being a doormat had a long preparation of my posing the problem to her, and her gradually getting ready to revise her daily step of saying yes to everyone else’s need. That is the argument of the research of Prochaska, diClemente, and Norcross (1992; Prochaska & Norcross, 2001): long preparation, and finally a decisive step, and then some work of slipping and getting back to the decisive step. This preparation to say no, instead of yes (Anthony, 1976), is probably the most common psychotherapy in our clinic. Essentially, this is what Selvini-Palazzoli, Cirillo, Selvini, and Sorrentino (1989) found to be fundamental in family therapy: that the mother and father finally got together to say no to a child or adolescent running rampant over them.

Second, very brief psychotherapy can take the form of what Talmon (1990) Hoyt, Rosenbaum and Talmon (1996) and Hoyt (2000) called single-session psychotherapy, because the patient, perhaps, with help, has already done the work of preparation (see, particularly, the Case of the Beautiful Wife in chapter 10 of this book, and the follow-up remarks by the patient in chapter 14, and also the Case of the Northwoods Girl in chapter 12, and her follow-up remarks in chapter 14). The latter case is illustrative of single-session psychotherapy, and the intrusion of further trauma requiring more work.

Third, very brief psychotherapy is about the moment of change being only a single step which is unprecedented, as in the “new beginning” of Michael Balint (1968), or a single step which has been taken before but is not allowed to slip away. I am arguing here the critical importance of sensitive dependence on initial conditions, or, the first step, iterated for the entire trajectory. Thus, our patients overwhelmingly say yes (i) to being taken advantage of in their exchanges, and this doormat step always leads to eruption of anxiety and depression, compensations in fantasy, and eventual emptiness. The compensatory step (i’) of psychic inflation in fantasy also leads to ruin, because the world always punctures psychic inflation, as it punctures every bull market.

Conversely, the step (i”) out the back door from compulsory yes (i), or compensatory inflation (i’), has huge consequences, and has huge applicability for our most demeaned patients, as I just described in regard to the mother of the convict. It may take a lot of waiting, and posing the problem, and letting the patient get it wrong, or hit bottom, as they say in AA, but the turn (i”) may be a different life altogether. Finally, the turn back (i”’) to face the impasse of work, or love or development may also have a
long preparation, while the step itself is extremely simple, and takes but a split second. It means something like what Anthony (1976) called “between yes and no,” because always yes means servility, and always no means breaking up, and the beauty of exchange is for yes and no to stay in balance between your demands and my demands.

Fourth, very brief psychotherapy means psychotherapy in its entirety generated in infinitesimal form like the calculus (Berlinski, 1995) from these four steps (i, i’, i”, and i”). In other words, very brief psychotherapy is all of psychotherapy presented in very brief form, as a kind of motion, from a single step, iterated, to a new trajectory. It is all of psychotherapy translated very briefly into chaos therapy.

I recognize that this claim is not proven by this book, but I also believe that this book is entirely consistent with such a theory. All I can say at this point is that I operate in such a theory of single steps, especially in the transitional space (Winnicott, 1971; Gustafson, 1986) between the steps that keep things on the same downhill course, i and i’, or compulsory yes, and compensatory fantasy, and the steps that open up a new world, i” and i”’, navigating the opposing current, or no, and surmounting the impasse, between yes and no. I can also say that I can teach this readily to nearly every novice resident and psychology trainee, and to nearly every seasoned veteran I have met so far. Surely, it will be disputed, and that is what science is all about, and to be welcomed.

Finally, I want to thank those who have helped me in the last year with this book. I cannot possibly thank all of those who came before. Michael Moran, Jim Donovan, Ruth Gustafson, Michael Wood, and Lowell Cooper have stood by my work for 20 to 35 years, and have come through beautifully for me with this manuscript. My newer helpers include Chris Clancy, Peter Hoey, Matt Meyer, Andy Moore, Rick Schramm, and Gary Simoneau. My secretaries have been devoted, exact, and quick, namely, Dee Jones, Pam DeGolyer, and Tammy Ennis. The Door County Summer Institute in Egg Harbor, Wisconsin, has provided a beautiful place for my teaching since 1993, under the direction of Dr. Carl Chan at Medical College of Wisconsin, Department of Psychiatry, email dcsi@mcw.edu.

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