CASEBOOK OF ECLECTIC PSYCHOTHERAPY

FUNCTIONAL THERAPY:

A Case of Training

John Hart
Joseph Hart

Commentaries by
Hugh C. H. Koch & Malcolm H. Robertson

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Table of Contents

REFERENCES

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Functional Therapy: A Case of Training

John Hart and Joseph Hart

BACKGROUND

Functional therapy is a historically based eclectic orientation derived from the general functional psychology of William James and the clinical functionalism of Pierre Janet. Unlike most other contemporary eclectic approaches, functional therapy began as an eclectic orientation. (For a critique of functional therapy as an eclectic therapy see Patterson, 1986.) William James was the great synthesizer of the early 1900s, hospitable to a range of psychoanalytic and behavioral, philosophical and experimental methods and ideas. James' style of eclectic synthesis was not inclined to look for a single overarching theory but to evaluate the potentials of many theories. The hallmark of Jamesian functionalism was an emphasis on consciousness as the central concern of psychology. Concerns about accessing subconscious contents and modifying behavior followed from his central concern—to learn as much as possible about each individual's "stream of

consciousness" (see Hart, 1981; James, 1950).

Functional therapists pay attention to both personality characteristics and moments of consciousness. A "reactive personality" is one that operates with little awareness; a "responsive personality" is one that functions with a high level of awareness and responsivity. The overall task of therapy is to help clients become more responsive and less reactive. The shifting of personality functioning from reactivity to responsivity entails: (1) becoming more aware of reactive moments (i.e., of happenings that appear as gaps in consciousness), (2) feeling and showing those automatisms within the safety of the therapeutic encounter, and (3) beginning to experience the real-life possibilities of an expansive personality existing in non-defensive, open, responsive moments.

It is important to note that a reactive personality can be either adapted or socially maladapted. From the phenomenological point of view, both adaptive and non-adaptive reactivity are impediments to development. The first clinical and experimental demonstrations of reactivity in the history of functional therapy were made by Trigant Burrow (see Hart, 1983, Chapter 5, "The Iconoclastic Eclecticism of Trigant Burrow," and Burrow, 1953). Burrow's psychophysiological experiments provide the first evidence for defensive versus non-defensive experiencing and patterning in the clinical-experimental literature.

A modern theorist who has made full use of the James-Janet ideas about the subconscious is Ernest Hilgard. In his book *Divided Consciousness* (1977), which attempts to revive the James-Janet theory of dissociation, Hilgard argues that a failure to recognize the difference between dissociated mental contents and repressed mental contents can lead to therapeutic errors. Dissociated contents are directly accessible to consciousness, but repressed contents are only indirectly accessible through derivatives such as dream symbols and interpretations *(ibid.,* pp. 248-255). Hilgard points out that Janet used the term "subconscious" to avoid the undesirable implications of the term "unconscious." For both James and Janet the subconscious or subliminal was an accessible psychic process. The most direct means of access was by attending to "gaps" in consciousness and by subjectively staying with "felt tendencies" to fill those gaps. This method is essential in almost every session of functional therapy. The modern humanistic-existential theorist Eugene Gendlin has devised a specific training method to instruct clients in this form of inner attending called "focusing"; the focusing method is taught to all clients who participate in functional therapy. (See Gendlin, 1981, and Gendlin, 1962.)

All the techniques of functional therapy that will be illustrated in the case sessions (focusing, work with personality dynamisms or styles, and work with dynamics of expression) are intended to help clients move from automatic reactivity to awareness, and from closed functioning to open

functioning.

TRAINING GROUP FOR FUNCTIONAL THERAPY

The training case format was chosen to illustrate functional theory and methods for a number of reasons. Most important, within the training, a variety of eclectic techniques are used by the trainer in every group. The training also shows an important philosophical stance of functional therapy, i.e., that therapists need ongoing training and therapy to maintain their own best therapeutic personality. (For contemporary case illustrations of functional therapy with clients rather than trainees, see Hart, 1983, and Hart 1986. Famous historical cases within the functional tradition include those of Prince [1957], Janet [1929], and Taft [1933/1962].)

The training program is similar to the model training therapy program in the text *Modern Eclectic Therapy: A Functional Orientation to Counseling and Psychotherapy* (Hart, 1983). Each training group generally consists of a demonstration and explanation followed by a simple exercise in which the trainees take turns role playing a therapist and a client. One or more of the trainees then presents a case problem or issue that relates to the training exercise; the case problem might then be role-played or simply discussed. Each training group session usually lasts two hours once a week.

The training group takes place in the suite of offices occupied by Hart

and Associates on Wilshire Boulevard in West Los Angeles. (A less specialized, eclectic therapy training program, which includes instruction in Jungian, psychodynamic, humanistic, and cognitive behavioral approaches as well as functional therapy, is available at the Counseling Center, California Polytechnic University, Pomona,

California.) The office in which the training group meets is a large rectangular room that comfortably seats eight people. The office is decorated in contemporary fashion with large couches. A swivel chair is used by the training therapist. On one wall is a large drawing stand used for teaching purposes. The room has one wall of glass windows located at tree level giving the room a dramatic forest-like appearance. The other offices in the suite are available for use in one-on-one role-playing exercises.

Trainees must have completed or be enrolled in at least a master's-level degree program and be currently in practice or interning in a human services agency with a caseload of individual clients, families, or groups. Participants are expected to make a 9- to 12-month commitment to the training group.

The intent of the training group is to teach the functional orientation to counseling and therapy. Most of the trainees are attracted to and interested in the practical applications of the therapy, but they are also attracted by the philosophical attitude conveyed in the training.

All participants are clearly aware that group support and encouragement of other participants is expected. Although criticism is certainly appropriate, the general tone at all times is encouragement and support. In order to grow and change and develop their therapeutic personalities, trainees need to know that if they try something new or different, they will be supported and guided. Therapists in training tend to be cautious and careful to the point of timidity. Frequently, participants are being trained and supervised in their agency setting where they are experiencing so much criticism that they have become intimidated to the point of becoming passive listeners, afraid to interact and take chances with their clients.

Personality Fitness for therapists is a concept crucial to the training. The idea is that therapists need to be fit in order to practice most effectively. Their own personalities must be in shape, with good endurance and resilience in order for them to do fine therapy. Consequently, to develop a more "fit" personality, regular and consistent personality exercise must be maintained. Individual therapy, of course, is one means of achieving personality fitness; the training group is intended to be another form. Marston (1984) has made an argument that "the overall effectiveness of psychotherapy as a profession should be determined in part by the endurance of therapists in their careers and the consistency of their performance over time" (p. 456). The training experience emphasizes personality fitness for the trainees as a means of

enhancing endurance and consistent therapeutic quality.

The therapists in training are encouraged to try out new styles of working that stretch and exercise their personalities and also to become aware of the strengths, weaknesses, and limitations of their styles. Through homework exercises they try to develop approaches that can add to and strengthen their personality styles. The approach could be compared to fitness and skill training for athletes or to the practice of exercises by musicians. The same approach is used with clients in functional therapy.

INTAKE AND ASSESSMENT PROCEDURES

As stated earlier, a major purpose of the training group is to focus on the therapists' personalities in order to help them learn about their special problems in working with clients. Since most client situations begin with some sort of assessment and intake procedure, the training group begins the new training year with a discussion of assessment within the functional model. Next, there is an assessment of each trainee. The trainees have an opportunity to role-play both therapist and client.

Two methods will be discussed here: the life satisfaction and happiness chart and the personality pyramid graph.

Life Satisfaction and Happiness Chart

This is a simple exercise using paper and pen. Each trainee is given a large watercolor pad and two different colored marking pens. They are instructed to draw a large rectangle on their paper. The left vertical line is numbered from top to bottom 5-4-3-2-1. The bottom horizontal line is numbered left to right 0-5-10-15, and so on, up to 65.

The vertical line is for ratings of levels of life satisfaction and happiness, with 5 representing extremely happy and 1 representing very unhappy. The horizontal line represents age.

The trainees are instructed to draw in, first, their parents' lifeline and, next, their own. When doing their own, they are instructed to note any significant events or people around the dips and rises in their charts. The trainer then presents his own life chart. The trainer sets a tone and a level for the depth of sharing that can be elicited in doing the chart. Each trainee then discusses with the group his or her own life chart. The trainer guides each trainee through eliciting pertinent history, significant events, memories, and impressions from the life charts. (Note that the trainer is doing with the trainees, in these first training sessions, what the trainee therapists will be doing with their clients in early sessions.)

Following each chart presentation, the other trainees are asked to formulate clear descriptions about their colleagues and to include

characterizations of the strengths and weaknesses and the significant events and people who shaped the person's life. They are instructed to look for the beliefs and life philosophies that emerged from each individual's family background and life events. They also pay special attention to the attitudes and responses made by the person to stressful life events. The trainees' shared self-assessments develop a sympathy and understanding within the training group for each group member.

Graphing and telling about one's life is an experiential means for trainees to learn about functional diagnosis and assessment. Learning to assess others by assessing one's own intrapersonal and interpersonal skills is centrally important because, as Patterson (1984) has pointed out,

> . . . consistent positive findings regarding the elements of the therapeutic relationship are encouraging. This is particularly so in view of the lack of consistent findings in the area of (developmental) psychopathology. The research on the effectiveness of the relationship over a wide range of client conditions or problems provides a basis for a therapy which does not depend on identifying specific causal pathological factors. This suggests either that the specific content of the client's disturbance is unimportant, or that the cause of much, if not most, psychological disturbance is related to the absence of good human relationships, or deficiencies in such relationships. It is also possible that improvement in the client's relationships springing from the therapeutic relationship leads to improvement in other areas of the client's life [p. 438].

Functional therapy places more emphasis on Axes IV and V of DSM-III, than Axes I and II; the concern is more with appreciating the person's

strengths, weaknesses, potentials, and levels of functioning than with symptoms or personality psychopathology.

Personality Dynamics Assessments

For this exercise, the trainees are given poster paper and pencil. They are again instructed to draw a large rectangle. The vertical line is green—marked top to bottom 5-4-3-2-1. On the horizontal line they write "Expression-Activity-Feeling-Clarity-Contact."

They prepare graphs for each of the following life areas: work, play, friendship, sex, and intimacy. These graphs are used to picture the individual trainee's personality functions in different life areas. In functional terms, they illustrate personality strengths and weaknesses and life area accomplishments and deficiencies.

Integration of Assessment and Therapy

As with any clients, the trainee therapists are limited and/or constricted in their functioning by their personalities. Even though case problems and issues are the training focus, it soon becomes clear to trainees that their own personalities must be considered. Just as acceptance of personal responsibility is crucial to client change, so is it crucial to each trainee.

Trainees find themselves upset with their clients because the clients are not compliant, receptive, and welcoming of their interventions, suggestions, insights, and directions. They find themselves rejecting clients who are "cold" and who have difficulty with relationships and then diagnosing them as being "incapable of having relationships."

The trainees are shown that it is up to them to create a relationship with someone who has low skill levels. After all, tennis instructors do not complain about people with poor backhands who come to them for help about their strokes. Nor do dance instructors fret about non dancers wanting to learn to dance. A critical assumption, then, is that clients are doing what they know how to do best with their personalities. It is up to a therapist to help a client become what he or she could be.

A SAMPLE TRAINING SESSION

The following group session included Marvin and two other trainees, Carole and Donald. The intent of this training session was to extend the trainees' learning about assessment and about the possibilities for active involvement in early sessions with clients. The trainees are introduced to a way of thinking about their work which will be an ongoing emphasis in the group, viz., that the therapist's personality limits are crucial determinants of what can happen between therapist and client.

Marvin has completed his M.A. degree in psychology and is working full-time in a drug rehabilitation agency. The clients of the agency are court referred and are generally "hard-core," low-income drug users. Marvin is developing his bilingual skills and is responsible for one Spanish-speaking group.

Marvin is a strongly built man with dark hair and a brown complexion. His demeanor and bulky size can be imposing; however, he has warm, expressive eyes, a ready laugh, and a playful sense of humor. He supported himself through undergraduate and graduate school as a mechanic, carpenter, and helper in a children's home. He is a dedicated sort of person who tends toward depression at times.

Marvin's father was an alcoholic physician. Marvin was well off enough to attend prep school as a youth, where he was a good athlete and popular among his classmates. He is more ill at ease with women than with men. In the training sessions he shows himself as an honest person who is willing to work hard and expose his feelings in order to learn. He has received personal counseling for many years and is currently in therapy with a woman Gestalt therapist. Marvin has participated in this functional therapy training group for more than a year. In addition to his regular work at the agency, he sees two or three private, low-fee clients.

Marvin lives with a roommate who is also in the mental health field. The roommate has a regular woman friend, but Marvin does not; he dates infrequently. Dating is an area of his life he would like to improve. His goal is to eventually develop a permanent relationship.

In one training exercise the trainee therapists were instructed to do nothing more than listen attentively and ask questions. The therapist's aim in this clarity exercise is to notice when the client role player is seeming to drift or gap or be somewhere else and to bring it to his awareness. In a clarity exercise the trainees are trying to develop awareness in themselves that they can eventually use to further their clients' awareness. This requires that they be alert to subtle differences in the dynamics of expression.

The trainer chose Marvin to demonstrate the exercise:

T.: How are you doing, Marvin?

M.: Oh, fine [laughs nervously],

T.: And what are you thinking about?

M. [laughs loudly—but clearly stiffens]: Oh no! I want to leave now.

[Trainees all laugh sympathetically.]

M.: I want out because I'm probably thinking something awful about myself.

[Gap]

T.: What do you think after that?

M.: I don't like myself. I think I'm bad.

[Gap]

T.: What's that?

M.: I feel lonely [rushing] I don't want to say it because I think it's bad to feel lonely.

[Gap]

T.: What's there?

M.: I'm confused.

T.: "Lonely." Is that a thought or the way you're experiencing your life? Put your hand out in front of you. One hand is the experience of being lonely. The other hand is the thinking judgment "I'm a bad person. It's bad to feel lonely."

[T. claps his own hands together harshly and loudly.]

Clap your hands like this, Marvin. Really hit that lonely hand with the other.

[Marvin claps his hand against the other.]

Again. Again.

[Marvin is tearful and very affected.]

T.: What if that hand was a child—someone you loved? What if instead of judging it and thinking it was bad you reached out to someone? Reach out to C. [other group member] with that lonely hand. [Marvin reaches to C. C. gently holds his hand.] What is that hand saying, Marvin?

M.: I'm lonely, [begins to cry] I feel so lonely, [crying]

T.: How does that hand feel now, Marvin?

M.: Good!

T.: How is C. treating that lonely hand?

M.: Good.

T.: How else?

M.: Softly . . . gently.

T.: That's right! It's not bad to feel lonely; it's just painful, particularly if we put an old meaning on that feeling. Right? When you're lonely and need contact with other people, your old reaction from your past is to move away and think badly of yourself.

Being responsive to that feeling moves you toward contact and people. Our feelings can guide, Marvin. If you touch a hot stove, you move away fast. Right?

M.: Right.

T.: Lonely is a guide too; only, sometimes when we grow up, we learn to move the wrong way and not trust our feelings or think they are bad. A lonely feeling is telling you what?

M.: I want to . . . I need to be with someone.

T.: Right. The feeling is mostly you, but, if an old thought comes in and says, "Lonely is bad," then you'll get stuck and keep feeling distant emotionally. What about a lonely client?

[Marvin claps loudly.] Are they bad?

M.: No. [laughing]

T.: What do they need?

[Marvin reaches his hand out. T. takes Marvin's hand, they laugh.]

T.: You could all see when we started what were the thought or thoughts that stopped Marvin and made him react in his usual way. But by sharing the thought out loud and then the judgment and then exaggerating the judgment by clapping, he became aware of how he was feeling. Then, in choosing another movement like reaching out to C., you could see how tentative and vulnerable he was. New movements are difficult, they make your clients feel vulnerable too.

You can also see how your own beliefs about loneliness or other feelings could easily influence your sensitivity to a client. If we aren't able to deal with something in our own emotional life, it is going to be a black hole in our awareness; we will react blindly in our sessions with our clients. I liked seeing that movement today, Marvin, and your courage in relating what you were thinking about yourself.

[Marvin receives group support and compliments.]

For Marvin, this was the beginning of an important phase of his training. He began to learn about the harsh judgments he had about his own feelings and about how they affect his responsiveness and movement. Later training sessions with Marvin will illustrate how his client's feelings and confusions could directly impinge on his therapeutic effectiveness. For now, let us consider another training exercise that introduces another trainee.

In a second training exercise, the trainee is Carole; she recently completed her M.A. degree in counseling psychology. Carole is an attractive woman in her early forties, who in her thirties had a very successful career in the fashion industry.

She is recently divorced. She is the child of two functional alcoholics and has been the sole caretaker at times of her extremely self-destructive mother. The second career in counseling is an exciting new addition to her life. She is very serious and dedicated in her approach to education. She has been involved in personal therapy for several years and works as a training therapist at an inpatient facility for chronic schizophrenics.

She tends to have a straightforward, do-the-direct-thing kind of working style. She is quite composed in appearance, but the composure sometimes masks an uptight, frightened person who wants to do right and do well and yet constantly expects ridicule or abuse. She is socially charming and skilled, but has some difficulties with personal contact and closeness.

These problems are illustrated in the following training session. In this group, four trainees were divided into pairs for a role play of expressive style.

The therapist role player is to identify the client's style of expression and then to show how it works both for and against the person. The intent here is for the trainee therapists to become skilled at identifying styles or

patterns shown by their clients. These patterns are typical modes of expression in a client's personality repertoire that might be functional in some settings or in the past, but may not be appropriate or functional in the present. Clients are shown how the styles operate automatically, and by bringing this to their attention an opportunity is created to choose a different way of responding and expressing oneself.

The training therapist instructs the trainee to:

1. Explain and instruct the client regarding style.

2. Identify for the client, in a positive way, the manner in which the style functions—ways that work for and against.

3. Then, working with the client, identify a new style or alternative means that could be chosen.

In this session Marvin worked with Carole. These transcripts are from C.'s training notes and personal therapy tapes.

> [M. listens to C. talking about a conversation with her close friend who is having a potluck dinner party. The friend says she didn't invite C., assuming that she wouldn't be interested.]
>
> C.: I just pretended that my feelings weren't hurt. I didn't say anything. I just let it go by as though I really wasn't interested. I don't know what part of me invites people to do that to me. Uh-oh!
>
> [M. and C. laugh as C. is aware of what she is saying.]

M.: How would you describe that style?

C.: Anything anybody wants to say to me is okay. Nothing anyone can say bothers me.

M.: Try giving it a label.

C.: How I feel about it and how I act or talk don't match . . . it could be a "That's OK" style. "I won't say anything."

M. [Explains and discusses with C. how that style developed in her childhood and how it was necessary and worked for her survival in that environment but isn't working effectively for her now.]: What would be a new style?

C.: I could say: "What did you say?" It would give them a second chance.

M.: What about giving you a chance?

C.: I realize I'm so automatic with that stuff. I don't want to say anything, do I? I want them to.

M.: What if you said how you felt to your friend? How did you feel?

C.: Hurt.

M.: And . . .

C.: Left out.

M.: What if I were your friend and you could change your style and. . .

C. [interrupts]: . . . If I said how I felt, I would start to cry and I always feel like shit after I cry.

M. [Stops. He's stuck. He looks around . . .]: I don't know what to say to her now.

T.: She just went back again to her old reaction. It stops her feelings. It's a stopper.

C.: If I got this sad, I couldn't talk!

T. [directing Marvin—standing behind him]: Tell her, "You are sad and you are still talking."

[M. follows through with direction.]

[starting to cry]: I wouldn't have the strength.

T.: Another stopper. [He directs M. to say, "You are talking and you are sad and you can see you have the strength."]

[M. follows through.]

T: Tell her to say it louder.

C. [loudly and feelingfully through tears]: I don't think I'm strong enough to talk and cry!!

T.: You see, Marvin, you can counter her old belief system, those stopper thoughts that shut off her feelings and support her old expressive style, by having her say the old thoughts with her new expressive style. Marvin, have her say strongly, "I can take care of my feelings!"

[M. instructs Carole in the new expressive style.]

C. [laughing and crying]: I can take care of my feelings—I can take care of my feelings.

M.: What could you tell your friend if you could take care of your feelings?

C.: My feelings got hurt. Don't leave me out I would like to come to . . .

T.: Can you see how that sort of expressive style—"I won't say anything"—is

strongly supported by her thoughts—"I'll feel like a shit if I cry" and "I'm not strong enough, I can't respond"?

C.: You know I see how I teach people to think that nothing they say bothers me . . . that I don't care. [Shaking head] I'm so powerful. It's so automatic.

T.: This little exercise is an important reference point for you to counter that old style and belief. [Turns to M.] What do you like doing the most today?

M.: I liked the role playing.

T.: How did you do?

M.: I think I did well.

T.: I can't hear you.

M. [louder]: I did really well!

[Rest of group applauds.]

T.: You want to keep reminding yourself, in order to remind your clients, to match the expression to the feelings. If you don't, the doubts creep in. To follow up this session with a client, write down on a poster, "I let it go by." These are C.'s own words. Write it down in your notes, then you can keep working this with the client. When they are letting things go by without responses, it will be the same old style with likely the same strong old beliefs and thoughts stopping them from being able to express and respond. This style session is very important for you and the client. See what you have learned about each other and yourself in this exercise.

M.: I can see where I would believe the "stopper" thought and then stop too.

T.: Yes.

C.: To let things go by that personally affect me and then feel bad about what

someone is doing to me is the story of my life. This is like the core of me.

T.: It isn't your core, it is a passive shell that leaves the sensitive, responsive, inside person to get hurt.

[C. cries.]

T.: What's that? I can't hear you.

C.: I feel sad.

T.: Strongly sad?

C.[laughing and crying]: Yes! Strongly sad.

T.: There's the core. You see, with this exercise, there can be a new reality. An awareness or perspective on what's possible to experience and express. You don't look like you feel like shit.

C.: No, I don't.

[Group laughs.]

Commentary

This brief transcription does convey how the trainer and the trainee worked with both a specific expression dynamic and a particular personality style. When the client expressed herself more loudly she was varying a dynamic of expression, much as an actress would to convey a different feeling. By varying the expressive dynamic the client could become more easily aware of the rigidity of her typical personality style and of the meanings connected

to her automatic way of reacting. Every defensive style of reacting exists within a narrow band of expression dynamics; by changing those dynamics the client goes beyond the band of reactivity to allow, first, awareness and, second, responsivity to emerge. The session also shows how rapidly dissociation or gapping can occur; fortunately, Carole, with Marvin's help, was just as rapidly guided to become aware of the dissociative reaction "I just pretended that my feelings weren't hurt" and then to develop a new way of responding from her feelings.

GETTING HELP

In this training group, Marvin begins the group by asking for some help with one of his clients. He describes the difficulties he is experiencing working with a young woman whom he describes as "depressed, negative, and continuously resistant."

He goes on to describe how she seems to thwart his every effort. Whenever he tries to involve her in any sort of experiential exercises, she responds with "I can't" or "It won't work." Marvin says she is so difficult for him that he just feels like giving up.

T.: How does she look when she's sitting in front of you, Marvin?

M.: She looks . . .

T.: No, you be her—just sit and hold your body like her.

M.: Well, she . . .

T.: Say "I."

M.: I'm all slumped over and I'm looking down and I'm sighing and I don't really look at you.

T.: What is it like?

M.: I'm just all bound up here. I'm not going to move or talk.

T.: Okay. Let's change places. Now you're the therapist and I'm your client. Now how are you sitting?

M.: I'm leaning back and my head is down and I'm . . . my hands are behind my head.

T.: Okay. Now lean back a little more—head down more, just exaggerate it a bit.

M.: Okay.

T.: All right, is this how you get?

M.: Yes—this is it.

T.: Now who do you remind yourself of right now—what's your experience?

M.: I'm just like she is! I have just the same energy and dead hopeless feeling.

T.: So who's teaching whom?

M.: She is—

T.: Right, Marvin, she's training you to be like her. [Explains to the entire group.]

It's important to be aware of how powerful your clients' personalities are. She may sound sad, depressed, nonfunctional in many ways—which she is—but she is strongly that way. She is creating her reality in the room and within Marvin. What are you starting to think about with her Marvin?

M.: I can't do anything.

T.: And what is it she's always saying?

M.: "I can't do anything." Oh no!

T.: "Oh no!" is right. She's the Zen Master of "I can't" and she's converting you. The longer you sit there that way, the stronger she'll seem to you. Instead of trying so hard and so hopelessly to try to get her to do what she can't, why don't you try to show her how strong she is at this. Get up and just walk around in here and describe out loud what she is good at.

M. [standing up and moving around]: I can see you're good at being depressed.

T.: How good, Marvin?

M.: Really good—I mean great.

T.: Good enough to get you depressed.

M. [louder now]: Yes! Good enough to make me depressed. You're great at being depressed.

T.: What else?

M.: You're invincible at being resistant and saying you can't do anything. You're amazing. You've convinced me I can't do anything.

T.: Louder!

M.: I can't do anything!

T.: All right. Now that you're moving around, you seem much clearer about everything. It's important for you to maintain some movement—actual physical movement, Marvin. Otherwise you begin to stop and get depressed yourself in the sessions with her. Does "I can't do anything" remind you of something and someone?

M.: Yes, my father and his drinking.

T.: Good clarity, so it's important to be able to move—now what if you could show your client how good she is—how strong this "I can't and won't" style of personality functioning really is. On the board, you could show her the strength of that way of functioning and then the little and big ways that it is working against her. Then, when you next encounter that form of resistance with her, you can point out to her how she's "doing it again." She's the best. She's showing her strength whenever she's saying, "I can't." The key to this, though, is you. If she can convince you that she can't, then she is essentially teaching you rather than you helping her. All right?

Commentary

This was a critical session for Marvin's training. It was a dramatic illustration for him of the powerful influence of a client's personality. For Marvin, the quiet, passive acceptance of his client's reality could be counteracted by maintaining a vigorous, active, playful interactive mode that accepted the client's strength rather than trying to take it away, while maintaining his own independent activity level. In follow-up, Marvin reported that the training allowed both himself and his client to view "can't" and "won't" from a new perspective and enabled his client to move toward a wider range of more effective functioning and living. Just as it is important for clients to actively bring therapeutic movement from their sessions to

movement in their lives, so is it crucial that therapists in training bring the movement they make in the training sessions to their work with clients. By actually getting up out of the chair, physically moving, and vigorously engaging the client, Marvin was able to avoid the nonresponsive pattern that contributed to his believing that the client was hopeless.

This session is a good illustration of functional therapy's insistence that the therapist examine his or her own personality functioning within the session. In this training instance, Marvin was capable of matching his own expression, activity, and clarity level to those of the client. The feeling experience in his session with the client was close to his own family experiences with his alcoholic father. By consciously using movement, Marvin can maintain his own present reality and function effectively in his work with this client.

This is further illustrated with Marvin in another training group session with another of his clients with whom he had similar difficulties.

A FOLLOW-UP TRAINING GROUP

Marvin begins by saying that he feels like he "missed something" in his last session with V. She had entered in a low mood, saying that she had again begun seeing a man she had "swore off" some time ago. She said she was "confused" and wondered whether Marvin felt that "it was OK" that she take

up with a man who was physically and emotionally abusive with her. Marvin suggested doing a sentence completion exercise to help her with her "confusion." She was apathetic and resistant during the exercise and then after the exercise. Marvin remarked, "Her affect kept going down and down and . . . I went down with her."

T.: Could someone role-play his client?

C.: I'll do it.

T.: Okay. Now Marvin, just go ahead and listen to her describe going back to this abusive guy and how confused she is and then go ahead with the sentence completion exercise—and Carole, just kind of go along but be depressed and sort of blaming and then criticize what Marvin is doing.

[C. & M. role-play.]

T.: Okay. Freeze! Marvin, don't move! All right, group, where is he?

C.: He's depressed.

D.: He's slumped down and she's abusing him.

T.: Right—you're right. Marvin, you were missing something last session—you! You were missing. Let's send out an APB missing person report and get back! She's a victim and now you're the victim.

M.: I've seen this position before. [laughing cynically]

T.: You sure have—physically and psychologically. So what do you need to do?

M.: Get up and move.

T.: Good start. Try this. Let's get your own clarity back—talk as if you could say anything you want to your client. Do the role-play but you talk—say what you see—that is what clarity is about.

[M. begins talking.]

T.: Loudly, Marvin, very dramatic. There's no victim here. Act like everything you say is THE TRUTH—be a television preacher.

M.: You want me to tell you what to do.

I even louder I You want me to say it's OK to do what you feel bad about. You want me to be responsible. I won't do it! I won't be responsible! You don't want to be clear about this. You don't want to be responsible. You want to stay confused and be a victim and have it be someone's fault!

[T. and group clapping and cheering.]

T.: All right. Marvin is clear, if I draw a bulls-eye and a big target on the board [draws target] where are you hitting?

M.: In the middle—right on.

T.: Right. Where were you before?

M.: Way off target.

T.: Why?

M.: I wasn't saying what I could see and sense.

T.: And then what happens?

M.: I'm a victim. I get confused and depressed.

T.: Okay, all. I want you to get up and shoot bulls-eyes while you work. Go for

clarity. Say what you see. Your homework is, at least two times every session, hit the center of the target—that's clear awareness.

Commentary

This group showed Marvin falling back into the personality patterns of expression, activity, feeling, and clarity that had caused him problems. As with clients, the problem process stays constant; it just has different content at different times. This particular episode was helpful in showing Marvin the importance of expressing what he sees and knows with his clients. If he shuts up and isn't direct, he becomes confused.

This session also shows the positive aspects of breaking old roles or images. When given "permission" to say or talk to the client any way he wanted to (rather than from the image of the quiet, compassionate, empathic counselor), he was also capable of a much clearer understanding of the client as well as the restrictions of the role he had adopted. Even experienced therapists are often surprised at the role they have allowed themselves to assume with a client and experience real difficulties altering dysfunctional roles. The functional approach emphasizes the advantages of consistently being responsive rather than attached to a reactive role, even a positive one such as guide, teacher, coach, counselor, or therapist.

Each session includes a follow-up for the trainee therapists to take to

their work. Change requires practice in order to become a part of a trainee therapist's repertoire. By giving Marvin a homework exercise to be clear and confrontative in his sessions with clients and by attaching that new role image to the imagery of shooting bulls-eyes, the trainer is trying to give Marvin something he will be able to hold in consciousness and use. That will be essential if Marvin is to integrate this side of himself into his work. The practice of doing it under pressure in the training group will enable him to have the confidence to try it on his own. Having to exaggerate it beyond the extremes of nearly any real session will affect the feeling "If I can do that, I can do anything." The role-playing tasks are supported by the group and the trainer but are still very difficult. They need to be difficult to put a demand on the trainee's personality so that there is an "exercising" of the personality. As a consequence of this sort of exercising, the trainees can develop awareness of the strengths and weaknesses of their own personalities in action. Only the action or expressive mode provides a chance to choose responsivity over reactivity, which, of course, is the same choice that the trainees as therapists will offer their clients.

ANOTHER TRAINING EXAMPLE

Donald is 50 years old and recently remarried. He has completed his M.A. degree and an internship and presently is working part-time in a counseling agency to earn hours toward licensure. Counseling is a second

career for him; he has a Ph.D. and is a tenured professor at a major university. Although he had a successful academic career, Donald has always been interested in psychotherapy and prefers to make therapy his career focus now.

He grew up in a middle-class home where he had a rather "cool and distant" relationship with his parents. He was a good student. Although he has a very pleasant and likable personality, he feels that his childhood affected his ability to fully experience his feelings. He has been personally involved in psychotherapy as a client throughout much of his life with an emphasis on abreactive modalities. He is an active and willing participant in the training group.

In this example he is shown asking for some help with his work with a client named Robert. He describes Robert as a withdrawn individual who has low motivation, few skills, and no friends, whose only strong interest is in plants. He lives alone in a small guest house. Donald feels that his client is not being responsible in his work or seriously committed to change in the therapy. He can't involve him in looking at alternatives to his behavior and is concerned that perhaps he is "too difficult." Donald states that he has been trying to understand his client but feels that Robert "blocks out" any form of intervention.

T.: Okay. We need a volunteer to role-play.

M.: Okay.

T.: All right, Marvin, Donald will work with you and you just block him out and withdraw.

M.: No problem [laughing],

D.: I'd like to follow up on last week's session with you.

M.: Um.

D.: I've suggested you look into taking that class—look over here at me.

M.: Oh, okay.

D.: Let me show you something. Let me show you how you are acting in here. First of all, you aren't looking—remember our talk about contact and the importance of eye contact with people?

M.: Uh . . . yeah, I think so.

T.: Okay, okay, enough—you're too good at this, M. All right D., what's going on?

D.: I just can't get through this. He just doesn't seem interested enough.

T.: Are you?

D.: What?

T.: Interested.

D.: In what?

T.: Him. You seem involved in what you are trying to teach him. But are you interested in him?

M.: I feel like he just wanted to show me something.

D.: I guess that's what I'm doing. He's so frustrating.

T.: Switch places with Marvin. Marvin, you communicate like Donald but not out loud. Nonverbally convey the posture and gestures. Donald, you just slouch down like your client and watch.

[M. goes through nonverbal imitation of D.]

T.: All right, very good. What's that like, Donald?

D.: I'm just talking down to him. I'm trying to teach him something I know and he doesn't.

T.: How was it being your client?

D.: I felt unimportant.

T.: And how much contact do you experience coming from the therapist?

D.: I don't feel he's interested in me.

T.: Come sit over here next to your client.

[D. sits next to Marvin.]

T.: All right, put yourself in his world. Put yourself in his place. See the world his way. What is it like?

D.: Well, my world is . . . lonely. No one notices me . . . even my therapist doesn't notice me.

[Begins to be sad. Speaks tearfully.]

T.: What do you care about?

D.: What?

T.: What do you care about the most? What are you most interested in?

D.: Plants.

T.: Plants. Now Donald as the therapist. What are you interested in?

D.: Plants.

T.: Right—why?

D.: Because he's interested in plants.

T.: What else?

D.: Because that's something he really cares about—it's him. It's a way to make contact with him.

T.: For who?

D.: For me to make contact with him—to show him I care.

Commentary

This example was included because it makes a basic point very clearly —therapists must not over-focus on techniques. Even effective techniques will not work when they are used without close contact between the therapist and the client. Sometimes caring but inexperienced co-counselors or paraprofessionals are more effective than experienced but overtaxed

professionals. It is desirable for therapists of all levels of experience to be reminded that human caring is a necessary condition for therapeutic change. Donald was able to take what he learned from this training session into his next meeting with Robert and relate to him personally and caringly rather than just as a teacher-technician.

TRAINEES' IMPRESSIONS

The following comments were supplied by the trainees in response to an invitation to answer these questions: How would you evaluate your training group experiences? What parts of the training were especially valuable for you? And what are your criticisms of the training?

Marvin's Comments

My reasons for being in the group are: I'd like to continue to improve my skills as a therapist. I like the trainer's approach and orientation. I'd like to learn as much about the functional approach as possible. Also, I feel comfortable with the group, and that is important to me.

The group is very supportive. Definitely has "home court" feeling. The trainer gives suggestions and works with us in very noncritical or maybe I should say "non-hostile" manner, very supportive and encouraging yet also direct in talking about our dynamics. Another positive strength is the

information about functional theory and different techniques or viewpoints offered by me or others. A weakness is I haven't heard much about working with couples or families mostly because I haven't had that many couples and families as clients. I would like to focus on the functional approach with couples and families in the future.

Through my almost two years in the training group I've definitely developed an awareness of my movement/activity with clients in sessions and especially in groups. At times I forget, yet I'm definitely more aware of my posture and of the need for changing it when stuck or tired. Also, I've gained confidence in expressing myself and my thoughts/opinions to clients. In addition, I've grown confident in myself with groups. I feel stronger and I'm more aware of using my body activity to be more effective in the group.

One of the main sessions that has affected me was my very first session, which focused on me standing up from my chair and moving. I still remember and use this to help myself adopt a different role or posture when I get stopped by the client's behavior or problem. Another critical session was one where I was working on getting angry with T.J. and realizing that, beneath this, I do care about my clients and can express that or get in touch with that.

Carole's Comments

My overall impression of the training group is that sharing the

experiences of being a therapist with other therapists is critical to developing into a first-rate counselor. Realizing my own issues and learning to recognize my own instinctual material—how I'm feeling as I listen to a client—are paramount in the therapeutic setting. To switch over from worrying about how I'm feeling, i.e., negative, and letting that feeling overwhelm me, to instead realize that what I am feeling as a reaction to the client is valid. When I recognize these feelings as valid, I therefore realize that this is the way most people would react to the client. This is best described as seeing and feeling the client's PROCESS versus content analysis.

This gift we have of feelings, intuition, or instincts is the part of the therapist that needs fine tuning. In training this was demonstrated endlessly; each and every time I sat amazed at how WE need to continually retune and become re-aware of this V.I.P. aspect. The group also enabled me to move from the spot of wanting to be right (perfect), never making mistakes, to feeling more open, more able to share, and thus able to HEAR non-defensively.

For example, I walked away feeling that not only is it OKAY to need help and training, but, in fact, that simply by attending this group I was demonstrating my eagerness and forthrightness in wanting (desiring) to become an excellent therapist versus just an average one.

Personally, when taking this training group when I did, during a developmentally heightened period in my personal growth, I was still under the impression that therapy was MAGIC. By this I mean I had still not fully arrived at total adult awareness. (A secret plot was underway to get me well, but OTHERS were knowledgeable about the system.) Not till I started my own career as a therapist was I able to leave the cocoon of mystery and realize that NO MAGIC existed, that in fact the magic questions disappeared when I welcomed myself to the land of REALITY. At this point many of my defenses faded, and as an adult living in reality land, I am now able to feel and know what is happening in a therapeutic exchange.

I feel that a good therapist should always have either a group or a class like this throughout his or her career to BOUNCE OFF OF OR TO HELP STAY ON TRACK OR TO HELP JUDGE their own CENTEREDNESS with people or a person trusted to KNOW enough about his or her system, so old stuff, etc., is picked up easily by that person. HEY CAROLE, HERE'S THAT BLOCK. DO YOU HEAR OR FEEL IT? "I SEE IT."

Here's a quote from my supervisor's letter of recommendation: "Carole has always been very willing to share herself in supervision and understands the importance of self-examination for a therapist." There's no question in my mind that the training gave me the example, role model, and understanding of this process.

Donald's Comments

When I first joined the group, the members were working on "activity," one of the five dynamics. I discovered my typical "activity" style is "driven." Somewhere inside I knew that about myself, but identifying it in this way in the group felt like a revelation nonetheless. I had all sorts of thoughts I carried around constantly, that I called into play whenever I might have relaxed to enjoy the moment.

This characteristic style of mine was consistent with styles I was able to identify in the other dynamics: for example, my "clarity" style is to stay "one step ahead" of everyone as much as I can, and my "contact" style is to be a "fortress" around others.

In the training group I chose new styles to develop as alternatives to my old characteristics. My favorite was a new "contact" style of "lean forward." By consciously identifying these, I was able to practice, model, even exaggerate a new style like "lean forward" enough to create the experience of a "lean-forward" approach in my ordinary life, and in my counseling work. "Lean forward" had definite spillover effects in other areas of my life and in other personality styles, such as my "activity" and "expression" and "contact."

One specific episode that affected me more than any other was a lesson I learned during the time the group was working on "contact" as a personality

dynamic or style. I presented a difficult case that I was dealing with in my counseling, of a client who was extremely bright and extremely scattered. This client liked to cross back and forth over the line of what seemed to me to be reality, and I was experiencing considerable frustration making and staying in contact with him. While I was working on my lean-forward style, the trainer also helped me give up my effort to stay "one step ahead" of him, and just be with him, and, in effect, allow him to lead me. In subsequent experiences with this client, I was able to put this into practice, with the result that the client and I developed an entirely new connection and personal bond. This alone proved more helpful to this client than all my prior efforts with him.

CONCLUDING COMMENTS

It should be apparent by now that functional therapy is more closely aligned with the humanistic-existential mode of therapy than with the psychoanalytic-behavioral mode; there is more concern with existential issues than with clinical issues and more emphasis on understanding and contact than with diagnosis and treatment. Because the field of psychotherapy has become so dominated by the medical model (because of pressures from insurance companies, pressures from licensing and certification boards, and the rivalries between various competing professional groups), the existential approach is of lesser influence now than

it was in previous decades. However, hegemony is not proof and influence is not truth. It remains to be seen whether people are most helped with problems of living and personality conflicts by regimens of treatment or by the same kinds of human effort that are required in art, education, politics, and religion. Here is a test: If a therapist truly believes that ideas such as "love," "faith," "hope," "courage," "will," and "destiny" are useless and irrelevant in the practice of therapy, then that therapist is a candidate for the "doctor-patient" orientation; therapists who believe that these are real and necessary ideas, rather than mere words, will be inclined toward the "counselor-client" orientation.

Let's expand this argument with a few commonplace observations and several speculations.

First, it is important for therapists to keep in mind that there are many more people who do not suffer from psychopathological disorders than there are who do. Even when the big-number psychopathologies are considered, such as schizophrenia and depression (which may turn out to be chemical disorders best treated within the medical framework), in general, most people in the population are not clinically disturbed.

Second, people can suffer from depressive feelings, confusion, anxiety, conflict, frustration, indecision, stress, and other problems of living without

being clinically abnormal.

Third, people can benefit from help, but "getting help" and "getting treatment" are very different activities. The state of mind of a patient and the state of mind of a client are necessarily different (at least within traditional, rather than holistic, medicine). The authentic help that a counselor or psychotherapist can offer is much more like what is offered by a priest, a friend, or (sometimes) a teacher than it is like the treatment given by a medical doctor. To change a person's personality, beliefs, feelings, attitudes, and actions so that he or she can more effectively and more fully live is not the same as setting bones, doing appendectomies, or prescribing pills.

Personal change requires a change in awareness, understanding, and responsibility—it cannot be done to the person. Vital change can only be brought about with the person and by the person—it is a process of discovery and growth, not a treatment process.

We speculate that the current ensnarement of therapists in the false medical model will lead to two possible outcomes (which, perhaps, have already come about). One, the field of therapy will be divided into clinical practitioners, who follow the medical model of diagnosis-treatment plan-prognosis-treatment evaluation, and nonmedical counselors, who follow the humanistic model. Or, two, psychotherapy and counseling will be more

definitely separated, with psychotherapists modeling physicians and counselors taking a nonclinical approach. Of course, real life is more complicated than these logical divisions—in some states counselors are already pushing for licensure so that they will be able to receive insurance reimbursements in the same ways that physicians and psychologists (who are generally licensed under state medical boards!) are reimbursed. Counselors who move in the direction of licensure will inevitably be pressured to conform to the medical model, just as psychologists have. From an insurance company's point of view, unrealistic specificity, which can be entered neatly onto forms, is better than realistic open-endedness. Human problems, existential issues, personal conflicts, and self-development are very difficult to fit into reimbursement schedules.

We further speculate that genuine eclecticism in the field of therapy will not emerge until the dominant medical model is supplanted. It would require that therapists be born in the nether regions of the Amazon or New Guinea jungles to avoid some degree of eclecticism in their practices today. There have been too many contributors to therapy's store of ideas and methods in the last one hundred years of Western culture for any contemporary therapist to be anything but eclectic. But there are broad schools of thought that are almost fundamentally incompatible, such as the medical-clinical versus the humanistic-existential. William James sought to maintain the dialectical tensions between "tough-minded" and "tender-minded" evaluations, between

philosophy and religion, and between science and art. That is the kind of effort that is required for true eclecticism; it is an eclectic attitude of mind incompatible with medicalism.

In a recent, significant social-psychological study of American life by Professor Robert Bellah and his colleagues (1985), the place of therapy in our culture was recognized as serving an important, widely accepted function parallel to that of the manager: "The therapist, like the manager, takes the ends as they are given; the focus is upon the effectiveness of the means" (p. 47) and "Compared to the practices members of a traditional family, church, or town share over a lifetime, the therapeutic relationship leaves us with relatively little to do together except communicate, and much less time in which to do it. In this, the therapeutic relationship resembles many other relationships in our complex functionally differentiated society, particularly in professional and managerial life" (p. 123).

The problem with this circumscribed kind of relationship, which is based on a doctor-patient or manager-employee model, is that it provides for no other moral standard than that of utilitarian individualism or expressive individualism: "The question is whether an individualism in which the self has become the main form of reality can really be sustained. What is at issue is not simply whether self-contained individuals might withdraw from the public sphere to pursue purely private ends, but whether such individuals are

capable of sustaining either a public *or* a private life" (p. 143).

To put some of these questions of the profession's identity into perspective, we will quote from the comments of another of our trainee therapists, Jason:

> In my lifetime, which is now nearly 50 years, I have only needed the services of a physician or hospital a few times and each time those services were performed quickly and skillfully. I count four times in all: once when I was sick with pneumonia at age two, once when I had a bad cut at age ten, once when I was 35 and broke my arm, and more recently when I was about 47 for allergy treatments. I don't count my birth because I believe the doctor was there more for my mother than for me—I could have been born without his help but I definitely needed hers. At this rate, if I live another 20 years, maybe I'll need a physician another dozen times at most, even if I accelerate the number of visits due to the accumulated wear and tear on my body machinery. (I'm not counting dying since, as with my birth, I think I can probably do it better without a doctor's assistance.)

Now compare the number of doctor's visits, about 16, to the number of times I expect to need counseling help from a therapist or friend. I would estimate that I've had at least 20 sessions a year, on average, since I was 20 years old. That is 30 times 20, or 600 sessions. If I live another 20 years and need counseling help at the same rate, that will amount to 600 plus 400, or 1,000 total sessions in my lifetime. Look at the comparisons: 1,000 therapy sessions to 16 physician's treatments, or a ratio of better than 60 to 1. I suppose that someone could say that the medical visits should be weighted more heavily because, in some instances, they were dealing with life-

threatening and painful illnesses. However, some of the counseling sessions were lifesavers too, and all of them helped me improve the quality of my life. From that standpoint the counseling sessions may have contributed as much to my physical health as did the medical treatments; it is well known that quality of life contributes to longevity.

I find it ludicrous to apply the medical model to evaluate counseling. Even from the standpoint of the raw numbers, there is no viable comparison —the number and kinds of counseling help that I needed far exceeded the number of doctor's visits that I needed. It doesn't make sense to evaluate them with the same yardstick. Both medical treatment and counseling are personally important to me, I want access to both kinds of help. But they are such different kinds of life events that it is not even close to say that we should not compare "apples and oranges"—it's more like "fruit and aspirins" or "words and medicines." The words-medicines equation is a seductive form of psychobabble that misleads both therapists and clients.

Functional therapy is a philosophical-psychological orientation to helping people, not a medical-managerial orientation. This emphasis has been true from the beginning of the functional approach in the works of William James. The scholar Professor Eugene Taylor makes the point that

James' theory "implies a therapeutic method allied as much with

therapy and religion as with experimental medicine and psychology: one based ultimately on understanding of the patient's problem followed by self-help, rather than on professional diagnosis by classification followed by impersonal treatment" (Taylor, 1982, p. 12). In the 1901-1902 Gifford Lectures, which formed the notes for his book *The Varieties of Religious Experience,* James stressed the need for a tolerant attitude toward the boundaries of consciousness and human nature. In *Varieties* he sought to explore . . the true record of great-souled persons wrestling with the crises of their fate . . ." (James, 1958, p. 23). He concludes the book with this famous passage: "The whole drift of my education goes to persuade me that the world of our present consciousness is only one out of many worlds that exist, and that those other worlds must contain a meaning for our life also . . ." *(ibid.,* p. 391).

The wider questions of therapy, for the functional therapist, are: How open can people be? What are the varieties of consciousness? What are the consequences of more openness, more consciousness, and more responsivity? What are the personal and social consequences of failing to achieve more openness? To what extent can reactivity be replaced by responsivity? These are questions that require a very broad model both for the professional helper and for the client who comes for help in the discovery of personal answers to essential questions; that is what we try to convey to both our trainees and our clients.

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Commentary: Present-Centeredness and the Client-Therapist Relationship

Hugh C. H. Koch

A "responsive personality" is one, according to Hart and Hart, that functions with a high level of awareness and responsivity, as opposed to operating with little awareness, i.e., a more reactive approach. One of the most direct means of access to this "responsivity" is by training and shaping up the inner attending process called "focusing," a central technique in Functional Therapy (Gendlin, 1981). As the authors suggest, to be able to use this technique therapist trainees themselves have to develop this awareness so that they can eventually use it to further their clients awareness. This self-awareness on the part of the therapist involves examining his/her own personality functioning within, as well as outside, the therapeutic session.

Currently, most therapeutic schools are developing awareness of basic personal and interpersonal "nonspecific" factors, which may well account for much of the so-called "success" that therapists and clients achieve together. The mere fact of establishing a relationship based on listening and sharing is fundamental. Encouraging a structure or "container" for personal or emotional problem solving via regular meetings or regular session formats can itself be

very reassuring and facilitative. In addition to these fundamental factors, of which there are several more documented (Meyer & Chuser, 1970), this idea of focusing presented in Hart and Hart's chapter is also well known to the psychoanalyst, the cognitive-behaviorist, and the humanist-existentialist. However, I feel it is the interpersonally oriented therapist who perhaps can offer an additional slant on this focusing process when he/she confronts the reality which each client sets up in the therapy room with the therapist. This reality may be partly what Ryle (1975) calls "metaphorical," i.e., an "as if" relationship based on fantasy, desire, or transferential feelings, or it may well be a very personal and real, in the proper sense of the word, relationship based on an adaptive or maladaptive interaction between two people, the client and the therapist.

When listening carefully to clients, the therapist picks up feelings within himself toward his clients—feelings of intimacy, attraction, antipathy, coolness. He notices that he feels "impelled," or, as Kiesler (1982) puts it, "pulled," to respond in a certain way to the client. In one situation, he wants to solve the problem and give advice. In another, he wants to hold back and wait for the client to react. These inner engagements on the part of the therapist are elicited at the beginning by the client's nonverbal and verbal behavior. To be fully aware of the client-therapist relationship and then to be able to confront the meaning and behavior occurring in it, which I feel is one of the most powerful therapeutic techniques, these "impact messages" or "countertransference"

feelings must be identified and focused upon. These impact messages, as Kiesler (1982) calls them, refer to all internal events a therapist experiences and all the overt behaviors he shows in his session with a client where the client-therapist relationship is the focus. They include direct feelings (e.g., angry, bored, cautious), action tendencies (e.g., I must give advice here; I must be careful with him), cognitive attributions (e.g., the client wants me to do the work; I'm going too fast for him; she wants to be in control), and, last, fantasies (e.g., I wonder what a sexual relationship with him would be like; I'd like a good row with her).

Impact messages are multidimensional—they include a complex mixture of positive and negative feelings. They are important to share with the client because not only will these messages be elicited by the client's distinctive interpersonal style in therapy but they may well occur when he/she repetitively engages other significant persons in his/her life. Unless confronted and understood, those transactions which are "disordered" or "dysfunctional" continue to cause havoc in the client's (as in all our own) relationships.

There is insufficient space here to elaborate on how the therapist confronts relationship issues with clients. For this the reader is referred to Kiesler's (1982) excellent text Handbook of Interpersonal Psychotherapy. However, I would like to briefly describe a more precise scheme for understanding the variety of "meaning frames" that represent the dyadic options the therapist has in responding to the explicit or implicit meanings of

clients' statements.

Any client statement or behavior has relationship, as well as content, meanings, which can be divided into a client-client component (how the client sees himself, expresses feelings about and evaluates himself) and a client-therapist component (feelings and thoughts the client has toward the therapist). Both relationship aspects are communicated not only by the statements the client makes, but also by the nonverbal behavior accompanying the words.

As a recipient or participant in the dyad, the therapist can be aware of two corresponding aspects of relationship messages, the therapist-client meaning and therapist-therapist meaning. Therefore, following any comment or action by the client in a session, the therapist has four options:

1. *To respond to the explicit content of what the client has said*
2. *To respond to one of the four relationship aspects (CC, CT, TC, TT) just outlined*
3. *To change the subject*
4. *Not to say anything*

Which option is taken depends on the therapist's personal judgment as to which would help the client most at that particular time. It will also depend on

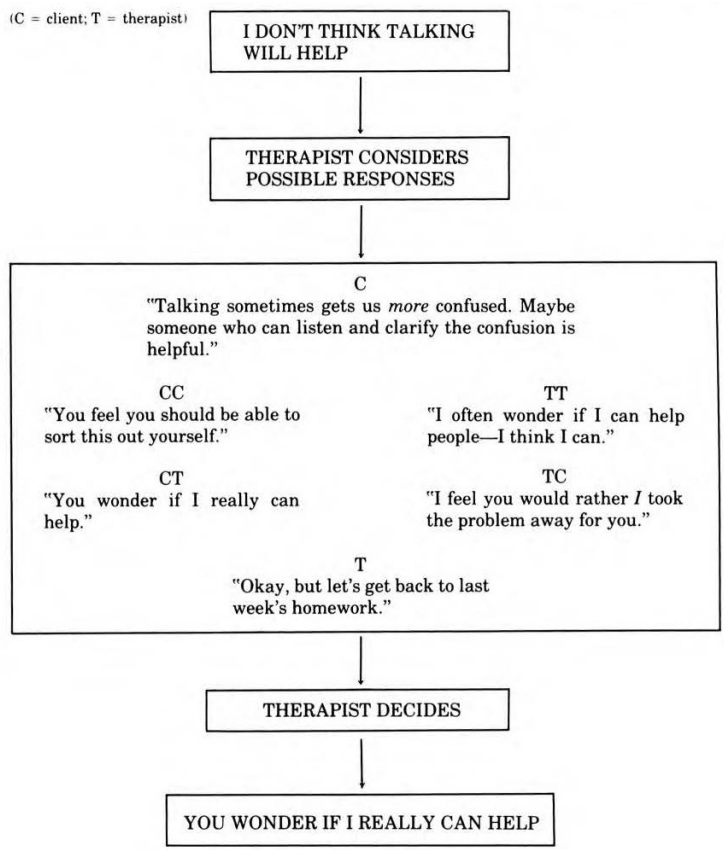
what has gone before and on the therapist's own model of what is useful in therapy.

Figure 1 shows how a client's statement 'T don't think talking will help" can be focused upon by the therapist listening to the variety of internal messages or impact messages he receives from the statement.

It should be clear from this that the therapist is very much a participant in the client's interpersonal world and that both a real and metaphorical relationship is established in therapy. The client inevitably has feelings and thoughts about the therapist. It is essential and very useful to conceptualize what these impact messages are and how they can be acknowledged and clarified. According to Gendlin (1981), "Without detailed vocabulary about what we do inwardly, we cannot talk to each other or train new therapists" (p. 375) and "if the patient does so and so, I find it helpful to do so and so" (p. 375). Kiesler has offered, via this interpersonal model, a clear and most useful elaboration of how to focus carefully and productively on the client's behavior as it relates to one of the most important aspects of therapy—the client-therapist relationship.

Hart and Hart have provided a service by illustrating these themes in their training program.

Figure 1: An example of relationship meanings in psychotherapy.



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Commentary:
Therapist, Heal Thyself First

Malcolm H. Robertson

Drs. Hart and Hart conduct a psychotherapy training program that is: (1) experiential (learning by doing); (2) based on the theory of functional therapy; (3) eclectic (encompassing theoretically diverse interventions); and (4) philosophically committed to developing a therapeutic personality through ongoing training and therapy.

My understanding of the authors' approach is that a therapist's self-awareness and self-change, in response to a client's interpersonal style, is a necessary condition for client change. In relating to a therapist, a client frequently replicates interpersonal problems that characterize significant relationships outside therapy. Instead of being controlled by what a client is or is not doing in the relationship, a therapist responds as if a client were capable of a more spontaneous and self-disclosing interaction. This strategy is consistent with a familiar principle of interpersonal problem solving, i.e., to change another person, change oneself first and in the direction one wishes the relationship to be. Therefore, the task of a therapist is to show rather than to

tell a client, to respond actively rather than passively to a client's behavior.

A slightly different conceptualization is that a therapist responds to a client's behavior with recipathy, a term coined by Murray (1938). Recipathy is a therapist's self-awareness and self-disclosure of what is called forth or evoked by the client's behavior in the session. The therapist uses his or her own personal reactions to encourage a client to experiment with a different style of relating both within and outside therapy.

Although the authors state that trainees learn to do therapy by taking turns as therapist and as client, the main thrust of the chapter is personal growth gained in a client role. Trainees learn how to change clients by first learning as clients how to change their own behavior. As clients, trainees are taught how to increase self-awareness and how to use the increased self-awareness to relate more effectively as therapists. The learning experience is directed by a therapist/trainer who explains, demonstrates, and models how new awareness's, if transformed into action, may result in therapeutic change. Once trainees have discovered how to modify personality dynamics that block critical awareness of self and others, and to express the new awareness in thought, feelings, and actions, they are ready to assume a therapist role in which they learn and practice specific therapy techniques.

I agree with the authors' training philosophy because of my conception of

therapy as an educational process, and because of my belief that therapists teach clients more effectively and convincingly when they teach from experiential knowledge rather than from conceptual knowledge. In comparing their training program to the one I conduct at Western Michigan University, I place more emphasis on specific skill training in the therapist role and less emphasis on personal growth acquired in the client role. On the other hand, the close attention that the authors give to a trainee's personal growth, especially the experience of being in therapy as a client, has strong support in the literature on eclectic psychotherapy training (cited in Robertson, 1986).

Hart and Hart draw an interesting parallel between the fitness and skill training of therapists and that of artists and athletes. I am reminded of Strupp's (1978) comment that "a fine therapist closely resembles a painter, novelist, or composer" (p. 317). Like an accomplished artist or athlete, an accomplished therapist must maintain fitness, i.e., a high degree of psychological responsiveness and expressiveness, and must hone his or her technical skills by continued performance, as well as by arranging for periodic coaching and consultation. Although likening a therapist to a performing artist or athlete might be opposed in some circles, the commitment to upgrade or at least maintain clinical skills through continuing professional education has become an integral part of professional life.

ADDITIONAL COMMENTS

I would describe the authors' psychotherapy approach as an example of technical eclecticism. That is, client problems and goals, and the therapist-client relationship, are conceptualized within a single theoretical orientation (existential-humanistic), although specific techniques may be selected from other theories on the basis of perceived relevance to client problems and potency for implementing therapy goals. There is at least an implicit acknowledgment of the efficacy of tailoring interventions to clients' personality styles and problems. In addition to empathy, relational immediacy, Gestalt awareness tasks, and therapist self-disclosure, which I subsume under an existential-humanistic orientation, other interventions, such as contracting, cognitive restructuring, role playing, and psychodynamically based interpretation, may be used at a therapist's discretion.

To support their conclusion that the training program translates into improved therapist performance with clients, the authors cite a number of positive evaluations given by trainees. However, the reader is not presented with direct evidence of transfer and generalization of learning from the training role to the therapist role, a limitation that this program shares with so many others that fail to establish competency-based criteria. The authors would strengthen their conclusion if they provided excerpts of therapy sessions that demonstrate changes which the therapist trainees have made as a result of the training sessions. Another omission is how the authors' program prepares trainees to do eclectic group, marital, and family therapy'

In contrast to traditional psychotherapy training, the authors do deal directly and decisively with the trainees' personality dynamics and blind spots. On the other hand, at least in the chapter, development of relationship skills and intervention strategies is not given as much emphasis as I believe it deserves and receives in the literature on eclectic training (Robertson, 1986).

Relatedly, diagnostic competence seems to be downplayed, partly in the authors' assertion that most clients are not clinically disturbed and do not suffer from major psychological disorders. The fact that a large majority of clients are not clinically disturbed is useful base rate data. However, a therapist's clinical decision about the presence or absence of psychopathology in a particular client still requires diagnostic acuity.

To conclude, I commend Hart and Hart for training psychotherapists by means of personal and professional growth experiences rather than by formal didactic presentations, for their commitment to developing a therapist's personhood, and finally for their concrete illustrations of how to assist trainees to overcome personality dynamics and developmental experiences that limit therapeutic effectiveness.

For some psychotherapy trainers the chapter will reinforce their commitment to experiential eclectic training, and hopefully it will encourage others to follow suit.

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