THE TECHNIQUE OF PSYCHOTHERAPY

MISCELLANEOUS THERAPIES

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Miscellaneous Therapies

Throughout the world a brotherhood of distraught people in search of peace of mind constantly exploit miscellaneous therapies held out to them as recipes for mental health. Feeding this ever-increasing quest is a supermarket of psychotherapeutic methods that are designed to suit the most diverse tastes. Some of these are carefully thought-out interventions, drawing their substance from established supportive, reeducative, and reconstructive therapies, put together into creative constellations. Others exploit unconventional and dubious methods, sustaining these with fanciful theories, exploiting an uncritical eclecticism on the basis that "anything that works is acceptable" (Grinker, 1964). Common sense here is usually buried under a landslide of optimism and is palpable testimony to humankind's need to yield its emotional miseries at any cost. At the very time that Cassandras are bemoaning the death of psychoanalysis and other traditional therapies, these "new" treatments dip into the pool of mortal credulity to exploit anomalous "cures" for all imaginable ailments. It is almost impossible to chronicle the myriad systems of helping that have appeared on the psychotherapeutic horizon. Many of these are revivals of old and discarded methods; others are more novel and innovative. Still others are products of the counterculture, which spawns a variety of egregious approaches reflecting the anti-intellectualism of the day. All inspire expectations of success, especially when promoted by charismatic leaders who seek to etch a lasting profile on posterity. Most of these approaches, following a spectacular rise in popularity, fizzle out like a Fourth of July pinwheel. Among the surviving systems are some that, blending with the personalities and working styles of certain therapists, actually enhance therapeutic outcomes. They then acquire conventional respectability and become part of an eclectic schema.

Innovative therapies come about largely as a revolt against the semantics and rigidities of the traditional therapies. Some of our present-day theories and methods are coached in language that is confusing not only to patients but also to professionals trying to make sense out of them. When we examine critically what the "new" therapies introduce, however, we usually find nothing essentially original. Rather they take a small section of the familiar ideas long in use and merely explicate this area in terms that may be more comprehensible and hence acceptable to patients. The great dedication and

enthusiasm of the innovators come through to enhance the placebo effect and to enliven other non-specific elements.

Because therapists practicing innovative therapies are so intensely convinced of the validity of what they do, they will score greater triumphs than if they were to use traditional methods about which they feel lukewarm. The results of innovative therapies show that about two-thirds of the patients "improve," irrespective of the models used. This compares favorably with the traditional therapies, which to some observers implies that the theories and even the methods we employ do not account for success in psychotherapy. Rather, the constructive use the patient makes out of the relationship with the therapist toward acquisition of a sense of mastery and more adaptive modes of coping is believed to count most. All therapies are not the same, however, because there are differences in the dimensions and permanence of improvement with different treatment methods. We cannot expect that short-term treatment with supportive educational interventions will influence the personality structure in as great depth as will properly conducted techniques aimed at the intrapsychic structure and dynamic interpersonal operations. But irrespective of the kinds of therapy done, their alignment with the personality and style of the therapist and their coordination with the essential learning capacities of the patient are fundamental ingredients of success (see also Abroms, 1969; Corini, 1981; Dolliver, 1981; Halleck, 1974; Marmor, 1974, 1980.)

Because the faith of the patient in the therapist's techniques is one of the most effective elements of cure, the virtue of the interventions themselves remains open to question. This, however, should not discourage experimentation with a variety of methods. There is no reason why a therapist should not cautiously test those techniques that possess a reasonable scientific propriety to see whether they blend with one's personality and style of operation, provided that the innovations introduced preserve accepted bounds of patient-therapist decorum. It is only too common to observe therapists so rigidly anchored to standard systems that they stubbornly resist learning innovations even though they have proven merit (Martin & Lief, 1973).

It is beyond the scope of this book to describe all or most of the miscellaneous treatment methods in use today. Corsini (1981) has listed and Herink (1980) has described more than 250 different kinds of psychotherapy. New techniques are evolved yearly. Some come into the therapeutic arena like lions only

to depart like lambs when their placebo effect has been expended. Others persevere with ebbs and spurts of popularity. Examples of surviving representative therapies are outlined below.

EMOTIVE RELEASE (BODY THERAPIES)

The paradigm for emotive release was the "cathartic method" developed by Breuer and Freud in the late 1800s, which served as the precursor of psychoanalysis. The theory behind the method was that neurosis developed as a product of psychical traumas that evoked fright, anxiety, shame, or physical pain if there had not been an adequate discharge of affect at the time. Emotion then was so bound up that it could only be discharged subversively in the form of symptoms. It was posited, however, that a cure might be achieved by reviving the memory of the event and putting the buried emotion into words. The task of the therapist was to induce the patient to give utterance to the traumatic event "with an expression of affect." This could be done by eliminating the defense or resistance to permit the proper release or abreaction. Neurosis was thus essentially a "splitting of consciousness" between memory and affect, the cure lying in the healing of this split.

These ideas still form a basic part of the philosophy behind later abreactive, emotionally oriented release methods, including those of scream therapy, active analysis, narcotherapy, primal therapy, expressive hypnotherapy, bioenergetic analysis, orgone therapy, direct analysis (Rosen J, 1947, 1962), and scientology among others. Various rituals are organized around each of these therapies focused on breaking down defenses to the presumably barricaded early psychic traumas. After a period of treatment with the release of a good deal of emotion and the lessening of tension we would expect an impact on the physiological state of the individual, such as the pulse, temperature, and blood pressure. This effect can be significant (Karle et al, 1973), and indicates a reduction of tension as registered on body organs. In some patients, too, there is at least temporary improvement in their psychological state as a consequence of the total therapeutic experience. Whether this improvement is any greater than in other kinds of treatment is open to question. There are some patients whose learning patterns are singularly susceptible to release techniques, particularly when rendered by an enthusiastic and charismatic therapist. Other patients fail to respond to these techniques and do better with nonrelease modalities to which they are more attuned.

Bioenergetics

Bioenergetic therapy is a modification of orthodox Reichian therapy. Reich (1942, 1949) contended that interruption of the life-energy flow through repression was aided by seven rings of "muscle armoring" and that this was the basis of neurosis. By manipulating these rings progressively from head to pelvis (orgone therapy) conscious awareness of painful vegetative sensations occurred, the energy flow was encouraged, and health brought about. The Lowenian emphasis (Lowen, 1958) in bioenergetics is also on muscular energy blockages, but rather than the therapist manipulating the muscles, as in orgone therapy, reliance is placed on the patient's own muscle activity exercises and verbalizations. The exercises open up an awareness in the patient of malfunctioning of breathing and other muscular operations that are presumably crippled by blockage of the energy flow. The loosening of the muscle armoring is believed to be the first step in personality reorganization.

The actual technique consists, at the start, of assumption of a painful "stress position," such as lying on the floor with the back arched so that support is maintained by the top of the head, the elbows, and the soles of the feet. Other exercises consist of kicking or hitting the couch. The "stress positions" assumed can actually cause the body to vibrate, and the discomfort may lead to yelling or screaming, which the therapist encourages.

A number of adaptations of Lowen's technique have appeared, especially in the behavior therapy field. One innovation is to fuse bioenergetics with assertive training. An effort is made to elicit in various ways, as through facial, postural, verbal, and other expressive channels, patterns associated with emotion. Assertive behavior, along with expression of appropriate feelings, is in this way gradually shaped. The therapist here participates in the exercises given the patient by modeling an appropriate behavior and by role playing. Emotional release is stimulated by such games as rolling up a towel, with the therapist grasping one end and the patient the other. A tug of war then ensues, the patient being told the towel is his and that he must wrest it from the therapist, demanding "It is mine, give it to me," and maintaining eye contact while the therapist resists and goads the patient on (Palmer, RD, 1971). Other "exercises" given the patient are punching a pillow violently in private, yelling such phrases as "you bitch," "Damn you," and the like. The therapist handles the patient's reactions in the office, reassuring the patient, if necessary, not to be afraid, or forcibly insisting on the patient yelling louder. Some

therapists encourage the use of obscenities to cut into the patient's repressions. Some provide the patient with a tennis racket with which to hit the couch, while uttering such statements as "Bastard, I hate you." Some encourage the patient to growl through bared teeth with jaw thrust forward, shaking fists at the therapist while maintaining eye contact. Some ask the patient to repeat angrily, "Yes, I am mean and ugly and nasty, and I will become more so if you don't stop bothering me." Bioenergetic assertive techniques have also been used with proper organization to release affectionate and sexual feelings.

Scream Therapies

Organized to thaw out and to liberate fundamental "survival-based" feelings frozen within the individual by society, scream therapies prescribe a special regime for the patient and subject him or her to maneuvers to melt resistance to "letting go." A typical example are the exercises devised by Daniel Casriel (1972). In a group setting the emphasis is first placed on screaming to *express* feelings rather than to talk about them. Casriel differentiates several types of screaming, each with different sounds and expressing different emotions. "There are basic screams of fear, of pain, of need and entitlement and four screams of anger—the deepest one accompanied by strong feelings of pleasure." In addition, there are joyous sounds of pleasure. Confrontation, encounter methods, and marathons are utilized to loosen feelings as these come up. The patient is encouraged to scream at the top of his or her lungs. If the patient gets too disturbed, he or she is held or hugged for reassurance and comfort. Once the sounds of repudiated emotions are released and accepted, the patient is encouraged to explore the reasons for them. Role playing may be utilized here to open up pockets of understanding and to reprogram behavioral habits. Progress with feeling emotion and dealing with its source, outside of therapy, is reported to the group at later sessions. The use is made of floor mats for patients to express their "historical feelings" and then to connect these with present-day problems. Character disorders as well as neuroses are said to respond readily to these methods.

Some scream therapy interventions are rationalized by the theory that the release of rage is a precursor to eliminating resistance to emotional growth and development. In one technique to induce rage, the patient is placed on the laps of six or eight people who physically restrain him or her while the therapist, on whose lap the patient's head rests, fires pointed questions at the patient about his or her past. Simultaneously or somewhat later the therapist tickles or prods the rib cage of the patient to induce

discomfort or pain. This usually releases cries of helpless protest and violent rage. The "treatment" goes on for as long as 4-6 hours until the patient is literally exhausted. The patient is then released and embraced affectionately by members of the group and the therapist.

EST

Contracted from "Erhard Seminars Training," a brainchild of Werner Erhard, EST was founded in 1971 and essentially is organized around a two-weekend experience designed to transform the participants' ability to "clear up" disabling life situations. Many thousands of people have graduated from EST training courses, which are offered throughout the country. Sessions are conducted in a rigidly disciplinary way to stir up tension. Discomfort and deprivations are deliberately organized, along with a grueling confrontation. Honesty of revelation is stressed, and the emphasis is on assuming responsibility for one's own actions. "Much of the effectiveness of training is based on surprise, or shock... . You are simply caught off balance... . Our bodies scream for relief' (Kettle, 1976). The leader "harangues us, urges, cajoles, wheedles, roars ... one thing that happens in the est training is the attack on the armor with a consequent release of energy." The participants cry, laugh, scream, vomit. Testimonials are ample from participants as to how much they have been helped by EST. The marketing techniques used to publicize the program have made it extremely popular. There is evidence that some persons with good ego strength and strong motivation derive benefits from participation (Simon, 1978), as they might with other experiential groups. On the other hand, psychoses may be precipitated in vulnerable persons as a consequence of the intensive experience (Glass et al, 1977; Kirsch & Glass, 1977).

Primal Therapy

The best known of the scream therapies is primal therapy which had a brief period of popularity. According to Janov (1970), people are born with needs, a part of their "real selves." When these needs are unmet, the neurotic process begins. When the pain of unfulfilled needs is not alleviated, the infant diverts the pain by shutting off the need that is unsatisfied; the child then separates himself or herself from the needs and feelings. Substitute gratifications ensue, usually symbolically, and become the modes of functioning of the "unreal self." Sensations caused by unattended needs are relocated to areas where greater control or relief can be provided. For instance, early weaning can find a symbolic satisfaction later

in incessant smoking.

"Neurosis is a symbolic behavior in defense against excessive biological pain." But symbolic satisfactions never really gratify the needs from which they issue, which unfortunately are not available to the person because they have been buried. Tension issues from unsatisfied needs. A constant denial of real needs ("minor Primal Scenes") sensitizes the individual to a precipitating traumatic event (the "major Primal Scene"), usually between the ages of 5 and 7, that produces in the child the realization "There is no hope of being loved for what I am." The child then shields himself from this realization "by becoming split from his feelings, and slips quietly into neurosis." Neurotic behavior becomes automatic. "Primal Pains" are so intolerable that they, and the memories with which they are associated, become disconnected from consciousness. This resulting tension promotes a life style or "personality" to minimize and dull suffering.

Primal therapy, continues Janov, constitutes a systematic assault on the unreal self "which eventually produces a new quality of being—normality—just as the original assaults on the real self produced a new state of being—neurosis. Pain is both the way in and the way out." There can be no resolution until the "Primal Pains" are reexperienced consciously. This breaks open the memory bank associated with the "Primal Pains."

As with other therapeutic systems, splits have occurred among therapists who practice primal therapy on the basis of dissatisfaction with results.

Criticism of Emotive Release

The concentration on causation in the early years to the exclusion of later etiological factors is a defect from which many therapies, including emotive-release therapies, are blighted. We may rightfully be suspicious of any theory that proposes a unitary cause for all emotional problems. Human behavior is extremely reticular, and unfortunate conditionings may occur anytime between birth and the grave. The traumas of middle age can be no less endurable than those of early childhood. An adult victimized by disastrous contemporary circumstances that are beyond the individual's existing coping capacities may show catastrophic responses that may permanently injure faith in oneself and open the door to

emotional illness that plagues the individual for the remainder of life.

This does not minimize the cathartic effect of emotive release. The ability to let go without restraint discharges a good deal of pent-up emotion, for example, fear, indignation, and rage. Relief of tension may then ensue. The ability to express uncurbed emotion without encountering anticipated punitive retaliation or rejection—indeed being encouraged to emote freely in the face of a new, accepting authority—can have an important impact on the superego. The lessening of controls of the conscience and the freedom in unleashing inner feeling have a strengthening effect on the ego. With the discharge of affect a flood of insights may then be liberated. Surfacing of repressed memories and of repudiated aspects of the self may occur where defenses are broken down catastrophically in the therapeutic process so that the individual has no way of dealing with the stress situation except through regressive parental invocation in screaming. Where dependency needs are extraordinarily pronounced and where one does not encounter a parental agency who comes to one's aid by one's screaming, the individual may in some instances have to develop a more mature way of dealing with needs, such as by greater self-reliance and assertiveness. In other cases the screaming furthers rather than lessens the regressive tendency, and, from a long-term standpoint, this does not help the patient's condition. In borderline cases or schizophrenics, damage may be done to the defensive system so that a break with reality may occur.

The more drastic emotive-release therapies are tailor-made for patients who have a stake in feeling pain as a condition for well-being. If they can accept the premise that suffering of pain is mandatory to overcome problems and that feeling pain fulfills certain needs, such as the propitiation of guilt, the therapy may constitute a tension-releasing experience for them. The charisma of the therapist acts as a catalyst for these patients, but the basic need to accept pain is a primary requirement. Obviously many patients react adversely to paying penance by suffering and will not abide by this premise. Indeed, feeling pain for them will act as a deterrent to getting well. One may call this, if one wishes, a resistance to getting well. In the field of psychotherapy we too often credit an individual's inability to respond to therapeutic stratagems as resistance rather than acknowledge shortcomings in the system itself.

Despite defects in the system, for some individuals, such as severe character disorders, or those unmotivated for traditional therapies, assuming they are not borderline cases or schizophrenics, the dramatic treatment techniques such as emotive release may operate as means of penetrating otherwise

unyielding defenses that isolate individuals from themselves or others.

GUIDED IMAGERY

About 1895, Sigmund Freud utilized the "concentration technique." He enjoined his patients to shut their eyes. While he pressed on their foreheads, he instructed his patients to let images come to their minds and, without holding anything back, to verbalize what they imagined. Because Freud felt that touching his patients interfered with the transference, he abandoned this technique in favor of free association and the use of dreams. Since Freud's early use of fantasies, methods of image associations have been periodically introduced that the authors presented as original and unique, even though on scrutiny they were quite similar to Freud's old technique. Some therapists find that imagery plays an important role in their treatment of a number of disorders (Horowitz 1970, 1976; Brett, 1985), and may serve as a vehicle to expedite treatment.

Psychoimagination Therapy

Integrating phenomenology and imagination, Shorr (1972) has introduced what he describes as an existentially based therapy (psychoimagination therapy) organized around how patients view themselves from the inside and how they believe other people view them. Imagery and imagination are used as a means of examining how patients regard themselves and how they see their phenomenological world. Shorr discovered that when a person is asked to say how he or she imagines a thing in two different ways and there is a conflict between the two, a "bipolarization" in the meaning systems will be exposed. A new more unified meaning system must then be organized.

The search for meaning is one of the most powerful strivings in the human being. To survive in a hostile world as a child, the meaning of events may be perverted and this can distort reality. If true facts about oneself and about past personal experiences can be laid bare, new and more adaptive meanings are made available to the patient. The problem lies in how best to achieve true meanings. Shorr believes this can be done through imagery and imagination, which can be used to reach out into the world and differentiate fantasy about oneself from reality. In this way, one can alter one's sense of values. The therapist tries to get from patients their definitions of themselves, how they think other people define

them, and confirmation of these ideas from those they are with. A disparity in definitions about oneself from these various sources makes for conflict. The job of therapy, Shorr alleges, is to change a distorted negative self-definition to a more positive one. Thus, one may ask a patient to look into a mirror and to imagine looking at a different image than one's usual self. Often the person fantasized is one toward whom the patient has a good deal of emotion. A dialogue may be set up between the person and the fantasized object in the mirror. Conflicts are easily elicited in this way. By coming to an awareness of the conflicts within oneself, the individual is more capable of resolving confusion in personal meaning systems.

The patient may be assigned to do "task imagery." For instance, the patient may be asked to climb 1000 steps in his or her imagination. Some will hesitate after a few steps; some will slowly ascent to the top but refuse to traverse the last few steps as if in fear of success; others will rapidly climb to the top. This yields clues as to achievement motives, power motives, and so on. Later the therapist encourages the patient to achieve the task in imagination (i.e., a person who cannot reach the top is enjoined to do so in fantasy). As a way of getting rid of parental representations (the introjects), Shorr utilizes "body focusing." Here patients are queried in what part of their body their mother or father resides. Once the body part is named the patient may be asked whether it can be removed and, if so, how this could best be achieved through imagery.

Imagery can be utilized in a group setting. All members may be asked to close their eyes, imagine throwing a fishing line in the water, and fantasize what they catch. This stirs up interaction between the members and brings out hidden wishes in each patient. Should the patient feel improperly defined by a member in the group, verbal confrontation in the group is encouraged. This may be more easily accomplished through "cathartic imagery," by setting up a psychodramatic scene in which one confronts a group member in the role of a significant personage who harbors a faulty image of the patient. The therapist sides with the patient and with the corrected definition of the self-image to render support in releasing feelings against fancied retaliation. Such expressions emerge as, "1 am not what you say I am. How dare you. Never will you do this to me again," along with expressions of outraged emotion. These reactions are essential for changing the self-definition. Reaction may vary from verbal outrage to violent screaming.

Shorr claims that his method is faster than analytic methods that depend solely on verbalization since through imagery one can see more clearly what is involved in change.

Psychosynthesis

As described by Assagioli (1965), the patient in psychosynthesis is asked, while relaxed on a couch, to visualize and relive, as realistically as possible, the scene or situation that is stimulating his or her upset and to let the emotion come out as freely as possible. This technique can also be applied to future events that the patient anticipates. Verbal expression, writing, keeping a diary, and muscular exercises are other modes of discharge for the emotions. Eclecticism of method is endorsed. Tien (1972) defines a psychosynthesist as a psychiatrist who fuses "classical psychoanalysis, modern chemotherapy, improved electroconvulsive therapy, family therapy, group therapy and community psychiatry with television as the storage, amplification and feedback system." The electroconvulsive therapy (ELT) is for the purpose of erasing disturbing memories or information. As in any other eclectic system, the practitioners of psychosynthesis design their own unique combination of modalities.

Miscellaneous Guided Imagery Techniques

There are other ways of working with guided imagery and a number of techniques have been evolved, including those taken from behavior therapy, hypnoanalysis, hypnogogic and "affective" imagery, eidetic analysis, and "in-the-body" daydreams.

In the behavioral technique of systematic desensitization a hierarchy of progressively more noxious phobic situations are constructed and the patient is gradually trained to fantasize and tolerate these situations from lowest to highest traumatic significance (Dyckman & Cowan, 1978). Implosive therapy also depends on mobilization of vivid exaggerated fantasies (Wolpin, 1969). In hypnoanalysis the patient is enjoined to visualize special scenes in order to elicit associations, dreams, and emotions (Wolberg, LR, 1964a; Rochkind & Conn, 1973). In eidetic analysis, a method developed by Ahsen (1968), a series of images involving the patient's parents in various situations are proposed and the patient is asked to tell a story about what he or she feels and sees (Ahsen, 1972). Hypnogogic imagery is a normal phenomenon appearing in some people spontaneously in a drowsy state. It has the same

dynamic significance as dreams. Images may be induced in subjects by relaxation exercises, meditation, autogenic training, hypnotic induction, and sensory deprivation during which an alteration of consciousness comes about. A form has been described by Leuner (1969) as "symboldrama-guided affective imagery." Here the patient lies down on a couch or sits comfortably in a reclining chair and is exposed to relaxing suggestions. The patient is told to picture himself or herself on a meadow and to describe what he or she sees and feels. The patient is then asked to take a walk in these surroundings and to describe what he or she sees. Thereafter the patient is enjoined to climb a mountain, to follow a stream, to picture and explore a house, to visualize family members, to see a rose bush and imagine a car coming by and stopping, to see a lion, and a number of other scenes that will bring up a variety of themes and associations. A passive attitude on the part of the therapist is usually adopted unless there is a block when active "symbol-confrontation" is employed. This technique is highly productive in dynamically oriented psychotherapy (Kosbab, 1974). The directive "in-the-body daydream" focuses on bodily tensions and may travel to different zones with many rich fantasies about what is going on (Alexander ED, 1971). The "Flomp Method" consists of daydreaming about a situation or event from one's life where one was disappointed and/or afraid. The patient is taught a relaxation method and asked to see himself or herself acting in the situation with the knowledge, power, and maturity that he or she now possesses "to make the done undone." Other situations are suggested and a variety of techniques of exploration utilized (Hagelin & Lazar, 1973).

Criticism of Guided Imagery

As part of an active psychoanalytically oriented psychotherapy, guided imagery may contribute substantially in the treatment of those patients who are capable of visualizing and working with fantasies and daydreams. Not all patients are proficient in doing this. Moreover, in borderline or schizophrenic states imagery techniques may liberate explosive emotions and even precipitate acute, though usually temporary, psychotic outbreaks. Reliance on guided imagery as the chief or only technique will bring many disappointments. It must be reinforced by other modes of operation. The data emerging from imagery should never be taken at its face value since distortion, secondary elaboration, and defensive rationalization are common.

ERICKSONIAN PSYCHOTHERAPY (STRATEGIC THERAPY)

"Ericksonian psychotherapy" is the name given to a body of interventions most of which have been taken from the lectures, seminars, workshops, and writings of Milton H. Erickson, perhaps the most outstanding practitioner of hypnosis in the United States. More important than the actual techniques is the philosophy behind the methods, as well as the tactical interpersonal approaches to the patient, which are designed to liberate potentials for self-help in either the hypnotic or waking state (Erickson & Rossi, 1980; Haley, 1973). Discounting the myths and anecdotes, that are so commonly expressed by devotees and detractors of any charismatic figure, Erickson has had a significant influence on thousands of professionals and is registering an imprint on American psychotherapy itself. This is evidenced by the many volumes about Erickson that have been and continue to be published (Hammond, 1984; Rossi & Ryan, 1985; Rossi et al., 1983; Zeig, 1980, 1982, 1985a, b). Some of Erickson's interventions were an outcome of coping techniques that he employed to moderate the pain and disabilities he suffered as a result of having had childhood poliomyelitis. Struggles with his handicaps made for a unique blend of resourcefulness, flexibility, ingenuity, artfulness, and improvisation which, combined with an unorthodox style and a penchant for brinksmanship have created a model of psychotherapy that is exciting to read about but difficult for the traditional therapist to duplicate. There are, nevertheless, lessons to be learned from the dexterous ways Erickson related to his patients and even from the dramatic, histrionic expediences devised by this talented innovator.

Acting variantly with each patient as counselor, analyst, referee, arbiter, advocate, prompter, mentor, accepting authority, or punitive parent, Erickson stressed the uniqueness of each individual, who, motivated by singular needs and idiomatic defenses, required an original mode of approach rather than orthodox, unimaginative, and doctrinal styles. He considered himself and his words, intonations, manner of speaking, and body movements vehicles of influence that could promote change. Interested in action rather then theory, he considered traditional theory a handicap that anchored therapists to a bedrock of hopeless imponderables. Toward this end he suggested, cajoled, and maneuvered with a host of individual, multilevel communicative thrusts, verbal and nonverbal, that were fabricated to influence the patient without the latter's full awareness of being manipulated. Sometimes he failed, but this merely provided him with new incentives to overcome the patient's reluctance to utilize latent resources and potentials for change. Frequently he would join the manifest resistance and seemingly side with the

patient's illness and defenses, or he would assign the patient what appeared to be peculiar, irrelevant tasks. He would offer homespun advice and common-sense remedies that made use of the obvious. Conversely, he would use metaphors and obtuse inferences that were not exactly to the point. He would set up situations "where people would spontaneously realize their previously unrecognized abilities to change" (Zeig, 1985). But there was a design in these contrivances if no more than to confuse patients enough to force them to open their minds to a different way of looking at things. Techniques were not selected in advance but were tailored to the exigencies of the immediate situation. Even though Erickson refused to identify himself with any of the well-known schools of psychotherapy, he often used behavioral, cognitive, analytic, and other methodologies within the framework of his unique modes of operation. Hypnosis was employed when it was considered useful in expediting therapy. His immediate objective was symptom relief and problem solving, although personality and value change were considered ideal goals that might sooner or later be achieved.

Some psychotherapists worship Erickson with a reverence that borders on idolatry. Every word, sentiment, opinion, or act are presumed to have an inspired meaning. Such deification, rooted in expectations of timeless power and omnipotence, can ultimately lead to disillusionment. Equally prejudiced are those who regard Erickson as a maverick whose egregious methods are a passing fancy that will eventually be consigned to the dustbin of outmoded schemes. These attitudes do injustice to a highly creative, imaginative, and original mind who evolved novel approaches to some of the most baffling problems in psychotherapy. Erickson was a marvelous influencing machine, crafted by years of struggle in mastering his painful physical disability. His courage, sensitivity, perceptiveness, and unique modes of coping made him, in the words of Haley (1973), an "uncommon therapist." But his approaches, which blended with his "uncommon" personality and styles of operation, cannot be easily transposed, digested, and used by others.

A poignant criticism of Erickson's strategic therapy is that it is overvalued by those who believe that clever tactics can substitute for disciplined training. Technical modes of operation are only a fragment of what goes into the gestalt of a psychotherapeutic program. For one thing we must know how to deal with a host of variables related to patients' defenses, belief systems, and characterological peculiarities, which can negate and cancel out the effect of all our strategic interventions.

LIFESPRING

An entry into the human potential movement is Lifespring, which, inspired by the work of Carl Rogers, Abraham Maslow, and Fritz Perls, aims to stimulate personal growth through "self-awareness and acceptance." The program is not designed for persons with severe emotional problems; nor is it recommended as adjunctive to an established therapeutic program. Be that as it may, many people attracted to Lifespring seek help for emotional difficulties. Such help may be forthcoming through the relationships that are established with the trainers and other participants, the emotional catharsis that takes place in "sharing" one's difficulties and opening up to others, the group support, persuasive suggestions, operant conditioning, educational awareness, and other bounties inherent in a helping situation. The group leaders, who consider themselves trainers rather than psychotherapists, use a variety of techniques such as meditation, role playing, guided fantasies, and group discussions. Many of the graduates of the program maintain contact with each other and the organization, gaining the benefits of an extended family.

TRANSNORMAL APPROACHES

The awesome mysteries of existence have inspired some therapists to speculate about the influence of the supernatural on what they do or can do in psychotherapy. Data for these speculations are boundless, having accumulated from such areas as meditation, hypnosis, psychodelic drugs, extrasensory perception, Kirlian photography, plants subjected to prayer, energy fields, biocycles, divination, reincarnation, demoniacal possession, out-of-the-body experiences, and other phenomena and whimsicalities reported by both reliable and dubious sources.

The influence of the occult for good or bad has been especially posited when there has been a shattering of accepted belief systems, as when insecurity and distrust in contemporary stabilizing sanctuaries has occurred. Natural catastrophes and chaotic social order historically have sent people into hopeful excursions into the arcane. At the present time young people particularly have registered suspicion of a society that sponsors violence, pollution, and massive preparations for nuclear war. An upsurge of interest in mysticism, shamanism, astrology, witchcraft, exorcism, and other esoteric subjects has followed. This interest has spilled over into the psychotherapeutic field, motivating some therapists

to explore the interfaces of the transnormal and scientific worlds. A new field of metapsychiatry is being promoted that endorses empirical explorations of the occult.

Paranormal (psi) phenomena involving motor and sensory manifestations (telepathy, clairvoyance, precognition, psychokinesis) that transcend normal human capacities have especially been subjected to scientific investigation (Rhine, 1938; Pratt et al, 1940; Soal & Bateman, 1954; Ullman & Krippner, 1970). The reported results have been startling and have left no doubt in the minds of the investigators regarding the authenticity of psi manifestations (Murphy, 1975). Interest in applying the telepathy hypothesis of psychotherapy was stimulated by the possibility that transference and countertransference could extend themselves through telepathy and thus interfere with the therapeutic relationship (Ehrenwald, 1954; Servadio, 1956; Eisenbud, 1970). The influence of psi events on dreams has also been elaborated (Ullman, 1959; Ullman & Krippner, 1970). What practical use can be made of psi phenomena if they do exist (there is question in the minds of many scientists regarding the validity of the reported experiments on psi) has not yet been demonstrated.

Psychic healing, such as by prayer and the laying-on-of-hands, has also been subjected to experimental investigation (Grad, 1965) as have the aura emanating from living things (Kirlian photography) (Krippner & Rubin, 1973). More scientific evidence will be needed before psychic healing as such can be endorsed as a modality beyond its suggestive and placebo effect.

Pursuit of more bizarre aspects of the occult has caught the fancy of large groups of people who gain stability or heal themselves without the formality of professional help through practices like astrology, witchcraft, and exorcism. Practices here resemble primitive magicoreligious indoctrinations and actually may be a reflection of early teachings or a regression to the pre-logical period of childhood. I recall one patient, a young intern who had come to this country from a Caribbean island to further his medical education. The purpose of the consultation was that he wanted me to hypnotize him to eliminate his impotence. This had developed a week before his departure from home and followed a sexual experience with a young lady, an acquaintance who had decided to pursue prostitution as a profession. Whether out of perversity or mischievousness, the patient had, after she had made clear her fee for services, refused to pay her. In rage, the frustrated entrepreneur shrieked that she would cast a spell over him that would take away his manhood forever. Amused, the patient had ridiculed this nonsense,

telling her he had long ago broken away from the voodoo superstitions of his parents. To his consternation and amazement, however, he had from that time on become impotent. Visits to urologists and psychiatrists had achieved no improvement. Discerning that he was not truly motivated for psychotherapy, I advised him that suggestive hypnosis might be of help but that a cure would be much more rapid and sure if he returned home and paid the disappointed lady the fee that he owed her. My advice worked out as I had predicted, and the patient never followed through on further therapy. The roots of superstition go deep and often are not apparent on the surface.

OTHER ECLECTIC METHODS

It is rare indeed that a therapist will use only one type of intervention and not exploit the rich body of procedures that lend themselves to usage for diverse conditions and situations. Even Freudian psychoanalysts, considered by many the traditional purists in the field, employ or refer patients who require medications, hypnosis, sexual therapy, marital therapy, or other adjunctive procedures in addition to their probings of the unconscious. The application of tactics to coordinate with the needs and specific learning patterns of the patient will promote the most effective results in therapy, and here the sensitivity, experience, and self-awareness of the therapist will be of consequence. Too often, however, therapists employ interventions that are designed to gratify their own needs rather than those of the patients. Under these circumstances the patient is subjected to strategies from which the therapist personally derives greater help than the patient.

Many "systems" of eclectic therapy are presented by their founders as late twentieth-century innovations even though they are derived from identifiable techniques employed for decades and even centuries in the past. Founders of some of these systems give to their schemes an academic primatur, adorning them with elaborate terminologies and neologisms and sometimes organizing a new school around them which if they are charismatic attract enthusiastic audiences.

This is not to deride practical attempts to combine therapies creatively to treat special problems, taking into account the cultural atmosphere of the patient. One such attempt was developed by Morita in 1917 to treat types of neurosis common in Japan. This is known as *Morita therapy* (Reynolds, DK, 1976). The difficulty for which this form of treatment was developed was a morbid preoccupation with bodily

odors, inferiority feelings, self-consciousness, problems in working, and other obsessional and hypochondriacal complaints. Therapy consists of hospitalization, usually in a Moritist hospital, the first week of which consists of complete bed rest and daily visits from the therapist. Patients are not allowed to have visitors or to engage in any reading or conversation. They may at this time worry and preoccupy themselves with their problems. The second week is more active. They are out of bed, engaging in light hospital work, and are assigned simple chores. They are not permitted to have visitors, to read, or to chat with others. They must keep a written diary, which the therapist reads daily and to which the therapist replies in writing. They attend lectures and meetings, being exposed to persuasive arguments toward accepting themselves and their symptoms and toward engaging in constructive activities. In the third week and thereafter they continue to go to lectures and meetings. They are assigned to heavy work and are enjoined to talk to other patients. They may read light literature. Finally they can engage in visits and are delegated to do errands. The Moritist life principles are also utilized on an outpatient basis and in groups.

Another therapy practiced in Japan is *Naikan,* which consists of a concentrated 7-day period of psychological and spiritual restoration during which the therapist as a guide subjects the patient to exercises in self-observation and remembrance of past experiences. The patient is also exposed to persuasive arguments. The sole aim is social readaptation. The technique is active and, as in Morita therapy, avoids focusing on transference and resistance. Where patients in our culture can accept principles of conformity to the teachings of a guiding authority and the fatalistic acceptance of situations that have happened to them, they may respond to Moritist or Naikan therapy.

An example of eclectic therapy in our culture is that introduced by Lazarus (1976) as *multimodal therapy*. It eschews identification with any specific school of psychological thought. Nor is it a separate school in itself. It draws from educational principles of social learning, cognitive processes, and behavioral precepts. First, patients are examined in relation to their salient behaviors, affective behaviors, affective processes, each of the five senses, basic images, cognitions, and interpersonal relations. Symptoms and behaviors in various areas, including thoughts, values, fantasies of past disturbing events, self-images, interpersonal difficulties, and behavioral lacks and deficits, are explored. The multimodal profile analysis consists of a structural framework to assess the clinical problem, the setting of goals, and the treatment techniques and evaluative procedures to be used. The modalities

toward which therapy is directed are, in summary, seven in nature: behavioral, affective, sensate, imagery, cognitive, interpersonal, and "drugs," a symbol for organic or physiological processes. The first letter of each modality spells out the acronym BASIC ID. Problems are treated by a variety of techniques, for example, operant conditioning, classical conditioning, implosion, paradoxical intent, catharsis, sentence completion, "hot seat," hypnosis, awareness exercises (Gestalt), group and individual physical activities, special techniques for sexual dysfunction, deep massage, yoga, meditation, relaxation, rational-emotive therapy techniques (self-talk), thought stopping, fantasy trips, self-suggestion, assertive training, modeling, role playing, role reversal, behavioral rehearsal, psychodrama, and drugs where necessary. These techniques are employed selectively in relation to the special needs and problems of each patient.

CRITICISM OF ECLECTIC THERAPIES

Eclectic therapies can easily get out of hand when they are applied unselectively to patients without considering the specific goals of the treatment effort. This necessitates an incisive study of the patient in all areas of his or her living and interpersonal adjustment. While an attempt to blend different theories inevitably results in a hopeless jumble of words and is a fallacy, using different techniques issuing from contributions of workers in the social and behavioral sciences can, if executed correctly, be a constructive and rewarding enterprise. Methodological eclecticism is founded on the premise that no one therapy covers every aspect of the therapeutic process. Each therapy seems to have selected a limited zone of pathology and to have focused on this dimension. In an eclectic approach therapists may employ techniques from different therapies at different phases of the treatment process; for example, they may use some of the methods of the client-centered school during the early stages when they seek to establish a therapeutic alliance; some of the methods of psychoanalysis (dreams, transference, and so on) when probing for conflicts; some of the methods of Gestalt therapy when confrontation is in order; some of the methods of behavior therapy when trying to convert insight into action; and some of the methods of cognitive therapy when attempting to alter belief systems. Modalities such as drug therapy, marital therapy, sex therapy, family therapy, and group therapy are also used as needed. These methods have to be employed selectively, coordinating them with the patient's needs and the objectives they are trying to achieve. The problem with most psychotherapeutic schools is that they try to approach all phases of the therapeutic process with a limited tool. It would be like building a house with a hammer alone when a

variety of tools is needed. Naturally, *how* eclectic methods are used is crucial for success. On the other hand, there is no earthly reason for jumping from one method to another if therapy is proceeding satisfactorily. Most therapists learn a few techniques thoroughly and do well with them. Only when a patient is not responding to one's habitual techniques, and the therapist is assured the failure is not rooted in transference and other resistances, should one change the interventions. The fact that a therapist uses eclectic methods does not mean that he or she cannot be discriminating in using them.

More recently, Frances et al. (1984) have reviewed the eclectic spirit in "differential therapeutics" and have shown the value of employing special modalities for select problems and situations. What we must keep in mind is that no matter how varied our skills may be acceptance by the patient is what crucially matters. In our culture, when we attempt to use psychotherapeutic interventions we find great variations in what patients find meaningful and to which they can respond favorably. The institution of third party payments has broadened the consumer groups seeking mental health services. But any attempt to bring into the mental health care system groups that have been underserved for socioeconomic and other reasons will require a careful study of the techniques that members of these groups find acceptable and those they are not willing to accept. This necessitates an understanding of the varieties of belief systems rampant in our patient population. It necessitates an acquaintance with a broad spectrum of psychological and sociological methods and a willingness to educate patients regarding methods that have a chance of helping them beyond the placebo effect.