Psychotherapy Guidebook

Anti-Expectation Psychotherapy Techniques

Roger P. Greenberg

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DEFINITION

I coined the term "Anti-Expectation Psychotherapy Techniques" in 1973 to refer to an array of procedures that have one major common element: they consistently contradict most patients' expectations of how a therapist will respond to their problems and symptoms. For example, most anti-expectation techniques involve a therapist encouraging the patient to produce or amplify symptoms, rather than a therapist emphasizing that the symptoms be suppressed, denied, or avoided. The techniques have been used mainly with patients demonstrating particular kinds of resistance to the more traditional therapy approaches and those who are unrealistically anxious about the meaning of their symptoms.

HISTORY

My interest in these techniques grew out of a number of encounters with resistant patients who stated that they were seeking change while at the same time they clung tenaciously to the symptoms and discomforts that brought them in. Such patients tended to externalize problems and emphasize

that the world was beyond their control while demonstrating the ability to control the therapy situation by fending off therapist attempts at exploration, interpretation, or direction. These patients often took the role of the help-rejecting complainer, first identified by Jerome Frank and later described by other clinicians. Thus, they continually attempted to pull advice from the therapist only to reject any suggestions that might be offered. They made their problems seem insoluble and appeared to take a special delight and pride in the insurmountability of their difficulties.

Perhaps the key to this type of patient's control of the therapy situation is his expectation that no matter what he does, the therapist will try to be therapeutic. The patient remains relatively confident that his negative view of himself will be matched by therapeutic interventions aimed at getting him to see the "causes" of his views, the alternatives he is overlooking, the positive assets he has, or the resistive nature of his communications. Typically, a static balance soon evolves in which the patient's negative statements are repeatedly counterbalanced by therapist intervention. While this kind of patient behavior may get attention and possibly preserve some inappropriate truths for the patient — such as, even the therapist can't help me solve my problems — it can prove extremely frustrating to therapists and potentially destructive of the therapeutic relationship. It eventually becomes imperative that the therapist somehow disturb the nonproductive stability of the resistant behavior. The use of Anti-Expectation Techniques allows the

therapist to regain control over this impasse to therapeutic progress.

TECHNIQUE

In dealing with resistance, the major aspect of the technique involves the therapist trying to break into the patient's closed system. This is done by aligning oneself with the patient's negative comments while echoing and greatly amplifying the views that the patient probably expects the therapist to oppose. For example, this might mean initially agreeing with the resistant neurotic housewife's complaint that she doesn't keep her house clean enough, and possibly even suggesting that she spend more than her usual ten hours a day cleaning. Or it might mean aligning oneself, at least temporarily, with a patient's statement that he must be defective since he is not perfect at everything he does. More complete case illustrations of the use of these techniques can be found in some of the references listed below.

When such techniques are employed, patients usually begin to find it extremely difficult to be resistive since there is no one to resist. From this position the therapist can begin to have the patient confront behavior and gain control over it. These techniques may be seen as "anti-expectation" — in that the therapist consistently goes against what the patient expects. It is done, however, within a framework that strongly implies that the therapist will be therapeutic. The results are: patients find themselves unable to use

comfortable old defenses, since they no longer produce the expected feedback; interactions are marked by the humor of the unexpected; and patients are forced to look at their problems from a different perspective.

It should be emphasized that Anti-Expectation Techniques usually represent only one segment of the therapy. Further, they do not substitute for a theoretical understanding of case material. Thus, such techniques are probably most effectively put into play after a strong therapeutic relationship has been established, the case has been conceptualized theoretically, and there are indications that the techniques are unlikely to precipitate harmful activities — such as self-destructive behavior.

Employing such techniques is difficult and requires considerable therapist sensitivity and skill. The therapist must develop the ability to resist the pull of the patient's message and continually anticipate where an anti-expectation communication will lead. The therapist must be able to put the intervention across without sarcasm and refrain from responding, at least initially, to the humorous or almost absurd aspects of the interactions. Finally, and perhaps most important, care must be taken to insure that the techniques are being employed to further the patient's progress and not to just fulfill the therapist's needs to exert power or express hostile feelings.

APPLICATIONS

Anti-Expectation Techniques can be used in two major ways: to directly deal with symptoms or to circumvent resistance and facilitate therapy within any theoretical framework. It may well be that the chief value of Anti-Expectation Techniques, with regard to combating symptoms, lies in their giving the patient a clear feeling that self-control can be exerted over behavior and problems.

There are a variety of other ideas expressed within the psychotherapy literature that are consistent with this approach. Behavior therapists have sometimes advocated the method of "negative practice," which involves having patients repeat again and again undesirable habits they are trying to break. A number of papers have described successful treatment of tics with this procedure. Similarly, the behavioral technique labeled "emotional flooding" involves the repeated presentation of anxiety-arousing stimuli until anxiety is extinguished. Implosive Therapy, as described by Stampfl and Levis, also involves a very similar behavioral approach based on psychoanalytic theorizing. They use the patients' own imagery to expose them to the most intense anxiety-eliciting stimuli the therapists can devise based on their theoretical understanding of the case. Again the expectation is that continuous exposure to such a stimulus without harmful consequences would cause it to lose all power to elicit anxiety.

Other examples of therapists using anti-expectation messages to

undermine patient defenses and gain control over the expression of symptoms can be found in Milton Erickson's descriptions of "naturalistic" and "utilization" hypnotherapy techniques and Jay Haley's views of the psychotherapy relationship from the standpoint of communications theory.

Interestingly, Albert Ellis's Rational-Emotive Therapy suggests that disturbances can be eradicated by patients learning to tell themselves more rational and less self-defeating sentences. Anti-expectation approaches highlight the fact that certain patients can gain control over their behavior by first trying to tell themselves more self-defeating sentences while being made very aware of what they are doing.