THE TECHNIQUE OF PSYCHOTHERAPY

THE BEGINNING PHASE OF TREATMENT

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Introduction

The beginning stage of therapy has for its principal objective the establishing of a working relationship with the patient. This is the crucible in which problem solving is forged and personality change cast. Without such a mutuality, maximum therapeutic progress will not be made. Because the working relationship is so vital to success in therapy, all tasks must be subordinated to the objective of its achievement. Too frequently the therapist plunges into an exploration of provocative stresses prematurely, or challenges the patient through strong confrontations, before the working relationship has become solidified. Attitudes of respect, trust, and confidence in the therapist, inherent in a good working relationship, enable the patient to endure anxiety and to cope with resistance inevitable in the challenging of basic adaptational patterns. If a working relationship does not exist to absorb the impact of suffering and resistance, the therapeutic process will be hampered. This, unfortunately, is often the outcome of therapy that is not carefully planned.

To ensure an adequate working relationship, a number of therapeutic tasks are in order. First, the patient must be motivated, if not already, to

accept treatment. Persons who are inadequately motivated— who come to therapy at the insistence of their physician, or of a concerned relative or friend, or to forestall punishment when they have been involved in some legal infraction—or who, for any other reason, are not convinced that they need psychological aid—start treatment with a handicap. The fact that an individual is unmotivated does not mean that he or she will not respond to therapy. The therapist here will have to concentrate efforts on creating in the patient the proper incentives for the acceptance of help. No matter how tempting it may be to work on provocative stress stimuli or the operative dynamisms, the therapist will have to inhibit this impulse until cooperation is secured from the patient.

Equally important is the second task of clarifying and removing misconceptions about therapy. Many persons coming for treatment have stereotypes about psychiatrists and other mental-health workers. They expect the therapist to be a miracle worker who reads minds and who can infallibly produce a rapid cure once guilt and problems have been aired. Popular periodicals and books may have depreciated the value of psychotherapy or warned of its potentially harmful effects. Attacks by uninformed speakers or professional people on psychiatry, psychoanalysis, and psychotherapy may have created a pessimistic attitude that will prove inhibiting to the fruitful utilization of treatment services. Countless other misconceptions may burden the therapeutic effort and will require careful

handling to bring about a proper working relationship.

The third therapeutic task of the first treatment phase is to convince the patient that the therapist understands the patient's suffering and is capable of helping. Heretofore the patient will probably have felt condemned or rejected for his or her impulses and complaints and anticipates the same kind of judgmental and punitive attitudes from the therapist. Guilt ridden and resentful, the patient dares not open up completely to anyone who will repeat the hurts previously experienced at the hands of authority. Obviously it would be futile to tell the patient that the therapist is a different kind of authority since the patient would not understand how this was possible and would regard such a statement as a dangerous lure. Respectful listening, sympathetic reflections, and accepting, non-condemning verbal and nonverbal responses eventually convince the patient that this is a new kind of interpersonal relationship that warrants full cooperation. The therapist must keep keenly attuned to new frequencies in the patient's attitudes that signal progress in the evolution of the working relationship.

The fourth therapeutic task, which follows upon the successful execution of the former three, is the tentative defining with the patient of objectives in therapy. This charge is one the patient may not readily accept since he or she is not sure how far to go in treatment or exactly what is involved. A brief account of possibilities in a factual unprejudiced way is

indicated. An explanation that a complete rehabilitation of the personality is the most desirable goal (but that it is indicated in some instances and not necessary in others) and that it will require a greater period of treatment than less ambitious goals. The latter may achieve a reasonable equilibrium, even though a few problems may still remain that the patient feels can be lived with. It is hardly to be expected that the patient will grasp the full meaning of this exposition.

If the patient is unable to comprehend what therapy is and how interviewing helps, time may have to be spent in structuring the therapeutic situation, expounding on the process in very simple language, illustrating with examples of how other persons have been helped by psychotherapy. This will usually lead to greater acceptance of technical procedures, and more sympathetic acknowledgement of the need for a relationship based on mutual interaction and responsibility.

Resistance to a working relationship and to the therapeutic tasks during the first phase are to be expected. Thus the patient may refuse to become motivated for therapy, boycotting attempts by the therapist to demonstrate that the problem is treatable. The investment in remaining ill and the need to perpetuate any secondary gains will interfere with reasoning powers. Similarly the therapist's explanation of the treatment situation may not be accepted, the patient instead insisting on a personal definition and on setting

the conditions for cooperation. These may not be congenial with the requirements of good therapy. The patient may, for instance, resent the professional nature of the relationship and wish to be handled in a special, more personalized manner, even to hobnobbing socially with the therapist. To yield to the patient's wishes may risk therapeutic failure.

Of greatest interference in the development of a working relationship are characterological resistances that crop up as manifestations of the patient's habitual interpersonal activities. The threatened intimacy of close contact with the therapist will kindle customary and conflagrate latent character distortions that prevent from evolving in treatment the kind of relationship that will be most conducive to therapeutic gain. Some of the distortions are unique in that they are inspired by the special kind of encounter that takes place in therapy. Thus, transference feelings and attitudes may flare up almost from the start in the form of irrational expectations, sexual desires, protective demands, guilt feelings, fears of injury, distrust, and intense hostility. The triad of dependency, aggression, and detachment may become operative alternately or in combination.

Dealing with these manifold resistances to a harmonious working relationship constitutes the primary pursuit in the opening phase of treatment. It is obviously difficult to attempt supportive palliations, reeducational tactics, reconditioning procedures, or active analysis of deep

conflict while such resistances are operative. Irrespective of how impatient the therapist may be to deal with symptoms or emerging conflicts, it may be necessary to devote the initial treatment sessions largely to the resolution of resistance, while observing rules that make for a positive consolidation of the working relationship. Resistances, however, may not yield themselves readily. Character resistances, especially, may persist for months, and in certain patients for years. Interpretation of these may meet with constant repudiation. Perseverance, nevertheless, coupled with continued demonstrations of understanding and empathy, may eventually lead to their successful un-ravelment.

Certain problems in the therapist— some of a countertransferential nature— also obstruct the achievement of a working relationship. The patient may arouse hostilities in the therapist that the latter neither fully recognizes nor can control. The therapist may not be able to show the quality of warmth or sympathy essential to enable the patient to feel accepted and understood. Where the patient is prominent socially, economically, or politically, the therapist may be in fear of the patient or even in too great awe. In addition the therapist may show irritability with the stubborn fight that the patient makes against accepting therapy and the therapist. Discouragement or any outbursts of vexation displayed by the therapist may have a disastrous effect on the creation of proper rapport.

These sketchy precepts will be elaborated in the forthcoming chapters.