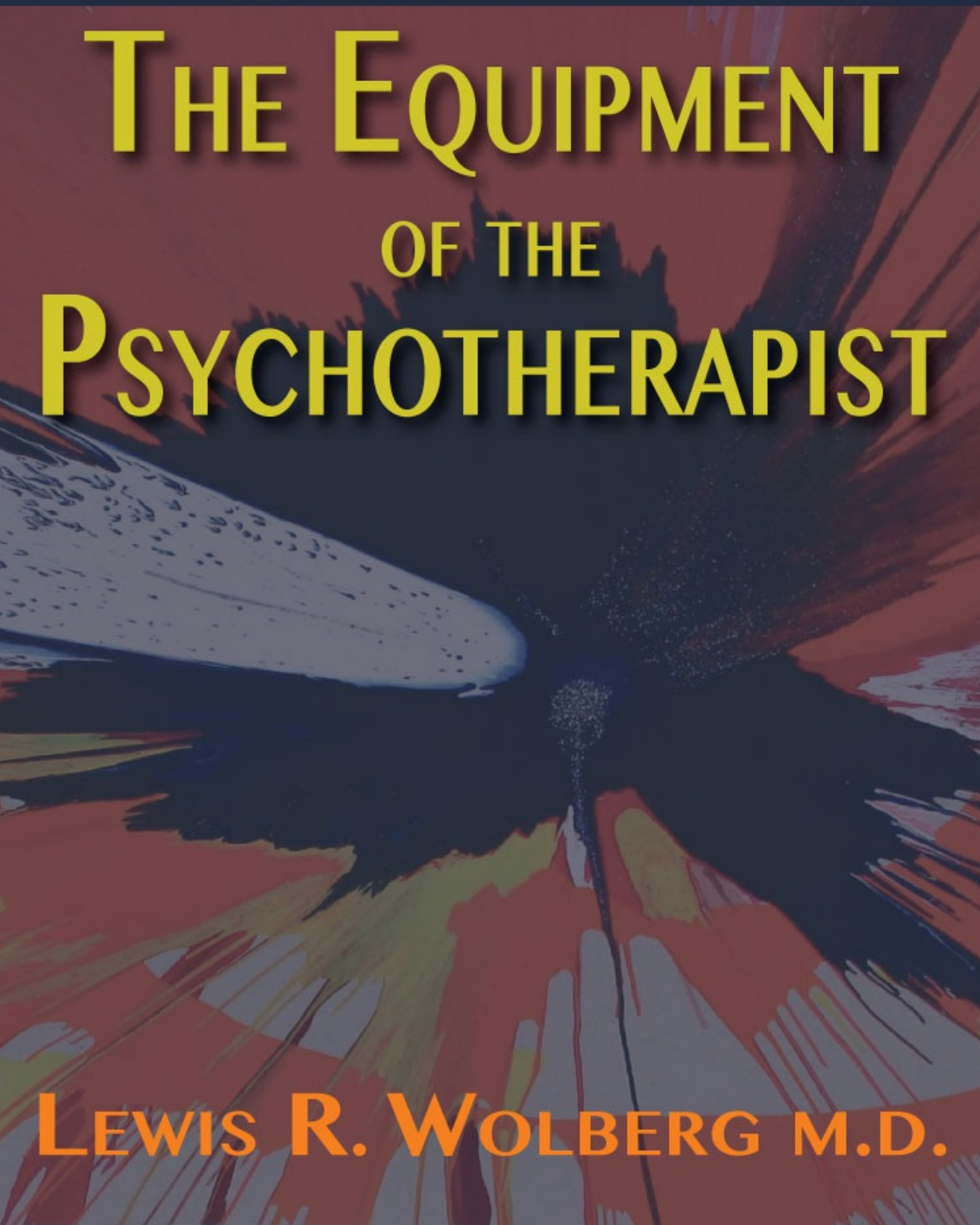
THE TECHNIQUE OF PSYCHOTHERAPY

THE EQUIPMENT OF THE PSYCHOTHERAPIST



LEWIS R. WOLBERG M.D.

The Equipment of the Psychotherapist

Lewis R. Wolberg, M.D.

e-Book 2016 International Psychotherapy Institute

From *The Technique of Psychotherapy* Lewis R. Wolberg

Table of Contents

The Equipment of the Psychotherapist

Competence in practicing psychotherapy is developed only after a disciplined exposure to a variety of learning experiences. Integrated didactic instruction, participation in clinical conferences, and supervision of one's work with patients constitute the essence of pedagogical grounding.

EDUCATIONAL EQUIPMENT

Unfortunately, there are no shortcuts to the achievement of therapeutic proficiency. Estimates of the length of time it takes to turn out a fairly seasoned therapist vary. In most instances it requires 5 or 6 years of intensive postgraduate work. A balanced curriculum includes the behavioral sciences, basic neuropsychiatry, the history of psychiatry, the development of dynamic psychological thinking, techniques of psychotherapy, group therapy, marital therapy, family therapy, principles of pharmacology, behavioral approaches, child therapy, preventive and community consultative techniques, research techniques in mental health, and clinical conferences and continuous case seminars. Recommended texts on the courses that follow will be found in a special section at the end of Volume 2. In this section each of the subject fields just listed is presented with a brief outline description of what may be included in the respective courses.

Behavioral Science Contributions to Psychotherapy

Contributions of the biological, social, psychological, and philosophic fields to modern psychotherapeutic theory and practice include the ways in which data from neurophysiology, biochemistry, genetics, behavior genetics, ethology, conditioning theory, learning theory, developmental theory, personality theory, psychoanalytic theory, cultural anthropology, social theory, role theory, group dynamics, communications theory, information theory, cybernetics, field theory, Gestalt theory, ecology, philosophy, and religion influence contemporary theoretical and methodological approaches to psychotherapy.

Basic Neuropsychiatry; The Practice of Psychiatry

Review of neuroanatomy, neurophysiology, neuropathology, descriptive psychiatry of schizophrenia, manic-depressive psychosis, involutional psychosis, psychosis with cerebral arteriosclerosis, senile psychosis, other organic psychoses, paranoia and paranoid conditions, mental deficiency, and epilepsy. Recent statistical surveys of mental illness. Classification of mental and emotional illness. Causes of mental disease. History taking (anamnesis) and the conduct of the psychiatric examination. Contemporary psychiatric practice.

History of Psychiatry

History of psychiatry up to the period of Sigmund Freud, including contributions of Mesmer, Braid, Bernheim, Charcot, Watson, Pavlov, Cannon, Janet, Baudouin, DuBois, Kretschmer, Kraepelin, and Bleuler. History of the mental hygiene movement. The psychobiology of Adolf Meyer.

The Development of Dynamic Psychology

Readings in psychoanalysis and allied fields. Selected writings of Sigmund Freud. Writings of contemporaries of Freud, including Abraham, Ferenczi, Adler, Jung, Stekel, Rank, Reich, Reik, Fromm, Sullivan, and Horney. Contributions of the ego psychological and object relation schools.

Psychosocial development. The various forces that enter into the molding of human personality. The roles of heredity, constitution, and environment in character formation. Experiences and conditionings in infancy, childhood, adolescence, and adult life that enter into conflict formation. The various methods of conflict solution.

Psychopathology and psychodynamics. Anxiety and its manifestations. Mechanisms of defense. Symptomatology, psychopathology, and psychodynamics of the principal neurotic and psychotic syndromes.

Techniques in Psychotherapy

Introduction to psychotherapy. Scientific foundations of a psychotherapeutic program. Prognosis and goals in psychotherapy. General outline of psychotherapy.

The various psychotherapeutic approaches. Similarities and differences in theory and technique of the various psychotherapeutic approaches:

1. *Supportive therapy*—environmental therapy, reassurance, guidance, persuasion, emotional catharsis, desensitization and somatic therapy, inspirational group therapy.

2. *Reeducative therapy*—behavior therapy, casework approaches, client-centered therapy, directive therapy, distributive analysis and synthesis, confrontation methods, reeducative group therapy, family therapy, and marital therapy.

3. *Reconstructive therapy*—Freudian psychoanalysis, Kleinian analysis, non-Freudian psychoanalysis with modifications of Adler, Jung, Rank, Stekel, Fromm, Horney, Reich, and Sullivan, object relations theory. Psychoanalytically oriented psychotherapy, Gestalt therapy, transactional analysis, and existential analysis. Analytic group therapy.

4. *Eclectic Therapies*—differential therapeutics.

Dream interpretation. Understanding, utilizing, and interpreting dreams in reconstructive psychotherapy.

Interviewing. Basic interview approaches—with methods of opening the session, maintaining the flow of verbalizations, directing the flow of verbalizations, selective focusing, and terminating the interview.

The initial interview. Problems involved in the initial interview. Motivating the patient for psychotherapy. Correcting misconceptions. Structuring the therapeutic situation.

Technical procedures in psychotherapy. The conduct of psychotherapy, including such aspects as the establishment of a working relationship with the patient, determining of the causes of the neurosis, the promotion of activity toward therapeutic change, and the termination of therapy.

Handling of special problems in therapy. Coping with severe reactions of panic, suicidal ideas, threats of violence, "acting-out," and other acute reactions of the patient. Somatic complications during psychotherapy and their management.

Short-term psychotherapy. Statistical studies on brief psychotherapy. Selection of cases and goals.

Methodological differences between long-term and short-term methods. Treating target symptoms. Conjunctive use of somatic and other methods. Psychoanalytic, behavioral, casework, and counseling approaches. Short-term group therapy.

Hypnosis as a therapeutic adjunct. Historical aspects. The phenomena of hypnosis. The nature of hypnosis. Hypnotic induction methods. Hypnosis in supportive, reeducative, and reconstructive psychotherapy. Limitations and dangers. Self-hypnosis. Group hypnosis.

Psychotropic drugs in psychiatric and psychotherapeutic practices. Biochemical interactions. Drug influences on neocortex, thalamus, reticular formation, limbic system, hypothalamus, synapses, interneuronal circuits, and neurohormonal depots. Biochemistry of depression. Biochemical postulates in schizophrenia. Action, uses, and misuses of neuroleptics, minor tranquilizers, and psychotomimetics.

Behavior (conditioning) therapy. Applications of learning theory to emotional problems. Classical and operant conditioning. Positive counterconditioning and aversive counterconditioning—extinction and reinforcement procedures. Implosive therapy. Values and limitations of behavior therapy.

Miscellaneous adjuncts. Uses of occupational therapy, recreational activities, dance therapy, music therapy, art therapy, play therapy, and bibliotherapy.

The Technique of Group Psychotherapy

Group therapy with parents of children who are in treatment. Inspirational, educational, activity, and analytic group therapy. Psychodrama. Group therapy in private practice. Group therapy with unselected groups as in institutions. The organizing and working with groups. The practical significance of group constellations, group dynamics, reexperiencing of historic nuclear conflicts, the use of dreams, imagery, and modes of self-expression in a group setting. The use of interpretation and countertransference. Multiple transference, resistance, and working through. The use of co-therapists.

Child Psychiatry and Psychotherapy

The organization and function of a child guidance and therapy clinic based on theoretical and

pragmatic child and adolescent practices. The intake process, evaluation of treatability, and initial stages of therapy with children and parents. The team approach. History of child psychiatry. The child in the process of growth; the interaction between the child and the environment. Diagnosis of childhood disorders. Organic, psychoneurotic, and psychosomatic disorders of childhood and adolescence. Behavior disorders and delinquency. Play therapy techniques. Use of creative media. The nonverbal and non-communicative child. Transference and countertransference problems in initial, middle, and terminal phases of child psychotherapy. Conjunctive treatment of child and parent. Family therapy in the treatment of the child.

Preventive and Community Consultative Techniques

Community mental health and the mental health consultant. The psychotherapist as a mental health consultant to community agencies. Theoretical and technical implications of the process of consultation. Orientation to types of problems and settings in which the consultant will work. Philosophy and structure of community coalitions and their relation to the larger community constellation—network of private and public service agencies in the community: concept of consultation and the nature of the relationship of consultant to agency, to community, to individuals; multilevel concept of social organization in institutions and its relation to consultation; supervisory and administrative processes; multidisciplinary interaction as a process in consultation; methods of determining need in response to request for mental health consultation; multisystem trend study as a survey method in assessing needs and providing a base for a blueprint of action.

Group methods and process in mental health consultation. Basic concepts and methods of group process utilized in mental health consultation. The achievement of educational, therapeutic, problem-solving and decision-making goals in group situations. The role and techniques of the consultant in helping leaders and group members to develop the responsibilities and skills required for group productivity. Dynamics of group process and group structure and the dynamics of the individual personality. Methods for analyzing and resolving group interaction problems.

Educational techniques. The use of educational media in preventive mental health. Methods of conducting discussion groups;—the use of films, recordings, and sociodramatic technqiues, An

evaluation of current books and pamphlets on mental health written for the public. The mental health lecture. Writing on mental health topics for the public and for ancillary professions.

The comprehensive community mental health center. The comprehensive mental health center, its philosophy, function, organization, financing, and operation. Inservice training programs. Inpatient services. Outpatient services. Partial hospitalization, including day, night, and weekend care. Community services, including consultation to community agencies and professional personnel. Diagnostic services. Rehabilitative services, including vocational and educational programs. Precare and aftercare community services, including foster home placement, home visiting, and halfway houses. Research and evaluation. Planning grants and hospital improvement programs. Outpatient clinical routines—the processes of reception, intake, history taking, initial interviewing, cooperation with outside agencies, the keeping of case records, the taking of progress notes, and methods of case presentation. Needs for consultative services in agencies such as social agencies, hospitals, outpatient clinics, schools, public health services, industry, unions, courts, civic organizations, etc. Methods of maximizing cooperative working relations with community organizations.

Function of clinical team members The professional responsibility of the psychiatrist, caseworker, nurse, and clinical psychologist in terms of specialized role and psychotherapeutic function. The uses and misuses of teamwork. The psychiatric consultant and the psychiatric supervisor. Survey of testing procedures used for diagnosis and treatment planning. The place of casework and counseling in a psychotherapeutic program.

Industrial mental health. Problems in industry of a normal and psychopathologic nature as they affect employers and employees. Application of psychologic and psychiatric techniques to situations of hiring, job placement, training, problems of staying on the job (including transferring), and discharge. Occupational neuroses, and placement of the handicapped, alcoholic and psychotic individual; accident proneness, absenteeism, problems of aging workers, role of the industrial nurse, problems of compensation. Techniques of interviewing, testing, and psychodramatic training.

Forensic aspects of emotional illness. Application of mental health information and knowledge to legal procedures in relation to such problems as criminal responsibility, determination of guilt, mental

fitness for trial, disposition of prisoners after conviction, torts, wills, contracts, deeds, guardianship, annulment, divorce, compensation as well as other medicolegal problems and tactical approaches to these.

Culture and Personality

Influence of culture on character structure. Effect of cultural background on response to therapeutic technique. Cultural anthropology.

Psychological Tests in the Field of Mental Health

The uses, values, and limitations of psychological tests in diagnosis and in appraising personality assets and liabilities. Mental ability, concept formation, special aptitude, attitude, interest, objective personality, and projective personality tests. Integration of test findings with clinical findings.

Research Techniques in Mental Health

Research design, methodology, and execution of projects in mental health; Evaluation of the results of research and their application. Process and outcome research in validating, sharpening, and testing techniques in individual and group psychotherapy and in investigating factors in epidemiology as a basis for organizing services and developing programs to meet community mental health needs.

The Treatment of Special Conditions

Treatment of the alcoholic. Hereditary, constitutional, and experiential factors associated with alcoholism. Treatment of the acute and chronic alcoholic patient from various viewpoints, including drug treatment (antabuse, LSD), institutionalization, individual and group psychotherapy.

Treatment of the drug addict. Background material and techniques for the treatment of narcotic, barbiturate, amphetamine, and tranquilizer addictions.

Management of delinquency. Major theories of the etiology and characteristics of juvenile delinquency; considering sociological, psychological and biological factors. Diagnostic formulations with

respect to their implications for the prevention, treatment, and control of juvenile delinquency. Somatic, casework, counseling and psychotherapeutic approaches. Techniques and methods as they relate to the entry into, relationship with, and withdrawal from client systems in the area of delinquency.

Treatment of the criminal. The role of psychiatry, casework, counseling, and psychotherapy in the prevention, control, and treatment of criminals.

Management of mental retardation. Etiology, diagnostic evaluation, prognosis, and management of the mentally retarded child and adult. Somatic, educational, vocational, casework, psychotherapeutic, and institutional placement approaches.

Treatment of anxiety, phobic, hysterical, somatoform, and obsessive-compulsive disorders. Etiology, diagnostic evaluation, prognosis, and therapy with drugs, and behavioral and psychotherapeutic methods.

Treatment of depressive reactions. Etiology, diagnosis, prognosis, and treatment of neurotic and psychotic depressions. Drug, electroconvulsive, and psychotherapeutic management.

Treatment of sexual problems. Psychopathology, psychodynamics, and treatment problems in sexual disorders—particularly impotence, priapism, frigidity, vaginospasm, fetishism, sadism, and masochism. Homosexuality as a problem.

Treatment of speech and voice disorders. Physiology of speech and the symptomatology of the most frequent disturbances in this area—including disturbances of articulation, motor function, phonation, symbolization, and rhythm in relation to organic and psychogenic varibles. Diagnostic, prognostic, and treatment aspects with special emphasis on stuttering.

Management of family problems. Premarital, postmarital, and parent-child problems and their handling. Problems of aging and aged parents in the transactions of the family in its beginning, expanding, and declining phases.

Treatment of psycho-physiologic disorders. Etiology, symptomatology, diagnosis, prognosis, and therapy of psychogenic autonomic and visceral reactions—including the skin, musculoskeletal,

respiratory, cardiovascular, hemic, gastrointestinal, genitourinary, endocrine, and special sensory systems.

Treatment of habit disorders. Etiology, diagnosis, prognosis and treatment of obesity, bulimia, anoroxia nervosa, alcoholism, substance abuse, and insomnia with hypnosis, drugs, behavior therapy, and psychotherapy.

Treatment of personality disorders. Etiology, manifestations, diagnosis, prognosis and therapy of personality pattern and trait disturbances. The management of "acting-out."

Treatment of schizophrenic and borderline patients. Special techniques and modifications of methods in dealing with schizophrenic and borderline schizophrenic patients.

Management of organic brain disorders. The etiology, symptomatology, diagnosis, prognosis, and treatment of organic brain syndromes. Thinking, memory, speech, learning, emotional, and behavioral disturbances. The treatment of convulsive phenomena and episodic psychotic outbreaks.

Hospital treatment of mental disorders. General hospital management; institutional management and aftercare of mental disorders. Rehabilitative, somatic, and psychotherapeutic procedures.

Management of the paranoid patient. Special problems involved in working with the projective mechanisms and acting-out behavior of the paranoid patient. Dealing with transference and countertransference phenomena.

Management of emergencies.

Clinical Seminars

Diagnostic conferences. Presentation of cases for purposes of discussing the diagnosis, psychopathology, and psychodynamics of different syndromes.

Clinical conferences. Problems in the conduct of therapy through presentation of a variety of cases.

Continuous case seminars. Presentation of one case throughout the course period, preferably by video, audio, or process recording. Discussions concerning the handling of the therapeutic situation as it develops over an extended period of time.

PERSONALITY EQUIPMENT

The most important variable in psychotherapy is not its techniques, but the human instrumentalities through which the techniques are implemented—i.e., the psychotherapist. This is because "the therapist sets an example of caring, reasonableness, predictability, maturity—in short is capable." (Strupp and Binder, 1984). The proficiency of the therapist, and the dexterity with which technical knowledge is employed are vital. Fundamental also, even crucial, is the presence in the therapist of certain kinds of personality characteristics without which the most highly trained therapist will be unsuccessful. As Strupp (1960) has pointed out, "The greatest technical skill can offer no substitute for nor will it obviate the preeminent need for integrity, honesty, and dedication on the part of the therapist."

The practice of psychotherapy requires that therapists possess special qualities that will enable them to establish and to maintain the proper kind of relationship with their patients. These characteristics may be roughly classified into five categories: namely, sensitivity, flexibility, objectivity, empathy, and relative freedom from serious emotional or characterologic disturbance. The personality ingredients of the therapist have a crucial influence on the direction and outcome of treatment.

Sensitivity

Essential is the capacity to perceive what is happening in the treatment process from the verbal and nonverbal behavior of the patient. Therapists must be attuned not only to the content of their patients' communications but also to the moods and conflicts that underlie the content. They must be aware also of their own feelings and attitudes, particularly those nurtured by their personal neuroses that are activated by contact with the patient. These qualities presuppose good judgment with the ability to utilize one's intelligence in managing practical life problems.

Objectivity

Awareness of one's own feelings and neurotic projections helps the therapist to remain tolerant and objective in the face of irrational, controversial, and provocative attitudes and behavior manifested by the patient. No matter what the patient thinks or says, it is urgent that the therapist have sufficient control over personal feelings so as not to become judgmental and, in this way, inspire guilt in the patient. Objectivity tends to neutralize untoward emotions in the therapist, particularly overidentification, which may stifle the therapeutic process, and hostility, which can destroy it. Objectivity enables the therapist to endure attitudes, impulses, and actions at variance with accepted norms. It permits the therapist to respect the patient and to realize essential integrity, no matter how disturbed or how serious the illness may be.

Among the most common projections and attitudes toward which objectivity is mandatory are infantile demands by the patient for protection, love, gifts, and favors; insistence that the therapist be omniscient at all times; desires to be preferred by the therapist above all other persons; demands for sexual responsiveness; expressions of resentment, hostility, and aggression; and complaints of being exploited, deceived, and victimized. In the face of such projections, it is essential that the therapist be able to recognize and handle personal fears, prejudices, intolerance, and other neurotic attitudes as they develop and be able to deal with such feelings as impatience, disgust, resentment, boredom, and disinterest, whenever these appear. This will necessitate self-understanding and awareness on the part of the therapist of self-possessed conflicts and problems in interpersonal relationships.

Flexibility

Rigidity in the therapist is a destructive force in psychotherapy. Unfortunately, it is a common occurrence whenever there is tenacious adherence to any one "system" of psychotherapy. Rigidity prevents coordinating one's approach with the exigencies of the therapeutic situation. Too zealous regard for the sanctity of any system must of necessity reduce therapeutic effectiveness, for the requirements of the therapeutic interpersonal relationship call forth promptings that defy methodologic bounds. Flexibility is not only essential in the execution of technical procedures but is also essential in other aspects of therapy, such as the defining of goals and the setting of standards. Flexibility is also

necessary in interpreting the value system of the culture in order to permit the relaxation of certain austere demands in the face of which a change in the patient's severity of conscience may be thwarted.

Empathy

Perhaps the most important characteristic of a good therapist is the capacity for empathy. This quality enables the therapist to appreciate the turmoil that the patient experiences during illness and the inevitable resistances that will become manifest toward change. It presupposes that the therapist is not characterologically detached, a trait most destructive to a proper relationship with the patient. Lack of empathy interferes with the respect the therapist needs to display toward the patient, with the interest to be shown in the patient's welfare, with the ability to give warmth and support when needed, with the capacity to concentrate on productions and to respond appropriately to these. Empathy must not be confused with maudlin sympathy or tendencies to overprotect the patient. Empathy means tolerance of the patient's making mistakes, of using his or her own judgments, and of developing an individual sense of values. This means that the therapist must harbor no preconceived notions as to the kind of person that the therapist wants the patient to be.

The importance of empathic understanding in psychoanalysis is stressed by Fleming and Benedek (1966): "The message from the patient, whose latent as well as manifest meanings are 'heard' with the analytic ear, is often responded to without any cognitive mediating step. The 'experiential fit' facilitated by empathy enables the analyst to identify the communication behind the patient's words and translate it into words not yet available to the patient."

RELATIVE ABSENCE OF SERIOUS EMOTIONAL PROBLEMS

Certain traits in the therapist have been shown by experience to be damaging to good psychotherapy. Among these are the following:

Tendencies to be Domineering, Pompous, and Authoritarian

While tolerable in supportive therapy, the tendency to be domineering, pompous, or authoritarian is not too helpful in reeducative therapy and is definitely harmful in reconstructive therapy. These

attitudes prevent patients from working things out for themselves in order to evolve their own growth patterns. They reinforce fears of authority and cause overevaluation of the powers of people in high positions. They inhibit self-growth and the development of assertiveness while reinforcing traits of dependency, submissiveness, ingratiation, and detachment. Sometimes they release rebellious and hostile tendencies that interfere with therapeutic gains. Domineering tendencies in the therapist may mask strong fears of people, and in the therapeutic situation they may constitute a way of maintaining control by putting the patient in a subordinate or inferior role. They may also be a means of expressing not fully conscious feelings of omniscience, grandiosity, and a need to play God. This does not imply that the therapist must shy away from assuming the role of an authority; it indicates that the therapist must have the capacity of acting as an authority without being authoritarian.

Tendencies Toward Passivity and Submissiveness

These traits may inspire insecurity and hopelessness in the patient. They stimulate latent hostile and sadistic traits as well as reactive defenses against such traits. Passivity may manifest itself in a fear of offending the patient or in an inability to be firm, on occasion, and to take a positive stand when it is essential that the therapist do so.

Detachment

Whereas the patient may manage to establish some kind of a relationship with a domineering or passive therapist, making essential contact is totally blocked because of detachment in the therapist. This trait may be rationalized by the therapist as a designed attempt to act neutral or to assume a scientific and structured attitude toward the patient. Detachment interferes with the capacity to empathize with the patient and to feel sympathetic with his or her problems. It thwarts the giving of the therapeutic doses of reassurance and support whenever these are required.

Need to Utilize the Patient for the Gratification of Repressed or Suppressed Impulses

The therapist may attempt to gain vicarious gratification of impulses by living them through in the experiences of the patient and by encouraging open or covert acting out. Where this is done, the therapist

will tend to lose objectivity and fail in the effort to help the patient. It is vitally important that the therapist be sufficiently well-adjusted and possessed of basic satisfactions in living or else compensating adequately for any lack in vital satisfactions so that he or she avoids using the patient to gratify any frustrated needs. Among the most common frustrated impulses are those related to sexuality, the expression of hostility, and the gaining of prestige. Unpropitiated sexual needs of a normal or perverse nature may be stimulated in the therapist by the patient's recital of past erotic behavior. The patient's present sexuality may also receive an unwarranted concentration and emphasis. The acting-out of sexuality with the patient poses destructive and other unfortunate risks for both, no matter how rationalized it may be. A therapist who harbors an excess amount of hostility may unduly encourage its expression in the patient, directing it toward those agencies with whom the therapist is neurotically concerned. Thus, the therapist may sanction a hostile defiance of authority or aggressive acts toward parental figures, with a resultant involvement of the patient in activities that are not in his or her best interests. Finally, overambitious therapists may, under press of this impulse, goad patients into working for success, power and fame, much as parents dissatisfied with their own mediocrity will try to fulfill themselves through their offspring. Such efforts tend to arouse defiance in the patient and interfere with the proper patient-therapist relationship. Ambitiousness may additionally cause the therapist to react with resentment to the patient's resistances and to the absence of what the therapist considers to be appropriate progress; the feeling here is that the therapist's own reputation is at stake.

Inability to Tolerate the Expression of Certain Impulses

Reaction formations and other defenses in the therapist against important inner drives may mobilize antitherapeutic tendencies. Thus, anxieties investing the therapist's sexuality, hostility, and assertiveness may result in minimization of the importance of such impulses in the patient.

The therapist may divert the patient from talking about these topics whenever they are brought up or adopt subtle punitive tactics that cause the patient to repress such impulses or their derivatives—driving them deeper away from awareness and preventing a coming to grips with them. In the same way the therapist, sensitive to anxiety within, may be unable to tolerate it in others. Therefore, when even minimal quantities of this emotion arise during treatment, the therapist may tend to dissipate anxiety with reassurance and other supportive measures, in this way obstructing an examination of its source. A

therapist with this kind of problem may do excellent supportive therapy but will fail in the more extensive reeducative and reconstructive approaches.

Neurotic Attitudes Toward Money

The therapist's insecurity may reflect itself in anxiety about fees and payments. Such concerns will stimulate in many patients feelings of being exploited and hostile attitudes toward the therapist on the basis that there is more interest in the patient's money than in the patient.

Sundry Destructive Traits

Many neurotic character traits in the therapist are detrimental to good functioning. Included are these:

1. The therapist may be unable to tolerate blows to his or her self-esteem by the patient's acting-out tendencies, by manifestations of resistance and transference, and by the inevitable failures and frustrations in treatment.

2. A neurotic need to be liked and desires for admiration and homage may prevent the therapist from making interpretations that are offensive to the patient or otherwise challenging of the patient's defenses.

3. Compulsive tendencies toward perfectionism may make less ambitious goals than the patient's complete character reconstruction unacceptable and may cause the therapist to drive the patient obstinately toward such goals even when there is little chance of achieving them. Perfectionism may also produce a fear in the therapist of making mistakes.

4. Perhaps the most destructive traits present in the therapist are those that create a relationship that specifically duplicates and perpetuates the early defeating, frustrating, and traumatizing experiences in the patient's childhood. The patient will, of course, always try to maneuver the therapist into such a relationship, but an observant and objective therapist will tend to block this design. However, where the therapist's personal needs play into the patient's demands, the therapist may lose perspective and enthusiastically enact the kind of role that must inevitably end in defeat.

5. Any character traits that interfere with the therapist's ability to understand, to accept, and to deal constructively with the verbal and nonverbal behavior of the patient without feelings of threat or counterhostility are damaging to the treatment relationship.

6. Hostility toward the patient, open or disguised, justified by reality or inspired by prejudices and countertransference, brings about rejection, lack of empathy, loss of objectivity, and other manifestations destructive to therapeutic objectives.

7. Lack of faith in what he or she is doing can sabotage and destroy a therapist's effectiveness. Trust in techniques can have a most pronounced influence on therapeutic results, even when the methods employed are unscientific. Indeed, it has been said that an important possession of the psychotherapist is an undaunted belief in the virtue of one's system.

8. Militating against good therapy are a number of other characteristics—inhibited creativity, a poor sense of humor, an inability to take criticism, low personal integrity, diminished respect for people, failure to acknowledge self-limitations, low energy level, and poor physical health.

Influence of Therapists' Attitudes

The proper therapists' attitudes, as has been explained, are crucial for effective psychotherapy as they are probably important for all kinds of learning. They constitute powerful reinforcers that may effectively influence the patient's behavior. Not only do such attitudes as empathy, warmth, and understanding tend to promote positive feelings in the patient, but they also relieve tension and lower the anxiety level. In such an atmosphere learning is enhanced. Interviewing, focused by the therapist on anxiety-laden content, may then be rewarding. Thus the dynamically oriented therapist will probe for and encourage the patient to talk about areas with an anxiety potential that are usually resisted or repressed. The patient is rewarded by approving responses from the therapist when dealing with repudiated material. Apart from the temporary benefits of emotional catharsis, the patient learns to tolerate this material, thus placing it in the context of the historical past. An opportunity of revaluing it is then possible.

Schedules of selected reinforcement, in the course of probing for anxiety material and exploring its origins and meaning, tend to extinguish responses previously affiliated with the anxiety content. These aspects of operant conditioning are an integral part of cure in dynamically oriented psychotherapy. In behavior therapy, while the dynamic anxiety sources are not delineated or examined, the patient is also exposed in the medium of a rewarding emotional climate to reinforcers that tend to extinguish self-defeating responses and to accentuate others that have adaptive promise. Symptom relief and the

acquisition of constructive behavior patterns occur without the formality of insight. In both dynamic psychotherapy and behavior therapy operant conditioning thus plays an important role. In both it encourages the regurgitation of material that affirms the therapist's personal theoretical biases.

Apart from the specific reinforcing maneuvers executed in dynamic and behavioral approaches, the therapist-patient relationship itself serves as a relearning experience from which the patient may generalize responses toward other relationships. Dynamic approaches have the advantage of working with transferential contaminants that can effectively block therapy. Where transference is not bypassed but dealt with firmly in terms of its genetic roots, and the patterns and defenses that it embraces are skillfully analyzed, they will tend to undergo negative reinforcement and extinction. The therapist relationship will then become a corrective experience for the patient. This does not mean that cure is automatically guaranteed, since in some cases psychic damage is so profound, the secondary gain benefits so intense, the masochistic needs so great, that the inner rewards for the perpetuation of transference exceed those the therapist can supply by approving-disapproving tactics. Nevertheless, in a considerable number of patients the development and unravelment of transference can be most recompensing toward fostering personality alterations. Behavior therapies, while remarkably effective in promoting symptomatic improvement and behavior change in some cases, cannot approach the depth of reconstructive personality alteration possible in selected patients exposed to dynamic therapy with trained psychotherapists whose personality structures contain the proper ingredients of warmth and understanding.

A question immediately poses itself. Is not the proper climate of classical psychoanalysis a neutral, detached one, and if so, would not the patient then respond in an antitherapeutic way to the unconcerned, non-sympathetic manner of the therapist? The answer to this question lies in the simple fact that effective psychoanalysts are not really neutral and unconcerned. They communicate, in spite of practiced noninterference and passivity, an understanding of and empathy toward their patients. The patient quickly discerns from nonverbal cues the true emotional feeling of the analyst. The non-effective psychoanalyst is personality-wise truly detached, cold, and uninvolved, and this lack of empathy will reflect itself in negative therapeutic results.

IS PERSONAL PSYCHOTHERAPY OR PSYCHOANALYSIS NECESSARY FOR THE THERAPIST?

It is obviously impossible for any one person to possess a totality of positive personality features or to be devoid of every negative characteristic that makes for an ideal psychotherapist. These deficiencies do not obstruct good psychotherapy, provided the therapist is not too seriously handicapped by personality disturbances. The therapist, like any other person, will undoubtedly be possessed of a certain amount of neurotic illness. This may manifest itself in difficulties in personal adjustment outside of the therapeutic situation. The fact that the therapist exhibits evidences of personal problems in everyday life does not always mean that it is impossible to manage therapy in the unique setting of the patient-therapist relationship, for in this relationship the therapist plays a different role than in usual associations with people. The position occupied with the patient generally makes the therapist feel more secure and permits divestiture of self from many personal customary neurotic defense mechanisms. A mild neurosis need not necessarily interfere with the effective conduct of therapy if the therapist is aware of interpersonal problems and is capable of inhibiting their operation in the encounter with patients. The therapist will, of course, exhibit greater insecurity with some patients than with others. Varying defenses will be mobilized to ensure handling better certain kinds of problems and with selected patients. Yet mandatory in all individuals doing any kind of psychotherapy is some awareness of and control over their stereotyped interpersonal reactions. There are some individuals who are sufficiently healthy by virtue of a sound upbringing and a spontaneously mature development so as to be able to avoid untoward reactions in therapy. Additionally, they possess values and attitudes that are consonant with mental health objectives. Admittedly, such persons are in the minority since most of us are not so bountifully blessed by a fortunate upbringing and wholesome childhood experiences to make us completely integrated human beings.

The burdens imposed on the average therapist, particularly in doing reconstructive therapy, the fact that personal unconscious conflicts may be mobilized, and the need for him or her to function simultaneously in multiple roles require greater freedom from neurosis than the average person. Categorically, it may be stated that all therapists may benefit from personal psychotherapy if they plan to do reconstructive therapeutic work. Such personal therapy provides the individual with an opportunity to study psychodynamics through self-observation, in watching minutely one's own emotional conflicts, their genetic origin, and their projection in present-day functioning. It also helps to liberate the therapist

from those problems and character disturbances that interfere with the establishing and maintaining of a therapeutic interpersonal relationship.

Where the therapist contemplates specializing in psychoanalysis, a "didactic" personal analysis is one of the training requirements. According to Freud, a personal psychoanalysis is vital in bringing the analyst to a standard of psychical normality that one sets for one's patient. Only in this way can the therapist serve as an appropriate model. The end of a training analysis is reached, said Freud, when the learner has arrived at a sincere conviction about the existence of the unconscious and of the repressed conflicts and pathological processes that otherwise would have been considered incredible. This acts as a basis for further ego transformation after the analysis has ended, enabling the analyst to apply new insight to all subsequent experiences. In the face of the tensions and anxieties that the analyst is forced to handle in patients, it is not remarkable that instinctual demands that had hitherto been restrained may be violently awakened. For this reason Freud enjoined every analyst periodically, say every 5 years, to enter analysis once more "without any feeling of shame in so doing" (Freud, 1952). Few analysts have heeded this injunction.

In delving into unconscious processes, the basic understanding of dynamics derived from personal experience is far more meaningful than knowledge from traditional forms of instruction. A personal psychoanalytic adventure, particularly one in which a transference neurosis is instituted, permits the analysand to observe conflictual aspects of oneself and to objectify this learning. This contributes to the empathic understanding, intuitive perceiving, cognitive discernment, and conceptual generalizing that are essential for psychoanalytic work.

Personal therapy is not always necessary where the psychotherapist confines work to supportive, reeducative, and the less intensive reconstructive approaches, provided, of course, that he or she does not possess too many therapeutically destructive personality handicaps. However, a period of personal treatment may eventually prove itself to be one of the soundest investments the therapist can make. In addition to helping with the therapist's own problems, personal reconstructive therapy or analysis contributes to one's sophistication in understanding what is happening, even in supportive treatment. For instance, by observing (without interpreting) the patient's dreams, fantasies, and acting out, one may follow more effectively resistance to change, the development and vicissitudes of transference, the

building of more adaptive defenses, and the general trend of progress.

There are many variables in assaying how much more effective the therapist will be with and without personal therapy. Some therapists, never having received personal analysis, are remarkably flexible, sensitive, empathic, and intuitive. They recognize and are capable of dealing with their own and their patient's unconscious mental processes, and they are able to do better psychotherapy than many therapists who have undergone treatment. It does not, however, follow from this that they could not have developed themselves even further with personal therapy.

Entering into therapy does not necessarily guarantee the success of the effort. Over and over again we observe well-qualified individuals who, exposed to prolonged personal analyses, characterologically seem to be little influenced by the process. There are many reasons for this failure. Perhaps of greatest import is the tendency for the student therapist to consider personal therapy a "didactic" requirement rather than a therapeutic necessity. Unlike the average patient who is driven to treatment by anxiety and the discomfort of disabling symptoms, the student therapist enters therapy because it is something that one is "supposed to go through" as a requirement in his or her training. The latter motivation is not strong enough to induce one to tolerate the anxieties necessary for the yielding of the protective and pleasure values of his or her neurosis. One's resistance to deep change is consequently greater than that of the patient, since the student therapist is not enjoined by suffering to revise personality patterns. Sometimes a training analysis may have bad effects on a trainee, where flexibility becomes impaled on the sword of the trainer's theoretical dogma, resulting in a handicapping rigidity.

Currently, there is a tendency to shy away from a labeling of personal therapy or analysis as "didactic" and to accept the principle that every student therapist possesses a neurosis that requires treatment. Accepted, also, is the premise that even where symptoms are lacking, the alteration of character patterns, with removal of therapeutically destructive traits and the expansion of therapeutically constructive tendencies, will be a long-term proposition. It is recognized that failure in personal therapy to achieve goals of character change, does not cast a slur on the therapist's integrity or the ability to engage in successful supportive and reeducative approaches. These are to be regarded not as methods substitutive for, or inferior to, reconstructive therapy, but rather as processes that have a preferred validity in the specific instances where they are employed.

EXPERIENTIAL EQUIPMENT

The basic knowledge a good psychotherapist must possess is substantial. Especially where one wishes to deal with dynamic vectors in the personality, a consideration of the following is in order:

1. How people evolve their personality structures in the matrix of hereditary constitutional, experiential, and cultural variables.

2. The psychodynamics of healthy and pathological adaptation.

3. The mechanisms of defense and the psychological constellations that accrue from insoluble stress and anxiety.

4. The interviewing tactics through which rapport is established, communication facilitated, essential content explicated, and obstructive emotional projections resolved.

5. The principles of eliciting and understanding unconscious material—including fantasies, undirected associations, dreams, and transference phenomena.

6. The stratagems of dealing with resistances that strangle therapeutic progress.

7. The understanding and management of one's own irrational drives and conflicts that interfere with sensitivity, spontaneity, and self-discipline.

8. The specific problems of and suitable tactics for dealing with children, adults, the aged, the infirm, the families of patients, and persons from varying socioeconomic and cultural backgrounds.

Without extensive experience in the therapeutic handling of a variety of cases, no therapist can be considered well trained. Preferably the therapist should have treated the common clinical syndromes, including anxiety disorders, phobic disorders, conversion hysteria, obsessive-compulsive neurosis, psychosomatic problems, personality disorders, behavior problems, alcoholism, drug addiction, personality disorders including borderline patients, schizophrenia, manic-depressive psychosis, involutional psychosis, and paranoid states. Experience should have included varied emotional problems in children. It should have given the therapist an opportunity to observe and to do group therapy, marital therapy, and family therapy. The therapist should know the basics of psychopharmacology, the drugs in common usage, and other forms of somatic therapy. Therapists should

be acquainted with the common emergencies in therapy and how to deal with them. Therapists working in hospitals and clinics also ideally should learn how to operate in the kind of teamwork with psychiatrists, nurses, caseworkers, and clinical psychologists in which the professional responsibility of each team member is defined, providing a basis for mutual interaction and the pooling of skills. They should be capable of playing a specialized role within the team and of functioning ably as psychotherapists. Understanding the principles of preventive mental health and how to utilize educational media in a skilled way is also important. They should finally be able to act as a consultant to those community agencies and auxiliary professions that are in contact with people suffering from emotional ailments.

Such training will obviously take a long time. Indeed, as has been previously mentioned, it is rare for any student to become a seasoned therapist without a backlog of at least 5 or 6 years experience under competent guidance. Each therapist must be "custom-tailored," serving an apprenticeship under careful supervision that is specifically designed to take into account the therapist's various personality problems and characteristics. Sharing experiences in the actual practice of psychotherapy with a highly trained supervisor is the greatest catalyst to the learning of psychotherapy. By bringing students to an awareness of their blind spots and their personality and learning blocks, one can most effectively help them toward matureness as psychotherapists. Supervision of the psychotherapeutic process is so important and essential an experience that an entire chapter in this book will later be devoted to it.