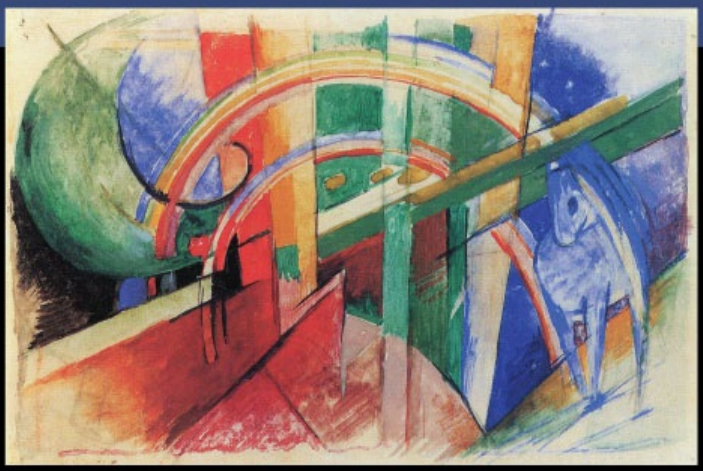
THE TECHNIQUE OF PSYCHOTHERAPY

THE SELECTIVE USE OF SUPPORTIVE, REEDUCATIVE, AND RECONSTRUCTIVE APPROACHES



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The Selective Use of Supportive, Reeducative, and Reconstructive Approaches

Treatment objectives are, more or less, determined by the needs of patients, their motivations, and capacities for change. We converge on these objectives with special psychotherapeutic techniques, always mindful of the fact that patients are the ultimate arbiter of how far they will go toward cure. If they possesses a readiness for change, they may achieve surprising development even with short-term superficial approaches; if there is an inherent resistance to change, the most dedicated depth maneuvers may scarcely move them from their neurotic stalemate.[1] An aspect of all good psychotherapies is facilitation of proclivities for change by rectifying faulty incentives and resolving obstructive resistances. Another requirement is the use of therapeutic measures that potentially can bring about the objectives toward which our treatment effort is being pointed.

First, by supportive stratagems we may focus our sights on a reduction of the patients' suffering and an elimination of their symptoms. Hopefully, through these measures, patients will additionally be restored to a more propitious level of functioning with a healing of their shattered sense of mastery. Second, with reeducative therapy we may aim for a correction of disturbed patterns of behavior with the object being to help patients utilize the resources already possessed to the fullest in quest of a more satisfactory work, interpersonal, and social adjustment. Finally, by employing reconstructive measures we may strive for the development of new resources through resolution of personality blocks, which have strangled maturity, mindful of the many obstructions that lie in our path.

To illustrate how supportive, reeducative, and reconstructive approaches may be employed in practice, we may consider the case of a patient who applies for therapy after the onset of an emotional illness characterized by tension, depression, anxiety, loss of appetite, insomnia, and gastrointestinal symptoms, especially hyperacidity. The patient in explaining his upset attributes it to challenging work pressures brought about by a shift in his position from a relatively routine one to that involving considerable responsibility.

RESTORATION OF MASTERY THROUGH SUPPORTIVE SYMPTOM RELIEF OR REMOVAL

In reviewing his history, it appears that the patient has, up to the onset of his work problem, made a satisfactory adjustment. He has a good home life; he enjoys his children and loves his wife; he is an excellent provider who conscientiously performs his work duties; he belongs to a number of social organizations; and he fraternizes with the usual quota of friends. According to this record, it would seem reasonable to scale our goals toward bringing him back to where he was prior to his illness. We might calculate that once his symptoms were eliminated or under control, he would have the best chance of recovering his equilibrium. With this in mind, we might attack his symptoms along several different lines. First, we may attempt to subdue them by the administration of medicaments, such as antacids for hyperacidity, tonics for anorexia, hypnotics for insomnia, and Xanax for anxiety and depression. If his depression is intense we might consider a tricyclic antidepressant drug. The patient may also be trained in progressive muscular relaxation in an attempt to relieve his taut muscular state. He may be reassured to the effect that his problem is not irremediable and persuaded to utilize his will power to get well. He may also be removed from his environmental situation. By absenting himself from existing areas of stress, he may experience an assuaging of tension and other symptoms.

Instead of these efforts, attention may be focused on the patient's work difficulty, reasoning as follows: "Here is a man who is involved in a work situation that is too difficult for him to handle. Competitiveness demanded by his present job is not for one with his kind of personality. Prior to the unhappy job change, he was getting along adequately. The treatment objective, then, is for him to obtain another position to which he will be able to adjust satisfactorily."

Assuming that his vocational situation is the primary source of his difficulty, the patient would be helped to appreciate that he cannot and should not adjust to extreme competitive stresses, and he may be encouraged to return to his old position or to seek a type of work that avoids competition. Where the patient is willing to give up his present job and to secure a less burdensome one, he may manage to regain his customary equilibrium.

Environmental difficulties may exist in addition to the work problem that upset the patient, rendering it additionally impossible for him to make an adequate adjustment. For example, were our patient to suffer from a marital or family difficulty in conjunction with his work problem, our focus in

therapy would of necessity expand utilizing marital or family therapy.

These measures are obviously all aimed at symptom relief or removal. The philosophy behind such approaches is that symptoms impair the functional efficiency of the psyche like a diseased gall bladder upsets the entire digestive system. Suggestion, persuasion, "thought control," progressive relaxation, purposeful forgetting, the plunging of the self into extroverted activities, and behavioral techniques are among the devices aimed at the symptom, as if it were a foreign body whose presence obstructed an otherwise intact psychic mechanism. In some cases substantial successes may be scored by this type of therapy. Indeed, formal psychotherapy may not even be needed in certain personality types who are able to forestall emotional collapse by practicing such devices as "riding their symptoms," substituting innocuous for painful thoughts, engaging in distracting pursuit of social activities, and observing a punctilious performance of ritual and prayer. In justification of these methods, it must be said that many persons are not motivated to accept more intensive treatment. In these cases the mastery of symptoms helps individuals gain freedom from excruciating distress and sometimes permits them to order their lives in a more fulfilling way.

One must not overestimate what is being accomplished, however. While the manipulation of the patient's environment toward alleviation or removal of stressful circumstances, or the employment of other supporting measures might be helpful in some cases, in others results would be singularly barren, especially where the individual is victimized by inner conflicts that create these symptoms, or are projected onto the environment sustaining the family and environmental distortions about which he or she complains. Results are poor also when the environmental difficulty has overwhelmed the individual with a substantial shattering of present defenses. Here, infantile defenses may regressively be revived that cripple the patient's adaptive resources to a point where, even though the environmental disturbance has abated, the patient is burdened with continuing problems.

We may compare this situation with that of a man suffering from a minor heart ailment that does not incapacitate him so long as no great strain is imposed on his circulation. Should a severe shock or catastrophic happening occur, or should he engage in physical work that is beyond his endurance, the resources of the heart may fail, producing cardiac damage with symptoms of circulatory failure that remain long after the initiating stress has disappeared. The same applies to a personality disorder

around which the individual has managed to organize his or her life. When circumstances remove erected safeguards and the individual is propelled into a situation he or she cannot handle, severe disorganization may result that persists from this point on.

Environmental adjustment may also fail because patients feel tied to their life situation no matter how inimical they may be, considering it an inevitable eventuality they have no right to challenge, let alone change. Any tension and anxiety that accompany this acceptance are usually credited by the individual to sources outside of the self.

MODIFICATION OF DISTURBED ATTITUDES THROUGH REEDUCATIVE THERAPY

An investigation may disclose that our patient's inability to endure competition at his place of work may not be due so much to an environmental peculiarity as it is to the fact that unique ideas and attitudes possessed by the patient make competition an inacceptable or dangerous circumstance.

When we examine the exact nature of his disturbed attitudes, we may find that the patient is being victimized by a tangle of contradictory character trends that inspire personal insecurity, promote devaluated self-esteem, and impair relationships with people. For example, we may observe that a basic character trend is that of dependency, which operates insidiously, causing the patient to ally himself with some other person who is a symbol of strength and omniscience. The patient relates to this person as if the latter were a powerful and providing parental agency. Accordingly, the individual may assume a passive role, exhibiting little spontaneity and initiative, anticipating that these needs and demands will automatically be satisfied. Competition poses a threat to the dependency need, for it puts the responsibility on his own shoulders, which he believes to be too fragile to bear the burden of dutiful pressures. Other character trends may exist that both reinforce and oppose his dependency. While he has managed to keep a tenuous emotional balance up to the time of the present crisis, the alteration of his vocational situation has disrupted his equilibrium, threatening his sense of mastery and precipitating catastrophic fears and anticipations of disaster. He may be aware of how dependent he is, and may even resent this dependency as opposed to his best interests; yet security is so bound to this trend that he may be unable to subdue its operation.

When we inquire further into the circumstances underlying the presumably good adjustment prior to the outbreak of his illness, we find that the patient's security has always been maintained by the satisfaction of his dependency. So long as this has been gratified, he has been able to get along splendidly. Ungratified, he has been riddled with disquieting fears and threatened with an ill-defined sense of restlessness. Investigating the conditions prevailing at the onset of the patient's illness, we discover that for some time prior to the onset, the wife has been withdrawing her attention from the patient and transferring it to her brother and his wife who have, because of financial pressures, moved into the patient's home. As her interest became increasingly diverted from the patient, his feelings of insecurity and resentment expanded. The more importunate his demands, the less she responded, until finally he reacted like an abandoned child in a rejecting world. His helplessness and fears of aggression mounted, until the very act of going to work constituted a challenge that taxed his capacities. Promotion to a more responsible position was the last straw that precipitated a breakdown in adaptation.

As a consequence of this discovery, we may attempt as a goal to inculcate in the patient some awareness of his dependency as well as of other disorganizing attitudes and strivings. The eventual object here is the retraining of reaction patterns. Thus, we might try to bring our patient to an understanding of the attitudes and designs that he habitually exploits, and we would demonstrate to him which of these facilitate and which obstruct his adjustment. Next we would help him to apply this knowledge toward modifying or changing his behavior.

We would also evaluate his assets and his liabilities to see how much he had minimized the former and exaggerated the latter.

We may attempt to shortcut the therapeutic process by behavioral desensitization slowly exposing the patient to increments of anxiety associated with his job responsibilities, or we may employ assertive training. The mastery of graded tasks, both in fantasy and in reality, abetted by positive reinforcements from the therapist, may enable him to overcome the imagined liabilities of competitiveness and to brace himself to accept hardier burdens.

In the course of strengthening his adaptive reserves, with or without the guidance of the therapist, he may begin to realize the depth of his dependency. He may become cognizant of how compliant he is to

authority, overestimating the virtues of others to the minimization of his own abilities and capacities. He may recognize that his fear of competition is actually associated with anticipating hostilities from people or with the belief that in pitting himself against others he would come out second best, thus exposing himself to ridicule. He may discover also that he harbors ambitions that are totally beyond possibilities of fulfillment, contributing to his sense of defeat. Cognitive therapy may help rectify faulty attitudes and self-statements.

The patient would probably be surprised to learn that his character patterns are regarded as problems, since he has accepted them as normal for himself. As soon as he realizes that his patterns are responsible for much of his turmoil, he may be supplied with a valid motivation to alter his scheme of life. While this motivation in itself would not be enough to produce the desired change, his patterns constituting the only routes that he knows to security and self-esteem, it might help him to approach his problems from a different perspective. Faced with his usual difficulties, the patient would, as a rule, be unable at first to give up his destructive drives. Knowledge that frustration or pain was inevitable to their pursuit would not be enough to get him to relinquish whatever gratifications followed their exploitation. However, even the mere cognizance that his attitudes were responsible for his plight would be healthier from a therapeutic viewpoint than the conviction, existing previously, that sources of misery lay outside of himself. Eventually, when he realized that his suffering did not compensate for the dubious gratifications accruing from indulgence of immature drives and when he understood that his reactions interfered with important life goals, the patient might begin experimenting with more congruous ways of relating.

Once convinced that more creative attitudes were possible, a long period of experiment and training would be necessary before habitual values were abandoned. Generally, habits that have persisted over a long time do not vanish within a few weeks or a few months. In spite of good resolutions, automatic responses operate in line with established routines. Struggle is inevitable until control is won over old patterns, and new ones take their place.

PERSONALITY GROWTH AND MATURITY THROUGH RECONSTRUCTIVE THERAPY

The most ambitious objective we could achieve in therapy, and the most difficult to achieve, would

be a replacement of neurotic character strivings with those which will enable the person to develop new potentials toward self-actualization. This objective would be advantageously reached through elimination of anxieties and fears that were rooted in past experiences and conditionings. Important also would be the development of ego strengths to a point where they could cope realistically with inner strivings and environmental pressures.

The individual would evolve into a free agent with the willingness to make independent decisions and to take the consequences of his or her acts. There would be an adaptive choice of ends and means and an ability to act without undue restraint from others. Capacities to plan his or her life and to develop goals and ideals in harmony with the disciplines of society would be vital. A sense of inner freedom, independence, assertiveness, and self-reliance would, furthermore, add to the dimensions of a well-balanced personality.

To achieve these objectives in our patient with the work difficulty, it would be necessary to eliminate the source of his problem rather than only to control its effects. This would necessitate an understanding of the roots of his disorder with resolution of factors that continue to sponsor regressive defenses. We would strive to expand our patient's sense of self so that he might outgrow the need to fasten himself to a parental figure for purposes of emotional support. The focus of our treatment would be the therapeutic relationship into which the patient would project his most intense and unconscious impulses and conflicts.

Were we to treat our patient with the work problem according to these principles we would become involved in a more or less extensive therapeutic procedure that would have to go beyond the mere correction of his work difficulty. Indeed, we would consider the vocational disorder as but one aspect of the problem, and our therapeutic effort would be directed toward mediating disorganizing drives that issued from excessive dependency and a devalued self-image and that were destructive to his total adjustment.

The patient, by becoming aware during therapy of contradictory forces within him would gradually realize that he was harboring attitudes that were a carry-over of early conditionings. The most powerful happening leading to such awareness would be transference to the therapist toward whom he would

express and live through vital early formative experiences. Our exploratory process would take the patient back to the genetic origins of his difficulty. For instance, it might reveal the patient's mother as a woman who had prevented him from achieving that type of independent assertiveness that enables a child to resolve his dependent ties. It would demonstrate how the mother's own neurotic needs sponsored a cloying overprotectiveness that kept the patient infantilized and helpless. It would bring out how his efforts at aggressive defiance were met with uncompromising harshness, until he gave up in his attempts at independence and shielded himself by complying with his mother's demands. It might uncover passive wishes, fears of violence in the assumption of a desired masculine role, and a host of other unconscious conflicts that were engendered by his early experiences. It would finally expose his infantile impulses as living on in his adult life, transferring themselves to those with whom the patient became intimately involved. His wife would be revealed as a figure toward whom the patient reacted as if she were a reincarnation of his mother. Partly because of her own impulses and partly because the patient had maneuvered her into a parental role, the wife might be shown as having responded by mothering him. In this protective atmosphere the patient had made a tolerable adaptation even while he repressed desires for freedom and growth. Interpreting the wife's withdrawal as rejection, the patient had reacted with intense hostility. This he needed to smother for fear of losing every vestige of his wife's affection. His increasing helplessness soon reached an intensity where he could no longer carry on. At this point he was faced with a greater work challenge in the form of added responsibility, and continuing at work meant coping with further stress. The patient reacted to this threat as a child would react—by screaming for help.

Reconstructive psychotherapy would bring the patient to an awareness of these facts challenging him to stand up to the drives sponsored by his past. The taming of irrational impulses, the expansion of the repertory of adaptive defenses toward greater flexibility and balance, and the reduction of the severity of the conscience with a more wholesome adjustment to inner promptings and demands are ambitious objectives. This is the complex task of reconstructive psychotherapy, which, implemented by a trained and skilled therapist, offers the individual the greatest opportunities for constructive personality growth. But whether it can be achieved, or whether we might have to contend with the more partial goals described under supportive and reeducative approaches, will be adjudicated by the patient's readiness and capacities for change, which most advantageously will be influenced toward a constructive end by a

knowledgeable and empathic therapist.

Notes

1 For example, an investigation of the results of 241 private patients treated over a 15-year span revealed that psychoanalysis of whatever duration and intensity had only supportive value for seriously sick patients (Heilbrunn, 1963).