Similarities and Differences among the Various Psychotherapies

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SPECIFIC DIFFERENCES AMONG PSYCHOTHERAPIES

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Psychotherapy is a “stew” of a large number of ingredients, most of which are common to its variations. Without minimizing the uniqueness of methodologies among the different psychotherapies, remarkably similar forces are universally manifest. It would seem that the diverse techniques we employ act as forms of communication through which identical influencing processes operate. Except for a few interventions that are best suited for special syndromes most schools of psychotherapy, as heterogeneous as their premises may seem on the surface, display a remarkable unity in the way they register themselves on neurotic problems. In randomized studies of patients selected for treatment, good therapists of even dissident orientations are believed to achieve approximately the same proportion of “cures” and failures (Fiedler, 1950a & 1951). This fact solicits the tempting proposition among the various psychotherapies, that their differences are more in design than effect.

If this proposition is true, the question arises as to what common elements in all psychotherapies serve to bring about therapeutic gains. The windfalls of placebo influence, emotional catharsis, idealized relationship, suggestion, and group dynamics in themselves may restore the individual to homeostasis. These expediencies operate automatically in all relationships, although therapists may credit to their methods the non-specific profits that accrue from nothing more than the patient’s faith, hope, trust, and expectancy. Parcels of all therapeutic relationships, transference and resistance display themselves in myriad forms and are tolerated, accepted, bypassed, or resolved depending on the sophistication of the therapist and the goals toward which therapeutic efforts are directed. Psychotherapies are often wrecked on the reefs of resistance and transference, which may have little to do with the specific tactical maneuvers. Crucially influencing results also are a variety of positive “therapeutic” personality qualities in the therapist, which in their presence expedite and in their absence vitiate the applied techniques. Moreover, negative countertransference will universally prejudice the outcome and will, in each therapist, masquerade itself in diversified forms. Furthermore, in all therapies, explicitly or implicitly, there is an influencing of the patient toward a productive life philosophy. The particular kind of ideology is bound to reflect that which the therapist finds meaningful, and the values of the patient will be molded by this. Even though the therapist may try to avoid revealing them, standards will ultimately

become apparent by the therapist's interview focus and interpretative activities.

The confluence of these common elements during any psychotherapeutic endeavor tends to reduce the differences among the psychotherapies even though each applies itself with unique theories and special techniques to singular personality dimensions. A brief description of some of the chief orientations in psychotherapy may illustrate this. In the main, three positions are identifiable:

1. The relationship position (e.g., client-centered and phenomenologically oriented therapies)

2. The reward-punishment position (e.g., behavior therapy)

3. The cognitive restructuring position (e.g., psychoanalytic therapy)

The relationship position rests on the surmise that all persons, including emotionally sick people, possess an inherent drive for self-actualization. In the medium of a congenial, accepting, empathic relationship, positive growth factors can be released. The therapist consequently must communicate to the patient during the therapeutic encounter both understanding and respect for self-worth. Therapeutic methods are designed around these premises. For example, therapy may embrace tactics of "accepting the patient completely," of reflecting and restating the problems expressed, of recognizing and clarifying feelings, and of displaying tolerance toward aberrant impulses that come to light. In an atmosphere devoid of threat, the patient is presumed to be capable of examining and reorganizing a sense of self. This phenomenological viewpoint is bolstered by some research findings that indicate that children who feel accepted achieve greater intellectual maturation than those who feel rejected and hence unwanted. Clinical studies also show that rejected children tend to respond with coping mechanisms, such as helplessness, defiance, aggression, and withdrawal that can easily interfere with development. In all helping relationships, such as counselor-client, physician-patient, administrator-worker, etc., a warm, respectful, nonpossessive "caring" attitude facilitates security and leads to enhanced self-realization (Rogers, C, 1961b). Theoretical systems do not in themselves cure. What brings results, according to the relationship position, is the dedication of the therapist to a system, the avidity with which the therapist applies it, the sincerity of purpose, and the communication to the patient that the therapist "cares" about what happens to him.

The reward-punishment position contends that behavior, including neurotic behavior, can be altered

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by exploiting certain consequences of behavior, namely, through the presentation or withholding of rewards or the inflicting of punishment. Neurotic behavior is learned. Anxiety, a secondary drive, fosters neurotic learning by promoting avoidance responses that diminish the intensity and rate of appropriate reactions. It is reasonable consequently to resolve anxiety by the same principles through which it is learned. Environmental stimuli are consequently manipulated to encourage constructive types of behavior. The therapist functions here as a kind of “social reinforcement machine.” Various deconditioning techniques, such as “reciprocal inhibition,” “operant conditioning,” “conditioned reflex therapy,” “aversive conditioning,” “stimulus satiation,” etc., are employed to weaken the conditioned connections between provocative stimuli and anxiety responses. Insight techniques are not considered adequate in breaking up these connections. On the other hand, reconditioning and desensitizing maneuvers are said to be most effective. Illustrative of the behavior therapies is “systematic desensitization” in which the patient is enjoined to fantasy, during hypnotic relaxation, a graded series of progressively intense stressful images, mastering each until all manifestations of anxiety disappear. A generalization of response eventually is said to occur that extends itself to the actual stress situation.

The cognitive position resists any possibility of extensive personality change without a significant alteration of the intrapsychic structure. This may involve a minor shift in symbolic meanings through educational promptings, or it may embrace a widespread reorganization of value systems and patterns of behavior through the provision within the therapeutic situation of a corrective experience. Illustrative are philosophic and insight approaches.

Philosophic therapies are organized around the doctrine that it is reason’s role to organize a happy and harmonious life in the context of the realities of the environment. Modes of facing reality are then offered to the individual in the hopes that one will find new purpose and meaning in one’s existence. A change in cognitive organization is thus attempted directly by manipulating personal ideologies.

Considering such a change temporary, the dynamic schools attempt to produce a more permanent reconstructive alteration through various insight maneuvers, including probings of the unconscious. In classical psychoanalysis cognitive alterations are said to be best insured by permitting transference to build up to intense proportions through the therapist’s adoption of a passive, neutral, non-interfering manner and through offerings of appropriate interpretations. The hypothesis around which techniques

are constituted posits that emotional illness is the product of arrested development fostered by a neurotic disturbance in childhood (infantile neurosis). Cure is possible only when there is a reactivation of this neurosis and a resolution under circumstances that are favorable for its “working through.” Appearing and reappearing in the form of the “repetition compulsion,” the infantile neurosis is revived in the transference situation (“transference neurosis”) as the therapist slowly induces the patient to push aside defenses that act as resistances to an awareness and resolution of childhood conflicts. Submerged in the unconscious to avoid anxiety, these conflicts support neurotic coping mechanisms that sabotage adjustment. An activation of unconscious conflict is fostered by such techniques as free association, dream analysis, a focusing on the past, frequent sessions, and relative passivity and anonymity on the part of the therapist. The patient, however, continuously resists dealing with the infantile conflict. The task of the therapist is to bring the patient to an awareness of any impulses to avoid the anxiety associated with its revival. The relationship with the therapist is of help in the interpretation of resistances. Helpful too is the more benevolent atmosphere that exists now as compared to that which prevailed at the time that the neurotic conflict was originally developed. Under the auspices of the unique therapeutic relationship, the patient is said to undergo an experience that encourages one to approach life from a perspective shorn of hurtful expectations and neurotic defenses.

Among the interpersonal dynamic schools the focus is on the patient’s security operations to neutralize anxiety that derives from the relationships to others. An understanding of the developmental experiences that have led to untoward coping methods and to disturbed behavior is considered vital. Formative tribulations with significant adults in the past are explored. A “corrective emotional experience” issues out of the testing of the patient’s assumptions with new authority as vested in the therapist. Activity in the relationship and presentation of the therapist as a “real” person distinguishes the interpersonal from the classical analyst. Through these techniques, dissociated aspects of the self-system hopefully become consolidated.

The “relationship position,” the “reward-punishment position,” and the “cognitive position” seem worlds apart. However, when we peer beyond their manifest descriptions, we find that they deal with essentially the same processes, in each of which the following are operative—non-specific therapeutic elements, the personality of the therapist, reinforcement of selected responses, and cognitive restructuring.

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Non-specific Therapeutic Elements

In themselves the forces of placebo, emotional catharsis, projected idealized relationship, suggestion, and group dynamics (see Chapter 4) can bring the individual to homeostatic equilibrium apart from any specific therapeutic tactics that are being employed. Restoration of a sense of mastery may lead to more appropriate attitudes and even to behavior change. Some reconstructive impact may even be registered in a propitious environment.

Determining Personality Ingredients of the Therapist

The most common elements in the resolution of stress, irrespective of the professional identification or theoretical orientation of the helping agency, or the stratagems employed in the therapeutic process are (1) a *feeling* on the part of the patient of being understood, liked, and respected by the helping agency, in spite of any weaknesses and problems and (2) a *conviction* of trusting, liking, and respecting the agency. Faith in the latter as a person who *wants* to understand and is capable of understanding is crucial. This would seem to point to “acceptance” as a facilitating factor in being helped. The therapist who is capable of communicating empathy, understanding, and “genuineness” will be rewarded with the highest proportion of “improvements” or “cures.” So crucial is the issue of the therapist’s personality, that consideration of the relative value of the different treatment procedures must presuppose that they are being implemented by therapists with effective personality structures. Since the personality of the therapist has jurisdiction over what happens during psychotherapy, the absence of essential traits, or the presence of negative countertransference that diverts the therapist from professional objectives, will make a shambles out of the therapeutic effort with little regard to the nature and extent of the therapist’s training or the special theoretical school espoused. Therapists of the “relationship position” deliberately gear themselves to the expression of therapeutic traits nonverbally, if not verbally. The manipulative techniques of the therapist who supports the “reward-punishment position” and the benevolent paternalism of the psychoanalyst, neutral and seemingly detached as he or she appears to be, cannot conceal essential qualities of humanness, sincerity, acceptance, understanding, and empathy, which will either display themselves or fail to come through during the treatment hour.

Positive Reinforcement of Selected Responses

The relationship situation in all forms of psychotherapy supports selected reinforcement of special aspects of behavior. Widespread and consistent changes in behavior may be influenced by no more than nodding of the head and repetition of the words “uh-huh” or “hmm-hmm” on the part of the therapist (Thorndike, 1935; Greenspoon, 1950;Taffel, 1955; Verplanck, 1955; Wickes, 1956; Salzinger, 1959). Accepting and approving responses from the therapist thus act as reinforcing stimuli in learning, and experiments in operant conditioning seem to bear this out (Verplanck, 1955; Greenspoon, 1954a & b; Lindsley, 1964).

In the behavior and conditioning therapies the therapist openly and directly presents the reinforcing and extinguishing cues. In the relationship, “client centered,” and analytic therapies such cues are constantly being proffered—if not openly, then indirectly. For example, the patient may be rewarded by “approving” vocal and subvocal utterances whenever he or she responds the way the therapist considers appropriate. It is apparent that the therapist galvanizes into alertness and interacts much more readily when the patient deals with certain material. The patient will understandably focus on such rewarding constituents. Repetitive actions of the therapist will tend to circumscribe the patient’s focus and to bring forth responses that seem to validate the therapist’s theoretical beliefs.

An aspect of constructive relearning that takes place in psychotherapy is identification with the therapist who acts as a model for the reorganization of attitudes and values. In psychoanalytic therapy the working-through process involves a continued extinction of neurotic and reinforcement of positive responses. Motivation to approach life on different terms is provided by the emerging insights, and their translation into action harmonizes with a lessening of the severity of the superego. “Reward punishment” consequently enters into all psychotherapies, even those that disavow learning theory as a significant approach to the understanding of what is effective in treatment.

Cognitive Restructuring

It is doubtful if any significant or permanent personality changes are possible without some substantial shift in cognitive organization. Such shifts *may* occur when the individual gains sufficient understanding of inner needs and problems to challenge the assumptions that he or she cherishes. They

may develop without awareness of what is happening during systematic desensitization or other conditioning techniques. Occasionally they *may* follow productive interpersonal experiences, inside or outside the therapeutic situation, that do not repeat traumatic expectations. Unless the intrapsychic structure is altered, neurotic distortions will continue to be sustained, the productive experiences being regarded as happy coincidences to be followed by inevitable disappointments and hurts.

Change in intrapsychic structure is believed to issue most generally out of the working through of transference, which, recognized or not, openly or covertly shadows every therapeutic relationship. In all psychotherapies the patient assigns to the therapist a role of authority, and then tests the old expectations against this new image. As one realizes one is not criticized, condemned, scorned, or excoriated, the captious, accusatory, and fearsome attitudes toward punitive authority may become replaced, on the basis of constructive interactions with a tolerant authority figure, by a more wholesome representation that lessens the severity of the conscience, relieves guilt feelings, modulates expectations of punishment, and permits the avowal of repudiated impulses and needs. In psychoanalysis there is an encouragement, facilitated by techniques that activate the unconscious, of projections into the relationship of pathological needs and conflicts, evolved from past experiences, that continue to distort adjustment in the present. The emergence of these patterns within the treatment setting and the therapist's bringing the patient to an awareness through interpretation of such distortions enable the patient to learn more productive responses to authority. But even where transference is not encouraged, nor recognized, its emergence and working through will constitute one of the most important elements in change. Such resolution may take place on levels below awareness.

Discussion

Thus the three broad groupings of psychotherapy, while addressing themselves to distinctive areas of personality functioning, will evoke essentially similar processes. This does not mean that they will influence to the same degree all symptomatic, behavioral, and characterologic elements. We cannot expect that a few sessions in a benevolent accepting setting in relationship or client-centered therapy or exposure to a gradated sequence of fearsome images in behavior therapy, however rapidly they melt symptoms, will produce the depth of personality reconstruction possible in well-conducted long-term psychoanalytic therapy. However, alteration of vectors other than symptomatic will have been initiated,

and may in a wholesome environment continue to produce more substantial change. On the other hand, long-term analytic therapy may not immediately influence symptoms (which the supportive therapies may accomplish quite effectively and sometimes permanently); indeed, symptoms may even become exaggerated at first. Ultimately, however, where therapy is successful, symptom cure as well as reconstructive personality change may be anticipated.

There is some evidence that psychotherapists who dedicate themselves to special schools possess needs that the theoretical doctrines of the schools appear to satisfy, or they possess personality traits that coordinate with the school's methodological trajectories. Under such circumstances the postulates of a school will provide the therapist with an anchor to stabilize him or her in the uncharted sea of treatment. The abiding faith in the system will enable the therapist to approach with assurance the problems of a patient. It will give the therapist confidence in the patient's capacities to benefit from treatment. At the same time the school's technical maneuvers, appealing to the therapist's logic, permit the therapist to operate spontaneously and "genuinely" to heighten the patient's expectations of cure. These maneuvers are designed to deal with the presenting problem in terms of the assumptions and credos treasured by the particular school.

For example, in psychoanalytic theory a phobia may be regarded as a projected symbolic manifestation of an unconscious conflict or need. The therapeutic intervention then will be to expose, through uncovering techniques, the roots of the phobia as these appear in the unconscious. In behavior theory the phobia will be considered a conditioned response to which the patient is automatically reacting that requires extinction through deconditioning techniques. In relationship, transactional, game, and some forms of communication theory the phobic syndrome may be conceived of as a means of scoring an advantage, of protecting the individual from his or her own problems, and of achieving control in a relationship with another human being who must share the consequences of the phobia. Strategies will then be evolved to accept the patient unqualifiedly, to prevent the using of the phobia as a manipulative vehicle, while encouraging development of other, more appropriate ways of handling relationships.

In each of these three approaches the pathology has been circumscribed around a limited group of parameters, and operations are structured to deal pointedly with these demarcations. Such attempts, of course, are understandable; but the insistence of most schools to generalize their assumptions to the

entire psychological universe has led to much confusion and misunderstanding. It is quite probable that every individual with a phobia is projecting certain unconscious needs and fears on a symbolic level, that there has developed a set of conditioned responses that control one mercilessly, and that additionally leads to employing symptoms to gain certain advantages in one's relationships. Each of the schools considered above merely limits its focus to an aspect of the total problem.

The fact that, in the hands of skilled practitioners, patients get well through the use of any of the three approaches, to emphasize what has been said before, would seem to indicate that the psychotherapeutic experience encompasses factors other than those assigned to it by the different theoretical schools. When we deal with any one set of parameters, we inevitably must influence the others, just as in an equation where the unbalancing of coordinates on one side will require adjustment of the opposing variables. Thus, bringing the patient to an awareness of the unconscious drives that promote phobias may, if one is motivated, enable an effective deconditioning through active exposure to phobic situations. One may then be capable of deriving greater advantages from mature kinds of relationships than by the controlling tactics of the phobia. Or desensitizing oneself to increments of anxiety in behavior therapy may result in better interpersonal relationships as well as the resolution of certain conflicts that have their roots in the unconscious. Finally, dealing with the immediate transactions between therapist and patient during the therapeutic encounter may result in widespread changes in the habitual defensive operations of the individual, including the phobic facade, in addition to altering the character structure itself.

SPECIFIC DIFFERENCES AMONG PSYCHOTHERAPIES

The similarities of processes among the various psychotherapies does not sanction the idea that there are no differences. Before considering these, it may be wise to recognize that the language forms of the competitive schools emphasize a greater divergence than actually exists. Thus the orthodox Freudian speaks of bringing the patient to "psychosexual maturity"; the disciple of Horney, to "self-realization"; the follower of Fromm, to a "productive personality"; the Rankian, to an "active creative will"; the student of Sullivan, to a "socially integrated adjustment"; the Adlerian, to true "social interest"; the Jungian, to "full self-development"; the adherent of dynamic relationship therapy, to "creative individuality"; the client-centered therapist, to "empathic self-acceptance"; and the existential analyst, to a "being-in-the-

world” and understanding of the “meaning of existence.” When we examine the connotations of these phrases as well as their implications, we discover that they embody similar abstractions. They say very much the same things in different words.

In attempting to differentiate the sundry psychotherapeutic approaches, two kinds of data are apparent. The first relates to observations of clinical phenomena made by therapists in the course of working experimentally and therapeutically with patients. The second is concerned with the interpretation of this data along theoretic, speculative lines.

Common theoretic constructs deal with the following:

1. The nature of the predisposing factors in emotional illness
2. The manner in which childhood experiences and conditionings produce distortions in personality development
3. The relationship between personality structure and neurosis
4. The constituents of inner conflict
5. The meaning, function, and manifestations of anxiety
6. The structure of the psychic apparatus
7. The mechanisms of defense

Various schools may place an emphasis, duly or unduly, on some of these constructs, or they may accent certain phases of psychodynamics that may or may not be verifiable.

Techniques of psychotherapy, though diversified, are not nearly so disparate as theoretic concepts. Indeed, basic similarities are apparent among all psychotherapeutic schools, which include the following:

1. They are all goal-directed toward specific objectives
2. They are organized around a relationship between therapist and patient

3. They require some kind of interviewing procedure

4. They evoke emotional responses in the patient which must be therapeutically handled

The goals in treatment with supportive, reeducative, and reconstructive therapies have already been described. Briefly, they consist of a relief of symptoms and better adaptation in areas of living in which the patient has failed (supportive therapy), a reorganization of attitudes and values with expansion of personality assets and minimization of liabilities (reeducative therapy), and an alteration of the basic structure of the character with creation of potentialities that were thwarted in the course of the individual's development (reconstructive therapy). The setting of goals may be determined in some psychotherapeutic systems by the patient, in others by the therapist.

The type of relationship between therapist and patient varies among the different psychotherapies. There are some relationships deliberately set up by the therapist in which he or she assumes an authoritarian, domineering, directive, and disciplinary role. There are others that are non-authoritarian, permissive, nondirective, and non-disciplinary, sometimes to a point where the therapist seems detached. There are still others in between these two extremes in which the therapist attempts to relate to the patient as a cooperative partner. The degree of activity or passivity that the therapist assumes with the patient will vary with the relationship sought; it may remain consistent throughout the course of therapy or may shift at different stages of the treatment process. The kinds of attitudes displayed by the therapist will similarly range from moralistic to tolerant, from judgmental to nonjudgmental. Generally, the degree of authoritarianism of a therapist is dictated by his or her personality structure and may not readily be altered by design.

The kinds of verbalization obtained from the patient may be spontaneous and rambling to the point of "free association," or they may be focused by the therapist on selected topics. Similarly, the responses of the therapist may range from spontaneous comments and conversations to controlled utterances and pointed interpretations.

The interview focus will depend on the approach employed. For example, in supportive approaches it may be existent work, marital, social, and interpersonal difficulties with the object of correcting these as expeditiously as possible; or on faulty attitudes and values with the idea of directing

the patient toward more rewarding objectives; or on suppressed and repressed feelings and experiences, with the aim of releasing pent-up emotions; or on irrational fears and attitudes with the idea of mollifying them. In many reeducative therapies the focus is on distortions in interpersonal operations with the object of enhancing character assets and of minimizing liabilities. In semantic approaches it is on language and communication disturbances for the purpose of clarifying concepts, values, and goals. In nondirective client-centered therapy it is on the feelings behind verbalizations in the hope of releasing spontaneous growth forces. In Freudian psychoanalysis it is on past life experiences with an attempt to resolve the Oedipus complex toward development of mature genitality. In Adlerian analysis it is on the present "life style" with attempts to resolve feelings of inferiority and compensatory power mechanisms. In Jungian analysis it is on the exploration of elements in the collective unconscious with the aim of releasing the individual from the crippling influences of "archetypes." In Rankian analysis it is on the union and separation strivings of the patient with the ultimate objective of resolving the ubiquitous birth trauma. In Horney analysis the focus is on the contradictions of character structure with dissipation of character disturbances and of the unrealistic, idealized self-image. In Sullivanian analysis it is on the individual's relationships with people with the aim of restoring self-esteem and good interpersonal relationships.

It will be seen that the focus of inquiry is on selected aspects of the total functioning. Because the individual projects oneself as a whole into the most minute area of living, exhibiting in this area basic patterns of relatedness and basic defensive operations, the working through of problems in one area may result in a restructuring of the operations in other, apparently unrelated areas. Thus, if the focus chosen is inferiority feelings in relation to an employer, the limited resolution of the patient's attitudes inwardly and toward the employer may result in more harmonious attitudes toward other authorities, in greater self-esteem and feelings of mastery, and in greater self-acceptance including any impulses (i.e., sexual, hostile). If the focus is on sexuality and problems in relating sexually to others, or the resolution of fears of punishment, the capacity to separate the paralyzing archaic prohibitions of childhood from the present will probably eventuate in more constructive attitudes in the patient toward authority, toward colleagues, and inwardly. Consequently, even though our field of inquiry dealt practically exclusively with sexual problems, the total integrative function will have been influenced in successful therapy. These facts perhaps explain why the individual may be helped by many different approaches that

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selectively consider only a circumscribed aspect of functioning. Readjustment in one area starts a chain reaction that can involve the person as a whole.

The attitudes of the patient toward the therapist show extreme variations in all therapies, the patient reacting to the therapist, first, as a real person and, second, as a symbol of authority. Attitudes will consequently be molded by the actual role that the therapist plays with the patient as well as by habitual attitudes and feelings residual in the patient's previous dealings with authority. The attitudes of the therapist to the patient are also diverse. First, there are feelings toward the patient as a human being who needs help and services that the therapist renders for a fee; second, impulses are mobilized toward the patient that are neurotically nurtured and are parcels of disturbances in the therapist's own character structure (negative countertransference, or that are manifestations in countertransference of projections by the patient onto the therapist of unconscious needs and impulses.) The methods of handling transference and countertransference, such as by encouragement, avoidance, control, or interpretation, will differ according to the goals in therapy, the specific techniques being followed, and the level of the therapist's understanding of psychodynamic processes in both the patient and personally.

A private survey among a sizable number of psychotherapists practicing supportive, reeducative, and reconstructive therapies yielded some interesting facts that have been detailed in Table 13-1, page 348 Outlined is a comparison of technical procedures in the three main psychotherapeutic groups, according to the duration of therapy, frequency of visits, the taking of detailed histories, routine psychologic examinations, the kinds of communications obtained from the patient, the general activity of the therapist, the frequency of advice giving to the patient, the handling of transference, the general relationship of the patient to the therapist, the physical position of the patient during therapy, the handling of dream material, and adjuncts utilized during treatment.

Table 13-1 Technical Psychotherapeutic Similarities and Differences

			Reconstructive Therapy		
	Supportive Therapy	Reeducative Therapy	Classical Psychoanalysis	Non-Freudian Psychoanalysis	Psychoanalytically Oriented Psychotherapy
Duration of	One to several	Several sessions	2-5 years or	1-5 years or longer	Several sessions to

therapy	hundred sessions	to several hundred sessions	longer		several hundred sessions
Frequency of visits	1-3 times weekly	1-2 times weekly	4-5 times weekly	2-4 times weekly	1-3 times weekly
Detailed history taking	Usually	Often	Rarely	Occasionally	Often
Psychologic examinations	Intelligence testing, Vocational battery	Intelligence testing, Vocational battery, Projective testing	Projective testing may be employed	Projective testing may be employed	Projective testing often employed
Patient's communications	Interviews focused on symptoms and environmental disturbances	Interviews focused on daily events and interpersonal relationships	Unguided free associations	Interviews focused on current situations, interpersonal relationships, and other conflictual sources Free associations sometimes used	Interviews focused on current situations, interpersonal relationships, and other conflictual sources Free associations sometimes used
General activity of therapist	Toward strengthening of existing defenses	Challenging of existing defenses Activity - directiveness to nondirectiveness	Challenging of existing defenses Passivity, anonymity, nondirectiveness Constant analysis of transference and resistance	Challenging of existing defenses Activity - moderate directiveness to nondirectiveness Constant analysis of transference and resistance	Challenging of existing defenses Greater activity - directiveness to relative nondirectiveness Constant analysis of transference and resistance
Advice giving to patient	Often	Occasionally	Never	Rarely	Rarely
Transference	Positive transference encouraged and utilized to promote improvement	Positive transference controlled, and if possible utilized to promote improvement Negative transference analyzed as it develops in terms of the reality situation	Transference encouraged to point of development of transference neurosis Transference analyzed in terms of genetic origins	Transference encouraged to point of awareness of repressed attitudes and feelings Transference neurosis avoided by some analysts Transference analyzed in terms of character structure or genetic origins	Transference encouraged to point of awareness of repressed attitudes and feelings Transference neurosis avoided as a rule Transference analyzed in terms of character structure and occasionally genetic origins
General relationship of patient to therapist	Positive relationship fostered and utilized	Positive relationship fostered and utilized	Relationship permitted to develop spontaneously	Relationship permitted to develop spontaneously	Relationship permitted to develop spontaneously Positive relationship occasionally fostered and utilized

Physical position of patient during therapy	Sitting up, face to face	Sitting up, face to face	Recumbent on couch	Sitting up, face to face or Recumbent on couch	Sitting up, face to face or Occasionally recumbent on couch
Dream material	Not utilized	Not utilized	Constantly utilized	Constantly utilized	Constantly utilized
Adjuncts utilized during therapy	Bibliotherapy Art therapy Group therapy Physical therapy Somatic therapy Hypnotherapy Occupational therapy etc.	Group therapy Bibliotherapy Other adjuncts occasionally used	None	Few or none	Analytic group therapy Hypnoanalysis Narcotherapy > Play therapy occasionally Art therapy occasionally Drug therapy occasionally

Duration of Therapy

No exact estimate of the time required to achieve therapeutic goals is possible in supportive, reeducative, and reconstructive psychotherapies. In some instances satisfactory goals are achieved in several sessions; in others treatment requires several hundred sessions. However, the tendency is toward relatively short-term intervals, averaging 10 to 50 sessions in supportive, reeducative, and psychoanalytically oriented psychotherapy. In classical and non-Freudian psychoanalysis the time estimate is from two to five years with an average of three years.

Frequency of Visits

Under most circumstances the frequency of visits, is lowest in the supportive and reeducative therapies, averaging no more than one or two visits weekly. In some instances, as where anxiety is great, it is as high as three times weekly. In psychoanalytically oriented psychotherapy, visits average twice weekly, with a low of one and a high of three. Most non-Freudian analysts prefer seeing their patients three times each week, occasionally lowering this to twice, or raising it to four times weekly. Some Freudian analysts are insistent on visits no less than five times weekly, but others allege that they can handle patients on a four-times-a-week basis. A minority of analysts contend that, with experience and the proper selection of cases, psychoanalysis can be conducted on the premise of three, two, or even one

session a week (Saul, 1958).

Detailed History Taking

In supportive therapy, a routine detailed history is the rule. It is employed in reeducative therapy in the form of a systematic inquiry into areas of adjustment and maladjustment. In reconstructive therapy, analysts, particularly Freudian analysts, prefer a spontaneous unfolding of historical data, some even condemning the practice of history taking as prejudicial to good therapy.

Psychologic Examinations

Intelligence testing and vocational batteries are often used in supportive and reeducative therapies as a means of assaying intellectual capacities, vocational interests, and work potentials. Projective testing, most frequently the Rorschach test, is employed in reeducative and reconstructive therapies, mostly as an aid in diagnosis to determine the presence of organic brain conditions and to ascertain the strength of latent schizophrenic tendencies.

Patient's Communications

The kinds of communication encouraged in the different therapies vary to a considerable degree. Free associations are rarely or never employed in non-reconstructive treatment. Guided interviews are organized in supportive therapy around symptoms, environmental disturbances, and immediate interpersonal problems, and in reeducative therapy such interviews are organized around daily events and the current life situation. In classical psychoanalysis unguided free associations are considered mandatory in order to circumvent conventional resistances to unconscious content. Content dealing with everyday problems is felt to be of secondary importance, often serving as a diversion from focal areas of conflict. In non-Freudian psychoanalysis, free associations are believed to be useful, but are not felt to be absolutely essential. Interviews are often focused on interpersonal relationships and other apparent areas of conflict. Analysts who employ psychoanalytically oriented psychotherapy tend even more toward focused interviews, especially in short-term approaches.

General Activity of Therapist

As might be expected, activity and directiveness are greatest in those who do supportive therapy and least in practitioners who employ nondirective and Freudian analytic approaches. Irrespective of intent or the kind of therapy practiced, the degree of activity or passivity is determined largely by the personality structure of the therapist. Recordings of treatment sessions prove this point amply, therapists of active temperament finding it difficult to maintain passivity and anonymity even though their brand of therapy calls for these roles. Often therapists whose recordings show them to be very active and directive have no awareness of their activity or directiveness. In supportive therapy an active approach reinforces the authoritarian position of the therapist. This is felt to be helpful to the therapeutic objective. Moderate directiveness in other therapies, except perhaps in Freudian psychoanalysis, is not considered prejudicial to the therapeutic aim, provided it is controlled during phases of therapy where it is essential for patients to think through their own problems and to arrive at their own set of goals and values.

The lines along which the therapist actively works are determined in part by attitudes toward the patient’s defensive mechanisms. In supportive and reeducative therapies the defenses are resurrected and strengthened with a rebuilding of those that have enabled the individual to function satisfactorily prior to the present upset. In reconstructive psychotherapy the defenses are challenged for the purpose of eliminating those that perpetuate the neurosis and as a means toward alteration of the character structure itself.

Advice Giving to Patient

The amount of advice offered to the patient correlates positively with the degree of directiveness and authoritarianism assumed by the therapist in his or her relationship with the patient. In supportive therapy, accordingly, it is often given; in reeducational therapy it is occasionally proffered; while in reconstructive therapy it is, more or less, avoided except in emergencies.

Transference

In supportive and reeducative therapies certain aspects of the positive transference are encouraged, and utilized to facilitate therapeutic change. There is also a constant attack on, and

dissipation of, negative transference as soon as this develops. In classical psychoanalysis the spontaneous feelings and attitudes of the patient are encouraged to a point where he or she may actually react to the therapist not as a real person, but as a symbol of authority toward whom archaic emotions and strivings are directed (transference). This enables the patient to live through with the therapist some of the most important traumatic experiences in the past (transference neurosis), gaining insight through actual revivification of events damaging to personality formation. Interpretation is in terms of genetic origins. In non-Freudian psychoanalysis and psychoanalytically oriented psychotherapy transference also is considered an essential part of therapy, but the transference neurosis is reduced by greater therapist activity, by less frequent visits, and by the immediate handling through interpretation of irrational trends and feelings. Transference is analyzed in terms of character structure as well as occasionally of genetic origins.

General Relationship of Patient to Therapist

In supportive and reeducative therapies, and occasionally in psychoanalytically oriented psychotherapy, a positive relationship is fostered and sustained as much as possible by appropriate actions and utterances, the relationship itself being utilized to promote therapeutic change. Transference reactions that interfere with a positive relationship are usually dealt with as expediently as possible. In all reconstructive therapies the relationship of the patient to the therapist is permitted to develop more or less spontaneously. Transference is encouraged in classical psychoanalysis as a vehicle of insight; it is controlled to a varying extent in non-Freudian psychoanalysis and in psychoanalytically oriented psychotherapy.

Physical Position of Patient during Therapy

The sitting-up position is always utilized in supportive and reeducative therapies. In classical psychoanalysis the recumbent couch position is employed as a means of fostering free associations. This requirement is less rigidly followed in non-Freudian psychoanalysis, in which the sitting-up position is alternately or exclusively used with certain patients. In psychoanalytically oriented psychotherapy the sitting-up position is employed, though occasionally, at certain phases of treatment, the recumbent position may be preferred.

Dream Material

Dream material is generally disregarded in supportive and reeducative therapies, although analytically trained therapists, who use such therapies, study dreams without interpreting them to the patient in order to observe the defensive reactions of the patient, including transference and resistance manifestations. In all of the reconstructive therapies dream material is employed as a principal means of access to unconscious conflict. The manner in which dreams are handled will vary according to the theoretic training and orientation of the therapist.

Adjuncts Utilized during Therapy

Somatic therapy, hypnosis, bibliotherapy, physical therapy, occupational therapy, and other adjuncts are often employed by therapists practicing supportive therapy. In reeducative approaches and in psychoanalytically oriented psychotherapy, group therapy, drug therapy, bibliotherapy, play therapy, art therapy, narcotherapy, and hypnotherapy are sometimes coordinated used. Few adjuncts are utilized in non-Freudian psychoanalysis, while in classical psychoanalysis most therapists avoid all adjunctive devices.

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