THE TECHNIQUE OF PSYCHOTHERAPY

SIGNIFICANT VARIABLES THAT INFLUENCE PSYCHOTHERAPY

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Significant Variables that Influence Psychotherapy

Apart from extratherapeutic aids that can positively influence results in psychotherapy, multiple variables enter into the treatment gestalt that bear upon results for the good or bad. At the outset it is necessary to recognize that no psychotherapeutic method exists today that is applicable to all patients or germane to the styles of all therapists.

As disparate as the various approaches to psychotherapy may seem, their impact on the patient is often registered in similar ways. First, they offer a unique kind of interpersonal relationship in which one feels accepted for what one is and where judgements concerning attitudes and behavior do not agree with habitual expectations. Second, there is an explicit and implicit reinforcement of selected responses with the object of overcoming important behavioral deficits and of extinguishing maladaptive habit patterns. Third, there are direct or indirect attempts made at cognitive restructuring, through various instrumentalities, such as (1) persuasive arguments and proffering of philosophical precepts, (2) the exploration of conscious and unconscious conflicts aimed at the inculcation of insight, and (3) the provision of a corrective behavioral and emotional experience within the matrix of the patient-therapist interaction. Irrespective of behavioral parameters that purportedly are selected for inquiry and rectification, the patient will respond to the therapeutic interventions being utilized in accordance with personal needs and readiness for change.

These facts have fathered a common idea among professionals that therapists of different theoretical orientations do essentially the same things. The patient presents a problem; an attempt is made to establish a meaningful relationship; some formulation is presented to the patient as a working hypothesis; and special procedures are implemented to enhance the patient's mastery and eliminate disruptive elements in adjustment. If this be true, then techniques are merely forms of communication secondary to a host of transactional processes that draw from many biological, intrapsychic, and interpersonal vectors.

A reasonable question that may be asked is whether current research can shed some light on how these vectors can be organized and manipulated to make our operations more effective. Specifically, do

we have reliable data that will permit us to match patients, therapists, and techniques? Offhand we must admit that empirical studies to date have not settled this question. In an extensive review of research on the assessment of psychosocial treatment of mental disorders by an NIMH working group functioning as an advisory committee on mental health to the Institute of Medicine of the National Academy of Sciences, it is concluded that we do not yet have the answers to the basic question of "what kinds of changes are effected by what kinds of techniques applied to what kinds of patients by what kinds of therapists under what kinds of conditions" (Parloff et al, 1978a). We have insufficient data to date regarding the relative effectiveness of the different therapeutic modalities as well as the patient-therapist preferences to make a scientific matching feasible. When we consider the choice of the best kind of therapy, the report sums up the following way: "In summary, the data does not show that any of the tested forms of therapy are unconditionally superior to any other form." The report goes on with the statement that the existing single studies have proved inadequate to answer questions that we need to resolve. What is required is a coordinated planning of wide-scale sophisticated research utilizing an agreed upon minimal set of standardized measures for describing and assessing the kinds of problems, the variety of treatment interventions, and the nature and degree of behavior change.

Since help from present-day research is so problematic, we must depend on clinical hunches in sorting out the significance of the many variables in psychotherapy. For convenience we may group these into:

1. Patient variables
2. Therapist variables
3. Social and environmental variables
4. Transferential and countertransferential variables
5. Resistance variables

PATIENT VARIABLES

The Syndrome or Symptomatic Complaint

Are there special techniques that coordinate best with selected symptom complexes, methods that are more rewarding with some types of complaints as compared to other types? How really important are techniques in psychotherapy? Can different therapists get the same results by utilizing various kinds of interventions with which they are individually expert?

By and large techniques do operate as a conduit through which a variety of healing and learning processes are liberated. How the techniques are applied, the faith of therapists in their methods, and the confidence of the patient in the procedures being utilized will definitely determine the degree of effectiveness of a special technique. But techniques are nevertheless important in themselves and experience over the years with the work of many therapists strongly indicates that certain methods score better results with special problems than other methods.

Thus symptoms associated with biochemical imbalances, as in *schizophrenia* or *affective disorders,* may be relieved with proper psychotropic medication, for example, neuroleptics in the case of schizophrenic thinking disorders, antidepressant drugs in depressive states, and lithium for manic excitement and bipolar depressions. While thinking disorders in schizophrenia are helped by neuroleptics, problems in social adjustment are better mediated by behavior therapy, family therapy, and counseling. Indeed, milieu therapy in the form of a therapeutic environment staffed by accepting, supportive persons or proper accepting, nonstressful surroundings in which to live and work (Warner, 1985) often permit an adequate adjustment without the use of drugs. Such a congenial atmosphere must be continued indefinitely, in some cases over a lifelong period. The presence of a hostile or nonaccepting family correlates with an increased rehospitalization rate. Research studies, i.e., controlled outcome studies for individual or group therapy in schizophrenia, provide no strong evidence for or against the value of psychotherapy. Generally with continued aftercare following hospitalization in the form of a behaviorally oriented program and an adequate residential regime (halfway houses, partial hospitals, rehabilitation units and other community support systems), over 90 percent of patients can be discharged in the community with a 2-year rehospitalization rate of less than 5 percent (Paul & Lentz, 1977).

Our experience at the Postgraduate Center for Mental Health confirms the value of a rehabilitation program in lowering rehospitalization rates and, in rehospitalized patients, reducing the time of

confinement. Behavioral token economies are often valuable in hospitalized patients toward regulating ward behaviors in areas such as self-care, grooming, and social adjustment, and to control target behaviors such as job performance. Behavioral extinction procedures have been utilized to manage gross pathological behavior, like violence and destructive tantrums in psychotic autistic children, especially when coupled with differential reinforcement of constructive behavior. Such behavioral gains are consolidated when management techniques are taught to parents or other adults with whom the patient lives. No cure of the basic condition is brought about by these methods, but definite improvement of behavioral repertoires may be achieved.

While drugs influence *depressive symptoms,* they have little effect on patterns of behaving and thinking, which are best mediated through dynamic interpersonal therapy, cognitive therapy, and behavior therapy aimed at reinforcing involvement with pleasant activities and changing target symptoms and behavior toward improvement of interpersonal relations and social functioning. Combined drug and psychosocial therapy is thus best in most depressions. In suicidal depression electroconvulsive therapy has proven to be a lifesaving measure.

In *hyperkinetic children* it is generally found that we may be able to reduce the overactivity with psychostimulant medications, like Ritalin® and Dexedrine®, plus behavioral forms of reinforcement of positive behavior or such mild aversive techniques as removing the child with disturbing behavior to a "time-out" room for a few minutes. To influence neurophysiological dimensions, as reflected in severe *tension states,* simple relaxation procedures like meditation, relaxing hypnosis, or autogenous training, or emotive release therapy have been instituted.

Certain *psychosomatic conditions,* such as muscle spasms, migraine, hypertension and arrhythmia, may sometimes be helped by biofeedback. Unfortunately, biofeedback has been oversold, its utility being limited to selected patients (Miller, 1978). Behavioral advocates claim that best results with obesity are obtained with measures directed at self- and stimulus control. Behavioral operant reinforcement techniques and systematic desensitization are being used in *anorexia nervosa,* although the evidence of their effectiveness is still unclear. More recently progress has been reported with anorexia and bulimia utilizing antidepressants. *Smoking* control, it is claimed, is best handled by multicomponent treatment packages that program a reinforcement of nonsmoking behaviors and utilize smoking suppressive tactics

(Bernstein & McAlister, 1976) supplemented by nicotine gum chewing. Stimulus satiation, i.e., rapid smoking to satiation, is temporarily effective but the physical side effects must be considered. Hypnosis is also useful in combination with follow-up behavioral methods. In *enuresis* behavioral approaches (such as a urine alarm bell) are claimed to be superior to dynamic psychotherapy and imipramine.

Sexual disorders (voyeurism, fetishism, sadomasochism, exhibitionism, transvestism), though difficult to treat, are approached by some therapists with aversive therapy, such as electrical stimulation for transvestism (Marks, 1976) and with certain idiosyncratic methods like having an exhibitionist appear before a female audience to expose himself while talking about his condition, the extraordinary procedure being credited with some success on follow-up (Wickramasekera, 1976). *Sexual dysfunctions* (impotence, frigidity, dyspareunia, vaginismus, anorgasmia, premature ejaculation) do well with various behavior therapies, hypnosis, and dynamic psychotherapy. Of all of these programs, the Masters and Johnson techniques have proven most popular and have in the opinion of some authorities been made more effective when blended with psychodynamic and interpersonal techniques (Sollod & Kaplan, 1976).

Phobias that have their origin in conditioning experiences (i.e., exposure to parental fears, like a mother who is in terror of mice or a father who shies away from heights), or to a catastrophic personal happening (i.e., an accident in an airplane in which a person was traveling, resulting in a fear of flying), or to an anxiety or physiologically distressing experience linking itself to a coincidental stimulus (i.e., nausea or gastric upset occurring at the same time that one is eating a certain food, resulting in a subsequent refusal to eat that food), seem to respond more rapidly to systematic desensitization, flooding or graded exposure to a phobic object than to any other kind of technique. On the other hand, phobias that are the product of deep personality conflicts, the projected symbols of unconscious needs and fears, are in a different class from conditioned phobias and do not respond as well to behavioral methods. In fact, they may stubbornly resist those techniques and are better suited for dynamic approaches. Of all phobias, agoraphobia seems to be the most resistant to verbal therapies but may respond to antidepressant drugs.

About two-thirds of patients with *anxiety reactions* are helped by both dynamic psychotherapy and behavioral techniques, such as systematic desensitization, progressive relaxation, "participant modeling"

(i.e., the therapist modeling how to master anxiety), and temporary drug therapy. Behavioral therapy has moved toward recognizing the importance of cognitive factors (such as irrational self-statements and false attributes) and the need not only to modify environmental parameters, but also to consider the patient's interpretation of events and thoughts that mold reactions to the environment. In line with this, applications of behavior therapy have expanded toward a wide spectrum of neuroses and personality disorders.

Some obsessive-compulsive disorders respond to such antidepressants as clomipramine (Anafranil®), others come under control with aversive behavioral techniques when they resist every other type of manipulation. Prolonged exposure to thoughts or situations that provoke compulsive rituals combined with blocking of the patient from engaging in such rituals has yielded some successes. In vivo exposure is superior to exposure to fantasies. We may minimize persuasion as a technique, but it can have a potent effect on some *obsessive states, adjustment reactions,* and related conditions (Truax & Carkhuff, 1967). Stubborn as they are, *personality problems* and most *neurotic disorders* that are bracketed to personality problems are conditions most subject to the utilization of a dynamic orientation that probes for provocative conflicts and defenses. *Relationship difficulties* are particularly suited for group therapy, marital therapy, and, especially where children are involved, family therapy.

Some *addictions* seem to respond best to certain inspirational groups (e.g. drugs with Synanon, alcohol with Alcoholics Anonymous, food gorging with Weight Watchers, gambling with Gamblers Anonymous). These groups are preferably led by a person who has gone through and has conquered a particular addiction and is willing to serve as a model for identification. Accordingly, where a therapist works with such groups, an ex-addict co-therapist may be a great asset.

Where repressions are extreme, classical psychoanalysis, intense confrontation, hypnoanalysis, narcoanalysis, and encounter groups have been employed in the attempt to blast the way through to the offensive pathogenic areas. Understandably, patients with weak ego structures are not candidates for such active techniques, and therapists implementing these techniques must be stable and experienced. *Antisocial personalities* subjected to a directive, authoritarian approach with a firm but kindly therapist sometimes manage to restrain their acting-out, but require prolonged supervised overseeing.

Apart from the few selected approaches pointed out above that are preferred methods under certain circumstances, we are led to the conclusion that no one technique is suitable for all problems. Given conditions of adequate patient motivation and proper therapist skills, many different modalities have yielded satisfactory results. It is my feeling, however, that whatever techniques are employed, they must be adapted to the patient's needs and are most advantageously utilized within a dynamic framework. Transference reactions may come through with any of the techniques, even with biofeedback and the physical therapies. Alerting oneself for transference, one must work with it when it operates as resistance to the working relationship. Unless this is done our best alignment of method and syndrome will prove useless.

The fact that certain techniques have yielded good results with special syndromes and symptoms does not mean they will do so for all therapists or for every patient. Interfering variables, such as will henceforth be described, will uniquely block results or will make the patient susceptible to other less popular methods.

Selective Response of the Patient to the Therapist

At its core the patient's reaction to the therapist often represents how the patient feels about authority in general, such emotions and attitudes being projected onto the therapist even before the patient has had his first sessions. The patient may rehearse in advance what to say and how to behave, setting up imaginary situations in the encounter to come. Such a mental set will fashion feelings that can influence the direction of therapy. Thus, if the patient believes that authority is bad or controlling, oppositional defenses may be apparent during the interview. These global notions about authority and the reactions they sponsor are usually reinforced or neutralized by the response to the therapist as a symbol of an actual person important to the patient in the past (transference). Some characteristic in the therapist may represent a quality in a father or mother or sibling and spark off a reaction akin to that which actually had occurred in past dealings with the person in question. Or the reaction may be counteracted by a defense of gracious compliance or guarded formality.

Confidence in one's therapist is enormously important—even when the therapist's ideas of the etiology or dynamics of the patient's difficulty are wrong. The patient's acceptance of explanations

proffered with conviction can have a determining influence on the patient. They are incorporated into the patient's belief system and sponsor tension reduction and restoration of habitual defenses. Through what means this alchemy takes place is not clearly known, but suggestion, the placebo effect, and the impact of the protecting relationship offered by the therapist undoubtedly play a part. Sometimes unpredictable elements operate in the direction of cure.

> This is illustrated by the case of a beautiful, poised female writer of 32 who was referred to me for hypnosis by a friend of mine after many attempts to stop smoking by herself, and after several unsuccessful tries at psychotherapy. While there were no serious emotional problems that I could detect, and her present work adjustment, relationships with people, and sexual life seemed fairly satisfactory, one piece of data that she gave me put doubts in my mind as to how successful I would be in getting her off tobacco. She confessed to me, somewhat shamefacedly, that she still used a baby pacifier that she stuck into her mouth alone at home (she was single) at times when a cigarette wasn't between her lips. Often she went to sleep with it in her mouth. I asked her if she knew what this meant. "After all, doctor," she replied, "I'm no fool. I'm just a plain oral character." Under the circumstances, I confessed to her that the chances of success with a symptom-oriented approach like suggestive hypnosis were poor, and that she had better get herself into analysis without wasting any more time or money. "God forbid," she retorted. Since I had promised to hypnotize her, I induced a trance with less than ardent enthusiasm, and went through my usual paces, hoping to demonstrate that my predictions of failure would surely come to pass. Two days later she telephoned me to tell me she had quit smoking, and she asked if I would make a hypnotic tape for her. We had three visits in all, and while she retained her discrete pacifier habit, she fooled me by staying off tobacco completely. A year went by and she still had not resumed smoking, nor were there any substitute symptoms. This abstinence was confirmed by several reliable friends who knew her well.

Now I have no idea of the dynamics of the symptomatic cure but it is possible that my pessimistic attitude was just the right tactic to use with her. She may have decided to accept the challenge and to show me that I was wrong concerning my estimate of her. Or perhaps the idea she would have to get into long-term analysis was more distasteful to her than giving up smoking. Frankly, I was delighted that I was such a poor prognosticator, even though I still am convinced that a good analysis would have been a worthwhile investment.

The point I am trying to stress is that as thorough as we believe our initial interviewing may be as a way of estimating outcome, we still do not have all the variables at our fingertips. We still can be right in our estimate, but sometimes, as in this case, we can be wrong, and to the patient's benefit.

Where the therapist becomes for the patient an idealized figure, the initial therapeutic impact may be enhanced. Or if the transference is to an irrational authority, resistance is more likely in evidence. The degree of charisma possessed by the therapist also influences the patient's responses. Reputation,

clothing, manner, and appearance all function to nurture the illusion of miracles to come. The various patterns that evolve have a powerful and often determining effect on any techniques the therapist may utilize.

Selective Response of the Patient to the Therapist's Techniques

Patients occasionally have preconceptions and prejudices about certain techniques. Hypnosis, for example, may be regarded as a magical device that can dissolve all encumbrances, or it may connote exposing oneself to Svengali-like dangers of control or seduction. Misconceptions about psychoanalysis are rampant in relation to both its powers and its ineffectualities. Frightening may be the idea that out of one's unconscious there will emerge monstrous devils who will take command—for example, the discovery that one is a potential rapist, pervert, or murderer. Should the therapist have an inkling as to what is on the patient's mind, clarification will then be in order. The manner of the therapist's style is also apt to influence reactions of rage at the therapist's passivity, balkiness at what is considered too intense activity, anger at aggressive confrontation. Some patients are frustrated by having to talk about themselves and not being given the answers.

Moreover, responses to different methods will vary. There is a story of a Gideon Bible (which may be apocryphal) that illustrates this. As is known, practically all hotel rooms contain, as part of the general equipment, a Bible placed there by the Gideon Society, which in the front pages are suggested reading for the weary traveler. For instance, if one is in need of salvation, the reference is to John 3:3; or desires peace to neutralize anxiety, Psalm 46; or relief in the time of suffering, Psalm 41; or consolation in conditions of loneliness, Psalm 23. In a certain hotel Bible opposite Psalm 23, there was written in the margin this inscription: "If after reading this Psalm you are still lonesome, upset, and feel life is not worthwhile, telephone 824-3921 and ask for Phyllis." This is eclecticism! To help in the selection there are minimal techniques an eclectic therapist should know. In my opinion, the following are most useful: dynamically oriented interview procedures, group therapy, marital therapy, family therapy, behavior modification, pharmacotherapy, cognitive therapy, relaxation methods, and hypnosis.

But irrespective of the techniques we select, we must be sure that they accord with the patient's belief systems. As has been mentioned previously a patient who is convinced that spirit infestation is a

cause of illness will do much better with a shaman or witch doctor than with a psychiatrist. The patient's lack of faith in what the psychiatrist does will render worthless the most sophisticated treatment efforts. Knowledge of the cultural concepts that mold a patient's ideas about what emotional suffering is all about may make necessary some preliminary education to prevent embarking on a futile therapeutic journey.

Some attempts have been made to assign patients to certain styles of therapeutic operation according to their unique characterological patterns (Horowitz, 1977). For example, hysterical personalities are presumed to require a mode of therapist management that differs from that effective in obsessional personalities. This distinction considers that certain optimal learning patterns correlate with identifiable personality typologies. The relationship between character structure, diagnostic category, and learning abilities, however, never has been fully clarified. Thus, among patients suffering from the same syndrome, let us say obsessive personality, there are great differences in the way they will respond to certain techniques and therapist styles. While some general principles may be applicable to all or most obsessives, the existing differences prevent our using a blanket approach. People possess different modes, even within the same syndrome, of absorbing, processing, and responding cognitively, emotionally, and behaviorally to therapeutic interventions.

Since psychotherapy is in a way a form of reeducation, the learning characteristics of a patient should best correspond with the techniques that are to be used. Problem-solving activities are often related to the kind of processes found successful in the past. Some patients learn best by working through a challenge by themselves, depending to a large extent on experiment. Some will solve their dilemmas by reasoning them out through thinking of the best solution in advance. Others learn more easily by following suggestions or incorporating precepts offered by a helpful authority figure. Some are helped best by modeling themselves after an admired person, through identification with that person. Some patients work well with free association, others do not. Some are able to utilize dreams productively, or behavior modification, or sensitivity training, or other methods. It would seem important to make the method fit the patient and not wedge the patient into the method.

The fact that learning patterns are so unique and modes of learning so varied lends justification to an eclectic approach. It would be advantageous, of course, in the initial phases of therapy to find out how a patient might learn best, but no expedient is available today that can give us this information. We

usually settle for the fact that when a patient is first seen, learning capacities and styles are unknown and the therapist must proceed somewhat blindly. We more or less shoot in the dark in order to coordinate a patient's specific problem and personality with our techniques. We may get some help during interviewing in discovering how the patient has learned best in the past. More pointedly, we get the most reliable data by actually exposing the patient to the interventions we have to offer and observing the response to what is being done.

A few other attempts have been made to identify variables that can make the selection of a therapeutic method more feasible. Among these are the patient's response to hypnotic induction (Spiegel & Spiegel, 1978) and the isolation of core conflicts through the making of a developmental diagnosis (Burke et al, 1979). Some interesting speculations may emerge in watching how patients react to the induction of hypnosis, but are these sufficiently reliable to pinpoint either the existing diagnosis or choices in therapeutic method? More experimental substantiation is required.

Some therapists have attempted to utilize the area of developmental arrest as a way of selecting the ideal technique. Where the patient's prime difficulty is centered around resolution of separation-individuation, this is believed best accomplished through a technique such as described by Mann (1973) in which the struggle over short-term termination of treatment threatens the patient's dependency, lights up the separation problem, and offers the opportunity to resolve the conflict in a favorable setting. Where the oedipal conflict is primary, the confrontation styles of Sifneos (1972) and Malan (1964, 1976a) are believed to be most effective. For problems originating in the latency period that precipitate out in the mid-life transition around issues of productivity and creativity, the "corrective action" approach of Alexander and French (1946) is recommended. However, it is difficult to substantiate these views because of the interference of so many other variables that can vaporize our best choice-of-method intentions.

While empirical studies tell us little about factors that make for a good patient-therapist match, we may speculate that the personalities, values, and physical characteristics of both patient and therapist must be such that severe transference and unfavorable countertransference problems do not erupt to interfere with the working relationship. A giving, accepting, warm, and active but not too interfering or obnoxiously confronting manner in the therapist is most conducive to good results.

Readiness for Change

Another important factor is the individual's readiness for change. This is a vast unexplored subject. A person with a readiness for change will respond to almost any technique and take out of that technique what he or she is prepared to use. What components enter into a satisfactory readiness for change have not been exactly defined, but they probably include a strong motivation for therapy, an expectation of success, an availability of flexible defenses, a willingness to tolerate a certain amount of anxiety and deprivation, the capacity to yield secondary gains accruing from indulgence of neurotic drives, and the ability either to adapt to or constructively change one's environment.

Patients come to therapy with different degrees of readiness to move ahead. Some have worked out their problems within themselves to the extent that they need only a little clarification to make progress, perhaps only one or two sessions of therapy. Others are scarcely prepared to proceed and they may require many sessions to prepare themselves for some change. We may compare this to climbing a ladder onto a platform. Some people are at the bottom of the ladder and before getting to the top will need to climb many steps. Others will be just one rung from the top, requiring only a little push to send them over to their destination.

In therapy we see people in different stages of readiness for change, and we often at the start are unable to determine exactly how far they have progressed. One may arrive at an understanding of what is behind a patient's problem rapidly. From this we may get an idea that benefits will occur with little delay. Yet in relation to readiness for change, the patient may still be at the bottom of the ladder. Others are at a point where almost any technique one happens to be using will score a miracle. We may then overvalue the technique that seems to have worked so well and apply it to many different patients with such conviction that the placebo effect produces results.

We sometimes see patients who have been in therapy for a long time under the guidance of another therapist and who, on the surface, have made no progress at all. Surprisingly, after a few sessions the patient will begin to progress remarkably, creating the impression in both participants that the therapist is a genius in being able to do in three sessions what the previous therapist was not able to accomplish in three years. What actually may have happened is that the previous therapeutic effort succeeded in

pushing the patient up the ladder toward the top, requiring only a bit more therapy to be able to take the last step that was accomplished by the second therapist taking advantage of the work achieved by the first.

> I remember one patient who came to see me who advertised the fact that I had cured her in one session. She had been under the care of physicians for years, suffering from a host of physical complaints, and her last few doctors, who were burdened by her incessant shifting symptoms, had given up on her as an obstinate hypochondriac. No medicines seemed to help, and whenever psychiatric referral was mentioned she responded with an angry refusal and a host of new symptoms. Finally, one day she announced in frustration to her doctor that she was ready to see a psychiatrist and the doctor then referred her to me.
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> At the appointed time a buxom, handsome, middle-aged lady walked into my office and from the moment the door opened started and continued talking without giving me a chance even to introduce myself. My initial interview sheet in hand, I waited for a pause so that I could at least get some statistical data. After what seemed like an interminable span, she stopped for breath and I threw in an introductory: "By the way, how old are you?" Without pause she avoided the question and continued on her odyssey of voyages to doctors' offices around New York. After several futile attempts to interrupt. I gave up, put my sheet down, settled back in my chair and listened, interpolating an occasional "yes" and "hmm humm." I broke in at the end of the hour with: "Unfortunately our time is up." "Doctor," she said. "I feel so much better—thank you very much," and she got up and walked out without making another appointment.
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> I was curious about what had happened, so that a week later, I telephoned her doctor. His startling reply was: "I don't know what you did for her, but it was like a miracle. For the first time since I've known her, she's lost her symptoms and is interested in getting out of the house and doing things. And," he added humorously, "she says you are a brilliant conversationalist." Three months later the doctor called me and confirmed her continued improvement.

I do not know what happened but apparently my respecting her need to talk without interrupting was probably the best approach I could have used. She was under such great tension that had I not permitted her to let off steam verbally I may have succeeded merely in frustrating and antagonizing her. Grilling her with questions might have given me more information, but I am not sure what it would have done for her. She apparently had climbed the readiness ladder by herself up to the top rung and what she needed to push her over the top was to have someone sit back and listen. She undoubtedly wanted to talk freely to somebody who was not a member of her family, who was not going to judge her, who was passively objective, and who was, hopefully, nonjudgmental. Whatever qualities she projected onto me, she utilized the relationship in line with her needs.

Obviously, while this passive stance worked well with this woman, it would not have served other patients who might have required more active confrontation over a more protracted period. A person's readiness for change may, more than any other factor, be responsible for how rapidly movement

proceeds in psychotherapy.

Degree and Persistence of Childish Distortions

The distorted images of childhood, the ungratified needs, the unwholesome defenses, may persist into adult life and influence the speed, direction, and goals of therapy. These contaminations may obtrude themselves into the therapeutic situation irrespective of what kinds of technique are practiced. Insidiously, they operate as resistance and they can thwart movement toward a mature integration, no matter how persistent and dedicated the therapist may be.

> For example, one patient, a successful businessman of 50, came to therapy in a crisis over abandonment by his mistress 25 years his junior who had run off with another man. A deep depression and anxiety were the chief symptoms for which he sought help. He blamed the young lady's defection partly on his inability to compete with his rival and partly on the ubiquitous duplicity of all females. When he described his life, it became apparent that he had from the earliest days of adolescence looked for and pursued a certain physical type: blonde, fair skinned, long-legged, big-bosomed tarts whose teasing sexual provocativeness and irresponsibility added a fillip to his affairs. He invariably would select young women who were unable to establish a meaningful relationship and who eventually, despite his wealth and generosity, would reject him and finally leave him. This would make the relationship all the more precious in his mind and the rupture of the romance more disastrous.
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> During therapy he beat at himself, unmercifully proclaiming himself a worthless and destroyed person, a victim of the treachery of womankind. No amount of reassurance, challenge, and interpretation could penetrate his overwhelming despair, and antidepressants proved of little benefit. The fact that the great jewel in his life during the heyday of their relationship had led him a merry chase, deceiving and exploiting him mercilessly, made little difference. Her destructive exploits constituted the main content of his discussions with me, but his depreciating her had little effect on his yearning.
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> After 12 sessions of gripes in therapy, the lady returned without warning, complaining that her most recent paramour was unworthy of her, unreliable and, most importantly, penniless. She apologized for having hastily run off after knowing the man only several weeks and she begged the patient to take her back. The effect on the patient was electric. What common sense, medications, and psychiatry failed to do she accomplished in one evening. Depression, anxiety, and physical debility vanished. To justify the reunion, the patient offered to bring the lady to me for an interview to prove that she was now reformed.
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> At the interview there was no question that she had been trading solely on her physical assets, which were indeed ample, but emotionally and intellectually there was much to be desired. In fact, the most generous diagnosis one could bestow on her was that of a borderline case— and this was stretching a point. It was certainly apparent insofar as my patient was concerned that the only motivation he had for therapy was a desire to dull the pain of deprivation, not to inquire into or eliminate its source.
>
> My best efforts to halt the affair were of little avail since the lady could accomplish more with a casual pout than I could with all the armamentaria that Freud, Pavlov, and the other great pioneers had to offer. And even though she soon again started her nonsense, he hung on desperately to the relationship at the same time that he bellowed like a wounded buffalo.

> In going into the history, the background for his enslavement became apparent. The death of his mother when he was an infant and his placement with a series of relatives who provided him with a succession of nurses had failed to fulfill his need for real mothering. He was told, he said, that he was a colicky baby with respiratory trouble that was diagnosed as asthma. He failed to see any connection between his childhood and what was happening to him in the present. Interpretations of his orally frustrated dreams fell on deaf ears.
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> One day on inspiration I asked if he had ever seen a picture of his mother. This he denied. However, a later search by a relative through an old album yielded a startling picture that he excitedly handed me—a picture of a blonde beauty who presented an almost exact image of his present girlfriend. It took no great work to convince him that he had practically all his life been searching for a physical duplicate of his mother. This dramatic discovery had not the slightest effect on his futile mission to look for a symbolic breast, because after another abandonment, he started searching for a substitute blond, long-legged, big-breasted, unreliable paramour, whom unfortunately he found, starting a further round of exploitation, punishment, and anxiety.

Where severe traumas and deprivations are sustained in early infancy, especially prior to the acquisition of language, the damage may be so deep that all efforts to acquire that which never developed and to restore what never existed will fail. Transference with the therapist may assume a disturbingly regressive form and, while the genetic discoveries may be dramatic, the patient, despite intellectual understanding, will not integrate any learning and will fail to abandon patterns that end only in disappointment and frustration. Very little can be accomplished under such circumstances in short-term therapy, and even long-term depth therapy may lead to nothing except a transference neurosis that is difficult to manage or resolve. Lest we be too pessimistic about what may be accomplished through psychotherapy, there are some patients who, though seriously traumatized, may when properly motivated be induced to yield the yearnings of childhood and to control if not reverse the impulses issuing from improper discipline and unsatisfied need gratification. But this desirable achievement will require time, patience and, above all, perseverance.

APTITUDE FOR DYNAMICALLY ORIENTED PSYCHOTHERAPY

Practically all people who apply for help in managing emotional problems can be approached successfully with supportive and educational therapies. Eligibility for dynamically oriented treatment, however, requires some special characteristics. Some of the available research indicates that patients who respond best to psychodynamically oriented therapy need treatment the least. What this would imply is that persons with good ego strength can somehow muddle along without requiring depth therapy. That this is not always so becomes obvious when we examine the quality of adaptation of these near-to-healthy specimens. In view of the shortage of trained manpower, we may want to look for characteristics

in prospective candidates for therapy that have good prognostic value.

The following positive factors have been emphasized:

1. strong motivation for therapy (actually coming to therapy represents some commitment);
2. existence of some past successes and positive achievements;
3. presence of at least one good relationship in the past;
4. a personality structure that has permitted adequate coping in the past;
5. symptomatic discomfort related more to anxiety and mild depression than to somatic complaints;
6. an ability to feel and express emotion;
7. a capacity for reflection;
8. desire for self-understanding;
9. adequate preparation for therapy prior to referral; and
10. belief systems that accord with the therapist's theories.

The patient's expectations, age, and socioeconomic status are not too significant, provided the therapist and patient are able to communicate adequately with each other.

CHOICE OF GOAL AND FOCUS

If a patient through therapy expects to be a Nobel Prize winner, the patient will be rudely disappointed and soon lose faith in the therapist. There are certain realistic limits to how much we can accomplish through treatment, the boundaries largely being determined by the patient's dedication to the assigned task. Added to these are the curbs imposed by the many therapist variables soon to be considered. A great deal of tact will be required in dealing with inordinate expectations so as not to undermine further the already existent devalued self-image.

The selection by the patient of the area on which to concentrate during therapy is a legitimate and understandable theater around which initial interventions can be organized. It may not be the most culpable area stirring up trouble for the patient. But to push aside the patient's concerns with a symptom or a disturbing life situation and insist on attacking aspects of problems the patient does not understand or is not motivated to accept will lead to unnecessary complications and resistances. It is far better to work on zones of the patient's interest at the same time that we make connections for the patient and educate the need to deal with additional dimensions. Thus a man in the manic phase of a bipolar disorder may complain of a marital problem and press for its urgent resolution. Should we attempt to bypass his complaint factor and merely press lithium on him, we may be rewarded with an abrupt termination of treatment. His manic symptoms may subside, but his marital troubles may continue to plague him.

In attempting to choose the most productive arena for intervention we must keep in mind the fact that behavior is a complex integrate of biochemical, neuro-physiological, developmental, conditioning, intrapsychic, interpersonal, social, and spiritual elements intimately tied together like links in a chain. Problems in one link cybernetically influence other links. Elsewhere I have delineated the affiliation between the different links, contingent fields of inquiry, associated therapeutic modalities, and related syndromes. Without denigrating the importance of the patient's chosen area of focus, we may most propitiously deal with a link in the behavioral chain that, in our opinion, needs the most urgent attention, that the patient is willing to work on, and that is realistically modifiable with the patient's current or potential resources. Once we strengthen a pathogenic link through therapy, the effects will usually reverberate through the entire behavioral chain.

THERAPIST VARIABLES

Personality Factors

Observations of the determining influence of personality traits in the therapist on outcome have been repeatedly made and reported by Whitehorn and Betz (1960), Betz (1962), Rogers et al, (1967), Truax and Carkhuff (1967), and Truax and Mitchell (1972). One finding is that a relatively untrained person with a concerned manner and empathic personality will get better immediate results, especially with sicker patients, than a highly trained therapist who manifests a "deadpan" detached professional

attitude. One should not assume from this that a therapist with a pleasing personality without adequate training will invariably get good results. Some of the available research alerts us to the fact that the level of therapist expectations and the triad of empathy, warmth, and genuineness do not invariably represent the "necessary and sufficient" conditions of effective therapy (Parloff et al, 1978b). A well-trained therapist, however, who also possesses the proper "therapeutic" personality is by far best qualified to do successful therapy.

A good deal of the flesh and blood of what happens in treatment, short-term or long-term, is provided by the relationship the therapist establishes with the patient, the quality of which is largely influenced by the therapist's personality in operation. Personality expressions, good and bad, come through not only in the content of verbal communications but in nonverbal manifestations. The latter are not merely the epiphenomena of interaction but are directly related to the outcome. Nor does the factor of experience always operate to subdue damaging traits. In some cases earnest, dedicated beginners may relate better to patients than do more experienced, scientifically oriented, passive practitioners. Of course, we must consider some other variables also since we may be dealing here with different classes of patients, i.e., patients seeking a warm, giving authority as contrasted to those who want less personal involvement and greater ability to probe for and resolve defenses in quest of more extensive self-understanding.

After many years of training students and observing their work, I would estimate that the most meritorious personality traits sponsoring a good relationship are objectivity, flexibility, empathy, and the absence of serious emotional pathology. Successful therapists possess a bountiful blend of these attributes, unsuccessful therapists a dearth. Where a student therapist in training possesses a healthy combination of such positive personality characteristics, we may anticipate a good career, although this is not guaranteed. Where a candidate is less bountifully blessed, but cherishes rudiments of essential traits, these may be maximized by careful instruction and personal psychotherapy. A few enter training with such rigid defenses that they scarcely budge even after years of intensive analysis.

How to find candidates who personality-wise have a good chance of becoming competent therapists is a challenge confronting all training institutions. In the early days of existence of the Postgraduate Center for Mental Health, I once asked Paul Hoch, who was then Commissioner of Mental Health of New

York State, what he believed the value to be of recommendations for admission to training from a candidate's personal analyst. "From my own experience," replied Hoch waggishly, "when you first start treating or supervising students, your immediate impression is that they are practically psychotic. But shortly thereafter you develop a relationship with them and you believe that they are only neurotic. And a while later you start endorsing them as either completely normal, or even better than normal." Could it be, I inquired, "that therapy changed their personalities for the better?" "More likely," answered Hoch, "as a therapist works with a student, this changes the therapist's judgment for the worse." What he was referring to, of course, was the ubiquitous problem of countertransference that can mask or distort one's appraisal of a partner in a relationship dyad. Other criteria for selection are undoubtedly more reliable than endorsements from one's personal analyst. But the real test of how effective a candidate will be as a therapist is the actual performance with patients with varying syndromes and degrees of pathology, under the surveillance and tutelage of a competent supervisor. Observation of a student's performance behind a one-way mirror and the use of videotape recordings are also of substantial help.

Specifically, especially where the patient requires rapid stabilization, the therapist's manner must convey empathy, confidence, and understanding of the patient's turmoil and what is behind it. The patient, no matter how upset, will usually discern these qualities in the therapist and react to them. It is important also that therapists be able to control their own difficulties sufficiently so as to avoid the pitfalls of their own countertransferential problems interlocking with the problems of their patients. Particularly important is sensitivity to and the ability to manage irrational projections of patients, hallmarks of transference neuroses.

Considering that desirable character traits, if absent, are difficult to acquire even with personal therapy, it would seem important in the selection of candidates for training that some criteria be available to spot in advance students who possess or will be able to develop appropriate personality characteristics. This is more easily said than done. When we first founded the Postgraduate Center we experimented with many devices, including projective psychological testing and structured and nonstructured interviews. We failed to come up with any foolproof selection procedure. This is probably because the role that a candidate plays with an interviewer or psychologist tester is different from that assumed with patients.

My own experience convinces me that two personality qualities are especially undesirable in a therapist doing therapy: First and most insidious is detachment. A detached therapist will be unable, within the time span of treatment, to relate to the patient or to become involved in the essential transactions of therapeutic process. A detached person finds it difficult to display empathy. To put it simply, one cannot hatch an egg in a refrigerator. A cold emotional relationship will not incubate much change in treatment. The second quality that I believe is inimical to doing good therapy is excessive hostility. Where therapists are angry people, they may utilize select patients as targets for their own irritations. A patient has enough trouble with personal hostility and may not be able to handle that of the therapist. A therapist, exposed to a restrictive childhood, having been reared by hostile parents, or forbidden to express indignation or rage, is apt to have difficulties with a patient who has similar problems. Thus the patient may be prevented from working through crippling rage by the subtle tactic of the therapist changing the subject when the patient talks about feeling angry, or by excessive reassurance, or by a verbal attack on the patient, or by making the patient feel guilty. However, a therapist who is aware of personal hostile propensities, who can be objective about these and willing to back down under a patient's challenge, may be able to do fairly good therapy, provided the patient is permitted to fight back, and is not too frightened to challenge and stand up to the therapist. But where the therapist refuses to allow the patient this freedom, and gets upset and vindictive, rejecting or punishing the patient, therapy has a good chance of coming to a halt.

By the same token, a therapist who has serious problems with sexuality may not be able to handle a patient who also has certain sexual impediments. For example, a therapist struggling with a homosexual impulse, may, when a patient with homosexual tendencies brings up the subject, become defensive, overmoralistic, punitive, or so intensely interested in the topic that the patient will be diverted from constructively dealing with other important concerns.

All in all, we hope that in doing therapy the therapist will be slightly less neurotic than the patient. The least we may expect is that the therapist will have a reasonable capacity for maintaining objectivity. Some neurosis or character disturbance is probably residual in all of us, but this need not interfere with doing good therapy provided that we have an awareness of our failings and do not permit them to contaminate the therapeutic atmosphere. One of my teachers, an analysand of Freud, once remarked: "If there ever were such a monster as a completely 'normal' human being, he would very soon get psychotic

trying to adjust to the rest of us neurotics." "Normal" probably embraces a host of minor neurotic vexations, but where a therapist finds that good results are not forthcoming, some personal psychotherapy or analysis would seem indicated.

Choice of Techniques

Technical preferences by therapists are territories ruled by personal taste rather than by objective identifiable criteria. As has been previously indicated, it matters lit-tie how scientifically based a system of psychotherapy may be or how skillfully it is implemented—if a patient does not accept it, or if it does not deal directly or indirectly with the problems requiring correction, it will fail. Because of the complex nature of human behavior, aspects that are pathologically implicated may require special interventions before any effect is registered. Prescribing a psychotropic drug like lithium for an excited reaction in a psychopathic personality will not have the healing effect that it would have in violent outbursts of a manic-depressive disorder. Unfortunately, some therapists still cling to a monolithic system into which they attempt to wedge all patients, crediting any failure of response to the patient's resistance.

> A young analyst, for example, one year after having completed her training in a classical psychoanalytic school, wanted to get some further training in hypnosis. It turned out that her entire patient load was exactly the same one she originally had when she started her personal analysis some years previously. All nine patients were being seen four or five times weekly, associating freely in the couch position, analyzing their dreams, but showing little or no improvement, some even regressing. The therapist, maintaining the traditional passive stance, tried to listen to what they were saying, but found herself getting more and more bored and increasingly discouraged at what was happening. She wanted to learn hypnosis, she said, to be able to get at the early memories of her patients, since few significant infantile revelations had been forthcoming. Her patients simply were not coming to grips with their unconscious. Hopefully, hypnosis might be able to break through their resistance and bring to the surface the noxious memories and conflicts that were responsible for their complaints.

In reviewing her caseload, one could see three obsessive patients—one with a germ phobia who avoided contact with people; the second, a compulsive handwasher who spent most of the day in the bathroom; the third, a salesman with an obsession of death and killing, who, when he came across the number 23, had to engage in elaborate counting and other rituals to neutralize torturesome preoccupations. In all of these cases analysis had succeeded merely in providing some answers regarding the sources and meaning of these symptoms. The other six patients ranged from severe borderline cases who went over the border periodically, to various species of schizophrenia, with one

man, an engineer, actively hallucinating. There was not a single case, in my opinion, that could be considered a suitable candidate for classical psychoanalysis. And yet here was an earnest, dedicated professional digging away at their unconscious in the hopes of uncovering some mnemonic treasures that would ransom them from the prison of their past. My unverbalized hunch was that all hypnosis would do for her stockpile of patients would be to add more fascinating imaginative data to the huge store of information that the therapist had already accumulated, without budging their afflictions a single whit.

To expose all of these cases to one technique would be like a surgeon who, because he specializes in appendectomies, removes the appendix in every patient who comes to him with stomachaches, abdominal pains, and diarrhea. No one technique can serve to ameliorate all maladies that burden humankind. This is the best argument for a balanced and conservative eclecticism toward which modern psychotherapy has gainfully been moving in the past decades. But there are still a few diehards who, loyal to the traditions of their chosen theoretical school, try to force a circumscribed method on all patients. Such a tactic, following an analogy once proffered by Freud, usually proves no more effective than trying to appease victims of a famine by passing out menus of a French cuisine. For reasons difficult to justify, some earnest students are unable to break away from the strictures of cherished theoretical systems and virtually become trapped along with their patients in its ineffectualities. The only way some can escape from their stagnant caseloads is by moving out of town!

To return to my student, another dilemma confounded her. When she started working with her patients, most of whom were therapeutic failures referred by other therapists only too happy to get them out of their offices, she had, as a beginner, accepted them at a low fee. Considering that they came four and five times weekly, and could scarcely afford paying the accumulated sum each month, the therapist could not, despite the economic havoc inflation imposed on her, bring herself to raise their fees to even the standard minimal level charged by colleagues of her rank. This added to her dilemma and undoubtedly created resentments that I felt enhanced depression.

My first task, prior to teaching her hypnosis, was to teach tactics of psychotherapy with sick patients. We chose as our first prospect the obsessional patient with a germ phobia and a detached borderline case with masochistic fantasies. She was to get them off the couch and allow them to sit up facing her. She was

to reduce their sessions to twice weekly and charge them the same fee monthly as before. Most importantly, she was to stop acting like a "phantom therapist" by dropping her anonymity, with little digging and more relating. Because she seemed bewildered at my unorthodoxy, I had to give her the exact words to say to her patients, which were to the effect that a point had been reached where it was no longer necessary to freely associate, where only two sessions weekly were needed, where only reality problems in the here-and-now were to be the focus. She was enjoined to interest herself in what her patients were doing, smiling naturally, interchanging ideas and, if necessary, giving advice and support. Curiously, the student showed no resistance to accepting my advice.

In two weeks a remarkable change developed in both the experimental patients and the therapist. The patients, for the first time, spoke about how much better they felt. And for good reason—they were relating to the therapist as a real person who was interested in them as people rather than as puppets of their unconscious. The therapist found herself liking the patients, and her resentment resolved as the per session fee approximated that of her colleagues. What occurred then was that she got all of her patients off the couch. Sensing that she was losing her confidence in the analytic method, I had to work on her mistaken belief that the techniques I taught her were standard for all patients. While they happened to be suited for the sick caseload she was currently carrying, they might not be right for other cases. Indeed, classical psychoanalysis could be a boon for some patients carefully selected for the procedure. Her supervision with me lasted one year, during which time she acquired new cases, one of which was a patient for classical analysis.

Skill and Experience in the Implementation of Techniques

The history of science is replete with epic struggles between proponents of special conceptual systems. Contemporary psychotherapists are no exception. In a field as elusive as mental health it is little wonder that we encounter a host of therapies, some old, some new, each of which proposes to provide all the answers to the manifold problems plaguing mankind. A scrupulous choice of techniques requires that they be adapted to the needs and learning capacities of patients and be executed with skill and confidence. Understandably, therapists do have predelections for certain approaches and they do vary in their facility for utilizing them. Faith in and conviction about the value of their methods are vital to the greatest success. Moreover, techniques must be implemented in an atmosphere of objectivity.

To function with greatest effectiveness, the therapist should ideally possess a good distribution of the following:

1. *Extensive training.* Training, in many parts of the country, has become parochial, therapists becoming wedded to special orientations that limit their use of techniques. Accordingly, patients become wedged into restricted interventions and when they do not respond to these the therapeutic stalemate is credited to resistance. Over and over, experience convinces that sophistication in a wide spectrum of techniques can be rewarding, especially if these are executed in a dynamic framework. Whether a personal psychoanalysis is essential or not will depend on what anxieties and personal difficulties the therapist displays in working with patients. The fact that the therapist does not resort to the discipline of formal analytic training does not imply being doomed to doing an inferior kind of therapy. Indeed, in some programs, where the analytic design is promoted as the only acceptable therapy, training may be counterproductive. Nevertheless, if a therapist does take advantage of a structured training program, which includes exposure to dynamic thinking and enough personal therapy to work out characterologic handicaps, this will open up rewarding dimensions, if solely to help resolve intrapsychic and interpersonal conflicts that could interfere with an effective therapeutic relationship.

   Irrespective of training, there is no substitute for management under supervision of the wide variety of problems that potentially present themselves. It is important that therapists try to recognize their strong and weak points in working with the various syndromes. No matter how well adjusted therapists may be, there are some critical conditions that cannot be handled as well as others. They may, when recognizing which problems give the greatest difficulties, experiment with ways of buttressing shortcomings.

2. *Flexibility in approach.* A lack of personal investment in any one technique is advantageous. This requires an understanding of the values and limitations of various procedures (differential therapeutics), experience in utilizing a selected technique as a preferred method, and the blending of a variety of approaches for their special combined effect. Application of techniques to the specific needs of patients at certain times, and to particular situations that arise, will require inventiveness and willingness to utilize the important contributions to therapeutic process of the various behavioral sciences, accepting the dictum that no one school has the monopoly on therapeutic wisdom.

SOCIAL AND ENVIRONMENTAL VARIABLES

Anyone who believes that the innate lenity of humankind can transcend some of the abuses and

indignities that society heaps on one is a victim of Utopian self-deception. Social and environmental variables are probably the most neglected of factors in psychotherapy and sometimes among the most important. If in doing therapy we do not consider the environment in which the patient will have to live and function, we will run the risk of annulling therapeutic gains. An environment that does not support and encourage the patient's newly developed patterns or that punishes the patient for their constructive behavior will tend to reverse the gains brought about by the therapeutic process. On the other hand, an environment that rewards for constructive behavior will reinforce therapeutic gains.

Treatment may be considered incomplete if it does not prepare the patient for contingencies that will have to be faced when treatment is over. Adolescents who belong to gangs, for example, who learn to control delinquent behavior, may find themselves rejected by their peers for abiding by the law. A young adult living at home under the yoke of domineering parents may not be permitted to assume an independent role after the therapeutic resolution of a pathological dependency drive. An alcoholic helped to give up drink may not be able to remain dry so long as membership in a wine-tasting club continues.

During therapy a thorough review of what the patient will be up against after termination will be urgently needed. Either the patient will have to modify a destructive environment, if this is possible, or will have to separate from it. Thus the adolescent and the alcoholic will need to find new friends. The young adult will have to get a job and take up residence in a more permissive atmosphere, that is, unless parents are willing to enter into family therapy and respond sufficiently to permit greater freedom. Too frequently it is assumed that the patient will somehow get along once the treatment sessions have ended. Because the environment will rarely take care of itself, its future impact on the patient must be studied as part of the treatment program.

TRANSFERENTIAL AND COUNTERTRANSFERENTIAL VARIABLES

In therapy the initial positive relationship often serves during the first few sessions to quiet the patient's tensions and temporarily to restore a sense of mastery. A good deal of the responsibility for this happening resides in the patient's need for an omnipotent idealized authority, which urgency is projected onto the therapist. Some therapists advocate ending treatment abruptly when the patient has

achieved a windfall of symptom relief, encouraging the patient to resume the customary threads of life and providing some awareness of the circumstances that contributed to this present disorder. Where therapy is terminated after a few sessions the patient may continue to retain the initial image of the therapist as a powerful, benevolent and perhaps magical figure, having utilized this image, however unrealistic it may be, as a vehicle for restoring customary stability.

Where the therapist is more ambitious, or the patient requires more sessions to get well, around the eighth session a change often occurs in the image of the therapist that can precipitate a crisis in treatment. The patient begins to realize that the therapist is not a god, does not have all the answers, and even possesses feet of clay. This disillusionment may exhibit itself in a forceful return of symptoms, and a crediting to the therapist of ineffectual or evil qualities. They draw their substance from a deep reservoir of fear and hate into which malevolent attitudes toward authority, some dating to childhood, have been stored. This transferential pollution may go on unconsciously and be manifested solely in dreams or acting-out away from the therapeutic situation. The only sign the therapist may detect from the patient's manifest behavior is in the form of resistance to treatment. The patient will complain about not getting well while breaking appointments or coming late for sessions and will delay the payment of bills for therapy.

A dynamically oriented therapist searches for transferential signs realizing both the potential for helping the patient resolve some of the deepest problems through the insightful understanding of transference, and the destructive effect that unrecognized capricious transference can have on the therapeutic process. A therapist who has no awareness of transference will be truly handicapped in managing patients whose reactions to treatment become paradoxical or inappropriate.

Understandably, the more serious the early problems with authority have been, the more likely will transference become apparent, and the more tumultuous its manifestations.

Where the therapist shares the initial illusions with the patient to the effect that he or she is a demigod, changing into a devil will be highly disturbing. Such therapists may try to avoid trouble by confining themselves to the briefest forms of short-term therapy, terminating all treatments before the sixth session. But sometimes this does not help, especially in vulnerable borderline or schizophrenic

patients who develop transference reactions toward the therapist even before seeing the therapist at the initial interview. It is far better that professionals who wish to do good therapy work through their godlike image, if it is at all resolvable, by themselves or in personal therapy. At any rate, a good degree of stability is required on the part of the therapist in order to handle transference reactions when they occur. An unstable therapist finds it difficult, because of countertransference, to control responding negatively when challenged or unfairly accused by a patient in transference. Impulsively discharging or furiously cowing the patient into submission will obviously rob the patient of an opportunity to work through problems with authority.

Whether personal psychotherapy is mandatory for all therapists in training as a means of preventing obstructive countertransference is a question about which there is much debate. If one is a good therapist, personal therapy will probably help make one a better therapist but will not accomplish miracles. There are certain problems that are so deep that personal therapy may not be able to budge them. For example, intense childish distortions developed in very early infancy may resist correction. The therapist may get an awareness of these distortions through personal therapy, yet be unable at times to control their surfacing. Nevertheless, therapy may have enabled the management of reactions sufficiently so that they do not interfere too much with functioning with patients. Personal psychotherapy will accomplish its mission if it can control the therapist's use of the patient for personal designs and projections. Destructive countertransference is probably present to some extent in all therapists, but this need not necessarily be hurtful if the therapist is aware of its presence, recognizes how it is manifesting itself, and takes steps to resolve it.

Countertransference is, of course, not always harmful. It may alert therapists to traits and maneuvers of the patient that arouse important feelings in other people. The important thing is how therapists utilize countertransference toward bringing out the unconscious needs and conflicts of the patient while describing the effect they can have personally as well as on others. The patient may learn something important from this. For example, a great deal of tolerance is required on the part of the therapist in adjusting to the habits of some patients. Most therapists are punctual in appointments (as they should be) even though certain patients are lax in appearing promptly at the scheduled hour. These patients are prone to subject the therapist to a bit of delinquency as a vehicle of testing or defiance. The therapist may particularly be irritated by patients who come to clinics, paying little or nothing yet

seeming unappreciative of what is being done for them. There is no reason why the therapist should not focus on the patient's offensive behavior, not as a way of reprimanding the patient, but to clarify the meaning of what is going on. There are certain patients we relish working with and others who are less than a joy to treat. There are therapists who are completely unable to handle adolescents while others do their best work with young people. Schizophrenic, violent, obsessional, paranoidal, psychopathic, hypochondriacal, suicidal, and delinquent patients stimulate aversive responses in many therapists. Yet other therapists not only tolerate these syndromes but enjoy handling them.

Countertransferential elements encourage therapists to project onto patients aspects of their own inner needs of which the therapists are partly or wholly unaware.

> One therapist whom I was supervising in a class reported that his patient was getting progressively more depressed. An audio cassette of a session brought out a repetitious theme voiced by the patient that nobody cared for her, nobody paid attention to her, nobody liked her; that she was the neglected child in the family whose destiny was to spend her life in misery as an isolate. She insisted that she could never command respect or attention from anybody. She went on and on in this depressive vein, and the therapist from his conversation seemed to be responding correctly to what the patient was saying. We decided then that the therapist should interview the patient behind a one-way mirror with the class observing. The therapist was instructed to set up the furniture similar to the arrangement in his office. When the patient entered the room she seemed fairly animated, but as she talked she appeared to get progressively more and more depressed, the content of her verbalizations centering around feeling rejected by her family, by people, and by the world. What was startling was that the therapist, without realizing it, was actually playing into her theme of rejection. He had placed his chair at an angle so that he did not face her, and while he would from time to time fire an interpretation at her, he was constantly busy writing or looking away toward the opposite corner of the room. Periodically the patient would glance at the therapist, who by all appearances was off in space. One got the impression that she was being treated like a scientific specimen, not like a needful human being. Having been reared by a schizoid mother who in later life was admitted to a mental institution, she undoubtedly interpreted the therapist's manner as rejection.

The interesting thing was that a sophisticated professional in his last year of postgraduate training did not realize that he was providing the patient with a stimulus that activated her habitual rejection theme. On questioning, the therapist admitted that he was losing interest in the patient because she was beating at him constantly with her griping and complaining and getting no better. He was unaware that the placement of his chair was a gesture that signaled his disinterest, nor did he realize that the sessions were as traumatic for the patient as they were for him. He was sufficiently advanced in his training and personal analysis to explore his feelings toward the patient and affiliate them with attitudes toward a hypochondriacal mother who drove his own father to distraction. In this way his countertransference interlocked with the transference projections of the patient.

What the patient was doing with her therapist she did with all people with whom she became intimate. She expected rejection so much that in testing their sincerity she did exactly the things that resulted in her being rejected. People then responded by avoiding her. I suggested that the next time the patient came for a session the interview be conducted face to face. The therapist was to put aside his pad and just talk about the patient's interests and experiences without probing her feelings—in other words to work on building a relationship. In a very short time the whole nature of the therapy sessions changed. The patient became livelier, more interested in what she was doing, and more able to joke and smile. And the therapist developed greater enthusiasm about the patient. Eventually the patient's depression lifted and the patient was able to manage the termination phases of therapy without too great difficulty.

Not all of a therapist's reactions are countertransferential. They may be prompted by deliberate, destructive, and outlandish conduct. I recall one patient whose behavior was so provocative as to challenge my capacity for disciplined objectivity. It was all I could do during some sessions when she acted particularly nasty and insulting to stop myself from responding defensively or punitively.

> The patient was a married woman in her late thirties who came to me not of her own free will but because of the pressures imposed on her by her friends and family, who realized that she was seriously depressed and disturbed. She was the only child of a wealthy couple who adulated, pampered, and spoiled her so that she soon ruled the household like a tyrannical princess with an iron fist without the traditional velvet glove. Screaming tantrums forced her parents and private tutors to yield to her slightest whim.
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> When she grew up she transferred these tactics to people around her, responding to not getting her way with violence, headaches, and paranoidal-like projections. Her marriage, she revealed, started off sizzling on a King-sized bed. But soon, after she had succeeded in verbally whip-lashing her husband into partial impotence, the couple retreated into twin beds, and, following the birth of her two children, they sought refuge in separate rooms from which they sauntered out to combat. Added to this the inanities of suburban life were more, she claimed, than human flesh could endure.
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> Her initial contacts with me were organized around exploratory maneuvers to determine how much she could win me over and manipulate me. Interpretations fell on deaf ears. She was certain that I was siding with the enemy at home who blamed her for the prevailing mess she was in. Hostility was expressed in subtle and not so subtle ways. On one occasion, she asked me to refer her to the *best* dermatologist in town. She appeared at his office with her dog whom she brought into the consulting room. It turned out that she wanted treatment not for herself but for her dog "who deserved the best." The dermatologist, who was a dear friend of mine, winked to his nurse and they proceeded to put the dog on the examining table and to treat him like a regular patient, right to the rendering of a prescription with the dog's name on it. Fortunately, the doctor, a dermatologic authority, had a great sense of humor and he went along with the "gag." On another occasion, being more careful to explore her complaint of backaches, I referred her to an orthopedic surgeon who on walking through the waiting room found her sitting in a chair with her feet on a new expensive coffee table. In not too gentle tones, he commanded her: "Won't you take your feet off my table?" Haughtily she turned on him with "It took me four months to hate Wolberg. You I hate right away."

With this as a background, I want to describe an incident where my loss of objectivity resulted in a significant therapeutic gain. During an interview, as she sat facing me, I confronted her with her responsibility in promoting a quarrel with her best friend. Furiously the patient removed a diamond ring from her finger and fired it at me. As the ring, a huge eight-carat gift from her father, whizzed by my ear, I tried to conceal my surprise and dismay by acting nonchalant and by not commenting on her behavior. I could see that she was nonplussed and irritated by my lack of concern. "Give me back my ring," she commanded imperiously. " *You* threw it," I replied, " *You* find it." After several such exchanges, she stormed over to my chair and began to search for the ring. It was nowhere in sight! "You better find my ring," she shrieked, but she got no response from me. However, after several minutes had passed in futile search, the ring remained undiscovered, and I leisurely proceeded to help her. But the ring was nowhere to be seen. By this time, I too was concerned. Yet a minute search of the room produced nothing. The patient burst into tears and I then tried to reassure her, utilizing the incident to accent my previous interpretations that her loss of temper hurt her more than it did other people.

After the patient left my office ringless, I went over the room minutely and finally I found the ring, which apparently had fallen on the couch and bounced off to the side, becoming wedged in between the mattress and the wooden side. The patient was relieved at my telephone call and thanked me. My victory, however, was short-lived. The next day when the patient came for her ring she burst angrily into my office and slammed the door shut with her foot, registering a dirty footprint on my newly painted door. I could feel my anger bubbling up. "You wash that footprint off that door," I ordered. "Ha, ha, ha," she retorted defiantly, "You make me." Reflexively, I grabbed her by the back of her neck and marched a frightened patient into the bathroom, stuck a wet soapy washcloth in her hand, and firmly marched her back to the door. She obediently washed the door, then quietly sat down; then we had our first constructive talk. She acted contented and even smiled. What the patient seemed to have done was to force me to set limits on her behavior that her father had failed to do. What she wanted and needed was some discipline. The positive effect on our relationship was amazing and we were able to achieve changes in her life that earned for me the gratitude of the patient and her family.

If through the relationship the patient is able to modify the introjected image of authority, the therapeutic process will have scored a great gain. Such modification comes about by a replacement of the patient's imprinted authority figure, which is often harsh or overprotective, or negligent, or distorted, with a new, more rational and constructive figure as vested in the therapist. An opportunity for this may come about through transference on the therapist of feelings or attitudes that relate to the authoritative introject. Manifestations of the transference appear in direct or disguised form, in oppositional resistance to the therapist or to the techniques being employed, in unreasonable demands for favors or affection, in fantasies or dreams, or in acting-out away from treatment with persons other than the therapist. The ability of the therapist to recognize transference when it appears, particularly in its disguised forms, and to deal with it through interpretation and proper management of the relationship will have a determining effect on the direction and results of treatment.

RESISTANCE VARIABLES

Shorr (1972) cited Saul Bellow, who in *Herzog* describes the common resistance to normality so often encountered in therapy: *"To tell the truth, I never had it so good ... but I lacked the strength of character to bear such joy.* That was hardly a joke. When a man's breast feels like a cage from which all the dark birds have flown—he is free, he is light. And he longs to have his vultures back again. He wants his customary struggles, his nameless empty works, his anger, his afflictions, and his sins." Paradoxically, some people are loath to give up the very chains that bind them to neurotic slavery.

Reluctance to accept normality is merely one of the many resistances that precipitate out in the course of therapy. Some resistances, inspired by lack of motivation and refusal to give up a stereotype of a nonrealistic therapist, occur at the start of therapy. Some, such as transference resistances, convert the therapeutic alliance into a battlefield of archaic projections and interfere with the treatment process itself. Others, like regressive dependency, mobilize anger and grief, and obstruct proper termination of therapy.

Resistances can take many forms, often following defensive maneuvers customary for the individual. Thus patients may become evasive or forgetful, breaking, cancelling or coming late for appointments, or they may engage in prolonged silences during sessions. They may indulge in superficial, rambling talk. They may try to disarm the therapist with praise, or become aggressive, argumentative, and accusatory. Women may become sexually seductive toward their male therapists and men toward their female therapists.

Destructive as they are, certain resistances protect the individual from catastrophic helplessness and anxiety. They are means of preserving important neurotic coping mechanisms. A phobia, for example, may disable the individual, but it still has a protective quality. A hysterical arm paralysis can shield the individual from awareness of murderous impulses, while blandly protesting the inconvenience of being unable to utilize the limb. Frigidity may mask overwhelming fear in a woman of assuming a feminine role. In all of these cases the yielding of important defenses promises exposure to dangers far greater than the torments the patient already suffers. Moreover, certain secondary gains of a positive nature may accrue to the indulgence of a neurosis. In industrial accidents the victim who is on disability payments may in giving up pain and physical illness lose not only financial security, but also

sympathy, freedom from responsibility, and the opportunity of occupying center stage with repetitive tales of what was endured at the hands of doctors. Having been referred to a therapist by an insurance company, which insists on the victim getting treatment, or brought in by family who tire of complaints, the victim is exposed to the threat of health, which is a barren bounty compared to the advantages of disability.

Experience with large numbers of patients convinces that three common dynamic problems most often initiate emotional difficulties and also create resistance to psychotherapy. They are:

1. inadequate separation-individuation;

2. a hypertrophied sadistic conscience; and

3. devaluated self-esteem.

These are never isolated units. Rather, they coexist and reinforce each other, and 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 bog down in a stalemate. The most the therapist may be able to do is to point out evidences of operation of resistance 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 personal responsibility in perpetuating their machinations. The frightening hold a self-devaluating resistance can have on a patient is illustrated by the following 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.

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 would 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, who was never satisfied with his even better than average marks at school, who compared him unfavorably with boys in the neighborhood who were prominent in athletics and received commendations for their schoolwork. It seemed to me that the paternal introject was operating in the patient long after he left home, carrying the same belittling activities that had plagued his existence when he was growing up.)*

Pt. (pause) There is no reason, *(pause)*

(In the last session the patient had talked about the unreasonableness of his father and his inability to please his father.)

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

(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?

(The patient responds with a dubious expression on his face and then quickly tries to change the

subject.)

In the conduct of treatment one may not have to deal with conflicts such as those above *so long as the patient is moving along and making progress. It is only when therapy is in a stalemate that sources of resistance must be uncovered.* These, as has been indicated are usually rooted in the immature needs and defenses inspired by dependent, masochistic, self-devaluating 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 impulse to make oneself dependent and the destructiveness of this impulse, the connection of suffering and symptoms with a pervasive need for punishment, the masochistic desire to appease a sadistic conscience that derives from a bad parental introject, the operation of a devalued self-image, with the subversive gains that accrue from victimizing oneself, must be repeated at every opportunity, confronting the patient with questions as to why he or she continues to sponsor such activities. When we consider the many patient, therapist, environmental, transferential and resistance variables that have been described above, and that are parcels of all therapies, irrespective of type, it becomes apparent that empirical research into their effects may do a great deal in promoting more effective practice and in advancing psychotherapy to its rightful place in the family of scientific methodologies.