THE TECHNIQUE OF PSYCHOTHERAPY

QUESTIONS THERAPISTS ASK ABOUT PSYCHOTHERAPY

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Questions Therapists Ask About Psychotherapy

Sundry questions plague the individual doing psychotherapy. Answers to these questions are not easily provided, since there are many ways of accomplishing the same task in psychotherapy, some of which are suitable for one therapist and wholly inappropriate for another. In this chapter a number of common questions, posed by therapists participating in case seminars conducted by the writer, and not answered completely in the text of this book, are considered. The answers given to these questions are, of course, not absolute and will require modification in terms of the individual's unique experience and specific style of working.

Q. *If a patient attacks you verbally at the initial interview, how would you handle the situation?*

A. An aggressive outburst in the first interview is clearly an indication of great insecurity or fear in the patient. Patients will generally rationalize the hostility on one basis or another. A way of handling the situation is to accept the patients' hostility and to inform the patients that under the circumstances, you do not blame them for being angry. As a matter of fact, it would be difficult for them to feel any other way. If possible, an effort should be made to bring the meaning of the aggressive outburst to the patients' awareness. If this can be done, it may alleviate their tension and initiate more positive feelings toward the therapist.

Q. *How do you handle patients who come to see you while they are being treated by another therapist?*

A. This situation occasionally happens and will have to be managed diplomatically. There are a number of reasons why patients find it necessary to consult a second therapist. They may be in a state of resistance, and their visit constitutes an attempt at escape from, or a gesture of hostility toward, their therapists. Or the patients may sense that they are unable to relate to their therapists, or that their therapists are unable to relate to them, and they are reaching out for a new, better therapeutic relationship. In either instance, one must respectfully listen to the patients and focus particularly on the specific meaning of their consultation with you. Under no

circumstances should one participate in criticism of the other therapists, no matter what outlandish activities are ascribed to them by the patient. On the contrary, one should be alerted to transference manifestations and attempt to clarify any misconceptions or irrational attitudes about the patients' therapists that present themselves. The ultimate result of the interview may be emotionally cathartic for patients, and they may return to their therapists with insight into their resistance. Should there be reason for your considering treating the patients, and if they had not informed their therapists about the prospective consultation with you, it will be important to emphasize the need to discuss the situation with their therapists. The patients may be told that for ethical reasons it will be impossible to start treatments with them unless both they and their therapists agree that a transfer is indicated. In the event the patients have, when they consult you, discontinued treatment with their therapists, the visit may, of course, be conducted as an initial interview.

Q. *Is it permissible to treat one's friends or relatives?*

A. It is extremely difficult to be therapeutically objective with friends and relatives. Nor will they be able to establish the proper kind of relationship with you. For these reasons, if they need treatment they are best referred to another therapist.

Q. *How far can the therapist go in making interpretations at the beginning of therapy?*

A. An experienced therapist may discern important dynamics in the first interview or shortly thereafter. To interpret these to patients may be harmful. A strategic moment must be waited for—which may come many months later—before revealing to patients what the therapist already knows. New therapists, in their enthusiasm, frequently violate this rule, as do experienced therapists with strong narcissistic leanings who attempt to demonstrate to patients how much they know about them.

Q. *What causes violent feelings that are stirred up in patients after the first interview?*

A. These may be caused by transference or by something the therapist has done in error.

Q. *Are mistakes that a therapist makes in psychotherapy irretrievably destructive*?

A. Even the most experienced psychotherapist makes mistakes in the conduct of therapy. There are many reasons for this, including the fact that the therapeutic relationship is so complex that the

therapist cannot see all of its facets. Such mistakes are not too important if the working relationship with patients is a good one.

Q. *Are the various psychotherapeutic approaches ever used together*?

A. Practically all forms of psychotherapy purposefully or inadvertently employ a combination of approaches. Even in formal psychoanalysis one may, at times, be unable to avoid suggestion and reassurance. Persuasive and other supportive influences may by design enter into insight therapy from time to time, and disturbing environmental factors may deliberately have to be handled in order to promote maximal progress. Wittingly or unwittingly, then, no approach is used in isolation. Rather, it is blended with other approaches, made necessary on occasion by the exigencies of the therapeutic situation.

Q. *Does one ever start off using one approach and then, in the course of treatment, switch over to another approach?*

A. This is very frequently the case. One may start off with an approach aimed at a supportive or palliative goal. In the course of treatment it may become apparent that no real improvement will be possible unless one deals with underlying causative factors. One will consequently have to motivate the patient toward accepting therapy aimed at more extensive goals. On the other hand, one may begin reconstructive treatment and, in the course of administering this, discover that circumstances make less extensive goals desirable. A supportive approach may therefore become advisable.

Q. *Should patients be required to pay for their own treatment?*

A. Some patients will get more out of therapy if they feel in some way responsible for its payment. This does not mean that they will not benefit from treatment financed for them if they cannot afford it. With the increasing incidence of third-party payments (insurance, Medicare, Medicaid), a considerable body of experience shows that good psychotherapy is possible even though patients do not pay for it themselves. In child and adolescent therapy, parents or guardians assume responsibility for fees, and this fact does not denigrate the therapeutic effort. When therapy is given free, and no payment is made for it by any party, some patients are handicapped in expressing any feelings toward the therapist that they believe will cause offense. A perceptive therapist can detect this reluctance and deal with it to promote freedom of expression.

Q. *How is the matter of fees best handled?*

A. The matter of setting a fee satisfactory to both therapist and patient, and of agreeing on the manner in which payments are to be made, is part of the reality that therapy imposes on patients. Many therapists gauge their fees according to patients' ability to pay. In setting a fee, it is important that the therapist consider the patient's capacity to carry the financial responsibility over the estimated treatment period. Unless this is done, both therapist and patients will find themselves in a difficult situation later on. Though grading the patients' fees according to the patients' ability to pay over the estimated time period of treatment, the therapist must be assured that the fee is adequate. Should the therapist accept a fee too low to meet personal obligations, the therapist will feel insecure. Resentment or anxiety may occur that will impose a destructive influence on the therapeutic relationship. Once a fee is set, it is difficult and unfair to raise it unless patients' financial situation has improved. Often a neurotic problem interferes with the work capacity and productivity of patients. At the start of therapy, patients' earning ability will therefore be minimal. Once therapy gets under way, patients may be able to earn a great deal more money. Under such circumstances, discussing with them the raising of a fee is justifiable, and an adjustment of fees upward usually will be acceptable. On the other hand, financial reverses may occur during the course of therapy. In such instances a reduction of fee may be required.

Q. *What do you do when patients neglect payment of fees?*

A. Lack of punctuality in the payment of fees may be a manifestation of temporary financial shortage, a problem related to money or to giving, or an indication of resentment toward, and desire to frustrate the therapist. Should patients disregard the payment of bills for a considerable period, the matter may merit inquiry and therapeutic handling. If the therapist has neurotic problems in relation to money, he or she may evidence marked anxiety when payments are not being made on time. The therapist may consequently tend to overemphasize the importance of punctuality in payments and may introduce the matter of finances completely out of context with the material that concerns the patients. On the other hand, the therapist may be negligent on the matter of payments and may fail to bring to the patients' awareness possible avoidance of a responsibility that is part of reality. Unless justified by financial reverses, the accumulation of a debt creates hardships for patients that may be harmful to their relationships with the therapist.

Q. *If you discover that patients' finances are greater than those reported at the beginning of therapy, would you boost the fee?*

A. Financial arrangements with patients may have been made on the basis of a reported low income. If patients have purposefully concealed their finances from the therapist, this deception will, in all probability, later create guilt and tension. The therapist may assure patients that there must have been reasons for falsification of income. Understandably, careful handling is necessary to avoid mobilizing further guilt. In the event the set fees require adjustment because of patients' larger income, this matter must be discussed thoroughly with the patients, no change of fees being made except on mutual agreement. If the patients' fees are arbitrarily raised without their complete cooperation, grave difficulties may be anticipated in the therapeutic relationship.

Q. *Should the therapist ever visit patients in their home?*

A. Only in the event of a crisis or serious incapacitating illness or accident when it is impossible for the patients to come to the therapist's office and when it is urgent to administer psychotherapy.

Q. *What do you do when patients talk too much and don't allow the therapist to speak?*

A. If patients are focused on an important area and doing good therapeutic work, one does not interrupt. If they are talking about irrelevant things or their rambling seems to be resistance, one interrupts and focuses on pertinent topics. If this does not help, one may question the reason for rambling, or perhaps attempt its interpretation.

Q. *Is there not a similarity between friendship and a working relationship?*

A. Only peripherally. The therapeutic relationship is a professional one. Implicit in it is the absolute promise of confidentiality, the recognition that the time span is a limited one, and that termination of the relationship will eventually come about.

Q. *What do you do if patients have been in negative transference for a long time and this continues no matter what the therapist does?*

A. First the therapist might undertake self-examination to see if he or she is provoking these feelings. If the therapist is sure there is nothing in the therapeutic situation that is stirring up the patient, analysis of possible projections by the patients into the present relationship of negative

attitudes toward important past personages may be undertaken. If this does not help, the therapist may go back to the first phase of therapy and actively try again to establish a working relationship with the patients.

Q. *What is the relative merit of focusing on past, as compared with present life difficulties in reconstructive therapy?*

A. In reconstructive psychotherapy, some controversy exists as to the relative importance of material that deals with the past and material relating to the present. Extremists of both points of view argue the merits of their particular emphasis. On the one hand, there are those who regard the present problems of individuals as a peripheral product of personality disturbances arising out of insecurities in childhood. These insecurities have undermined self-esteem and blanketed sexual and aggressive drives with a mantle of anxiety. Environmental difficulties and current situational distortions stir up hardships for individuals by agitating past problems. Dealing with provocative current situations may restore the individuals' equilibrium. This stability is, however, precarious due to the continued operation of immature strivings. Although harmony may be reconstituted, the recurrence of environmental stress will promote a new breakdown in adaptation. It is fruitless, therefore, always to concentrate on the present since the roots of the difficulty, imbedded in the past history, will remain firmly entrenched. On the other hand, there are therapists who are opposed to an emphasis on the past. It is claimed that individuals repeat in present-day patterns their important childhood disturbances. A concern with the present must of necessity involve a consideration of the past. To discuss the past in detail results in a mere raking over of dead historical ashes; though interesting material may be exposed, it may bear little relationship to current happenings. A dichotomy may then be set up between the past and the present, without unifying the two. As irreconcilable as these two viewpoints appear, they are not so disparate as the proposed arguments would seem to indicate. In psychotherapeutic practice one constantly uses current life experiences as vehicles for discussion, for it is in the present that individuals live and feel. Yet, a consideration of the past is mandatory in understanding what is happening in the present. Current life experiences may be regarded as reflecting the past through the use of present-day symbols. It is therefore necessary to blend the past and the present and to focus on whichever element is of immediate importance.

Q. *Is it ever permissible to assign "homework" to patients?*

A. This can be very rewarding, particularly if patients are not too productive and do not work industriously at therapy. Asking them to keep a kind of diary, writing out their reactions, observations, and dreams between sessions, may get them to approach treatment more seriously. Each interview may be organized around discerning and exploring basic patterns that are revealed in the patients' notes or observations. Patients should leave every session with a general problem to focus on until next session. They may then work on this problem, observing themselves and their reactions, noting which environmental or interpersonal situations tend to aggravate or moderate it. This "homework" may catalyze the patients' thinking and get them to assume more responsibility for treatment.

Q. *If patients want information about a subject like sex, do you give it to them?*

A. First find out why they ask for information and then give it to them or assign appropriate reading.

Q. *Should all patients have a physical examination prior to psychotherapy*

A. All patients about to enter psychotherapy should have a good physical examination and, if the practitioner deems necessary, a thorough neurological examination performed by a competent neurologist. The findings will be negative in the vast majority of patients, but the occasional case of early cancer, brain tumor, or other operable maladies that are detected will justify the precaution of routine physicals.

Q. *How would you handle patients who appear to have read just about everything on the subject of psychiatry and keep citing the opinions of different authorities that may or may not agree with your point of view?*

A. Some patients may have read more on psychiatry than you, but this does not mean that they have integrated what they have read. As a matter of fact, they will probably tend to use the knowledge they have gained in resistance, by intellectualizing what goes on, or by criticizing the technique or formulations of the therapist. At some point in therapy it may be necessary to mention to such patients that, while their reading has given them a good deal of information, this information may be a hindrance to therapy rather than a help. No two problems of an emotional nature are alike, and facts patients have read applying to other people surely do not exactly apply to themselves. They can be fair to themselves only by observing their feelings and attitudes, without speculating what these must be like on the basis of readings. Sometimes

it may be necessary to be very blunt and to tell patients that it is important for them to forget what they have read since this seems to interfere with their spontaneity.

Q. *What do you do when patients ask a question the therapist is unable to answer?*

A. The therapist may say that the question cannot be answered at this time but will be later when the answer becomes more clear.

Q. *Is it ever justifiable to lie to patients?*

A. Lies eventually reveal themselves and shatter the patients' trust and confidence in the therapist. Truthfulness is, consequently, the keynote in therapy. In an effort to be truthful, however, one should not reveal things to patients that may be harmful to them. It may be essential, therefore, if their security and health are menaced, to avoid answering certain questions directly. If, for instance, patients show symptoms of an impending psychosis, and are dangerously tottering between sanity and mental illness, and if they are frightened by the upsurge of archaic unconscious material to a point where they believe themselves to be insane, it may be harmful to tell them that they are approaching a psychosis. Rather, they may, if they question the therapist, be told that their preoccupation with becoming insane is more important then the symptoms they manifest. These are evidence of great insecurity. Whenever the patients asks a direct question, an honest answer to which may be upsetting in view of existing ego weaknesses, the patients may be asked why they ask this question, and their concern may be handled without upsetting them with a straight reply. It is important to remember that truthfulness must not be confused with necessary caution in divulging information and interpreting prematurely. If patients are insistent on a complete answer to their questions, it may be helpful to point out that therapy involves a mutual inquiry into a problem and an avoidance of premature judgments. One must patiently wait until enough evidence is available before being certain of one's observations. The answer to questions will soon become evident, both to the patients and to the therapist. If for any reason the patients cannot perceive the truth, the therapist will point out why it is difficult for them to understand what is happening. The patients will eventually develop confidence in the fact that the truth will not be withheld but that ideas must be checked and double-checked for their validity before they can be communicated.

Q. *Sometimes it is necessary to break an appointment with patients. How can this best be done?*

A. Appointments should, if possible, never be broken without adequate notice being given to the patients. Unless this is done, the relationship may be injured and a great deal of work may be necessary to undo the damage. If circumstances make it necessary to break an appointment, the therapist or the therapist's secretary should telephone the patients, explain that an emergency has developed that necessitates a revision of the therapist's schedule, and that, consequently, it will be necessary to make a new appointment or to skip the present appointment. In instances where the therapist is ill, or expects to be away from the practice for an indefinite period, patients may be informed that the therapist will get in touch with them shortly to set up a new appointment. If a reasonable explanation is given, there will probably be no interference with the working relationship.

Q. *How would you handle patients' resentment because you do not keep appointments on time?*

A. The patients' resentment may be justified. Because of ambivalent feelings, patients usually have difficulties trusting any human being completely. The therapist must, therefore, give patients as little basis for distrust as possible, always explaining the reasons for unavoidable irregularities in appointment times so patients will not assume that the therapist is irresponsible. Giving patients an allotted amount of time is part of a reality to which both patients and therapist must adjust. When appointments are forgotten by the therapist, or patients have to sit around and wait for the therapist because the therapist has not finished with a preceding patient, resentments will develop that may interfere with therapy. Of course, there will be occasions when the therapist cannot help being late for a session. Emergencies with a preceding patient may develop, and the therapist may have to run over in time into the next session. Under such circumstances an explanation must be given patients to the effect that an emergency occurred that could not be avoided and that necessitated a delay in starting the session. To impress on patients the fact that they are not being exploited, they may be told also that time taken from their sessions will be made up. In the event a mistake has been made in patients' appointments, and the patients appears for their session at a time allotted to another patient, they must be taken aside and given an explanation to the effect that an unfortunate error in scheduling has occurred that resulted in the patients' being given the wrong appointment time. Another appointment should then be given the patients, during which any resentment resulting from the errors may be handled.

Q. *If you are unable to understand what is going on dynamically in a case you are treating, what do you do?*

A. Occasions will arise when the therapist may be unable to discern exactly what is going on in treatment. Should this continue for long, it may be indicative of such blocks as unyielding resistance in the patients or of countertransference. In either instance, where the therapist is disturbed by what is happening or where progress is blocked, one or more supervisory sessions with an experienced psychotherapeutic supervisor may be helpful in resolving the difficulty.

Q. *When do you increase the frequency of sessions?*

A. During the course of therapy it may be necessary to increase the number of sessions weekly for the following reasons: (1) an upsurge of intense anxiety, depression, or hostility that the patients cannot themselves control; (2) violent intensification of symptoms; (3) severe resistance that interferes with progress; (4) negative transference; (5) unrestrained acting-out that requires checking; (6) threats of shattering of the ego unless constant support is given; and (7) when the therapist wishes to stimulate transference to the point of creating a transference neurosis.

Q. *When would you decrease the number of sessions weekly?*

A. A decrease in the number of weekly sessions is indicated (1) when patients are becoming too dependent on the therapist, (2) when alarming transference reactions are developing which one wishes to subdue, (3) when patients have a tendency to substitute transference reactions for real life experiences, and (4) when patients have progressed sufficiently in therapy so that they can carry on with a diminished number of visits.

Q. *How important is adhering to the exact time of a session?*

A. From the standpoint of scheduling, adhering to a set time may be necessary. The usual time is between 45 to 60 minutes. But shorter spans, as low as 15 minutes, can be effective in some patients, and certain situations can arise that require extending the scheduled time.

Q. *Is advice-giving taboo in reconstructive therapy?*

A. Generally. One must keep working on the patients' resistances to the solving of their own problems. The ultimate aim is self-assertiveness rather than reliance on the therapist. On rare occasions, however, advice-giving may be unavoidable.

Q. *Should the therapist ever insist on patients' engaging in a specific course of action?*

A. Only when it is absolutely necessary that patients execute it and its rationale is fully explained to and accepted by patients.

Q. *Should the therapist ever try to forbid patients from making crucial decisions during therapy?*

A. Although important changes in life status, like divorce or marriage, may best be delayed until patients have achieved stability and greater personality maturity, it is obviously difficult for the therapist to "forbid" patients to make any decisions. Patients may be reminded that it is important not to take any drastic steps in altering their life situations without discussing these thoroughly with the therapist. If the therapist believes the decisions to be neurotic, the decisions may be questioned, presenting interpretations if necessary. In the event patients decide, nevertheless, to go through with a move that is obviously impetuous, it means that they are still at the mercy of neurotic forces they cannot control, that their insight is not yet sufficiently developed, or that they have to defy or challenge the therapist. The therapist may have no other alternative than to let patients make a mistake, provided the patients realize that they have acted on their own impulses. It is important not to reject patients or to communicate resentment toward them for having made a move against advice. Only when patients are about to take a really destructive or dangerous step is the therapist justified in actively opposing it.

Q. *What do you do if patients bring in written material for you to discuss?*

A. Occasional written material may be important, but if large quantities are brought in, this practice should be discouraged.

Q. *What would you do if patients refuse to talk spontaneously session after session but offer to write out their ideas?*

A. If this is the only way patients will communicate, it should be accepted. An attempt must be made, however, to handle the patients' resistance to talk at the same time that they are encouraged to bring in written comments.

Q. *What do you do if patients say they fear they will kill someone?*

A. One should not reassure the patients or minimize what they say. Rather, they may be told that there are reasons why they feel so upset that they believe that they will kill someone. They may then be encouraged to explore their impulses and fears. If the patients are psychotic or

destructively dangerous, hospitalization may be required. If acting-out is likely, the intended victim should be notified.

Q. *Should the therapist permit patients to express hostility or aggression openly in the therapeutic situation?*

A. Any overt behavioral expressions of hostility or aggression are forbidden, although verbalization of these emotions or impulses is permissible, even indispensable.

Q. *Do you ever reassure patients during insight therapy?*

A. Reassurance should be kept at a minimum. Gross misconceptions, however, will require reassuring correction, or patients may be in an emotional crisis which needs mitigation. Reassurance should never be given patients when they are in a negativistic state, since this may produce an effect opposite to what is intended.

Q. *Are fleeting suicidal thoughts arising in patients during treatment important?*

A. Suicidal thoughts are not uncommon during therapy. They often serve a defensive purpose, acting as a kind of safety valve. Vague ideas of suicide may be entertained as a way of ultimate escape from suffering in the event life should become too intolerable. In most instances such ideas are fleeting and are never put into practice no matter how bad conditions become. They are handled therapeutically in the same way that any fantasy or idea might be managed. It is important not to convey undue alarm when patients talk about suicide as an escape fantasy. To do so will frighten patients or cause them to use suicidal threats against the therapist as a form of resistance. Rather, the therapist may listen respectfully to patients and then state simply that there may be other ways out of their situation than suicide. Suicide is an irrevocable act. More suitable ways of coping with the situation will present themselves as they explore their difficulty. If, however, the patients have, in the past, made attempts at suicide, fleeting suicidal thoughts must be taken very seriously. A careful watch is indicated since the attempt may be repeated. Any evidence of hopelessness or resentment that cannot be expressed as such must be explored and resolved if it is possible to do so. Should resolution be impossible and should the danger of suicide continue to lurk, hospitalization may be required. Suicidal thoughts in patients who are deeply depressed must be considered as dangerous, and the patients must be handled accordingly.

Q. *What do you do when patients you are treating telephone and insist on seeing you that very day?*

A. If possible, this request should be respected, provided the situation is an emergency. Should the therapist be unable to arrange for an appointment, or for a partial appointment, a promise may be made to telephone the patients at a specified time that day to discuss the situation with them. As early an appointment as possible may be arranged.

Q. *What would you say to those patients who ask whether they may telephone or write to you whenever they desire?*

A. Lack of time will obviously make it difficult for the therapist to answer telephone calls or to read all the material that patients wish to communicate in writing. The therapist may handle a request on the part of patients to telephone by saying simply that it is much better to take up matters during a session, since the limited time available during telephone conversations may create more problems than are solved. In response to excessive written communications, the therapist may remark that verbalization is to be preferred to writing. Patients may be informed that when emergencies occur, they may feel free to telephone the therapist. If a crisis has developed, patients may be given specific times at which they may call or may be told that the therapist will telephone them at a certain hour. It is usually best to keep such telephone calls at a minimum and to increase the sessions of the patients should a more intensive contact be required.

Q. *How would you handle patients who are insistent that you inform them of your whereabouts at all times so that they can get in touch with you?*

A. One would deal with this the way any other symptom in a neurosis would be handled. Patients may be told that it is important to find out why they need to know the therapist's whereabouts. It may be that they feel so helpless and insecure that they must be convinced that the therapist will not desert them or deny them help in the event of a catastrophe. Patients may be assured that the therapist will, in the instance of a real emergency, always be happy to talk with them but that it is important to understand what is behind the patients' insecurity in order that they be able to overcome their feelings of helplessness.

Q. *In the event patients in psychoanalysis who have been using the couch position manifest anxiety and ask to sit up, would you encourage this?*

A. Anxiety may be the product of penetration of unconscious material into pre-consciousness, or it may indicate a feeling of isolation from or a fear of the therapist. Encouraging patients to continue their verbal associations on the couch may enable them to gain awareness of important feelings or conflicts. If anxiety becomes too great, however, their request to assume the sitting-up, face-to-face position should be granted. This will generally permit a restoration of stability, especially if supportive measures are coordinately employed.

Q. *Should patients be encouraged to use the couch in psychotherapy?*

A. In most cases this is not indicated or advisable. The possible exception is in formal psychoanalysis in which free association is employed.

Q. *What do you do when patients have reached a stalemate in therapy? They are completely unproductive, and any attempts of the therapist to mobilize activity and to resolve resistance fail.*

A. Group therapy with alternate individual sessions often stimulates activity, as may several sessions of hypnosis or narcotherapy. Continued resistance may justify a vacation from therapy, or, as a last resort, transfer to another therapist.

Q. *When is psychotherapy likely to become interminable?*

A. Patients whose personalities have been so damaged in early childhood that their personalities have never allowed for a satisfactory gratification of needs or for an adequate defense against stress may feel they require a continuing dependent relationship to function. Transference here is organized around maneuvering the therapist into a parental role. There is strong resistance to a more mature relationship. If the therapist enters into the patient's design, due to needs to play parent, therapy is apt to become interminable.

Q. *What does dreaming indicate when it becomes so excessive that it takes up the entire session?*

A. If patients deluge the therapist with dreams, the therapist should suspect that the dreams are being used as resistance, perhaps to divert the therapist from other important material.

Q. *Which dreams that patients present should one consider of great importance?*

A. Repetitive dreams and those with an anxiety content may be of great importance.

Q. *What do you do when patients constantly bring up important material several minutes before the end of a session, leaving no time to discuss it?*

A. This is usually a manifestation of anxiety. It may be handled by mentioning to patients the fact that the material they have brought up sounds important and should be discussed at the next session. If patients do not spontaneously bring it up, the therapist may do so, handling whatever resistances arise.

Q. *How would you handle parents who bring a child to you for therapy, and you are impressed by the fact that the parent needs treatment more than does the child?*

A. It may be important to determine how much motivation the parents have for therapy and their level of understanding. Should the parents be unaware of how they participate in the child's neurosis, it may be necessary to inform them that the treatment of their child will require seeing the parents also, both to determine what is going on at home and to help the parents understand how to handle developing problems. In this way the parents themselves may be brought into a treatment situation.

Q. *Are interviews of any value with the patients' families or with other people important to adult patients?*

A. The therapist may frequently get information from people close to patients that the patients themselves has been unable to convey. Often a conference reveals distortions in the patients' attitudes and behavior that are not based on reality. One or more interviews with important family members may thus be useful. Furthermore, if patients are unable to correct disturbed environmental situations by themselves, the cooperation of a related person as an accessory may be helpful. If patients are reacting destructively to a relative who then responds in a counterdestructive manner, if demands on patients by relatives are stirring up problems in the patients, if relatives are opposing patients' therapy—and it is obvious, help, financial and other, is needed—an interview with the relative, aimed at the clarification of these issues, may yield many dividends. These relatives may require reassurance to neutralize their guilt about the patients. Sometimes relatives can be prepared for contingencies that may arise in therapy, such as rebelliousness and hostility directed at them by the patients. An explanation that such occurrences are inevitable in treatment, and that they are part of the process of getting well, may forestall retaliatory gestures. The patients' needs for independence and assertiveness may

be explained for the benefit of relatives who unwittingly overprotect the patients. Statements to the effect that the patients will get worse before they get better and that it will require time before results are apparent often prevent discouragement and feelings of hopelessness among concerned relatives. Because a therapeutically induced change in the patients' attitudes brought about by therapy may impose new and unaccustomed burdens on people with whom the patients live or associate, preparing these people for the change may avoid a crisis. An interpretation of the patients' actions in dynamic terms will often relieve relatives' guilt and lessen their resentment. For instance, if an adolescent is beginning to act cantankerous and resistive, an explanation to the parent that this behavior is to be expected at the patient's time of life, as a gesture toward cutting the umbilical cord of dependency, that all adolescents are often difficult to live with, and that parents are bound to feel resentful at the behavior of their offspring, may foster greater tolerance. Or a wife distraught at her husband's inattentiveness may be helped to realize that her spouse is responding not specifically to her as a person, but rather to her as a symbol of some actual past or fantasied personage against whom the patient had to build a wall of detachment. This insight may help avoid the creation of the very situations that would drive her husband deeper into isolation.

Q. *How would you approach patients should you decide a conference with a relative is necessary?*

A. The patients may be told that in psychotherapy the therapist may want to have an occasional conference with a relative or other person close to the patients. The purpose is to get to know the relatives and their attitudes. Following this, the therapist may say, "I wonder how you would feel if I thought it necessary to talk with _____ [*mentioning name of person*]?" The patients may acquiesce; they may question the need for such a conference; or they may refuse indignantly to permit it. If patients are insistent that no contact be made, their desire should be respected. Important material concerning the relative will undoubtedly be forthcoming and may constitute the material of later interviews.

Q. *If an interview with family members or other significant people is decided on, are there any rules one should follow?*

A. Experience has shown that a number of precautions are necessary when it is decided to contact the family. First, the patients' consent should always be obtained, the only exception being where they are dangerously psychotic or suicidal. Second, confidential material revealed by patients must never be divulged, since the breach of confidence will usually be flaunted at the

patients even if the relatives promise to keep the revelations to themselves. Third, in talking to the relatives or friends, the therapist will often have a temptation to blame, to scold, or to enjoin them to change their ways or attitudes toward the patient. Distraught, confused, frustrated, and filled with guilt and indignation, the relatives will expect the therapist to accuse them of delinquencies toward the patients. Permitting them to talk freely, sympathizing with their feelings, and encouraging them to express their ideas about the situation will tend to alleviate their tension. It is important to try to establish a rapid working relationship with them, if this is at all possible. Once they realize that the therapist is sympathetic toward them, they will be more amenable toward accepting interpretations, and more cooperative in the treatment plan. Indeed they may, if they have been hostile to the patients' therapy or to the therapist, become helpful accessories. Fourth, should they telephone the therapist, they must be told that it is best that the patients be informed about the call, although the specific details need not be revealed. Fifth, if the patients are insistent on knowing what went on in the conference or conversation with the therapist, they may be told that the conversation was general and dealt with many personal and other problems, as well as their relationships with the patients. Sixth, it may be necessary to see these relatives or friends more than once, perhaps even periodically. Seventh, the therapist should not participate with the patients in "tearing down" family members, nor should the members be defended when the patients launch an attack. A sympathetic, impartial attitude is best.

Q. *Under what conditions would you advise relatives of patients to get psychotherapy?*

A. If the patients are in close contact with neurotic relatives and they are being traumatized by the relatives, psychotherapy may be advised, provided the therapist has a sufficiently good relationship with the relatives to make this recommendation. Therapy may also be advised when a change in the patients' condition makes a new adjustment by the relatives necessary. For instance, a frigid wife, living with an impotent husband, may, as a result of psychotherapy, on the basis of experiencing sexual feelings, make sexual demands on her husband that the latter will be unable to fulfill. For the husband to make an adjustment, he may require psychotherapy.

Q. *Is it permissible to treat several members of the same family?*

A. The situation often becomes complicated, but it can be done. Whether or not simultaneous treatment is possible will depend on the therapist's ability to handle the inevitable

complications. Reconstructive individual therapy with several members of the same family is not easily managed. Treating all or a number of family members together in a group (family therapy) may result in better family adjustment. Marital problems are often advantageously handled in joint marital therapy.

Q. *How should one act when one meets patients on the street or at a social affair?*

A. A professional therapeutic relationship requires reducing social contacts to a minimum. Occasions will, however, arise when the therapist will run into patients on the street, in public places, or at private social affairs. This may prove embarrassing to both therapist and patients. One cannot handle such situations by running away from them. Once the therapist is recognized by patients, the former may greet them cordially and then proceed with activities as usual. Understandably, at private gatherings, one's spontaneity will have to be curtailed to some extent. The patients' reactions to seeing the therapist in a different role may have to be handled with them during the ensuing sessions.

Q. *Should you expect all your patients to like you?*

A. Except for very sick patients, a satisfactory resolution of prejudices, suspicions, and resentments will occur relatively early in therapy, leading to a good working relationship. Periodically, however, the patients' feeling about the therapist will be punctuated by hostility, issuing either out of transference or out of an inadvertent error in the therapist's handling of the patients. Analysis and resolution of hostilities as they develop should bring the relationship back to a working level.

Q. *If patients continue to dislike you no matter what you do, should you discontinue therapy?*

A. A continued dislike is usually indicative of either errors in therapeutic management or of transference that the patients cannot resolve. As long as the dislike persists, little progress can be expected in treatment. Should the patients' feelings persist, the therapist may have to suggest the possibility of transfer to a different therapist. This must be done in such a way that the patients realize that the transfer is being recommended out of consideration for their welfare and not because the therapist rejects them. As a general rule, very few patients will need to be transferred because of persistent negative feelings. If a therapist encounters this problem frequently, the chances are that he or she is doing something in the therapeutic situation that is inspiring the dislike of patients. The therapist should, therefore, seek

supervision with an experienced psychotherapist who may be able to help in understanding what is happening.

Q. *How should you act to displays of crying or rage on the part of patients?*

A. One generally permits these to go on without reassurance until the meaning of the reaction is explored and determined. If the reaction is dangerous to patients or to others, it should be controlled by supportive measures.

Q. *Should the therapist engage in a confessional, confiding about his or her life to the patient in an effort to show the patient that the therapist also has some personal frailties?*

A. This can be very destructive to the relationship, especially at the beginning of therapy. Patients may use any revelations made as a confession of the therapist's weakness and ineptness and may then decide to discontinue treatment. Patients will usually discover enough frailties in the therapist spontaneously without being alerted to them.

Q. *Should you ever admit to patients that you may be wrong about certain things?*

A. It is important to admit an error when this is obvious to patients and they question the therapist about it.

Q. *If patients ask you if you are ill or tired, would you admit it?*

A. If it is true, it may be important to confirm the patients' observation, adding that you do not believe this will interfere with your ability to work with them.

Q. *What happens in insight therapy if the therapist's personality is authoritarian?*

A. If the authoritarianism of the therapist interferes with the patients' ability to express hostility, and with their assertiveness, it will probably limit therapeutic goals.

Q. *Is it possible that a therapist may develop a deep hate for certain patients?*

A. If a circumstance like this develops in therapy, there is something seriously wrong with the therapist or the technique used. It is not possible for the therapist to like all patients to the same degree, nor is it possible to avoid disliking some patients temporarily in certain phases of treatment. When this happens, the therapist must resolve the untoward feeling before it

interferes with therapeutic progress. If this is not possible, the therapist should transfer the patients to another therapist and perhaps seek personal psychotherapy.

Q. *Does a therapist ever fall in love with patients?*

A. If such a situation develops, it is a manifestation of countertransference that will seriously interfere with the therapist's essential objectivity. Failure to analyze such a feeling and to resolve it will make it necessary to transfer these patients to another therapist.

Q. *Does a therapist ever develop sexual feelings for patients?*

A. It is possible that certain patients may arouse sexual feelings in the therapist. If this happens, such feelings must be subjected to self-analysis and resolved.

Q. *Should not the conduct and attitudes of the psychotherapist be as passive and non-committal as possible?*

A. The idea that the therapist should remain detached and completely passive stems from the notion that this attitude will best demonstrate to patients how they automatically project onto the therapist attitudes and feelings that are rooted in past relationships. Not having done anything to incite their attitudes, the therapist is in a better position to interpret transference. The passive, detached attitude also is believed to avoid dependency and to throw the patients on their own resources. Experience shows, however, that the projections of patients, which are sparked by past distortions in interpersonal relationships, will emerge whether the therapist is passive or active. Patients with hostility problems will thus develop hostility toward the therapist who acts detached as well as toward one who acts accepting. If patients have dependency problems, they will get dependent on the most passive therapist. Rather than cripple the spontaneity of the therapist in the dubious quest of interpreting transference phenomena, or of mobilizing assertiveness, it is best for the therapist to act natural and not to assume artificial passivity if the therapist is not normally a passive person. Such an assumption may signify rejection to patients and, in mobilizing hostility, may interfere with the working relationship.

Q. *Are not warmth and emotional support necessary for some patients?*

A. Yes, especially when the patients' adaptive resources are at a minimum. Unfortunately, some therapists have been reared in the tradition of passivity and non-directiveness to a point where

they provide for patients a sterile, refrigerated atmosphere that, in seriously sick patients, is anathema to a working relationship.

Q. *Is the assumption of a studied role by the therapist of any help in insight therapy?*

A. It has been recommended by some authorities that the therapist play a deliberate role in insight psychotherapy that is at variance with the therapist's usual neutral, though empathic, position. Such role playing, however, may inspire intense transference that the therapist may be unable to control. As a general rule, the therapist should not transgress the defined role of a professional person who seeks to enable patients to help through self-understanding. An exception to this rule is an extremely experienced and skilled therapist who is thoroughly acquainted with the existing dynamics operative in a patient and who, by dramatizing a part and becoming actively involved in the patients' lives, strives to expedite change. Such activity is not without risks, but it may, in some cases, produce brilliant results. On the whole, deceptive role playing is not to be recommended. Most patients quickly perceive the artificiality in the assumed part played by the therapist.

Q. *What about role playing to provide patients with corrective emotional experiences?*

A. One of the reasons that role playing with that aim is frowned on is that it is sometimes employed with incomplete evidence about what requires correction. Premature assumptions about factors responsible for patients' pathology, and about the dynamics of existing interactions with others, may be nothing more than guesswork. To act merely on such impressions is not only unscientific but also may be counterproductive. What could be most propitious is to observe patients in their actual life settings to study their interactions with people and examine their dreams, fantasies, and verbal associations. Since it is not possible to be with patients 24 hours a day and to observe them in their habitual environments, therapists have to rely only on fragmentary observations within the therapeutic situation. Some therapists believe that the therapist is playing a designed role with the patient in any case and that a specifically designed role offers the greatest opportunity for taking advantage of the limited time available. My own feeling about the active providing of patients with corrective emotional experiences is that good therapy in the medium of non-judgmental and empathic attitudes, as well as reasonably accurate interpretations of transference, will do this without the therapists' disguising their true selves by playacting in a deceptive manner. This is not to depreciate artificial role playing when it is needed to practice more desirable responses or to probe repudiated attitudes and

fantasies. But here the patients are aware that no deception is being employed and that the therapist is not putting on a false front by engaging in theatrical maneuvers.

Q. *If the therapist acts consistently permissive and accepting, will this not in itself eventually reduce the patients' irrational responses to authority?*

A. The behavior of the therapist, no matter how well controlled will, to some degree, always be subject to distortion in terms of the patients' conceptual framework, which, in turn, is based on their previous experiences with authority. This is not to say that gross deviations of behavior on the part of the therapist will not bring about appropriate reality-determined responses. A brusque, disinterested, detached, or hostile manner will produce untoward reactions in most patients. It must not be concluded, however, that absolutely correct activity and behavior will always bring about good responses, since patients may interpret the therapist's actions as a hypocritically conceived lure.

Q. *Should deprivations ever by imposed on patients?*

A. Occasionally, it is necessary to enjoin patients to deprive themselves of certain sources of gratification to help the exploratory process. Thus, patients with destructive sexual acting-out tendencies may be urged to control their sexual impulses so that tensions may accumulate that will facilitate an analysis of their problem. If patients are shown the reason for their need to give up certain pleasure promptings, they will be less inclined to resent the therapist.

Q. *How would you handle overanxious and completely unreasonable patients who act more like children than adults?*

A. It is essential to remember that though patients may be chronologically adults, emotionally they may not have progressed beyond a childhood level. One may expect, therefore, childish tantrums, ambivalent feelings, unrestrained enthusiasms, and other reactions. If one can respect patients despite their unreasonableness, one will best be able to help them.

Q. *What do you do when your relationship with patients starts getting bad?*

A. All other tasks cease, and one must concentrate on bringing the relationships back to a satisfactory level. It is useless to explore patterns, to interpret and to engage in any other interviewing tasks so long as good rapport is absent. Essentially one must go back to the first phase of therapy and focus on reestablishing a working relationship.

Q. *Why is the handling of transference important in reconstructive therapy?*

A. Since much of the suffering of patients is produced by destructive transference involvements with people, part of the therapeutic task in reconstructive therapy is to put a halt to such reactions and to replace them with those that have a foothold in reality. If, for instance, patients respond automatically to authority with violent hate, as a result of an unresolved hatred toward a parent or sibling, their reactions may have a disorganizing effect on their total adjustment. Patients usually do not appreciate that this response to all authority is undifferentiated. They may not even be aware of their hate, which, considered to be dangerous in expression, becomes internalized with psychosomatic or depressive consequences. Liberation from such reactions is essential before patients can get well. This can best be insured in therapy by bringing them to an awareness of their projections. Several means are available to the therapist in executing this goal. First, on the basis of functioning in the role of an objective and impartial observer, one may help patients realize how many of their reactions outside of therapy have no reality base. Second, by watching for instances of transference toward the therapist, one may demonstrate to patients, often quite dramatically, the nature of those projections that constitute basic patterns.

Q. *What is the difference between "transference," "transference neurosis," "parataxic distortions," and "positive relationship?"*

A. Stereotyped early patterns, projected into the relationship with the therapist, were called by Freud "transference reactions." When these became so intense that patients acted out important past situations, this was known as a "transference neurosis." No satisfactory name was given to repetitive early patterns occurring with people outside of the therapeutic situation until Sullivan invented the term "parataxic distortions," which included all stereotyped patterns that developed inside or outside of therapy. A "positive relationship" usually refers to a good working relationship with minimal transference contamination.

Q. *Isn't the accepted idea of transference as a manifestation of purely infantile or childish attitudes or feelings a restricted one?*

A. Probably. A broader concept of transference would consider it to be a blend of projections onto the therapist of attitudes and feelings that date back to infancy and childhood, as well as more

current attitudes that have had a formative influence on, and have been incorporated into, the character structure.

Q. *Do all patients have to go through a transference neurosis in order to achieve very deep, structural personality changes?*

A. There is much controversy on this point, but experience shows that some patients can achieve extensive personality growth without needing to live through a transference neurosis.

Q. *What activities on the part of the therapist encourage neurotic transference responses?*

A. Dependency may be stimulated in patients by such therapist activities as overprotecting patients, making decisions for them, and exhibiting directiveness in the relationship. Sexual feelings in patients may be provoked by seductive behavior displayed toward the patients, by socializing with the patients, and by physical contact of any kind. Fearful attitudes and hostile impulses may be mobilized if the therapist acts excessively passive, detached, authoritarian, overprotective, hostile, pompous, or belligerent. It must, however, be remembered that transference may arise without any provocation whatsoever on the part of the therapist. This is the case when needs are intense and can be voiced and expressed due to the permissiveness of the therapeutic relationship.

Q. *What is the best way of handling transference?*

A. There is no best way; methods depend on the kind of therapy done and the therapeutic goals. Transference may not be explored or handled in supportive therapy. In reeducative therapy it may be immediately interpreted in an effort at resolution whenever it becomes apparent as resistance. In some types of reconstructive therapy it may be allowed to develop until it becomes so disturbing that the patients themselves achieve awareness of its irrational nature. In Freudian analysis it may be encouraged to the point of evolution of a transference neurosis.

Q. *Are so-called "transference cures" ever permanently effective?*

A. Structural personality changes rarely occur. A "transference cure," however, may permit patients to relate better to their life situations. This facilitates the development of more adaptive patterns that can become permanent.

Q. *How does countertransference lead to an improper assessment of neurotic traits in patients?*

A. Countertransference may cause the therapist to make incorrect interpretations of the patterns exhibited by patients. Thus, the therapist may, if welcoming hostile outbursts, regard these as manifestations of assertiveness rather than as destructive responses. If the therapist relishes a submissive, passive attitude on the part of patients, he or she may credit this to cooperation and to the abatement of neurotic aggression rather than to a neurotic need for compliance.

Q. *Should you ever emphasize positive aspects of the patients' adjustment?*

A. Therapists too often tend to regard patients as a repository of pathologic strivings, emphasizing these to a neglect of constructive traits, mention of which is very important in reinforcing constructive behavior.

Q. *Is acting-out always a bad sign?*

A. No. It may be a transitional phase in therapy indicative of a shift in the psychic equilibrium. Thus repressed, fearful individuals, realizing that they have been intimidated by an archaic fear of physical hurt for assertiveness, may become overly aggressive and act-out their defiance of authority as a way of combating their terror. Proving themselves to be capable of this expression without experiencing the dreaded punishment may enable them to temper their outbursts. In the same way, sexually inhibited people may become temporarily promiscuous, almost as if liberation from fear is tantamount with indulgence in sexual excesses. Incorporated also in the acting-out process are unresolved impulses and conflicts, in relation to early authorities, that have been mobilized by the transference. When the therapist becomes aware of acting-out, it is important that it be discouraged in favor of verbalization. As verbalizations replace impetuous acts and as understanding progresses, a more rational solution is found for neurotic drives and impulses.

Q. *How do the value prejudices of therapists interfere with treatment?*

A. Whether intentional or not, therapists will accent in the interview attitudes and feelings that are in line with their value systems, and will minimize those that are opposed to it. If, for instance, therapists have a problem in their relationships with authority, manifesting submission and ingratiation, they may overvalue these traits. They may then tend to discourage assertiveness or aggressiveness when patients seek to take a stand with authority. Therapist may credit this philosophy to “good common sense” and justify it in terms of the benefits that accrue. This may seriously inhibit patients from working through neurotic feelings toward authority. On the

other hand, if therapists themselves react to authority with aggression and hostility, they may inspire defiance or promote aggressive attitudes toward authority figures, which may seriously endanger the patients' security.

Q. *What do you do with patients who break or cancel appointments consistently?*

A. This can be a disturbing problem since consistency in attendance is vital to good therapy. Should confrontation and discussion fail to resolve this problem, the therapist may suggest discontinuance of therapy. If, as in a clinic, the therapist is obliged to see patients irrespective of the latter's motivation, the therapist may insist on the patients' calling for an appointment when they want to be seen. In this way the burden of stopping therapy is put on the patients, and if there is any motivation at all, the patients may "shape up."

Q. *Shouldn't therapists be trained in all therapeutic approaches?*

A. The most effective therapists are those who can implement whatever therapies are indicated, whether these are of a supportive, reeducative, or reconstructive nature. If therapists have a broad understanding of various therapeutic procedures, know how to execute them, and are sufficiently flexible in personality so as not to be tied to a single treatment process, they will score the greatest therapeutic successes. This, however, is an idealistic situation. Most therapists learn only one kind of technique, which enables them to handle only a certain number of problems—those which are amenable to their technique. They may also be limited by their character structure so as to be unable to use certain techniques. For instance, a therapist may be an essentially passive person and, on this account, be unable to employ the directiveness and authoritativeness of approach essential for symptom removal, reassurance, guidance, persuasion, environmental manipulation, and other supportive therapies. On the other hand, the therapist may be so extremely authoritarian and dogmatic that patients may not be allowed to make mistakes, work out their own problems, or establish their own sense of values, so essential in reconstructive therapy.

Q. *Is there any consistency in therapeutic focus among therapists appraising the same patients?*

A. A therapist's judgment concerning existing core problems involves speculations that are not always consistent with what another therapist may hypothesize. Given the same data, different therapists will vary in choosing what is significant. In a small experiment I conducted, three experienced therapists trained in the same analytic school witnessed the first two sessions

conducted by a fourth colleague through a one-way mirror. Each therapist, including myself, had a somewhat different idea of what meaningful topic was best on which to focus. But such differences, in my opinion, are not significant. Even if one strikes the patient's core difficulties tangentially, one may still register a significant impact and spur patients on toward a better adaptation. After all, reasonably intelligent patients are capable of making connections and even of correcting the misperceptions of a therapist when a good working relationship exists and the therapist does not respond too drastically with wounded narcissism when challenged or corrected.

Q. *Is not insight a basic factor in all therapies?*

A. Insight on some level is helpful in all therapies. Even in supportive therapy, an understanding of the existing environmental encumbrances may eventually lead to a correction of remediable difficulties or to an adjustment to irremediable conditions. In reeducative therapy knowledge of the troublesome consequences of existing behavioral patterns may ultimately sponsor a substitution with more wholesome interpersonal relationships. In reconstructive therapy insight into unconscious conflicts, and their projected manifestations into everyday life, encourages patients toward actions motivated more by the demands of reality than by the archaic needs and fears of their childhood. Obviously, insight alone is not equivalent to cure.

Q. *What is the difference between the level of insight effectuated in reeducative therapy and the kind in reconstructive therapy?*

A. In reeducative therapy an inquiry is conducted into conscious and preconscious drives, impulses, feelings, and conflicts with the object of suppressing or changing those that disorganize behavior and of encouraging others that expedite adjustment. In reconstructive therapy the exploratory process deals with the more unconscious drives and conflicts. Due to the intensity of repression, one must implement the inquiry through examination of, and the inculcation of insight into, derivatives from the unconscious as revealed in verbal associations, dreams, fantasies, slips of speech, and transference. The object in reconstructive therapy is to liberate individuals as completely as possible from anachronistic values, attitudes, strivings, and defenses and to remove blocks to personality growth.

Q. *What is the best kind of therapy to use when the sole object is symptom relief or mere control of certain obnoxious personality traits?*

A. The objective in the treatment effort may be limited to the restoration of habitual controls to individuals, to the mediation of any continuing environmental stress, and to the modification of strivings and goals that are inimical to the patients' well-being or that are beyond their existing potentialities. Through the use of supportive and conditioning techniques, and by fostering an awareness of some of their character distortions and strivings, these objectives may be accomplished in a satisfactory way. There are, however, some conditions when character structure is so disturbed, and when elaborated crippling mechanisms of defense are so tenacious, that even the objective of mere symptom relief presupposes an extensive exploration of aspects of personality that have been repressed. This will necessitate reconstructive approaches.

Q. *Is it possible to do reconstructive therapy on the basis of once-a-week sessions?*

A. The effectiveness of therapy is dependent upon factors more important than the number of times each week patients are seen. Reconstructive therapy is possible in some patients on the basis of sessions once weekly; it is not possible in others. Great skill is required to bring about reconstructive changes when there are long intervals between visits. When a transference neurosis is to be created, four to five sessions weekly will be needed.

Q. *What is the difference between an apparent and a permanent recovery as related to reconstructive therapy?*

A. An apparent recovery is mere restoration to the premorbid level with the strengthening of the defensive techniques that have served, prior to illness, to maintain the ego free from anxiety. A permanent cure involves a real alteration of the ego to a point where those compromising defensive attitudes and mechanisms are no longer necessary to keep it free from anxiety. Under these circumstances, individuals are capable of gratifying their basic needs and strivings without undue conflict. Recovery in psychotherapy is permanent only insofar as it produces a real change in the character structure of individuals and a reorientation of their relationships with others and themselves. Due to the operation of resistances that blanket offending impulses, and because of repressions that keep from awareness the most important problems of the individual, reconstructive psychotherapy offers the greatest chance of overcoming a severe emotional difficulty.

Q. *What would you consider an acceptable minimal goal in reeducative therapy?*

A. The least we can do for patients is to bring them to as great an awareness of their problems as is reasonably possible, to enable them to lead as useful, happy, and constructive lives as they can with their personality and environmental handicaps, to help them overcome remediable life difficulties and adapt to irremediable ones, and adjust their ambitions to their existing capacities.

Q. *What is the difference between a "normal" and "neurotic" person?*

A. "Normality" is a social designation that embraces characteristics not entirely consonant with a definition of mental health. Average "normal" people in a culture possess many neurotic drives that are sanctioned and perhaps encouraged by society. Although these drives nurture some anxieties, "normal" individuals are still capable of functioning and of making a satisfactory social adjustment. If people are no longer able to adjust themselves and begin to manifest excessive anxiety and maladaptive mechanisms of defense, they may be classified as "neurotic." In therapy the objective may be to restore the individual's social adjustment and their "normal" neurotic tendencies. A more extensive objective, however, would be a correction of all neurotic traits, even those condoned as "normal," which is more idealistic than realistic.

Q. *If ideal goals of complete reconstruction are impossible, what would be reasonably good goals in reconstructive therapy?*

A. It is manifestly impossible for any one individual to reach the acme of emotional maturity in every psychic and interpersonal area. One may decide that a satisfactory result has been achieved when patients lose their symptoms, abandon their disturbing neurotic patterns, deal with their difficulties spontaneously without needing help from the therapist, manifest productivity and self-confidence, show absence of fear following expression of assertiveness, and exhibit an improvement in their interpersonal relationships with increased friendliness and respect and lessened suspiciousness, detachment, aggression, and dependency.

Q. *In interviewing patients, should a therapist disclose intimate personal facts as a way of positively influencing the therapeutic relationship?*

A. Studies of the effects of self-disclosure on the part of the therapist are inconclusive insofar as their influence on the relationship is concerned. The results cannot be predicted in advance. Depending on their personalities, patients may respond to a therapist's revelations positively

("My therapist is marvelously human," "He does not present himself as a flawless god," "She trust me by revealing these intimacies") or negatively ("This person has such weaknesses that I'm not sure she can help me," "If he can't help himself, how can he help me?"). Some research studies do indicate that therapist self-disclosure facilitates patient self-disclosure and greater therapist trustworthiness (Bierman, 1969; Sermat and Smyth, 1973). My personal view is to use self-disclosure very sparingly and only when it does not point to severe neurotic problems in the therapist. It may, for example, be employed to show how a therapist handled a problem or situation akin to that confronting patients, thus enhancing modeling.

Q. *How do therapists' personalities influence their techniques?*

A. Therapists eventually evolve their own therapeutic method, which is a composite of the methods they have learned, the experiences they have had, and their specific personality traits. For instance, analytically trained therapists, inclined by personality to be authoritarian, may be unable to maintain the traditional silence and passivity demanded by classical psychoanalysis. To do so robs them of spontaneity; it provokes tension and prevents them from exhibiting the kind of relaxed objectivity that is most helpful in treatment. They may find it necessary to abandon passivity and to permit themselves to participate more actively in the treatment process. Their patients will perhaps respond to this change in a gratifying way and react more positively than when the therapists were behaving in a stultified manner. This success may encourage the therapists to be themselves, and they will probably find that their results continue to justify their alteration of technique. For them, then, the shift is justified since it liberates them from acting in an artificial, inhibited way. Yet other therapists may not be able to do the same thing; for instance, those who by personality are more retiring, quiet, and unobtrusive. For them the passive technique will probably work well; to attempt to force activity would be as artificial as to expect active therapists to assume a feigned passivity.

Q. *How do you explain the misunderstanding that exists among the different schools of psychiatry and psychology?*

A. In so virgin a territory as the uncharted psyche, a diversity of theories, interpretations, and methods may be expected. A great deal of animosity has, however, unfortunately come to the surface among groups with divergent points of view. Splinter societies have erupted, justifying their break with the parent body on the basis of discrimination and lack of academic freedom in the older organization. Sparked at first by the impulse to create groups possessed of scientific

liberalism, a number of the splinter organizations have, upon achieving independence, then practiced the same intolerant bigotry that initiated their secession, developing their own dogmas and rejecting original thinking among the members. Such entrenched and reactionary attitudes are to be condemned in any scientific group.

Q. *Should a good therapist be able to cure or help all patients?*

A. No matter how highly trained the therapist may be, some patients will be able to be helped more than others. There will be certain patients therapists will not be able to treat—patients whom other therapists may successfully manage. On the other hand, therapists will probably be able to cure some patients with whom other therapists have failed. Therapists will make some mistakes during the course of therapy with all of their patients, but these mistakes need not interfere with ultimate beneficial results. Finally, therapists will be rewarded by a large number of successes, but they will also have their quota of failures.

Q. *Does it follow that psychoanalytically trained therapists will do better therapy than those who have not been analytically trained?*

A. It is fallacious to assume that non-analytically trained therapists are incapable of doing many kinds of psychotherapy as well as those who have been analytically trained. If therapists plan to do reconstructive psychotherapy, however, using dream interpretation, transference, and resistance, they will be helped by sound training in reconstructive therapy, including a personal analysis.

Q. *Must the therapist be completely free from neurosis?*

A. It is doubtful that any person in our culture is entirely free from neurosis, no matter how much personal psychotherapy has been undergone. To do psychotherapy, however, therapists must be sufficiently free from neurosis so that their own personal problems do not divert the relationship from therapeutic goals.

Q. *Will personal psychotherapy or psychoanalysis guarantee good functioning on the part of an adequately trained therapist?*

A. In most instances it will. Serious personality difficulties may in some cases not be resolved to a point where individuals will be able to function as therapists, however, although they might work satisfactorily in some other field. In other words, where their egos have been so damaged

through a combination of constitutional predisposition and traumatic life experiences, individuals may not, even with extensive psychotherapeutic help, be able to achieve that kind of personality flexibility, objectivity, sensitivity, and empathy that are prerequisite for functioning as an effective psychotherapist.

Q. *Why should not psychotherapy or psychoanalysis be able to resolve the neurotic problems of psychotherapists, since they actually are not as sick as most patients and should benefit greatly from psychotherapeutic help?*

A. The motivation to carry out psychotherapy, which is what inspires many therapists to seek personal therapy, may not be sufficient to enable therapists to endure and to work through the anxieties underlying their character distortions. For instance, the individuals may, prior to their determination to become therapists, have been functioning in a more or less detached manner, removing themselves from disturbing interpersonal situations periodically when these had become too difficult to handle. Under ordinary circumstances, and in average relationships, they would be able to function quite effectively with this kind of a defensive attitude. This detachment, however, may seriously affect their capacity to operate in a therapeutic interpersonal relationship, in which they will constantly be brought into contact with critically disturbed people who will seek to extract from them constructive responses they may be unable to give. A tremendous amount of personal psychotherapeutic work may be required before therapists will be able to give up their detachment as an interpersonal defense. If they do not have sufficient anxiety to incite them, however, to seek new modes of adjustment, they may not have the incentive to tolerate the great amount of work and suffering that will be involved in effecting a reconstructive change in their own personalities. Consequently, in their personal therapy, they will keep warding off the deepest character change and may go through their treatment without significant modification of their detachment. The fact that many therapists have exposed themselves to extensive personal therapy or psychoanalysis and have emerged from it without any basic character changes is no indictment of psychotherapy. Rather, it is an indication of how difficult it is to treat certain kinds of emotional disturbance without adequate motivation. In other words, the desire to become a psychotherapist is not in itself sufficient motivation to promote deep character change.

Q. *What can therapists do whose personality problems interfere with their executing good psychotherapy even after they has gotten extensive personal therapy and supervision?*

A. If a qualified supervisor finds that the supervisees' problems are interfering with their therapeutic effectiveness, the supervisees may be advised to seek further personal psychotherapy. Should no change occur, it may be necessary for the therapists completely to give up psychotherapy as a career. They should not regard this as a personal defeat or as a sign of devaluated status, since they will probably be able to function very effectively in another role. For example, psychiatrists may decide to do diagnostic, institutional, or other kinds of work that do not bring them into an intimate therapeutic relationship with patients. Caseworkers can confine activities to an agency organized around areas other than therapeutic services. Psychologists can restrict functions to diagnostic testing, research, vocational guidance, and counseling.

Q. *Don't you believe that every therapist should learn the principles of preventive mental health in addition to knowing how to do psychotherapy?*

A. Mental health needs are only partially served by an exclusive program of psychotherapy. This is because the impact of emotional problems on the lives of people so often reflect themselves in disturbances in work, family, marital, interpersonal, and social relations without causing collapse in adaptation characteristic of neuroses. The providing of help for these preclinical problems requires an ability to consult with, and to supervise, community workers and professionals such as social workers, teachers, nurses, physicians, psychologists, correctional workers, and ministers, who are unable to handle such problems alone. It is advisable that every therapist be acquainted with the principles of preventive mental health and know how to communicate well with community agencies and the ancillary professions.

Q. *What do you do if you make an outlandish error like forgetting patients' ages or marital status?*

A. Being human, therapists will, from time to time, unintentionally commit some blunders. They may forget patients' ages, details about their families, or items in the history that patients have already recounted. Distracted, the therapist may even forget the patients' first names. Sometimes a more flagrant blunder may occur, such as calling patients by the wrong name, or asking them if they have dreamed recently, when they already have in the first part of the interview recounted a dream. Should such slip-ups happen, there is no need to conceal them or to be too apologetic. Therapists may merely say: "Of course, you told me this" (or "1 know this") or "It just temporarily slipped my mind." Patients will not make too much of such errors

if a good relationship exists. At any rate, it may, if it seems indicated, be important to explore the patients' feelings immediately upon commission of a mistake.

Q. *Should psychiatrists do physical examinations if necessary?*

A. Psychiatrists will probably not be as skilled in diagnosis as the internists to whom they can refer patients needing medical treatment. A physical examination in any therapy other than psychoanalysis, however, theoretically need not interfere with the therapeutic process, if the patients' reactions to it are examined and explored. It may bring many interesting and important feelings to the surface.

Q. *Should two therapists, each working on separate members of the same family, confer?*

A. A conference may be helpful to clarify the patient's interactions with the other member and to check on data significant to both. Usually, however, this is not routine. If it is done, each therapist should be mindful of personal competitiveness with and need to impress the other therapist and of defensiveness regarding the patient's progress.

Q. *What is multiple therapy, and does it have a use?*

A. Multiple therapy is the treatment of a single patient or a group by two or more therapists. It is preferred by some therapists in the management of difficult patients, such as psychotics and psychopaths. Differences in opinion and transference reactions between the therapists will require careful handling, sometimes within and sometimes outside of the therapeutic session. There may be advantages in employing multiple therapy in cases that do not respond to conventional treatment.

Q. *Does not behavior therapy circumvent transference and other resistances?*

A. Behavior therapy possesses ingredients that are common to all psychotherapies. Inaugurated almost immediately is a relationship, patients responding to the therapist as an idealized authority who holds the key to their well-being. The trinity of faith, hope, and trust, while not openly expressed, are aspects that cannot be avoided. The placebo element is as much a component of behavior therapy as it is of any other kind of treatment. Factors of motivation and dyadic group dynamics undoubtedly come into play and act as accelerants or deterrents to progress. If readiness for change is lacking, one might expect a negative result in behavior therapy. Subtly, transference will be set into motion, no matter how assiduously the behavior

therapist attempts to avoid it, and resistances of various kinds will rear their obstructive heads at almost every phase of the therapeutic operation. Some behavior therapists refuse to acknowledge the presence of these intercurrent elements, though this obviously will not negate their influence.

Q. *If psychological tests indicate that particular patients are very sick, shouldn't you approach them carefully in therapy, and isn't this a sign that your goals have to be superficial ones?*

A. One may be forewarned about the strength of the individuals' egos from psychological tests, but this should not prejudice the treatment process. One of the disadvantages of testing is that it puts a label on patients the therapist may be reluctant to remove, even though the therapist's clinical judgment disagrees with the test findings. The therapeutic relationship is a better index of how deep one may go in therapy and the extensiveness of goals to be approached than any psychological test or battery of tests.

Q. *Isn't it difficult at present to develop a real science of mind because of the many divergent ideas about psychodynamics?*

A. The subject of psychodynamics opens up many founts of controversy because authorities with different orientations have different ways of looking at psychopathological phenomena. Irrespective of orientation, one can always find data that seems to substantiate one's particular point of view. The same interview material may thus be variously interpreted by several observers. Some regard it as confirming their theory that neurosis is essentially a clash between instinctual strivings and the environment. Others as enthusiastically demonstrate cultural forces as the primary provocative agent. Still others may find in the material evidence that neurosis is fostered by disturbances in the integrative functioning of the ego. Such divergent ideas are not too serious; they are to be regarded as the inevitable forerunners of a real science of mind. In the study of the uncharted psyche, theories in abundance were bound to emerge, supporting many rifts and controversies. Fortunately, the beginnings of amalgamation are occurring, an honest effort to blend the findings of the various schools into a body of knowledge shorn of prejudice and bias.

Q. *Is it possible for a therapist to be supervised by several different supervisors who espouse different theoretical viewpoints?*

A. Unavoidable, particularly in an eclectic atmosphere, is the fact that student therapists will be supervised by several supervisors whose approaches reflect wide theoretical differences. It is to be expected that these divergencies will mobilize insecurity in students who are seeking a definite structure in theory and process. The function of the good supervisor is to help students see that different views merely expose contrasting aspects of the same phenomenon. These multiform facets may seemingly conflict with each other, though they are actually constituents of a unified whole. One must handle the students' disappointments that everything does not harmonize and fit together into a master plan. Should their anxiety prove too great, students may need special, even psychotherapeutic, help. Appreciating that other points of view exist is one of the most important contributions of the supervisor. Only a supervisor who is sufficiently secure not to regard differences in approach as interferences and can view them as a challenge toward further scientific inquiry will be able to render the kind of help that students need and have a right to expect.

Q. *Can dependent patients progress in therapy beyond the goal of achieving freedom from symptoms?*

A. It is sometimes contended that if patients seek guidance and an authoritarian relationship in therapy their mental set will prohibit their entering into the participatory mode of activity essential for deeper therapy. Their desire for paternalism, it is said, will block essential collaboration. This is not always correct. The majority of patients, even those who have read tomes on psychoanalysis, seek a relationship with a strong, idealized parental figure who can lift them out of their distress. The stronger the anxiety, the greater the expectation. The task of the therapist is to promote a shift in motivation toward expanding the patients' inner resources and working cooperatively with the therapist. A fundamental task in all therapy is to promote the conviction in patients that they have the inner resources to resolve feelings of helplessness. Good technique in psychotherapy takes this factor into account. Understandably, there are some characterologically dependent souls and borderline patients so inwardly damaged that they will need a dependency prop in order to function. No amount of therapeutic work will deviate them from this aim. But even here the therapist owes it to the patients to make an effort to promote greater self-sufficiency. Patients may diagnostically be written off as candidates for reconstructive psychotherapy in view of the depth of their disturbance, their habitual infantile relationships with people, wretched past conditionings with emotionally ill parents, uncontrollable acting-out propensities, paranoiac ideas, and so forth. On this basis, a

supportive relationship is provided the patients, only to find that they press for deeper self-understanding. Yielding to this pressure, the therapist may institute reconstructive treatments, helping some to rise out of their dependent morass and to use their understanding toward great self-actualization.

Q. *Are there any diagnostic signs that will indicate how patients will actually respond to psychotherapy?*

A. Very few diagnostic or other rules can be laid down to anticipate patients' responses to therapy. The only true test is the way patients take hold of the opportunity offered them in psychotherapy to approach their lives from a different perspective. Trial interpretations may be instituted to determine how patients will respond in the relationship. Will they deny, resist, fight against, or accept the interpretation, and will they act on it?

Q. *What is the effect on patients of passivity in the therapist?*

A. Passivity on the part of the therapist may produce frustration and anxiety, which, if not too intense, may mobilize patients to think things through for themselves and to act on their own responsibility. Should excessive hostility and anxiety be engendered, however, or should patients interpret the therapist's passivity as rejection or incompetence, it may have a paralyzing effect on their progress. This is particularly the case when patients, in their upbringing, have been victimized by a neglectful or uninterested parent who put too much responsibility on their immature shoulders. The therapeutic situation then will merely tend to recapitulate the early traumatizing experience and reinforce the sense of rage and helplessness.

Q. *Should a trial period be instituted in psychotherapy to see how patients will react?*

A. Freud [1913] originally recommended that a trial period of a week or two be instituted to see if patients are suitable for psychoanalysis. A trial period is more or less inherent in all psychotherapeutic endeavors. Patients and therapists mutually survey one another to see whether they feel comfortable and confident about working together. Patients test therapists. Does the therapist like them? Does the therapist have confidence in them? Does the therapist trust them? The therapist subjects patients to an empirical scrutiny. Can he or she interact with the patients? Are the patients properly motivated, and if not, how can incentives be developed? Are patients operating under misconceptions about treatment? How far will they be able to go in therapy—toward symptom relief? Toward reconstructive personality change? The therapist

may, during this trial phase, make a few interpretations to test the patients' receptivity, flexibility, and capacities for change. At the same time that ground rules are established; a working hypothesis is laid down, and the beginnings of treatment are instituted. Reformulations of this early hypothesis will have to be made periodically in accord with the patients' reactions, resistances, and rate of movement.

Q. *Shouldn't therapists always remain neutral?*

A. Therapists as human beings have feelings, values, prejudices, and needs. They will reveal these to patients sooner or later, if not verbally then non-verbally, both directly in their interpretations and indirectly in their silences, pauses, content of questions, and emphasis. While ideally therapists should avoid prejudicial pronouncements, they should not deceive themselves into thinking that they can always maintain a neutral stand. Nor is this desirable. It may be quite suitable to apply value pressure where it is needed and sometimes, as in patients' acting-out proclivities, it is the only tactic that makes sense. Though maintaining the philosophy that patients have an inalienable right to their points of view, decisions, and behavioral twistings and turnings, therapists do not need to accept the validity of some ideas and actions. There is no such thing as true "neutrality" in therapists. Otherwise they would not care whether patients remained sick or got well. Therapists have opinions and prejudices. They will display these in one way or another, if not one day then the next.

Q. *Are there differences among psychoanalysts regarding the use of activity as opposed to passivity in psychoanalysis?*

A. Polemics have been organized around the matter of activity versus passivity. On the one hand there are purists like Glover who defend the sanctity of the passive classical procedure. There are non-purists, like Franz Alexander, who insist that the rejection of activity can only lead to therapeutic stagnation. Activity is generally eschewed in the classical technique on the basis that it tends to produce a refractory and insoluble as opposed to an ameliorative transference neurosis (Mitchell, 1927). Since the time of Ferenczi (1950b, 1950c) who instituted "active" approaches, many analysts have introduced manipulations that to Glover (1964) exceed the limits of pure analytic practice on the basis that "deliberately adopting special attitudes and time restrictions for special cases changes the character of therapy in these cases, converting it into a form of rapport therapy." Although such methodological innovations may produce excellent results and even be the best therapy for cases inaccessible to the customary

technique, they should not be confused with "psychoanalysis" in which one analyzes and does not manipulate the transference. Supporting rigidity in approach, Glover avows that "flexibility in both psychoanalytic theory and practice has in the past been a frequent preamble to abandonment of basic principles." Passivity and the adoption of a "blank screen" are advocated as the best of deliberately nurtured attitudes to reduce complications. On the other hand, there are analysts who disagree with Glover, recommending modifications in method from the manipulation of the transference to the open exhibition of interest in and modulated demonstrations of affection toward the patient (Bouvet, 1958; Eissler, 1958; Nacht, 1957, 1958). Commenting on the fact that few cases of simple transference neurosis are seen in practice, Lorand (1963) points out that psychoanalytic technique today "is quite different from that of earlier periods of analysis." Unless active interference is used in certain cases, for example in character disorders and infantile patterns of behavior, the analysis may stagnate or break down. Obviously, it is impossible at all times to adhere to the basic rules of psychoanalysis. Directiveness and active interference are sometimes essential, especially during stages of resistance "where the standard technical methods are of little help." Such variations in technique within the framework of classical psychoanalysis may be used to further therapeutic progress. The "dosing" of interpretations may also be necessary to activate the unconscious, to eliminate defenses as well as to prevent their too ready emergence. In a past contribution, Glover (1955) himself considered *complete* neutrality a myth and wondered whether adhering to the rule of not making important decisions was really desirable. When deviations from classical technique are in order, however, they must, he insisted, be dictated by the needs of the situation and not by countertransference. In practice, modification of analytic rules is frequently necessary. But whether we should label such deviations as "psychoanalysis" is another matter. There would seem to be some justification in restricting the term "psychoanalysis" to the classical technique and to entitle procedures incorporating modifications and active interventions as "modified psychoanalysis" or "psychoanalytically oriented psychotherapy."

Q. *What is the theory behind cognitive therapy, and does it have utility?*

A. The theory underlying cognitive therapy is that people are dragooned into maladaptive actions by distortions in thought that they can both understand and control; within themselves they possess capacities for awareness of such understanding and solution of their difficulties. Therapeutic techniques organized around this hypothesis are directed toward correcting

deformities in thinking and developing alternative and more realistic modes of looking at life experiences. It is said that this is a much more direct approach to problems than other approaches since it draws on patients' previous learning encounters. Interventions are aimed at rectifying misconceptions and conceptual flaws that are at the basis of individuals' difficulties. This technique involves explorations of the stream of consciousness with the object of modifying the ideational content associated with the symptoms. Among the basic assumptions here are that the quality of therapists' thinking will inevitably influence the prevailing mood and that the *meaning* of a stimulus to patients is more important than the nature of the stimulus itself.

There is a good deal of overlap of cognitive therapy with behavior therapy. Albert Ellis (1962, 1971) in his rational-emotive therapy pioneered cognitive approaches in a behavioral setting. Meichenbaum (1977) attempts to blend cognitive-semantic modification with behavioral modification. Aaron T. Beck (1976) has written extensively on cognitive therapy and has claimed advantages for it in treating depression over all other therapeutic methods, including drug therapy. A new magazine, *Cognitive Therapy and Research* (Plenum), is devoted to explicating the role of cognitive processes in human adaptation and adjustment. Whether cognitive therapy is useful for therapists depends on their skill and conviction and the special learning capacities of individual patients.