THE TECHNIQUE OF PSYCHOTHERAPY

SELECTING A THERAPEUTIC FOCUS

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Selecting a Therapeutic Focus

Psychotherapy is much more effective when a focal topic is selected by the therapist. Once the therapist has determined why the patient has come for therapy and explored the patient's account of the situation and the patient's treatment goals, the focal topic can be chosen. A too early concentration on the patient's psychopathology and past conditionings that have created the troubles, however important this inquiry may be, will support regression and encourage long-term lingering in treatment. Rather, the therapist should begin to focus on what is of *immediate* importance to the patient, such as incidents in life that have precipitated the symptoms for which the patient seeks help. In focusing on precipitating factors one must gauge the patient's vulnerability to stress as well as the virility of the stress factors themselves. In focusing on symptoms the therapist should view them as an assembly of reactions to anxiety as well as consequences of defense mechanisms elaborated to control the symptoms.

During the explorations it is important try to actuate to problem solving, while examining, encouraging, and helping the release of whatever positive adaptive forces are present in the patient, as well as studying the resistances that block their operation. In the course of doing this the therapist may be confronted by the patient with some early formative experiences, but these are not explored in depth. They are handled in the context of explaining obstructions to effective functioning in the present. Ample opportunities will be found later on to switch the focus to areas related to some central dynamic theme by establishing a connection between it and current problems and concerns, should this be deemed desirable. In some cases, powerful initial resistance to treatment may make an early focus on dynamics essential. Obviously, the therapist will deliberately have to select dynamic aspects that can be worked with expediently, while avoiding or dealing tangentially with even noticeable conflicts that do not seem too noxious or would be difficult or impossible to handle in the first part of therapy. In most cases, however, dynamic causative issues are not concentrated on during the first part of treatment.

FOCUSING ON PRECIPITATING EVENTS

Many patients come to therapy convinced that their problems were brought about by some

precipitating factor in their environment. An alcoholic husband, a disastrous investment, a broken love affair, a serious accident, these and many other real or exaggerated calamities may be blamed. What people usually want from treatment is help in getting rid of painful or disabling symptoms that are often ascribed to such offensive events. The symptoms are varied and include anxiety, depression, phobias, insomnia, sexual difficulties, obsessions, physical problems for which no organic cause can be found, and a great many other complaints and afflictions.

Even though the therapist may be correct in assuming that the basic troubles reside elsewhere than in environmental or symptomatic complaints, to bypass the patient's immediate concerns is a serious mistake. Later when there is firm evidence of the underlying causes, for example, faulty personality operations or unconscious conflict, a good interviewer, as has been mentioned, should be able to make connections between the precipitating events or existing symptoms and the less apparent dynamic sources of difficulty. There will then occur a change in focus. This shift, however desirable it may seem, is not always necessary because it may be found that therapeutic objectives are reached with symptom-oriented and problem-solving methods and that the patient achieves stabilization without delving into corrosive conflicts or stirring up ghosts of the past. It is only when goals go beyond symptom relief or behavioral improvement that the therapist will, in the hope of initiating some deeper personality alterations, delve into dynamic problem areas. Even when the objective is mere symptom relief or behavioral improvement, however, resistance to simple supportive and reeducative tactics may necessitate a serious look at underlying personality factors that are stirring up obstructive transference and other interference to change.

In practically all patients some immediate stress situation, usually one with which the individual is unable to cope, sparks the decision to get help. Usually the patient feels like the victim rather than perpetrator of his or her identified troubles. This, in some cases, may be true; in most cases it is false. It is necessary, therefore, in all patients to appraise the degree of personal participation in their difficulties.

Since we are actually dealing with situations that generate tension and anxiety, it is essential to view environmental incidents through the lens of their special meaning for the individual. What may for one person constitute an insurmountable difficulty may for another be a boon to adjustment. During World War II, for instance, the London bombings for some citizens were shattering assaults on emotional

well-being; for others they brought forth latent promptings of cooperation, brotherliness, and self-sacrifice that lent a new and more constructive meaning to the individual's existence. Indeed, wartime with its threat to life marshalled an interest in survival and subdued neurotic maladjustment, which returned in peacetime to plague the individual.

The understanding of stress necessitates acknowledging that there is no objective measure of it. One cannot say that such-and-such an environment is, for the average adult, 70 percent stressful and 30 percent nurturant. No matter how benevolent or stressful the environment, the individual will impart to it a special meaning as it is filtered through the individual's conceptual network. This shades the person's world with a significance that is largely subjective. Conceptual distortions particularly twist feelings toward other human beings and especially toward the self. A self-image that is hateful or inadequate may plague the individual the remainder of his or her life and cause self-devaluing interpretations of events. Most of what happens to the patient will be viewed as confirming a sense of low self-worth and that nothing that he or she does will amount to anything. Such a pervasive belief, of course, makes nearly any occurrence productive of considerable stress.

It is rare then that environmental stress alone is the sole culprit in any emotional problem. Inimical, frightening, and desperate situations do arise in the lives of people, but the *reactions* of the individual to happenings are what determine their pathological potential. Under these circumstances minor environmental stress can tax coping capacities and break down defenses so that an eventuating anxiety will promote regressive devices such as protective phobias. It is, therefore, essential that any precipitating incident that brings a patient into therapy be regarded as merely one element in an assembly of etiological factors, the most important variable being the degree of flexibility and integrity of the personality structure. It is this variable that determines a harmonious interaction of forces that power intrapsychic mechanisms when security and self-esteem are threatened by adversity from the outside and by common developmental crises that impose themselves from within. Through focusing on what is regarded as a precipitating incident, the therapist may be able not only to initiate remediable environmental corrections but also to open a window into hidden personality resources.

From a practical viewpoint, therefore, any environmental stress warrants close examination for its influence, good or bad, on the total resources of the patient. An understanding of the how and why of its

impact may prove invaluable. Sometimes the initiating factor may seem like a trivial spark to the therapist, but an exploration of the patient's history, attitudes, and values may reveal the emotionally explosive mixture that awaits detonation.

FOCUSING ON SYMPTOMS

Most patients are concerned with disturbing symptoms, which is the chief reason for their coming to treatment. The relief of such symptoms sometimes constitutes a legitimate beginning objective, particularly if the therapist employs a systems theory design that focuses on the causative link responsible for the current difficulty. One reason a systems approach has been resisted by some authorities is that in describing it, confusing language has been employed that is closer to theories of engineering and communication than to psychological constructs (e.g., "morphostatic principles," "negative feedback loops," "cybernetic regulation," "servomechanisms," "morphogenesis"). In the mental health field, a systems viewpoint shorn of these vertiginous linguistics can prove useful. Such a viewpoint would consider behavior a long chain of a number of operative units linked together. In psychotherapy, the focus can be on the particular unit link in the chain that is creating the greatest disturbance for the individual: biochemical, neurophysiological, developmental, conditioning, intrapsychic, interpersonal, social, philosophical-spiritual. Thus if the symptom is a product of a biochemical problem that produces an imbalance of neurotransmitters and hormones, the therapist may, after establishing a proper diagnosis that implicates biologic factors, attempt to deal with the *biochemical link* by prescribing appropriate corrective medications. In this way the therapist may relieve some disturbing symptoms of schizophrenia with neuroleptics, of depression with antidepressant drugs, mania with lithium, and anxiety with antianxiety medications. The mechanism of the action of psychotropic drugs in panic, bulimia, obsessive-compulsive, and attention disorders is not known, but apparently the biochemical link is somehow involved and antidepressant medications may be effective. More is being discovered about how the mind and brain work through modem neurophysiological research (e.g., nuclear magnetic resonance, imaging techniques, position emission tomography (PET), and studies of neuropsychological deficits brought about by lack of coordination of the right and left hemispheres, defective brain metabolism, and impaired cerebral circulation. Psychopathology brought about by structural defects and malfunctions of the *neurophysiological link* has been ameliorated through

psychopharmacology, relaxation techniques, and biofeedback.

Problems related to the *developmental-conditioning link,* e.g., disorganizing patterns due to improper early child-rearing practices and disruptive conditioning, and which manifest themselves as phobias, habit disorders, behavior problems, adjustment difficulties, and developmental retardation are sometimes definitively helped by behavior therapy, cognitive therapy, and hypnosis. Problems in the quality and flexibility of defenses, which are mediated by the *intrapsychic link* and register themselves as disturbances in the self-system and other components of the psychic apparatus, are best approached with dynamic psychotherapy. Insofar as the *interpersonal link* is concerned, personality, as well as marital, family, and other relationship factors may be optimally engaged by cognitive learning, transactional analysis, experiential therapy, psychodrama, dynamic psychotherapy, and group, marital, and family therapy. The *environmental-social* link involved in situational problems may best be dealt with by counseling, social casework, environmental manipulation, and milieu therapy. Finally, the *philosophical link* of belief systems, values, standards, and ideals when distorted make for a wealth of problems and may require concentrated attention through techniques like cognitive therapy and existential analysis.

Behavior can be looked upon as a mixture of these intimately connected systemic links, each of which is bracketed to specific areas of dysfunction and pathology for which special corrective modalities, as indicated above, are suggested. Rarely if ever is pathology confined to one system alone. Because biochemical, neurophysiological, intrapsychic, interpersonal, social-environmental, and philosophical-spiritual systems are interrelated, difficulties in one system inevitably will by feedback involve some or all of the others. By the same token, disruptions in any one system that have been corrected through therapy will probably have a congenial effect throughout the systemic continuum. An example of how approaches on different system levels may accomplish similar results is provided in depression. Cognitive and pharmacological approaches deal with opposite ends of the behavioral continuum, and yet, from the available research, depression is relieved with both methods. This lends credence to the hypothesis that a feedback occurs throughout the behavioral chain. Alteration of one link influences the other links. As Beck and Young (1985) have expressed it, “Our experience suggests that when we change depressive cognitions, we simultaneously change the characteristic mood, behavior, and (we presume) biochemistry of depression.” It is for this reason that an organizing framework such as suggested above can be useful in treatment planning and in providing a productive focus for therapeutic

intervention. Moreover, such a framework substantiates multifaceted therapeutic modes that are targeted on specific zones of pathology. This can be especially helpful in short-term therapeutic approaches in which time is of the essence. It can also be useful in longer kinds of treatment.

FOCUSING ON DYNAMICS

Sometimes an individual presents a problem during the initial interview that ostensibly is the product of intrapsychic malfunctioning (i.e., the intrapsychic link). As an example, the most effective therapeutic focus is one that deals with a basic repetitive conflict, the manifest form of which is being expressed through the immediate complaint factor. To illustrate, consider the situation of a patient of mine, the mother of two small children, who was insisting on a divorce because of continuing disenchantment with her marriage. The divorce decision appeared to be the terminal eruption of years of disappointment in her husband's failure to live up to her ideal of what a man should be like. After we cut through endless complaints, it became apparent that the standard against which she measured her husband was her father, whom she worshiped as the epitome of success and masculinity. This idealization I discovered later, actually had little basis in fact, being the remnant of an unresolved Oedipal conflict. Be this as it may, her idealization had thwarted her ability to make a proper adjustment to her marriage, and with the decision of a divorce the integrity of her family was being threatened. She came to therapy at the urging of her lawyer, who realized that she was too upset to make reasonable decisions.

A therapist who minimizes the importance of dynamic conflicts may attempt to deal with a situation of this nature by invoking logic or appeals to common sense. The therapist may suggest ways of patching things up, insisting that for the sake of the children a father, however inadequate, is better than no father. The therapist may, upon consulting with the husband, point out various compromises the husband can make, and after the wife has verbally disgorged a good deal of her hostility in the therapeutic session, she may be willing to cancel her divorce plans and settle for half a loaf rather than none. The reconciliation is executed through a suppression of her hostility, which finds an outlet through sexual frigidity and various physical symptoms. On the other hand, should the therapist recognize the core conflict that is motivating her idea of divorce, there is a chance that the patient may be helped to an awareness of her merciless involvement with her father and the destructive unreasonableness of her fantasies of what an

ideal marriage is like. She may then allow herself to examine the real virtues of her husband and the true advantages of her existing marriage.

A dynamic focus should, therefore, be prospected in the course of exploring the immediate complaint factor. Such a focus is often arrived at intuitively (Binder, 1977). The more empathic, skilled, and experienced the therapist, the more likely he or she will be to explore the actual operative dynamics. No matter how firmly convinced the therapist is in his or her immediate assumptions, however, it is with a realization that these are being predicated on incomplete data. The therapist theorizes the patient may deliberately withhold important information, or though the patient may recognize certain conflicts, she is still oblivious to their significance or completely unaware of their existence. Whatever tentative theories come to the therapist's mind, he or she will continue to check and to revise them as further information unfolds. Interviews with relatives and friends are extremely valuable since they may open facets of problems not evident in conversations with the patient. Moreover, once the patient during the first encounter has divulged data, later interviews will help uncover rationalizations, projections, and distortions that will force the therapist to revise the thesis and concentrate on a different focus from the one that originally seemed so obvious.

No matter how astute the therapist has been in exposing a truly momentous focus, the patient's reactions will determine whether the exposure turns out to be fruitful or not. For example, even though an underlying problem is causing havoc in a person's life and is responsible for the crisis that brings the person to therapy, this does not imply that the patient will elect to do anything about it. Its emotional meaning may be so important to the patient, the subversive pleasures and secondary gains so great, that suffering and misery are easily accepted as conditions for the indulgence of destructive drives even when the patient has full insight into the problem, recognizes its genetic roots, and realizes the complications that inevitably indemnify the indulgence. I recall one patient whose yearning for revenge on a younger sibling produced a repetitive series of competitive encounters with surrogate figures toward whom retaliatory hostilities and violence brought forth punishment by employers, colleagues, and friends. A series of abuses culminated in a disastrous incident in which a physical assault on a fellow employee resulted in the patient's discharge from a promising executive position. This happening was so widely publicized in the industry that the patient was unable to secure another job. During therapy the patient was confronted with the meaning of his behavior and particularly his revenge and masochistic

motives; he readily recognized and accepted their validity. This did not in the least deter his acting out on any occasion when he could vent his rage on a sibling figure. At the end of our brief treatment period, it was recommended that he go into long-term dynamic therapy, which he bluntly refused to do. He seemed reconciled to pursue a damaging course for the momentary joy that followed an outburst of aggression.

Experience with the addictions provide ample evidence of the futility of focusing on the dynamics of a dangerous and what appears on the surface to be a disagreeable way of behaving. But that some patients disregard logic does not nullify the need to persist in making careful interpretations in the hope of eventually eroding resistance to the voice of reason.

We may expect that a patient seeking help will communicate sufficiently to supply essential material from which a focus may be extrapolated. Understandably, there will be differences in emphasis among therapists, even among those who have received similar theoretical grounding. The available material is usually sufficiently rich to enable therapists to identify ample aspects that synchronize with their intuitions, ideas, and biases.

Since all people share certain conflicts that are basic in our culture, some of these can constitute the dynamic focus around which interpretations are made. Thus manifestations of the struggle over separation-individuation following the ideas of Mann (1973), persistence of Oedipal fantasies as exemplified in the work of Sifneos (1972), and residues of psychic masochism such as described by Lewin (1970) are some of the core conflicts that may be explored and interpreted. Sensitized to indications of such conflicts as they come through in the patient's communications, the therapist may repeatedly confront the patient with evidence of how the patient is being victimized by the operations of specific inner saboteurs. There is scarcely a person in whom one may not, if one searches assidiously enough, find indications of incomplete separation-individuation, fragments of the Oedipal struggle, and surges of guilt and masochism. It is essential, however, to show how these are intimately connected with the anxieties, needs, and defenses of each patient and how they ultimately have brought about the symptoms and behavioral difficulties for which the patient seeks help.

Lest we overemphasize the power of insight in bringing about change, we must stress that to a large

extent the choice of a dynamic focus will depend on the therapist's seeing the presenting problem of the patient through the perspective of certain theoretical convictions. A Freudian, Jungian, Adlerian, Kleinian, Horneyite, Sullivanian, Existentialist, or behavior therapist will focus on different aspects and will organize a treatment plan in accordance with personal ideologies. Although the focus, because of this, will vary, there is considerable evidence that *how* the focus is implemented and the quality of the relationship with the patient are at least as important factors in the cure, if not more so, than the prescience of the therapist and the insightful bone of dynamic wisdom given the patient to chew on. That implantations of insight sometimes do alter the balance between the repressed and repressive forces cannot be disputed. How much the benefits are due to this factor and how much are the product of the placebo effect of insight, however, is difficult to say. When a therapist is firmly convinced of the validity of the focus chosen and convinces the patient that neurotic demons within can be controlled through accepting and acting upon the "insights" presented, tension and anxiety may be sufficiently lifted to relieve symptoms and to promote productive adaptation. Even spurious insights if accepted may in this way serve a useful purpose. Without question, nevertheless, the closer one comes in approximating some of the sources of the patient's current troubles, the greater the likelihood that significant benefits will follow.

In this respect for some years I have employed a scheme that I have found valuable in working with patients. This, which is certainly not original with me, consists of studying which resistances arise during the implementation of any of the techniques that I happen to be employing at the time. The resistances will yield data on the existing dynamic conflicts, the most obstructive of which is then chosen as a focus.

Experience with large numbers of patients convinces that three common developmental problems initiate emotional difficulties and create resistance to psychotherapy—first, high levels of dependency (the product of inadequate separation-individuation), second, a hypertrophied sadistic conscience, and, third, devaluated self-esteem. Coexisting and reinforcing each other, they create needs to fasten onto and to distrust authority, to torment and punish oneself masochistically, and to wallow in a swamp of hopeless feelings of inferiority and ineffectuality. They frequently sabotage a therapist's most skilled treatment interventions, and, when they manifest themselves, unless dealt with deliberately and firmly, the treatment process will usually reach an unhappy end. Dedicated as the therapist may be to their resolution, the most the therapist may be able to do is to point out evidence of these saboteurs, to

delineate their origin in early life experience, to indicate their destructive impact on the achievement of reasonable adaptive goals, to warn that they may make a shambles out of the present treatment effort, and to encourage the patient to recognize his or her personal responsibility in perpetuating their operation. The tenacious hold they can have on a patient is illustrated by this fragment of an interview.

The patient, a writer 42 years of age, who made a skimpy living as an editor in a publishing house, came to therapy for depression and for help in working on a novel that had defied completion for years. Anger, guilt, shame and a host of other emotions bubbled over whenever he compared himself with his more successful colleagues. He was in a customarily frustrated, despondent mood when he complained:

Pt. I just can't get my ass moving on anything. I sit down and my mind goes blank. Staring at a blank piece of paper for hours, I finally give up.

Th. This must be terribly frustrating to you.

Pt. (*angrily*) Frustrating is a mild word, doctor. I can kill myself for being such a shit.

Th. You really think you are a shit?

Pt. (angrily) Not only do I think I am a shit, I am a shit, and nobody can convince me that I'm not. *[The self-devaluation could not be more clearly expressed.*]

Th. Frankly, Fred, I'm not even going to try. But you must have had some hope for yourself, otherwise you never would have come here.

Pt. I figured you could get me out of this, but I know it's no use. I've always been a tail ender.

Th. (*confronting the patient)* You know, I get the impression that you've got an investment in holding on to the impression you are a shit. What do you think you get out of this?

Pt. Nothing, absolutely nothing. Why should I need this?

Th. You tell me. *[In his upbringing the patient was exposed to a rejecting father who demanded perfection from his son. The father was never satisfied with the even better than average marks his son obtained at school and compared him unfavorably with boys in the neighborhood who were prominent in athletics and received commendations for their school work. It seemed to me that the paternal introject was operating in the patient long after he left home, carrying on the same belittling activities that had plagued his existence when he was growing up.] Pt. (pause*) There is no reason, *(pause*)

Th. You know I get the impression that you are doing the same job on yourself now that your father did on you when you were a boy. It's like you've got him in your head. *[In the first part of the session the patient had talked about the unreasonableness of his father and his own inability to please his father.]*

Pt. I am sure I do, but knowing this doesn't help.

Th. Could it be that if you make yourself helpless somebody will come along and help you out? [*I was convinced the patient was trying to foster a dependent relationship with me, one in which I would carry him to success that defied his own efforts.]*

Pt. You mean, you?

Th. Isn't that what you said at the beginning, that you came to me to get you out of this thing? You see, if I let you get dependent on me it wouldn't really solve your problem. What I want to do is help you help yourself. This will strengthen you.

Pt. But if I can't help myself, what then?

Th. From what I see there isn't any reason why you can't get out of this thing—this self-sabotage. *(The patient responds with a dubious expression on his face and then quickly tries to change the subject.)*

In the conduct of psychotherapy, especially in its briefer forms, one may not have to deal with the underlying conflicts such as those above *as long as the patient is moving along and making progress. It is only when therapy is bogged down that sources of resistance must be uncovered.* These, as has been indicated, are usually rooted in the immature needs and defenses staged by dependent, masochistic, self-defacing promptings. At some point an explanation of where such promptings originated and how they are now operating will have to be given the patient. This explanation may at first fall on deaf ears, but as the therapist consistently demonstrates their existence from the patient's reactions and patterns, the patient may eventually grasp their significance. The desire to make oneself dependent and the destructiveness of this impulse, the connection of suffering and symptoms with a pervasive desire for punishment, the masochistic need to appease a sadistic conscience that derives from a bad parental introject, the operation of a devalued self-image and the subversive gains that accrue from victimizing oneself, must be repeated at every opportunity, confronting the patient with questions as to why the patient needs to continue to sponsor such activities.

Sometimes a general outline of dynamics, such as will be detailed later (illustrated in Figure 37-1 may try to fit each patient's problems into it and then choose for focus whatever aspects are most important at the moment. For example, a man may during a session complain of a severe headache and thereafter proceed to beat himself masochistically, blaming himself for being weak and ineffectual. The therapist should then search to see how this trend affiliates itself with guilt feelings and what immediate situation inspired such feelings. The therapist may discover that what is behind the guilt is anger in the

patient at his wife for not living up to his expectations in executing her household duties. Further probing may reveal anger at the therapist for not doing more for the patient. Such transference manifestations may enable the therapist to make a connection with the patient's mother, toward whom there has existed since childhood a good deal of anger for her neglect and rejection. This will open up a discussion of the patient's excessive dependency needs and the inescapable hostility, low independence, and devalued self-esteem that dependency brings about. An association may be established between the patient's hostility turned inward and the migraine headaches for which therapy was sought in the first place. The therapist should in this way take advantage of every opportunity to show the patient the interrelationship between the various drives, traits, and symptoms, keeping in mind that though a certain trend may encompass the patient's chief concern at the moment, it never occurs in isolation. It is related intimately to other intrapsychic forces even though the connection may not be immediately clear.

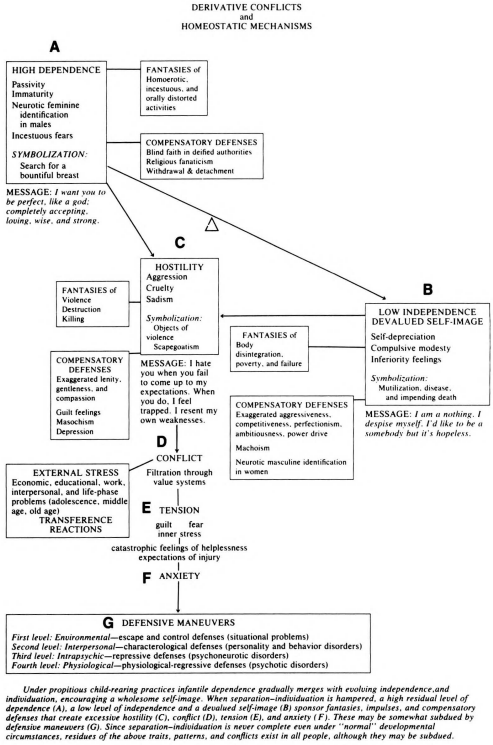

Fig. 37-1. Outline of Personality Operations

Figure 37-1 Outline of Personality Operations

An individual can make a reasonable adjustment for a long time even with a vulnerable character structure. The patient's personality, defective as it may have been, still operates harmoniously; various balances and counterbalances maintaining the psychological equilibrium. Then because of the imposition of an external crisis situation or because of stresses associated with inner needs and external demands, anxiety, depression, phobias, and other symptoms appear. The patient may consider that adjustment prior to the presence of some precipitating factor was satisfactory if not ideal, with no

awareness of how the tenuous personality interactions have been sponsoring various symptoms and ultimately had produced the patient's breakdown. The patient is very much like a man with back pain who credits his "sciatica" to one incident of lifting a weight that was too heavy, oblivious of the fact that for months or years he has, through faulty posture and lack of exercise, been accumulating weak and strained muscles.

Thus patients whose self-image is being sustained by a defense of perfectionism for as far back as they can remember will have to perform flawlessly even in tiny and most inconsequential areas of achievement. To perform less than perfectly is tantamount with failure and signals inferiority and a shattered identity. The merciless demands they keep making on themselves may be impossible to fulfill. At a certain point when unable to face up to demands in some truly important situation, the failure will act like a spark in an explosive mixture. The resulting symptoms that finally bring them into treatment are depression and insomnia. It will require little acumen for a therapist to spot the perfectionistic trends around which the patients fashion their existence. But to argue them out of the perfectionism and to counter the barrage of rationalizations evolved over a lifetime are difficult, if not impossible, tasks. We may, nevertheless, attempt to work with cognitive therapy and select perfectionism as a focus, pointing out the distortions in logic that govern the patients' thinking process. Not all therapists have the skill and stamina to do this, nor is there yet sufficient data to testify to the efficacy of this approach in all cases.

What would seem indicated is to review with the patients the implications of perfectionism, its relationship to the defective self-image, the sources of self-devaluation in incomplete separation-individuation, the operations of masochism, and so forth. Obviously, the therapist must have evidence to justify these connections, but even though the therapist presents an outline to patients of possibilities and stimulates the patients to make connections for themselves the therapist may be able to penetrate some of the patients' defenses. In the first part of therapy, psychodynamic explanations usually have little corrective influence. They simply may stir up the patient's curiosity and perhaps mobilize some defensive resistance, which may become a productive focus. Giving the patients a general idea about personality development may be occasionally helpful, especially when insufficient time is available in therapy to pinpoint the precise pathology. Patients are usually enthusiastic at first at having received some clarification and they may even acknowledge that segments of the presented picture relate to themselves. They then seem to lose the significance of what has been revealed to them. In my experience,

however, later on in follow-up many patients have brought up pertinent details and have confided that psychodynamic explanations stimulated productive thinking about themselves. (See also Chapters 44.)