THE TECHNIQUE OF PSYCHOTHERAPY

STRUCTURING THE THERAPEUTIC SITUATION

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Structuring the Therapeutic Situation

During the first phase of therapy the patient becomes aware of the routines, requirements, and responsibilities of psychotherapy. The patient relinquishes the idea that things will be done for and to him or her and accepts the patient's role as active participant in the therapeutic process.

Some patients assume the obligations of the therapeutic situation with scarcely any direction from the therapist. Other patients balk every inch of the way, resisting the conditions with a doggedness that seems borne of perversity. Research data exist which that certain procedures as facilitative of a therapeutic alliance (Goldstein, 1980, Goldstein & Wolpe 1971). First, preparatory structuring for the patient by the initial screener of what to expect from the assigned therapist and from therapy itself, couched in enthusiastic constructive terms, has a beneficial influence on the patient. If the initial interviewer will not continue with the case, but will make an assignment of a therapist after the patient describes the kind of therapist desired, assurance that the therapist to whom one will be assigned actually possesses the desired qualities appears to promote expectant trust. The screener, in further describing the assigned therapist, makes the patient additionally receptive by indicating the latter's expertise, warmth, and capacities to help. When the therapist comes from the same background as the patient, a statement to that effect has also been shown to facilitate the forthcoming relationship. Finally, role-expectancy structuring can be useful in terms of what the patient and therapist will do and what the patient may expect from therapy. This helps eliminate surprise, confusion, and negative feelings.

A recommended article is that by Orne and Wender (1968), which details the words to use in a structuring interview. In my 1980 (pp. 41-42) book there are also precise ways of structuring the therapeutic situation. Sometimes a cassette tape is given to the patient that contains clarifying instructions of how the patient and the therapist are to behave with each other. Research studies show that modeling or observational learning can add to the attraction potential the patient has for the therapist. Here an audio-or videotape that is played containing an actual or simulated session that brings out the therapist's sympathetic and caring qualities in relation to a patient seems to have an impressive effect on some patients. According to some studies, the higher the expertise and status of the therapist in

the mind of the patient the greater the patient's confidence in what the therapist is doing; the stronger the activity level and degree of demonstrable conviction, the more manifest the empathy with the patient's feelings, the more attracted the patient will be to the therapist and hence the more likely a therapeutic alliance will develop.

As long as the patient is observing the "rules" of therapy, there is no need to emphasize any aspect of procedure. When, however, the patient seems confused or shows resistance, clarification will be necessary. Among areas that may require structuring are the manner of communication, the general routines of therapy, the responsibilities of the patient, the role of the therapist, and a description of the psychotherapeutic process.

EXPLAINING THE MANNER OF COMMUNICATION

The Focused Interview

The kind of communication that is used in psychotherapy is generally that of the focused interview, which has been described in Chapter 19, "The Conduct of the Psychotherapeutic Interview." It is usually unnecessary to instruct the patient on what to say and how to say it since the therapist will, by skillful focusing and by the use of other techniques that have been described, manage any problems in this area that develop. If the patient does specifically ask what topic to bring up, the therapist can say to report on any present thoughts and ideas including those that are fleeting, seemingly insignificant, or repulsive, or might ordinarily be suppressed. Also, the patient may be told that it is important to mention any tensions or physical symptoms that occur during the session as well as anxieties, fears, or feelings of resentment. The patient may be enjoined to observe the relationship between symptoms and environmental happenings. The patient may also be asked to indicate if he or she has ever had thoughts, feelings, and anxieties similar to those being experienced at present, and, if so, under what circumstances these occurred.

The following are excerpts from sessions with patients who required instruction in the manner of communication:

Example 1:

Pt. I don't know what I should say.

Th. It is important to talk about anything that is immediately pressing on your mind no matter what it might be. This refers to your feelings and your ideas. If there is an immediate problem you are facing at your job, with your family, or in any other area, talk about that. The best rule to follow is to talk about things that are bothering you most.

Example 2:

Pt. Is there anything special you want me to talk about?

Th. I want you to tell me what is mostly on your mind. You may have to face yourself to tell me things that are painful or shameful. Talking about these things may be hard, but it will be most helpful to you.

Pt. But how do I do this?

Th. Try to "think out loud" and not hold anything back. In the process of "thinking out loud," you may want to express what you have been thinking or feeling about me.

Example 3:

Pt. What should I talk about?

Th. Anything that is on your mind is important.

Pt. Like what?

Th. Well, any factual observations that you make as well as irrational ideas or feelings that come to you. For instance, you may go out with your girl and then get furious with her or indifferent to her, for little apparent reason. Mention these things to me. If you are emotionally bothered by anything at all, talk about it. If you have fantasies or daydreams or dreams at night, these are very important. If there is anything good or bad that you feel about your treatments here, or good or bad thoughts about me, bring these up too.

Example 4:

Pt. I just don't know what's causing these feelings. I get so frightened and upset, and I don't know why.

Th. That's why you are coming here, to find out the reasons, so you can do something about your trouble.

Pt. But why is it that I can't sleep and concentrate?

Th. That's what we'll begin to explore.

Pt. But why?

Th. What comes to your mind? What do you think?

Pt. I don't know.

Th. You know, there are reasons for troubles like yours, and one must patiently explore them. It may take a little time. I know you'd like to get rid of this trouble right away, but the only way one can do this is by careful exploring.

Pt. Yes.

Th. And to take your anxiety feelings, for example, you may not be aware of the reasons for them now, but as we talk about you, your ideas, your troubles, and your feelings, you should be able to find out what they are.

Pt. How do I do this?

Th. When I ask you to talk about your feelings and thrash things around in your mind, you won't be able to put your finger on what bothers you immediately, but at least you will have started thinking about the sources of the problem. Right now, the only thing you're concerned with is escaping from the emotion. That's why you're just going around in a circle. While you're operating to seal off anxiety, you're doing nothing about finding out what's producing this anxiety.

Pt. It sounds sort of clear when you say it. (*laughs*)

Th. Well, do you think you understand what I mean?

Pt. What you're explaining now?

Th. Yes.

Pt. Yes. *{pause*) The point is that I keep thinking about myself too much. It's that I feel inferior to everyone. I must win at rummy. When I play golf, I practically beat myself red if I don't get the low score. And this is silly.

Th. What happens when someone beats you at golf?

Pt. I get upset and these feelings come.

Th. Now there seems to be some kind of connection here; let's talk some more about that.

Free Association

Except in Freudian psychoanalysis, free association will rarely be employed. When the therapist uses it as a means of communication, the patient may be given the following explanation:

The kind of communication that we will use here is different from the ordinary back-and-forth talk. It is called "free association." To do free association, you just talk about whatever comes to your mind without censoring anything. Try not to hold things back, including any ideas, feelings, or impulses, no matter how insignificant or ridiculous they may seem. If you think that something is too trivial to report, it may be doubly important to

> mention it. If you notice any tension in your muscles or if you experience fear, happiness, excitement, or resentment, tell me about these. In other words, I'd like to explore with you thoughts and feelings that are sort of on the periphery of awareness. In this way we will be able to understand some of the problems and conflicts that are hard to get at by ordinary conversations.

In using free association, it will be necessary to give the patient a reason why the therapist does not respond constantly to the patient's productions with comments and explanations. The following exemplifies how this may be done:

> Another important thing for you to know is that I will not interfere with your flow of ideas by interrupting with comments. This may puzzle you, but if I don't keep up a conversation with you and enter into back-and-forth talk, there's a good reason for it. I will, of course, occasionally bring important things to your attention. But don't be upset if I fail to respond to everything you say.

Dreams

When the therapist uses dreams, it will be necessary to request that the patient recount dreams. The patient may be told:

> I should like to have you try to remember your dreams and tell me about them in as full detail as possible.

In the event that the dreams cannot be remembered, the patient may be asked to keep a pad of paper and a pencil next to the bed and to jot down any dreams the first thing in the morning before they are forgotten. Often this safeguard helps the patient to remember dreams that otherwise would be forgotten.

Should the patient ask why dreams are important, the following might be the reply:

> Dreams are important because the mind asleep thinks thoughts in dreams that tell a story about inner problems and conflicts. Sometimes dreams tell us a clearer story than can be told in ordinary conversations. It's hard to understand this, but the best way you can find out how dreams work is to bring them in so we can talk about them.

It is generally not wise to encourage the patient to write dreams down in detail unless there is a tendency to forget them. Some patients get so immersed in detailed dreaming, which they record painstakingly, that the entire session may be spent on dream material to the neglect of other aspects of the psychic life. This activity may be a subtle form of resistance by the patient to avoid talking about anxiety-provoking reality situations.

EXPLAINING GENERAL ROUTINES IN THERAPY

Explaining the Time Limits of the Interview

A brief explanation may be given the patient regarding the duration of a treatment session, the fact that sessions begin and end promptly at the appointed time, and the need to keep appointments regularly. If the patient challenges these limits or defies them, the resistance must be handled.

Informing the Patient of Expected Delays in Getting Well

Early in treatment the therapist may discuss the expected ups and downs in treatment and the possibility of temporary relapses. The patient may also be told that alleviation of symptoms may not come immediately and that there might even be a slight setback before improvement occurs. This helps to forestall untoward reactions to delays in achieving relief, and to mollify the inevitable suffering associated with the giving up of neurotic patterns.

Discussing the Confidential Nature of Communications

It is usually advisable to explain to the patient that any information revealed to the therapist is completely confidential and will, under no circumstances, be divulged. This allays the patient's fear that the therapist will discuss the patient with others. The same reassurance may be given the patient about the patient's case record, pointing out that it will not be released, even to the patient's personal physician, without his or her permission.

Explaining the Use of the Couch When It Is to Be Employed

There are advantages and disadvantages to the recumbent position in psychotherapy. Lying on the couch out of visual range of the therapist enables the patient to delve into personal aspects without restraining the thought processes. Reality is tempered for the time being, and the patient is less apt to respond to what he or she believes the therapist demands or to modify thought content in accordance with the facial responses and nonverbal gestures of the therapist. However, the couch position is not indicated in most forms of psychotherapy because of the very fact that it removes the patient from reality.

Lying on a couch may furthermore mobilize anxiety in some patients. It may foster silence or a senseless rambling of fantasy material. Face-to-face interviewing, thus, is generally preferred, and, since this is the natural conversational position, it will not have to be explained to the patient. In reconstructive therapy, however, when free association is to be employed, the couch position may be desired. Here the patient may be told:

> Now in talking about yourself, it is helpful to use the couch. The reason for this is that when you face me you are apt to be distracted by what I say and do, and by my facial expressions. This restricts you and makes it hard for you to concentrate on deeper feelings. We can make faster progress by your reclining while you talk.

Planning for Vacations

It is necessary to inform patients well in advance regarding any vacations or extended absences the therapist plans to take. This enables patients to handle their emotions in advance and minimizes their feeling of being deserted when the time comes for vacation. "Springing" a vacation or recess on a patient without prior notice is apt to precipitate anxiety and to stimulate conceptions of the therapist as a rejecting or irresponsible person. Most therapists urge their patients to plan for their own vacations at a time that coincides with the therapist's absence.

Smoking during the Interview

The presence of ash trays generally invites the patient to smoke, should the patient desire. Sometimes the patient asks permission when it is noticed that the therapist does not smoke. To forbid the patient to smoke imposes what to the patient may look like authoritarian pressure. Should the therapist be sensitive or allergic to smoking, a good ventilation system will be helpful. If the therapist is unable to tolerate smoke or is dead set against smoking, the reasons should be explained to the patient and the patient asked how he or she would feel about not smoking. If the matter is tactfully presented, the patient may willingly forego the indulgence during the treatment session.

The Taking of Notes

Some patients object to the taking of notes. If the therapist explains the purpose of note taking and confines it to recording only important data such as dreams, the patient will generally adjust to this

practice. If the patient continues to object, even after such feelings have been discussed and the reasons for the objections explored, the therapist should confine entries in the case record to the period following the session.

Accounting for the Long Time It Takes to Get Well

If the patient is insistent on knowing how long it will take to get well and if, as in some cases, long-term therapy is necessary, an explanation is helpful, such as the one given to the patient in the following excerpt:

Th. Now your problem seems to have originated way back in your life, as far back as childhood. It will, therefore, require a little time to correct.

Pt. How long would I need?

Th. That will depend on your cooperation and desire to get well.

Pt. I do, I mean I want to get well. But could you tell me approximately how long it will be?

Th. Now, because the problem goes so far back it may need 2 or 3 years of treatment.

Pt. As long as that?

Th. Unfortunately, deep change takes time. Actually, it's not so long. It took you all your life to get tangled up in a knot. It's been with you for a long time. And a couple of years of treatment is short compared to how long you've had it.

Pt. Aren't there any shortcuts like hypnosis?

Th. Yes, there are, and we'll use whatever techniques are best for you to cut down the time. But hypnosis does not shorten the period of treatment in a problem such as yours. Time itself seems to be an element of cure. You know how hard it is to overcome a tobacco habit?

Pt. Yes, I know.

Th. Well, personality habits require even more time, because they are part of a person from childhood on.

Pt. Yes, I see.

Handling Consistent Lateness

If the patient is consistently late, this may indicate resistance and will necessitate an inquiry. The

therapist may ask, "I wonder if there is any reason why you have come so late the last few times." The patient may possibly then bring up an area of resistance. If the patient is defensive and insists on explaining the lateness on the basis of a reality factor, it is best not to challenge this. Instead one may say, "Let us see what happens in the future." If lateness persists, the patient may be more directly challenged.

Handling Broken Appointments

If the patient breaks an appointment without telephoning, this must be considered seriously and discussed thoroughly at the next session. If two successive appointments are broken, the therapist may advantageously telephone the patient and inquire as to the reasons. Should the patient remark that he or she has decided to terminate therapy, it is advisable to invite the patient to come in to talk things over. Consistent breaking of appointments is a critical matter and calls for active analysis of prevailing resistances.

Handling Too Frequent Cancellations

When the patient calls in advance to cancel an appointment, there is generally no charge for the session, provided the reasons for the cancellations are valid emergencies. Should cancellations be too frequent, resistance is probably operative, and the patient may be reminded that interruptions in therapy are not only expensive but also detrimental to the progress of treatment.

Handling Nonpayment of Bills

Most patients pay their bills promptly if, during the initial interview, mention is made of the fact that bills are sent out at the end of the month. Should a considerable time elapse without payment, and without mention by the patient of the reasons for this deficiency, the therapist may discuss the matter frankly in a manner such as the following:

Th. I noticed that you haven't paid your bill for the past two months. I wonder if there are material reasons for this or whether you have forgotten.

Pt. Oh, I just don't think of it; haven't gotten around to it.

Th. Do you have any feelings about paying the bill?

Pt. Why no. It's that so many other expenses have come up.

Th. Well, look into it anyway. There may be emotional reasons for your forgetting. Are you at all irritated with me or uncertain about your treatment?

Pt. {*pause*} Maybe, in some ways. I feel we haven't been going fast enough.

Th. Let's talk about that.

The subject of nonpayment of bills may open up a pocket of transference. Should there be realistic budgetary problems, it is incumbent on the therapist to make as liberal allowances for the patient as circumstances permit. On the other hand, not too much time should be permitted to elapse without some arrangement being made for the liquidation or other disposal of the bill, otherwise the therapist may become resentful and lose therapeutic objectivity.

DELINEATING THE PATIENT'S RESPONSIBILITIES

Most patients will proceed to work actively in therapy without too much prodding or too extensive a definition of their responsibilities in the treatment situation. In some patients, however, confusion about their role or resistance to activity may require that the therapist delineate their obligations.

How best to present the matter of the patient's responsibilities will depend on the kinds of resistances displayed. In addition to dealing with a specific resistance, the patient may be told that comprehending the problem is the first step in its control. It is often hard for the patient to do this independently because of a lack of objectivity. In treatment the therapist can help the patient find out the cause of the trouble by guiding the patient along certain paths of thinking. The patient and therapist act together in a sort of partnership in the project of exploring the patient's patterns. Knowing what is behind the difficulties will help the patient to do what is necessary to be rid of them. The therapist may say:

> Perhaps we can regard therapy as an arrangement in which we both are participants. You will help me understand you by telling me about your thoughts and feelings, and I will help you understand what goes on inside of you that creates your trouble. Together we can work this thing out.

When the therapist informs the patient that the therapeutic situation is one in which the patient is expected to work out the problems independently, resentment, depression, or panic may be mobilized,

because the patient feels that this has already been attempted and not been unsuccessful. The patient may then look upon the therapist's refusal to take complete responsibility as a dereliction. Consequently, it is best not to stress too much, at the start, the obligations that the patient must assume. Instead, it is best to let the relationship develop naturally, helping the patient slowly to accept more and more responsibility. It is, of course, essential that eventually the patient come to an understanding that the extent of his or her participation will determine the ultimate goal. If the therapist makes decisions for the patient and gives directives on how to conduct his or her life, this will delay the development of essential inner resources that enable the patient to manage problems constructively. If the aim is for goals of assertiveness and independence, it will, therefore, be necessary for the patient to treat the treatment situation as a medium in which independent decision-making capacities can be developed.

One way of insuring the patient's cooperation is to present the process of working in psychotherapy in terms that will be at least partially cogent to the patient. For instance, a patient during the third interview expresses confusion about what to say. He then expostulates that he would like the therapist to do something positive for him. An excerpt of the interview follows:

> *Th.* I know how difficult this has been for you. Were it possible to remove your trouble immediately, I would want to do it. But this thing has been with you for some time, and it may require a little time to get at the bottom of it.
>
> *Pt.* How can I get well, then, how?
>
> *Th.* There are ways of working in psychotherapy that will help you get well. Let's look at it this way: you've learned patterns of feeling and behaving that have gotten you into trouble. These patterns are part of you. What we'll do is examine these patterns and see why they've failed and have gotten you into a mess. After that you'll be able to learn new patterns that will make it possible to enjoy life.
>
> *Pt.* But how do I do this?
>
> *Th.* Now, learning new patterns is like learning a new language. If you were going to learn a new language, you would have to start talking that language. It would be difficult at first and you would make mistakes, but you would eventually learn it through practice. I'll be like a teacher helping you when you make mistakes. But if I were to do all the talking in this new language, you would never learn how to talk.
>
> *Pt.* I see, but how do I start?
>
> *Th.* The best way is to tell me what is on your mind, what you feel, what bothers you. I'll ask you questions from time to time. Now I'm not going to give you the answers, for if I did, it wouldn't help you. But I'll help you find the answers for yourself.
>
> *Pt.* I see.

Th. It's like doing algebra. To learn algebra it wouldn't help you if I gave you the answers. The important thing is to learn how to get the answers. In problems like yours, learning *how* to arrive at the answers to your disturbing feelings and patterns is as important as getting the answers themselves.

Pt. Yes.

Th. This may sound mysterious, but as we go on, it will become clearer.

Assigning Tasks to the Patient

Sometimes it is feasible to assign certain tasks to the patient to work on between sessions, such as observation of dreams, and attitudes toward the therapist, which situations exaggerate or alleviate symptoms, and to execute certain behavioral assignments essential to acquire new patterns. The patient may deny that there is any connection between his or her life circumstances and symptoms, but the therapist must insist that the patient keep watching for a relationship between the severity of the symptoms and provocative environmental happenings. Whenever the patient brings up the circumstance of exacerbation of symptoms, it will be important to explore the conditions associated with it. Should the patient balk at performing this assignment, the resistance must be thoroughly explored.

Explaining the Need Not to Make Important Decisions without Discussing These with the Therapist

During therapy the patient's values are in more or less of a transitional state. Extremely important decisions, like changes in occupation or marital status, must be considered very carefully before acting on them. Tragic consequences may follow impulsive decisions. For these reasons the patient may be told that a rule in therapy is that the patient must not spontaneously and impulsively make any radical changes in his or her life situation and that all important actions be discussed with the therapist first.

DEFINING THE ROLE OF THE THERAPIST

In supportive therapy it is usually unnecessary to define the role of the therapist, since the latter consciously functions as a "giving" authority. In deeper therapy, on the other hand, as has been explained above, the therapist's role may have to be delimited when the patient protests the apparent lack of direction. The patient must be apprised of the fact that the therapist's giving advice and guidance will block the patient's development and prevent achievement of strengths essential to independent

functioning.

Psychotherapy calls for respectful listening and a communicating to the patient of an understanding of the patient's turmoil and of a desire to help the patient's plight. This process is different from an artificial cultivation of dependence on the therapist. No promises are made to the patient, nor is the therapist held out as a savior. Rather, the therapist indicates that there are ways of getting relief for one's problems contingent on the patient's active cooperation in therapy.

Partly because the patient puts the therapist in the traditional role of magical healer and partly because the patient's helplessness inspires regressive dependency impulses, he or she demands or secretly expects immediate and dramatic relief. The patient is bound to feel resentful and hopeless if this relief is not immediately forthcoming. The patient may be unable to understand why a rapid cure is not possible, why therapy requires frequent sessions over a prolonged period, and why the therapist displays minimal activity, expecting the patient to shoulder the brunt of the work.

As soon as possible, the therapist must clarify these doubts and hopes to help prevent the experiencing by the patient of too great disappointment and to thwart the patient's leaving therapy in confusion.

The following excerpts from early sessions illustrate the defining of the therapist's role:

Example 1:

Pt. I'd like to know, doctor, what makes me feel so sick.

Th. There are reasons why you feel the way you do. Those reasons may not be clear to you, because you are living too close to your difficulties. We will discuss your ideas and particularly your feelings, and in not too long a time, we should discover what is behind your problem.

Pt. Yes, but what would you like to know? I mean what do you want me to talk about?

Th. Just anything that bothers you, that's on your mind. In discussing your ideas, reactions, and feelings, we will gradually be able to understand what is happening to you, and this understanding will permit you to take definite steps to correct your difficulty.

Pt. And you'll tell me what is wrong?

Th. Not exactly. I'll, of course, help you with your problem, by acting as your third eye, so to speak. You may not be

able to do this for yourself because, as I said, you are living too close to your problem to see the forest for the trees. But I can be more objective, and I shall direct your thinking along certain lines.

Pt. You mean you will not do the work for me; you'll just show me what to do.

Th. Yes. You see, if my doing the work and telling you what to do would really help you, I'd do it. But experience shows that emotional problems are not helped this way. In being told what's wrong with you and what to do, you may never be able to develop as much personality strength as in working things out with my help. Together we can work out a logical and constructive solution for your problem.

Example 2:

Pt. But aren't *you* able to take these fears away from me?

Th. Your fears bother you a great deal, and you want to get rid of them as soon as possible, don't you?

Pt. Yes.

Th. Now it would be natural for you to expect me to give you medicines or some other remedy, or to do something forceful to make your troubles disappear. Believe me, I would do this for you if they *would* disappear this way. But experience shows that you *can* get rid of them by first finding out what they mean, how they got started, and why they continue to bother you. This will take time, and you're likely to get impatient with the slowness of the process.

Pt. (*laughing*) I hope it isn't too slow.

Th. (*smiling*) Well, we'll go as fast as *you* can travel.

Verbalizing the permissive nature of the relationship is not advisable since the patient may interpret this as a lure. Rather, it is important that the patient, on the basis of personal experience, spontaneously arrive at the conclusion that the therapeutic situation is unique in its permissiveness, that things that are ordinarily censored can be talked about, that he or she will not be held in judgment, and that reprimand and punishment will not be forthcoming. The permissiveness of therapy does not presuppose that the patient will receive unmitigated support and reassurance. Things will not be done for the patient; rather, the patient will be helped to decide the best course of action. As has been mentioned previously, in reeducation and reconstructive therapy especially, it is important to explain to the patient, as soon as the patient expresses disappointment with the amount of direction the therapist is giving, the reasons for the seeming passivity of the therapist. To delay this explanation is apt to result in feelings of helplessness, hopelessness, and despair. Dependent patients will, of course, be loathe to accept the defined limits in therapist responsibility, but they will be much less hostile if they understand

that the role of the therapist is a deliberately cultivated one rather than one of neglect.

Limits of Demonstrativeness

Displaying acceptance does not mean that the therapist should behave too demonstratively toward the patient. Such acts as putting one's arm around the patient, comforting the patient solicitously, helping with the patient's coat, and other pleasantries are not to be encouraged. Should the patient wait for such attentions or show expectation of amenities from the therapist, the therapist may briefly explain that it is not the custom in psychotherapy to treat the patient in a conventional sense. For example, a female patient, having placed her wrap on a chair in a male therapist's office, walks over to it at the end of a session and then waits for the therapist to help her with her coat. To respond by doing this would be a normal thing in the ordinary social atmosphere or when purely supportive approaches are employed. To act this way, however, may cause the patient to regard the therapist as a person who should act in other conventional ways toward her. Generally, when the therapist, at the end of the session, does not offer to help the patient with her coat, the patient will do this for herself. Should she ask the therapist to help her, the therapist may do so, remarking, "Much as I'd like to do this regularly, it is customary not to do this in therapy. It tends to put the therapist and patient in a sort of conventional relationship that may interfere with your progress. If I don't help you with your coat from now on, you'll know that it's because it isn't wise to do so."

Limits in Gift Giving

The same taboo is extended toward giving the patient gifts. There are times in supportive therapy when a small gift may be tendered the patient as a demonstration of the therapist's thoughtfulness and desire to bring comfort to the patient. In insight therapy, gift giving puts an artificial bias on the relationship and may be harmful. Similarly, accepting gifts from the patient must be handled carefully. Even small gifts must be questioned. Should the patient offer the therapist a small gift, the therapist may accept it appreciatively but ask why the patient gave it. An excerpt from a session illustrates this point:

Pt. I thought you would like this necktie.

Th. Thank you very much. I appreciate your thoughtfulness, but I wonder why you got it for me.

Pt. (*blushes*) Oh, I just thought you'd like it.

Th. (smiling) You know in therapy one has to look a gift horse in the mouth, and inquire into the meaning of everything that happens, including bringing gifts. For instance, let's try to figure out why you gave me this tie.

Pt. (*laughing*) I suppose it's because I wanted to. I noticed that you wear drab ties.

Th. You thought I might look better in a snappy tie?

Pt. (*laughing*) Not that you haven't good taste, but ... *(pause)*

Th. Perhaps you're not quite sure of my taste.

Pt. (laughing) Come to think of it, maybe I'm not.

Under no circumstances should the therapist accept a large gift, for this is generally a manifestation of resistance or a way of bribing the therapist. When a patient offers the therapist such a gift, the therapist must refuse it without rejecting the patient. The following excerpt is illustrative:

Pt. I brought you a little something, *(gives therapist a box)*

Th. Thank you, very much, but I wonder why you got it.

Pt. Oh, I know you'll like this. It's a very nice thing.

Th. What is it?

Pt. A fine watch.

Th. Well, now I do appreciate your thoughtfulness, but one of the rules of therapy is not to accept gifts. It may interfere with your treatment. If I don't accept it, it's because of this rule. But tell me, why did you get it for me?

Pt Well, does there have to be a special reason?

Th. There usually is. You know, in therapy one looks a gift horse in the mouth. Mind you, I think it's very fine of you to bring me a gift, but let's explore this a little. We may learn something important from it.

Avoiding Social Contact

Meeting the patient on a social basis may be destructive to the relationship. The patient may employ his or her observations of the therapist's behavior as a weapon to reinforce resistance. The patient may use the social relationship as a means of neutralizing the therapist's effectiveness. On the other hand, if the therapist happens to meet the patient at a party or function, there is no reason to make a hasty retreat,

although there may have to be some restraint on the therapist's spontaneity.

Avoiding Physical Contact

It goes without saying that physical contact with the patient is absolutely taboo. Rubbing, stroking, or kissing the patient may mobilize sexual feelings in the patient and therapist or bring forth violent outbursts of anger. Should the patient approach the therapist sexually, this must be handled as a manifestation of transference, and the patient should be encouraged to verbalize his or her feelings. Were the therapist to respond to the patient's gesture, therapy would terminate immediately with perhaps disastrous consequences for both patient and therapist. The utmost care must be exercised to avoid mobilizing guilt in the patient if the patient makes a physical gesture toward the therapist. Occasionally an enthusiastic patient may embrace and kiss the therapist. This embarrassing situation will call for the greatest tact. If the patient is pushed away harshly and scolded, the patient will feel rejected and resentful. To respond by embracing the patient may be interpreted as a seductive lure for which the therapist will pay dearly later on. The best way to handle this contingency is to stand one's ground, smile, and ask, "Now, I wonder why you did that?" By facial expression the therapist must convey no embarrassment, fright, hostility, or excitement. If the embrace is during a session, the focus of the session should be on the meaning of the gesture to the patient. If it is at the end of a session, the therapist may add to the statement made, "Suppose you think about why you kissed me, and we'll talk about it next time." Therapists who advocate sexual relations with their patients as a therapeutic measure deceive themselves about their designs, which are usually countertransferential and exploitative.

Avoiding Business Dealings

Sometimes patients will offer the therapist opportunities to enter into business dealings with them. The temptation may be great, since the therapist may assume that an investment in the patient's enterprise will be helpful to both of them. Such business arrangements will usually be very destructive to therapy and should be resisted unequivocally. Similarly, one must never take advantage of patients' professional or social contacts, if they happen to be prominent because this again will dilute one's therapeutic impact.

EXPLAINING HOW PSYCHOTHERAPY WORKS

A case history explaining how another patient developed an understanding of oneself in therapy, and of how that patient achieved relief or cure, is a dramatic way of persuading the patient to accept the treatment situation when it is stubbornly resisted. The following is an example of such a history. Undoubtedly, the therapist will be able to present examples from personal experience. These should be sufficiently disguised so that the discussed patient's identity will not be revealed. In the case that follows, of a patient with migraine, symptomatic treatment along medical lines and brief supportive therapy with a counselor had failed to bring relief.

The patient was referred to me for treatment of migraine headaches that did not respond to medication. It was apparent to me that the patient did not really want psychotherapy because he was not convinced that the headaches were caused by psychological factors. What he really wanted from me was a prescription for another more powerful medicine. When I suggested that there might be a connection between his tension and his headaches he replied that this might be so, but that the headaches came first and gave him tension.

At the next visit he described his having suffered from an especially bad headache during the past week. When I asked him to describe the circumstances that immediately preceded his headaches, he said, "I can see no reason why I had the headache from the different things that happened during the day. I went to work, and everything went along pretty well. I did a job that was assigned to me with no trouble at all. That night I had a bowling date with a friend. Now this friend called me up, and we were supposed to go out on a date. He said, 'Suppose I meet you at eight o'clock.' Right at that point my wife, who had been coming down with a head cold, says to me, 'Why don't you postpone your going out until later on, after the kids are in bed or tomorrow?' And she did have a terrible cold. So I told my friend we'd go out the next day. I didn't want the youngsters to catch my wife's cold, so I helped them. Then I sat on my wife's bed. She was sniffling, and I began getting an awful headache right at that point. And there was no reason for it." When asked whether he might have resented the fact that he had to stay home and put the children to bed, he remarked, "No, why should I? The kids would have gotten a cold, I could have bowled the next day; there's no reason why I should." The patient was assured that perhaps there was no cause for the headache that we could see at this time but that it was necessary to continue observing

the circumstances under which his headache developed.

One week later the patient reported a severe migrainous attack. “Again I had an awful headache. Things went around. I had a bunch of junk last night, and it was probably what I ate.” When asked to talk about the events that had occurred, he said, “We went over to call on some people we know. They are nice people, but I don’t care very much for them. But my wife thinks that because he is my superior at work, we’ve got to cultivate them; and I suppose if I really want to go along, get ahead in my job, that I might as well try to be friends with him. So I went over there, and sat there, and we drank a while and we talked. They’re terrible bores. I really don’t like being with them. Then it started, an awful headache.”

When asked whether he resented making the visit, the patient replied, “Sure, I didn’t want to be there. I just resented being there.” He was then reminded that he had presented two instances in which his wife had asked him to comply and that in each case a headache followed. “Yes,” he admitted, “I don’t know; maybe you’ve got something.”

That he had made a connection was evidenced by his reaction to his next headache. He said, “By George, you know what happened? My wife asked me to stay at home again and not go bowling, but afterward I got a bad headache.” Almost excitedly he continued, “When I look back, I can see the headache just comes like that. There have been innumerable times when automatically I feel as if I have to do what my wife asks me to do, that I can’t say no. I say she is a reasonable person and a nice person, and I get a bad headache every time. Now, why should that be?” What we had done was to make a connection between the patient’s symptoms and some life events that at the time did not seem too important.

Therapists can refer to cases such as this and note to their patients: “This is what we shall try to do in your case in the event there is such a connection. We will also try to figure out if we can deal directly with the symptom and with problems in your life situation through various symptom-relieving or problem-solving interventions, or whether it is necessary to deal with some carry-overs in your early development that are causing your trouble now.”

In the case of the man with migraine, it became apparent that he had never gotten over his strong dependency on his mother whose dictates and demands he followed punctiliously, even though he

resented yielding to her wishes. His passivity led to the choice of a wife who was strong and who, with his cooperation and even insistence, took him over the way his mother did. This wife, of course, had gotten herself into a no-win situation. Because he idealized his mother, his wife could never come up to his expectations. When he forced her to make decisions, he resisted her interfering with his independence. When she tried to shift responsibility onto him he resented her ineffectuality. The resulting anger was not expressed outwardly but was turned back on himself and resulted in tension and migraine. Naturally he acted the same way with other people, and he did it even with me. This is a transference reaction, and it was possible to point out during our sessions how he was trying to force me to make decisions for him and then resenting whatever I did. Sometimes these activities are not at all conscious to the person. This is what happened to our man, but he was able to recognize from his dreams, fantasies, and feelings toward me that his world was populated with good mothers, bad mothers, and in-between mothers who dominated or rejected or loved or hated him and that he was responding to all their actions, good and bad, with physical symptoms.

Knowing this was only half the battle. The important thing was doing something with this insight. This involved changing habit and behavioral patterns that were about as old as he was. First, he had to get over his demand that I act like his mother. Next we had to involve his wife in treatment so that she could resist his demands that she be like a mother figure. We worked together, the man, the wife, and I in "couples therapy" and some of the sessions were stormy, resulting in *her* getting headaches. But before her husband could get well, she also had to get over her own bossiness so that she would not reinforce her spouse's passivity. The end result was a better and much less headache-ridden marriage. The man achieved enough personality reconstruction so that he functioned, for the first time in his life, with freedom and assertiveness and without debilitating headaches.

The therapist may remark, "This prolonged description illustrates how psychotherapy works. What happened to this patient naturally does not apply to you. But by examining *your* ideas and feelings, and talking about *your* problems, we should be able to help you too."

SIGNS OF ACCEPTANCE OF THERAPEUTIC STRUCTURING

Signs of acceptance of the structuring of the therapeutic situation are reflected in greater

participation and activity. This is illustrated in the following excerpt. The patient is a 40-year-old married woman with a hysterical symptom of vaginal burning, which, since its inception eight years previously, had been increasing in severity until she could no longer tolerate it. It was apparent that she had magical expectations of my removing her difficulty in a few sessions. When I structured the ideal way of working in psychotherapy, she responded with silence. At the sixth session, she complained of intense burning and remarked that she was thinking of stopping therapy. I attempted to analyze her resentment at my passivity and tried to justify my stand on the basis that if I could remove her trouble by waving a wand, I would do so. I explained that emotional problems like hers could be resolved—but that it was necessary for the patient to work hard and to cooperate actively. During the next session, the seventh, she seemed to be resolving her resistance to accepting the way that we were supposed to work together. A part of the session follows:

Pt. Today I'm 40 years old.

Th. Are congratulations in order?

Pt. No, nor commiserations. But I never thought I'd spend it here in New York getting treatment away from home. (*laughs)*

Th. You never realized 10 years ago, or even 5, that at your fortieth birthday you'd be sitting opposite a psychiatrist.

Pt. (laughs) I finally had a dream. I didn't have that dream until this morning. It was the silliest thing. I was living in this large room. I was living there with a man. He looked like a combination of an old boyfriend and a man who works in the same place I do. And we weren't sharing the same bed for some strange reason. And there was a double cot over on one side of the room and a double cot on the other side. And there was a sink, and there was a bunch of people there having a party for some reason. I was supposed to wash up the dishes, and I was very resentful of the fact that everyone was having a good time and I wasn't. In fact, I had to go out to go to work, and the dirty dishes were going to be left for me to do. And all of a sudden I realized that the man in the room had taken the sink out and put it up so high that I had to stand on my toes to reach it. Then I realized that one of the cots had been taken out. I was shocked, as if I was being eliminated. *[This dream seems to reflect a feeling of rejection and resentment at being made to do "dirty work." The idea occurs to me that this is a transference dream.]*

Th. What does that make you think of? Do you have any associations?

Pt. Why no. I just awoke and was going to go to work.

Th. But the emotion in the dream. What was that like?

Pt. Well, there didn't seem to be any love involved.

Th. Here was a man doing peculiar things?

Pt. Well, it didn't seem to be a man I was emotionally involved with, yet I was sharing the room with him. *(pause)*

Th. And what was he trying to make you do?

Pt. The dirty dishes while the others were standing around, talking and having a good time. *[Could this possibly refer to my wanting her to do the "dirty" work in therapy?]*

Th. Mm hmm.

Pt. And I was under strain. I had to stand on my toes to do that, and it was hard. He had put the sink up too high. I could see the bolt holes where the sink had been before. He put it up too high, *[indicating that I was making the therapeutic task impossibly hard for her?]*

Th. He was making you do the work.

Pt. Yes, and when I noticed the other cot gone, I said, "What the hell does he think he's doing?"

Th. Why would he take the cot away?

Pt. I don't know; maybe so the woman sharing the room would sleep with him.

Th. What kind of person was he?

Pt. He reminds me of two people I know: one, handsome and charming; the other, boorish and vulgar. He clowns around, but he's a good Joe.

Th. I see.

Pt. And something very peculiar happened last week, something I couldn't quite figure out. First, I realized I wasn't so frightened as I used to be. And I wasn't complaining as much. And I said, "Won't Dr. Wolberg be pleased to hear that," and all of a sudden this vaginal burning that I have went away completely. It made me chuckle. (*laughs)*

Th. All right, how do you make the connection?

Pt. I don't make any connection *(laughs)* except that maybe the treatments are doing me good in spite of myself.

Th. In spite of the fact that you may be a little annoyed at the way the treatments are going. *(pause) [It was hoped here that the patient would verbalize her feelings of resentment or disappointment. Because she did not do so, the next comment was made.]* Perhaps you feel disappointed that so much responsibility is being put on you?

Pt. Possibly, possibly. (*laughs)*

Th. Like being made to do the dirty dishes. *[interpreting one aspect of the dream]*

Pt. (laughs uproariously) I just hate to do dishes. That's my mother's fault. She wanted me to be a pianist and not spoil my hands. I was always annoyed at doing dishes. What you say is right; I don't want, didn't want, the responsibility of figuring things out myself.

Th. Are you annoyed at accepting responsibility?

Pt. Well... not exactly, that is, when I am not under tension, I don't mind responsibility. But since this tension started, I have tried to evade responsibility as much as possible, because I felt I couldn't accept it or carry it out.

Th. And how do you feel about accepting responsibility in our therapy here?

Pt. I am a little confused about that. (*laughs)* Less than before though. I just didn't feel as if I was capable.

Th. You see, if it were possible for me to remove these symptoms from you myself, I would do it. I would want to do it. But we find that cures are not accomplished this way. As a matter of fact, the more active a person is in working out the sources of a problem, even though the person has to sweat it through a little, the quicker one gets well. In the long run this is what strengthens the person. The ability to understand the sources of one's problem and to handle the resistance in working things out for himself or herself ... [*I continue to structure the therapeutic situation.]*

Pt. (*laughs*) It's not conscious resistance I assure you.

Th. I know.

Pt. I want to tell you what happened last night. This symptom that I have had is associated with sex in my mind, for some reason. I started thinking about my husband and all of a sudden this burning began to loosen up and to become a sexual feeling. Ordinarily I would have stopped thinking right there, because in the past if I started thinking about the person involved and couldn't do anything about it, the burning would keep on, and keep on, and only go away when I slept. So I just decided that I would keep on thinking about it just to see what would happen. *[This is an excellent sign of her beginning to accept responsibility by working on a problem.]*

Th. Good.

Pt. And I didn't get a sexual craving and I started being able to think about something else and I wasn't afraid of what would happen ... and, for heaven's sake, the burning went away.

Th. It sounds as if you've been afraid to let your mind wander in the past.

Pt. I see. You mean if I'm afraid to think about sex, I might get pain there instead.

Th. Yes, perhaps in the future you could let your mind wander and see what you think about.

Pt. I guess I'm afraid to think because, after all, it's been seven years that I've lived with this thing. If I thought it would clear things up, I wouldn't be afraid to think anything I want. Mother was very moral about sex, and I could never bring it up. Oh, yes, after I left you, I went to the store to get groceries. I wanted to get out so I got in line ahead of other people and the burning started. Then it went away. I went to sleep and had a dream I forgot. When I tried to remember the dream, the burning returned and my mind got hazy.

Th. Now it's important for you to continue thinking about yourself, like making a connection between your symptoms and your thoughts, you may not at first see the connection, but you will, after a while, see a trend developing, a connection. Now one impression I get that I can offer to you is that every time you feel you've done anything that's "bad," the burning comes on you.

Pt. When I ever did anything bad as a child, mother would scream, bang her head against the wall, and practically have a breakdown. *[Patient continues to associate to her early relations with her mother.]*

From this session on the patient accepted the conditions of therapy and worked actively and successfully.