THE TECHNIQUE OF PSYCHOTHERAPY

BASIC INGREDIENTS OF PSYCHOTHERAPY

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Basic Ingredients of Psychotherapy

Emotionally upset people are constantly being assisted in achieving homeostatic equilibrium through a variety of approaches. Taking a vacation, changing jobs, confiding in a concerned and wise friend, consulting a minister, swallowing tranquilizing substances, adopting a different philosophical outlook, and talking to a professional consultant all seem to bring relief. Both informal approaches *and* formal psychotherapy are helpful. The soothing embraces of a human relationship, the automatic arousal of a magical placebo element, and the releasing powers of emotional catharsis are parcels that may bring a person to an adaptive equilibrium. The method is non-specific and diverse: it could be amulet, pill, environmental change, homely philosophy, systematized dogma, or scientific method.

But the fact that any contact between two human beings or that any device, appliance, or technique seems to bring relief does not justify our applying the label of psychotherapist to the healer and psychotherapy to the tactic. People are abidingly achieving relief from symptoms in a propitious environment. But only rarely—and this is most fortuitous—do they acquire a significant enrichment of their behavioral or creative potentials. What we are concerned with is the studied manipulation of forces in a professional relationship that can, in addition to restoring homeostatic equilibrium, bring about behavioral and personality change with greater frequency than would occur by chance or through the activities of nonprofessional "helping" agencies or professional counseling. Can we identify properties of psychotherapy that can bring about deeper and more permanent change than other forms of helping?

One of the great bewilderments in appraising the virtues of psychotherapy is the difficulty of assigning to it *specific* processes and effects apart from the non-specific instrumentalities of "helping" and the subsidies of casework and counseling. In practice, the techniques of helping, counseling, and psychotherapy merge imperceptibly; as to effects, it is generally impossible to apportion the degree of improvement brought about by non-specific and specific moieties. Nevertheless, it is of more than heuristic value to attempt to distinguish aspects of relating to which we may affix the term "psychotherapeutic" as differentiated from counseling and helping.

Psychotherapeutic-like services are often rendered without intent by persons with no training

whatsoever. For example, what would one call the ministrations of an individual who is visited regularly —sometimes as often as six times weekly—by a steady "clientele" suffering from a wide range of psychiatric syndromes, a person who serves the purpose of relieving their emotional symptoms by (1) dispensing a tranquilizing substance more effective than the most powerful psychotropic drug and (2) relating with the clientele, variantly reassuring, guiding, advising, and interpreting. The "clients" in turn interact with this administrative individual as well as with the souls around them, participating in the boons associated with placebo influence, suggestion, and group dynamics. Under the influence of the "tranquilizing drug" their resistances are softened, and they are apt to express themselves volubly, often with free associations, experiencing emotional catharsis, exhibiting transference reactions (sometimes an actual transference neurosis), revealing aspects of their unconscious, and occasionally exhibiting acting-out tendencies that are usually dealt with firmly by the individual in charge. No patients are more dedicated to their "sessions" than are these clients. The individual to whom I refer practices the skills daily in every local bar in the country; his steady clients are among the sickest individuals in our society. There are probably more bartenders functioning in the role of psychotherapists in this country than there are psychiatrists, psychologists, and psychiatric social workers combined. Yet they dispense their medicaments without prescription, and they go through their interviewing maneuvers with no psychiatric supervision whatsoever. To call such an individual a psychotherapist is obviously preposterous, and to dignify his activities as a form of psychotherapy would be a disservice to the art. This is only one example (and there are many) of untutored helping agencies to whom an emotionally upset individual may turn who may serve a therapeutic-like function.

Helpful intervention is also the intent of many professionals whose training equips them to deal with special segments of behavior and to enlist in this process community resources. Human beings in trouble are constantly consulting such professionals to aid them in resolving their distress. Generally the agency selected is authorized by social sanctions to manage a particular complaint; the assessment by the client of the problem will determine the choice of professional. Thus, for marital difficulties a lawyer may be the counsel; for economic hardships, a social worker; for educational failings, a teacher or educational psychologist; for moral quandaries, a minister; and for physical troubles, a physician. The goals of such consultations are (1) to assuage the prevailing tension, (2) to correct remediable disturbances responsible for the individual's present predicament, (3) to rectify deviant behavior, and (4) to prevent

the outbreak of more serious disorders. The responsibilities of both counselor and client are more or less explicitly defined, the role expectations of the counselor being structured by training and experience. The effect of such counseling may be psychotherapeutic in essence, but the techniques employed and the objectives approached vary from those of psychotherapy. Moreover, these counselors in other professional areas generally do not have the training or experience to deal definitively and correctly with emotional difficulties, although they may be able to mediate their effects.

Perhaps the most significant way psychotherapeutic relationships (other than supportive psychotherapy, which has a kinship with counseling) differ from non-psychotherapeutic ones is that in the latter the helping agency or counselor enters into collusion with the neurotic forces to achieve an immediate objective. In psychotherapy, there is an opposition to, and a direct attack made on, the neurotic forces in the hope of disposing of them and of reconstituting new and more adaptive defenses. Table 7-1 attempts to distinguish helping, counseling, and psychotherapeutic situations in reference to a number of important variables. Perhaps the main reason that psychotherapy has so often been considered affiliated with casework and counseling is that no attempt has been made to classify supportive psychotherapy in a category apart from re-educative and reconstructive psychotherapy. Unless this is done we are unable to separate psychotherapy from other forms of helping.

Table 7-1 Helping, Counseling, and Psychotherapeutic Relationships

	Helping Situation	**Counseling Supportive Psychotherapy**	**Psychotherapy (Reeducative and Reconstructive Goals)**
Objectives	Symptom relief	Correction of situational problem, rectification of deviant behavior, expansion of personal abilities and skills, restoration of defenses, prevention of emotional breakdown	Alteration of defenses, facilitation of interpersonal and social adjustment, personality growth and development
Interview focus	Manifest complaints and interpersonal problems	Symptoms, situational problems, conflicts, attitudes	Underlying roots of complaints and conflicts, defenses, coping mechanisms, fantasies, symbolisms
Psychic arena	Conscious processes	Conscious processes	Conscious, preconscious, and in psychoanalysis, unconscious processes
Temporal focus	Immediate present	Immediate present	Immediate present and historical past
Technical processes	Support,	Guidance, clarification, suggestion,	Inculcation of insight, pattern

	reassurance, emotional catharsis, placebo influence, group dynamics	environmental manipulation, use of community resources	reinforcement and extinction, and in psychoanalysis, dreams and free association
Transference	Positive transference encouraged and utilized	Positive transference encouraged and utilized, negative transference discouraged	Transference interpreted when it acts as resistance
Transference neurosis	Avoided	Avoided	In psychoanalysis purposefully promoted to release repressions and to detect sources of inner conflict, otherwise circumvented if possible
Countertransference	Positive feelings utilized to promote supportive process	Positive feelings utilized, negative feelings controlled	Constantly examined, analyzed, and resolved

All helping, counseling, and psychotherapeutic situations embrace automatic healing elements that are released during the relationship between client-patient and helper-counselor-psychotherapist. These include the positive accruals of a projected idealized relationship along with the bounties of placebo influence, emotional catharsis, suggestion, and group dynamics. A vital aspect of the prevailing interaction is identification with the helper-counselor-psychotherapist. More or less, all clients-patients will regard the person to whom they relate as a model to pattern themselves by. They will incorporate, consciously or unconsciously, that individual's ideas, attitudes, and values into their reality-testing and problem-solving activities. The possession by the helper-counselor-psychotherapist of appropriate personality characteristics and attitudes will enhance this therapeutic dimension, while their absence may interfere with it. Present also in all helping, counseling, and therapeutic relationships are elements of transference and countertransference, the understanding and management of which may constitute the difference between a successful and unsuccessful outcome. In helping situations, counseling, and supportive psychotherapy, positive aspects of transference and countertransference are cultivated to enhance the operations being promoted; negative aspects, if recognized, are reasoned away or avoided. In some reeducative and all reconstructive psychotherapies, positive and negative transference and countertransference are examined and analyzed as a means of understanding the patient's behavior and of aiding him or her in altering it.

COMMON ELEMENTS IN ALL PSYCHOTHERAPIES

Let us now, then, attempt to delineate some processes that are inherent in effective psychotherapy, which while perhaps present to some extent in helping and counseling are not deliberately nurtured. All good psychotherapeutic systems—irrespective of their theoretical underpinnings and while they manifest some differences—employ these processes to a greater or lesser degree, whether they involve conventional dyadic insight approaches, manipulations of the patient-therapist relationship, or selected reinforcement of special aspects of behavior.

Interviewing Procedures

Communication is the channel of interchange between patient and therapist. Practitioners of different methods are usually taught principles of interviewing consonant with their theoretical systems. In the main, the practitioner must be able to subject the patient's communications to selective scrutiny, directing comments toward facilitating and constructively utilizing verbalizations. This involves an ability to employ language that is understandable to the patient. It includes an awareness of nonverbal behavior, an index of some of the most important defensive operations. It entails knowledge of techniques of maintaining the flow of significant verbalizations either toward free association or toward selective focusing on pertinent themes. It embraces methods of understanding or inculcating insight by various techniques, including interpretation. It encompasses an understanding of how to terminate the interview. These formalities are often left to chance during training, and it is only through experience that the practitioner gains the interviewing skills that are most helpful to his patients.

Establishment of a Working Therapeutic Relationship

Unless a cooperative empathic contact is established with the patient, the therapeutic process may come to naught. An effective system must maintain this as a prime objective during the first part of therapy. The techniques of achieving a relationship are rarely formalized, but usually they involve gaining the patient's confidence, arousing expectations of help, accenting the conviction that the therapist wishes to work with the patient and is able to do so, motivating the patient to accept the conditions of therapy, and clarifying misconceptions. Without a working relationship, in reconstructive therapy, there can be no movement into the exploratory and working through phases of therapy; the

patient will be unable to handle anxieties associated with the recognition and facing of unconscious conflict. In supportive and reeducative therapy, a good relationship expedites progress immeasurably.

Determination of the Sources and Dynamics of the Patient's Problem

Cognitive learning is present in all therapies. The different psychotherapies attempt to search for and to explain the patient's emotional difficulties in varying terms, such as discordant elements in the environment that mobilize stress, distorted interpersonal relationships that prevent the individual from self-fulfillment, conditionings that rigidly dragoon the patient to destructive behavior, and unconscious conflicts that mobilize anxiety and interfere with a realistic adjustment. All psychotherapies attempt such explorations within the framework of special theories about human development and adaptation that include to a greater or lesser degree some of Freud's monumental discoveries and refinements of Pavlovian concepts. It is generally considered essential in the resolution of a problem toward reconstructive change for the individual to become aware of the fact that one is being victimized by repetitive patterns that force one to actions opposed to a productive life. These patterns are rigid and compulsive; they defy logic and common sense; they are both supported and opposed by ambivalent value systems that have been incorporated within the self; they make for an undermining of security and self-esteem, and for helpless expectations of injury that are registered in reactions of anxiety. The physiologic and psychologic manifestations of anxiety, and the marshalling of defenses against anxiety create various symptoms of neurosis. Much of this dynamic turmoil goes on below the level of awareness, and its recognition is opposed by the mechanisms of denial and repression that both safeguard the individual against anxiety and help to retain the neurotic gains residual in their preservation. A variety of resistances operate to maintain this denial-repression. The individual who is being treated under the aegis of this dynamic model is, through a number of techniques, taught to recognize personal offensive patterns and their consequences, the repudiated conflictual aspects of the psyche, and the origins of difficulties in destructive past conditionings. Awareness of stress sources and conflicts hopefully enables the individual better to challenge current maladaptive patterns, to be liberated from old values, to rectify the disturbed life situation with new modes of relating to people, and to develop a more wholesome and realistic conception of the self. Supportive and reeducative therapies deal more with provocative reality factors in the here and now, while attempting to correct faulty past learnings in line with goals of

symptom alleviation and problem solving.

Many contemporary psychotherapeutic systems utilize some of the fundamental principles of Freud, though they affix to these their own labels. To a greater or lesser degree, concepts of the unconscious, repression, transference, and resistance are acknowledged. The means by which the patient is brought to an awareness of problems and the extent of exploration of the unconscious, will depend on the type of theoretical orientation to which the therapist has been exposed. The focused interview, free association, dream interpretation, analysis of the transference, exploration of genetic material, and the buildup of a transference neurosis will thus be employed in varying degrees.

Behavioral therapies, rooted in conditioning theories, do not put much credence on insight acquisition; rather they focus more on tactics of relearning. But inherent in the techniques employed is a relationship between therapist and patient and the inevitable derivation of some insight as part of the corrective therapeutic experience.

Utilization of Insight and Understanding in the Direction of Change

Effective psychotherapies acknowledge that understanding is not enough, that conditioned patterns of behavior do not allow themselves to be displaced so easily, and that various techniques must be implemented to produce change. Techniques, therefore, are put into effect to create incentives for change, to deal with forces that block action, to promote problem-solving and reality testing, to help the patient to master anxieties investing normal life goals, to correct remediable environmental distortions, to encourage adjustment to irremedial conditions, and to accept personal limitations and handicaps while fulfilling creative potential to the highest degree. Behavior therapies focus on this relearning dimension almost exclusively.

Resistance and the Readiness for Change

In all forms of therapy resistance will appear in stark or disguised forms and may block or destroy therapeutic progress. Despite the fact that suffering is intense and symptoms disabling, the patient may resist changing a preferred way of life. Toward this end the efforts of even experienced therapists may be blocked. The bounties derived from pursuing a course that must inevitably result in anxiety and turmoil

may not be apparent on the surface. The patient seems frozen into unreasonable bad habits that refuse to dissolve. And credit for failure may be ascribed to the impotence of the therapist and the worthlessness of the latter's methods. Resistance to change can paralyze all forms of therapy, and the capacity to recognize their subtleties and to deal with them constructively spell the difference in any psychotherapeutic endeavor between a therapeutic triumph or a debacle.

What we seem to be dealing with in all of our patients is their *readiness* for change, which apparently involves the degree to which they have spontaneously or with professional help resolved their resistance to change. An individual with reasonable readiness to move forward will seem to benefit from almost any situation or tactic that can be used constructively. For years there may have been silent building either through spontaneous insights and propitiously reinforcing life experiences or in formal therapy, with few apparent signs of improvement. Should more psychotherapy later be sought, improvement or cure may then unjustifiably be entirely credited to the second treatment experience, however brief or coincidental it may be, or to some dramatic event in life that actually served as a convenience that was successfully manipulated.

Multiple obstructions in the form of resistance are apt to present themselves at every phase of treatment. They may oppose the establishing of a working relationship, the acceptance of explanations of the therapist, the full cooperation with the therapist's techniques, the search for provocative conflicts, the probing into genetic material, the facing of reality, the abandoning of the pleasure values and secondary gains of neurotic tendencies, the acceptance of maturity, and the giving up of the treatment situation when termination is necessary. Obstructions appear in various masquerades, as transference, as "acting out," as forced "flight into health," as self-devaluation, and as innumerable other disguises. The skill of the therapist is revealed by dexterity in recognizing and managing the resistive maneuvers of the patient.

Patient Variables

There are an endless number of variables that the patient brings into therapy that will augment or negate the direction of psychotherapy. The expectations of the patient, the kinds of symptoms possessed, the attitudes and reactions to the therapist as an authority as well as to the techniques being employed,

and the intensity and persistence of childish distortions are among the most common factors that must be taken into account. Perhaps of greatest importance is whether or not the patient will utilize the relationship with the therapist for objectives inimical to therapeutic goals. Thus if residual dependency needs exist, the patient may overidealize the therapist and project personal aspirations for magic onto the therapist. Basking in the sun of the therapist's celestial power, the patient will establish a satellite position insisting that the therapist cure him or her even in the absence of any personal effort. We are all victims of past conditionings and habit patterns, some of which interpose themselves subtly on our present-day adaptations. If a person as a child has been able to maintain identity only by resisting or fighting parental authority, there is no reason why we should not suspect that the individual will attempt to treat the therapist with similar defensive tokens. These may never interpose themselves in outright defiance; rather they may take the more subtle form of an inability to respond to remedial promptings. An insidious pattern possessed by some patients who seek to enhance their independence and emancipation is a detachment that separates individuals from others and from themselves and accordingly tends to rob them of many of life's pleasures. The presenting complaint may be depression and generalized anhedonia. We may find that a meticulous application of techniques fails to register marks on the patient's indifference. When we realize that our patient has an investment in maintaining detachment, that it has always served the patient as armor against being controlled and manipulated, that it dulls threatened anxiety and a thousand imagined hurts, we can see that efforts toward its maintenance have greater reinforcement value for the patient than the rewards we as therapists can proffer. There may be nothing faulty in our techniques, but psychological obstructions act as impenetrable barriers to our efforts. This is why a high level of motivation is so important in all therapies.

Therapist Attitudes and Operant Conditioning

The proper therapist attitudes are therefore crucial for effective psychotherapy as they are probably important for all kinds of learning. They constitute powerful reinforcers that strongly influence the patient's behavior. Attitudes of empathy, warmth, and understanding tend to promote positive feelings in the patient; they relieve tension and lower the anxiety level. In such an atmosphere learning is enhanced. Interviewing, focused by the therapist on anxiety-laden content, may then prove rewarding. Thus, if dynamically oriented, the therapist will pursue and encourage the patient to explore zones that

are usually resisted or repressed. Approbative responses, verbal and nonverbal, from the therapist reward the patient when repudiated material is prosecuted. In addition to the temporary benefits of emotional catharsis, the patient learns that this material can be tolerated, and when placed it in the context of the historical past, a revaluation may occur. Schedules of selected reinforcement foster the extinction of anxiety-provoking past experiences and their present-day associations.

In behavior therapy the patient is also exposed, in the medium of a rewarding emotional climate, to reinforcers that help extinguish certain reactions that have been self-defeating and accentuate others that have an adaptive potential. Symptom relief and the acquisition of constructive behavior patterns occur without the formality of insight.

Apart from specific reinforcing maneuvers that are implemented in dynamic and behavioral approaches, the therapist-patient relationship itself serves as a relearning experience from which the patient may generalize constructive responses toward other relationships. This gratuity may occur in any helping or therapeutic relationship. Dynamic approaches have the advantage of working with transferential contaminants that can effectively block this happening. Where interfering transference is not bypassed, but dealt with firmly in terms of its genetic roots, and the patterns and defenses that it embraces are skillfully analyzed, it will tend to undergo negative reinforcement and extinction. The therapist relationship will then become a powerful corrective experience for the patient. This does not mean that cure is automatically guaranteed, since in some cases psychic damage is so profound, the secondary gain benefits so intense, the masochistic need so great, that inner rewards for the perpetuation of transference exceed those the therapist can supply by approving-disapproving tactics. Nevertheless, in a considerable number of patients the developing and unravelment of transference can be most facilitating of extensive personality alterations. Behavior therapies, while remarkably effective in promoting symptomatic improvement and behavior change, cannot approach the depth of reconstructive personality change possible in selected patients exposed to dynamic therapy with trained psychotherapists whose personality structures contain the proper ingredients of warmth and understanding, and who know how to deal with transference and countertransference.

A question immediately poses itself. Is not the proposed climate for some types of psychotherapy, for instance classical psychoanalysis, a neutral, detached one, and, if so, would not the patient then respond

in an antitherapeutic way to the traditional detached manner of the therapist? The answer to this question lies in the simple fact that effective psychotherapists, including psychoanalysts, are not really neutral and unconcerned. They communicate, in spite of practiced noninterference and passivity, an understanding of and empathy toward their patients. The patient quickly discerns from nonverbal cues the underlying true emotional feeling of the therapist. Noneffective therapists (including psychoanalysts), on the other hand, who personality-wise are detached, cold, uninvolved, or lacking in empathy will stimulate negative therapeutic reactions in their patients. Extensive training and experience will not compensate for the absence of positive personality qualities, without which no technique can truly be productive.

Psychotherapists generally practice preferred methods that over the years have yielded enough triumphs to reinforce faith in their powers. *What* we do in therapy is tempered constantly by *how* we do it. We have an affinity for some techniques and prejudices toward others. Not all procedures make sense, nor will they work for all therapists. A highly discriminating process generally takes place as therapists gain experience and find that certain theories and special techniques seem effective in their hands. A problem that plagues our field, of course, is the tendency to apply one's personal experience to the world at large. The fact that a therapist finds a particular approach of great value for her or him does not mean that other therapists will do likewise.

Countertransference

An effective psychotherapeutic system recognizes negative damaging consequences of countertransference. The prejudiced responses of the therapist to the patient, positive or negative, may interfere with the latter's getting well. The nature of countertransferential projections onto the patient will depend upon the specific problems of the therapist that are being activated by the patient at the lime. These may be unique to a single case, or they may occur in different forms with various patients. Where a therapist is victimized by feelings over which he or she has little control, such an individual may not be able to apply techniques with a proper measure of disciplined objectivity. For instance, a therapist repulsed by homosexuality is not the preferred resource for an individual pursuing a nonheterosexual life style. A therapist who is fearful of aggression may display anti-therapeutic behavior when verbally attacked by a disgruntled soul. The passive, ingratiating, helpless patient may arouse overprotective

attitudes in the therapist who may act as a crippling shield, isolating the patient from the realities of life. Such attitudes will interfere with the working relationship, the womb in which personality change and other benefits are propagated. In contrast, countertransference may be, if utilized correctly, an important indicator of nonverablized attitudes and feelings that are being projected onto the therapist and thus prove helpful in understanding the patient's conflicts and needs.

Environmental Variables

In considering what ingredients enter into psychotherapy, we cannot neglect social forces. Existing cultural trends and the prevailing life style may motivate patients to seek out special types of therapy and actually influence their learning patterns. In our present-day rock-loving, drug-dominated culture, members of the younger generation are especially attracted either to the expressive types of therapy characterized, on the one hand, by acting-out, screaming, and shedding superego restraints and, on the other hand, to an escape from tensions and responsibilities through meditation, psychotropic substances, and indulgence in Eastern philosophies. It may be futile to try to impose variant therapeutic techniques on such individuals. They may be more attuned to therapists with unconventional styles, particularly therapists labeling themselves as "avant-garde" who practice original and unorthodox methods that border on the irrational.

The environment itself in which the individual functions will influence therapeutic change both during and following treatment. Thus, a milieu that reinforces destructive behavior will neutralize and one that rewards healthy behavior will encourage the success of the therapist's efforts. Recognition of the environment in which the individual functions and will be forced to live in after therapy will permit the therapist to focus on elements that need to be altered or, if irremediable, adapted to without compromising the gains achieved in psychotherapy.

Termination of Therapy

The termination of all types of therapy is best handled in a planned way and not left to chance. An analysis of any obstructive dependency elements in the therapist-patient relationship is part of this process. The patient is generally induced to shoulder the bulk of probings into personal problems and to

take total responsibility for his or her plans and activities. Independence and assertiveness are goals toward which the patient is encouraged. The patient is prepared for possible relapses and reminded that should any symptoms return, the tool of self-understanding acquired in therapy should help him or her regain equilibrium.

SUMMARY

Having delineated the important aspects of process, can we reasonably assume that these will bring good results? In the main, yes; but, as has been indicated, there are important qualifications. There are certain limitations to change in all people; there are certain potentialities for change in all people. If the psychotherapist applies himself or herself to the task with disciplined process, he or she will be best equipped to foster in patients a successful outcome.