THE TECHNIQUE OF PSYCHOTHERAPY

TRANSLATING INSIGHT INTO ACTION

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Translating Insight into Action

A basic assumption in insight approaches is one made originally by Freud that was to the effect that once the individual becomes aware of unconscious motivations, one can then alter one's behavior and get well. That this fortunate consequence does not always follow (a circumstance also recognized by Freud) is the disillusioning experience of many young therapists, who have predicated their futures on the premise that analysis of resistances will inevitably bring forth insight and cure like a sunbeam breaking through a cloud.

The fact that a patient acquires a basic understanding of the problems and delves into their origins as far back as childhood, does not in the least guarantee being able to do anything about them. Even if an incentive to change is present, there are some patterns that cling to a person obstinately as if they derive from a world beyond the reach of reason and common sense. The patient is somewhat in the position of the inveterate smoker who has been warned by the physician to give up tobacco at the risk of an early demise, or of the obese hypertensive who pursues gluttony with avidity while reviling his or her weakness and lamenting an inevitable doom. Chided by the physician to reduce weight to avert the threat of a coronary attack, the patient is unable to avoid overstuffing with the foods marked taboo on the reducing chart, irrespective of how thoroughly the patient appreciates the folly of intemperance. In the same way, repetitive compulsive patterns lead an existence of their own seemingly impervious to entreaty or logic.

Complicating this enigma further is the fact that the acquisition of even inaccurate insights may register themselves with beneficial effect, particularly if the therapist interprets with conviction and the patient accepts those pronouncements on faith. Marmor (1962) has implied that "insight" usually means the confirmation by the patient of the hypotheses of the therapist that have been communicated by various verbal and nonverbal cues. Having arrived at a presumably crucial understanding as indicated by approving responses from the therapist, the patient experiences what is essentially a placebo effect. The restoration of the sense of mastery reinforces further belief in the validity of the supposition, and encourages the patient to search for further validations, which most certainly is bound to be found by the

patient in the suggestive pronouncements of the therapist.

One of my patients reported to me what he considered a significant flashback that almost immediately resolved his anxiety: "This," he avowed, "was a cock-sucking experience I reconstructed from what must have happened to me in childhood. It involved an affair with a Chinaman. My father gave me shirts to take to the Chinaman who had a laundry nearby. I got the slip, but when I brought my father along to collect the laundry, I took him by mistake to another Chinese laundry. My father had a fight with the Chinaman over the slip. Then I remembered and brought my father to the right laundry. We lived in Cleveland at the time. That's why I know it happened before I was 6. Seems young to be running errands, but I had a dream that convinced me that the Chinaman sucked my cock. I remember he gave me lychee nuts."

This memory served to convince the patient that he now had the key to his fear of wandering away from home and his sexual problems. It required no extensive work to reveal this bit of insight as false, although it had a most astonishing effect on the patient.

This does not mean that some of the insights patients arrive at may not be correct. But not too much wisdom is needed to recognize that, with all of the doctrines of psychodynamics current among contemporary schools of psychotherapy, each one of which finds its theories confirmed in work with patients, factors other than their precepts, reflected as insights, must be responsible for at least some of the cure. The nonspecific windfalls of insight do not invalidate the specific profits that can accrue from a true understanding of the forces that are undermining security, vitiating self-esteem, and provoking actions inimical to the interests of the individual.

In opening up areas for exploration, a therapist should, in the effort to minimize false insight, confine oneself as closely as possible to observable facts, avoiding speculations as to theory so as to reduce the suggestive component. The more experienced one is, the more capable one will be of collating pertinent material from the patient's verbal content and associations, gestures, facial expressions, hesitations, silences, emotional outbursts, dreams, and interpersonal reactions toward assumptions that, interpreted to the patient, permit the latter to acknowledge, deny, or resist these offerings. Dealing with the patient's resistances, the therapist studies the patient's behavior and continues to reexamine original

assumptions and to revise them in terms of any new data that come forth.

The collaborative effort between patient and therapist made in quest of insight is in itself a learning experience that has an emotional impact on the patient that is at least as strong as any sudden cognitive illumination (Bonime, 1961). Malvina Kramer (1959) has pointed out that "what appears from the patient-analyst viewpoint to be a matter of insight and intrapsychic rearrangement turns out to be a far more complex process which depends on fields of multiple interaction on many levels."

Improvement or cure in psychotherapy may be posited on the following propositions:

1. The patient successfully acquires an understanding of the nature of the problem by developing the capacity to conceive of it in terms that are meaningful.

2. On the basis of this understanding, the patient begins to organize a campaign of positive action, acquiring symbolic controls, replacing destructive with adaptive goals, and pursuing these in a productive way.

True insight is helpful in this process. It acts as a liberating and an enabling force; it upsets the balance between the repressed and repressing psychic elements; it creates motivations to test the reality of one's attitudes and values; it gives the person an opportunity to challenge the very philosophies with which one's life is governed. But insight is not equivalent to cure; by itself it is insufficient to arrest the neurotic process and to promote new and constructive patterns.

Indeed, the development of insight may surprisingly produce not relief from distress, but an accentuation of anxiety. The ensuing challenge to change one's modus operandi, and the sloughing off of neurotic protective devices make the possibility of exposure to hurt all the more real. No longer is one capable of hiding behind one's defense mechanisms. One must tear down one's facades and proceed to tackle life on assertive terms. Prior to acquiring insight, one may have envisaged "normality" in fantasy as a desirable quality, but the approaching new way of life fills the individual with a sense of foreboding.

Thus a man with an impotency problem may learn in therapy that his impotence is a defense against a fear of being mutilated by destructive, castrating women. Realizing that his defense is realistically unfounded, he must still expose himself to intercourse. This will continue to be extremely

frightening to him until he convinces himself,. through action, that the imagined dangers will not come to pass. A woman, working in an advertising agency, may discover that a fear of competition with men is associated with her repudiation, on the basis of anxiety, of a desire for masculinity. Her knowledge then opens up the possibility of her being able to stand up to men. Specifically, she may practice her new insight on a man in her office who has advanced himself professionally over her, because she had assumed a retiring and passive attitude. The understanding that she is playing a role with men akin to the subordinate role she had assumed as a child with her brother does not ameliorate the anxiety that she feels at having to compete with her office associate.

To protect themselves from facing the threatened perils of action, patients may throw up a smokescreen of resistance. They may reinforce old and employ new defensive mechanisms. They may devaluate strivings for health even though these had constituted strong incentives for starting therapy. The original motivations may be submerged under the anxiety of impending fulfillment and the patients may then interrupt treatment.

It is an unfortunate fact that only too often does therapy grind to a halt at a point where insight must be converted into action. The impediment encountered by the patient is complicated by resistance against releasing intolerable unconscious fantasies associated with action. In psychoanalysis action inhibition may symbolically be repeated in transference, and analysis of the resistance may liberate the patient. The therapist, while permitting the verbal expression of the unconscious fantasy in the relationship, does not participate in it; nor does the therapist encourage its sexual or hostile acting-out. Any interventions are predicated on the patient's need, not the countertransferential demands of the therapist. But even under those circumstances translation of insight into action may fail.

MODERN LEARNING THEORY AND PSYCHOTHERAPY

The difficulties that invest the resolution of old patterns and the elaboration of new ones make it necessary for therapists to use every stratagem at their disposal. Since psychotherapy involves a learning process in which the patient acquires abilities to abandon neurotic adjustment in favor of an adaptation consonant with reality, it may be interesting to consider the therapeutic situation in the light of a theory of learning. A number of attempts have been made to coordinate psychotherapy with the principles of

modern learning theory. None of these has proven successful since the various propounded theories—including the stimulus-response and cognitive theories—are unable to account for the complexities of ego functioning, both normal and pathological. The ego seems to operate under laws of its own that have scarcely been embraced by any of the learning theories. Furthermore, there are various kinds of learning to which different postulates may be applied. The unsolved problems of learning would seem too diffuse to permit of any real application of learning theory to the phenomena of psychotherapy.

It may be helpful, nevertheless, to consider a number of well-known learning principles and to attempt to apply them to psychotherapeutic situations.

Learning is most effective where the individual participates directly in the learning experience. For this reason, the greatest impact on a patient is registered by patterns that come out during the encounter with the therapist—patterns that are a product of the collaborative relationship. Such a learning experience gives the patient a basis on which to reconstitute ideas of reality. It permits the patient to experiment with the therapist as a new kind of authority in association with whom the patient can evolve a more wholesome image of the self.

This eventuality, however, does not always develop in therapy, and when it happens, it does not guarantee an integration of understanding toward productive behavioral change. First, the patient may have an investment in the maladaptive patterns that subserve spurious security needs. To give them up exposes the individual to fantasied dangers or to deprivations. For example, a homosexual man may learn that he seeks in the homosexual relationship a virile image to repair his own damaged genitalia. He learns also that avoidance of women is both a safety measure to withdraw him from competition with other men and a way of preventing his being overwhelmed and infantilized by a mother figure. These insights do not subdue his intense sexual interest in males nor stop him from seeking men as a source of gratification. They do not lessen his disgust toward women, with whom he continues to maintain a casual, detached, demanding, or hostile relationship.

A second factor that may hinder the occurrence of a meaningful learning experience in therapy is the fact that a patient's reactions may have become so automatic and conditioned that knowledge of their unreasonableness does not suffice to inhibit them; they continue in an almost reflex way. One patient as

a boy was constantly being taken to physicians by a hypochondriacal mother. Threats of operations were used as measures to exact the cooperation of the boy for various injections and diagnostic procedures. In later life, the patient developed a profound fear of doctors to a point where he refused to expose himself to essential medical contacts. An understanding of the sources of these fears, and an attempt to control them, did not inhibit explosive physiological reactions at the sight of a physician.

A third instance in which the learning experience in therapy may not be effective occurs when the attitudes and behavior of the therapist do not provide the conditions most conducive to change; because patterns, perhaps inspired by countertransference, may reinforce the patient's neurotic expectations. A woman patient, burdened in her work by damaging competitiveness with other women and constantly involved in winning the attentions of her male associates through her seductive manner, realizes during therapy the origin of these drives in her competitiveness with her mother for her father's favors. Yet she may cleverly maneuver the therapist into acting overprotective and reassuring toward her by playing on the therapist's personal interest in attractive women.

Repeated attempts to execute healthy responses may lead to their reinforcement. Nevertheless, repeated practice of rational reactions does not necessarily inhibit neurotic responses. The power of the repetition compulsion often neutralizes effective learning. Thus, a man who compulsively fails as soon as success becomes imminent may, on the basis of insight into this distortion, force himself diligently to take advantage of any emoluments his life situation yields. Yet the impulse to fail will become so overbearing that he may yield to failure even while trying to succeed. Learning, nevertheless, goes on in the medium of neurotic relapse, provided that the individual is aware of what is happening and has ideas of why he needs to foster his failure. This working through is helped by the therapist who is in a position to be objective. It may be achieved by the person alone if he has the motivation to examine and to correct his behavior.

Learning is facilitated through satisfaction of important needs, such as gaining of rewards and an avoidance of punishment. However, in the light of our experiences in psychotherapy, we have to recast our ideas about rewards and punishments due to the disordered values of the patient. Rewards to a neurotic person may most keenly be the expressed residues of surviving infantile needs, such as dependency or defiance, which are more or less unconscious. They may be organized around

maintenance of various neurotic mechanisms of defense that reduce anxiety. In the latter case the individual will develop not health-oriented behavior but more sophisticated methods of supporting defenses. Thus, a married man, pursuing at the sacrifice of his safety and economic security, a disturbed young woman, who constitutes for him a maternal symbol, is suffused with pleasure whenever the woman favors him with her attention. Due to her narcissism, immaturity, and fears of men, she rejects his advances, yet she demands that he protect and support her. Fearful that he will lose her affection, the man yields to the unsatisfactory arrangement of financing the irresponsible expenditures of the young woman in the hope that she will eventually bestow her favors on him. His hostility and anxiety mount as he becomes more and more trapped by his dependence. In therapy what the man seeks is freedom from his symptoms and, covertly, expert stratagems of breaking down the young woman's resistance to loving him unstintingly. After a period in treatment, he learns the meaning of his involvement. The rewards that he obtains in integrating this learning is the immediate approval of the therapist and the promised reward that his symptoms will be relieved if he extricates himself from his untenable situation. These satisfactions threaten the rewards he really seeks in terms of overcoming the young woman's rejection of him and of establishing himself as her favorite "son" and lover. What he does then is to utilize his psychological insights to understand the reactions of his desired mistress in order to outmaneuver her. Momentary sexual yieldings are followed by her executing violent scenes and threats of separation, which, precipitating anxiety in the man, binds him more firmly in his enslavement. The punishment that he receives is really no deterrent to his continued acting-out of this drama. Indeed, it fulfills an insidious need to appease his guilt feeling. Thus, as in many psychological problems, punishment becomes a masochistic reward.

We cannot, therefore, apply the same criteria of rewards and punishments to the complex problems of learning in psychotherapy as we do to some other forms of learning. This is why conditioning techniques that are utilized in behavior therapy fail to influence certain kinds of neurotic disturbance. As the working-through process continues in treatment, the patient may, however, eventually rearrange his value systems. He may then approximate healthy goals as rewards and conventional pain and suffering as punishments. Conditioning under these circumstances may then prove successful.

Rational understanding is a *sine qua non* of learning. Rational understanding in itself, as has repeatedly been emphasized, does not seem to help many emotional problems. This is because

behavioral change is predicated on complex rearrangements of thinking, feeling, and acting that are bound together in tangled disorder. We attempt a disentwining of this complex yarn by plucking away at the surface strands. There may be no other way of getting at the disorganized psychosociophysiological structure. Hopefully, our efforts will be rewarded. Even from superficial intellectual unravelings behavioral, and even physiological, readjustments may ensue. As S. Freud (1928) once said, "The voice of the intellect is a soft one, but it does not rest until it has gained a hearing." Ultimately our therapeutic operations may overcome the tumultuous emotions of the psychologically ill individual. Unfortunately, patterns and values acquired early in life may obstruct meaningful adult learning. The most obstructive interferences are systems that have been repressed and yet obtrude themselves in devious ways. For example, sexual education as it is now being taught in high schools and colleges may have little impact on a young woman who has developed, as a result of childhood anxieties, the practice of shunting sexual material out of her mind. Defiance of authority, developed to preserve autonomy and to neutralize overprotective and interfering parental figures, may subtly block the incorporation of factual data. Perfectionistic tendencies and fear of failure, residues of a damaged self-image, may interfere with effective recall in situations where performance is a measure of self-worth. The powerful imprint of early impressions and experiences on the total behavior of the individual cannot be overemphasized, and learning may be blocked until some resolution of inner conflict has been instituted.

Is it completely hopeless, then, to try to take advantage of any basic learning propositions in order to expedite psychotherapy? Let us attempt to answer this question by considering some of the positive learning factors that Hilgard (1956) has described so well.

Motivation is important in learning. Individuals who are motivated to learn will apply themselves to the learning task and more readily overcome their resistances. Rewards are much more effective learning stimulants than are punishments. In psychotherapy, rewards may be offered to patients in the form of encouragement and approval when they have come to important understandings or have engaged in constructive actions. The benefits of their activities may be pointed out in terms of what progress will do for them.

When learning failures occur, the person may be helped to tolerate them by pointing out previous successes. In psychotherapy failures are inevitable, partly due to resistance and partly to the repetitive

nature of neurotic drives. Reassurance of the patients when they become discouraged by failure and helping them to see why the failure occurred may encourage them to try again. The therapist may accent the patient's constructive activities that were initiated in the past.

Setting realistic goals during learning is an important step. Individuals may be unable to achieve success where their objectives are beyond their capacities or opportunities. Where their goals are too modest, also, they will not make the effort that would be most rewarding. In psychotherapy, where the therapist senses that the patient is overly ambitious and that his or her plans are unrealistic, it is essential that the therapist bring the patient back to earth. There are some memories the patient may be unable to recover, some patterns so imbedded in the past that they cannot be overcome. Pointing some of these facts out may prevent the individual from engaging in frustrating efforts that discourage productive learning. On the other hand, when the individual's targets are too limited, for instance, where one insists that one is so seriously and irretrievably ill that one cannot achieve certain gains or execute essential actions, the therapist has a responsibility in stimulating the patient toward more ambitious aims.

Learning is most effective where there is a good relationship with the teaching authority and where mutual respect prevails. This is, of course, the essence of good psychotherapy. Where habitual contacts with authority are predicated on fear, hostility, or excessive dependence, the patient will probably display these patterns, which will then inhibit learning. The patient may be diverted from the task of learning toward fulfillment of regressive needs in the association with the therapist. The therapist must be alert to these maneuvers and must constantly keep the working relationship at the proper pitch, devoting efforts to this above all other tasks.

Active participation by individuals in the learning process is more effective than a passive feeding of materials to them. If the learner is able to figure out facts and to apply these to a variety of situations, he or she will learn most readily. In therapy problem-solving tasks are given to the patients; questions are directed at them; a thinking through of solutions is encouraged. The motto is "Let's figure this thing out together" rather than "Here are the answers." The patients are constantly encouraged to enter into new situations and to observe their reactions to these challenges.

Where learning materials and tasks are understood by individuals, they will integrate knowledge better than where these are meaningless. Knowledge of how to perform well in the learning task, recognition of errors in operation, and the understanding of what constitutes effective performance are most helpful. In therapy the treatment situation is structured for the patient; the purpose of different techniques is presented to the patient in terms that can be understood. There are a number of routines that may seem mysterious to the patient, for instance, the refraining from advice given and the employment of dreams. A careful explanation of their rationale is conducive to greater cooperation.

Repetition makes for the greatest success in learning. Where recall can be spaced over an expanded span, material will be better retained. In psychotherapy the patient is continuously engaged in examining neurotic behavior; the patient acquires an increasing understanding of why one acts in certain ways. Repetition of successful behavioral responses is encouraged. The working-through process constitutes a continuous learning experience.

BUILDING MOTIVATION FOR ACTIVITY

If empirically we are to pay credence to these concepts of learning, we have to abide by the rule that the first step in helping patients to translate insight into action is to build adequate incentives toward the abandoning of old patterns of living. A constant analysis of the significance of the individual's habitual drives—their purpose, origins, contradictions, and resultant conflicts—casts doubt on the value of such drives. Gradually patients realize that their strivings do them more harm than they do them good, that they are responsible for much of their maladjustment, and that they promote many of their own symptoms. Eventually they understand that the pleasures that they derive from the fulfillment of their patterns are minute, indeed, compared to the devastation that are created in their lives. They then become willing to challenge the validity of their customary modes of adjustment. Whether they will change their behavior is a choice they themselves have to make.

For example, a woman with a strong dependency drive discovers that her need for dependence dominates every aspect of her thinking and feeling. Finding an omnipotent person on whom to lean fills her with a sense of goodness and security. Life than becomes a bountiful place; she is suffused with vitality, imagination, and creativeness. But not long after this metamorphosis a curious change takes

place in the way that she feels. Fear and panic begin to overwhelm her; she becomes sleepless and she feels depressed; headaches, dyspepsia, and muscle tension develop. To her consternation she seems to invite suffering, masochistically assuming the manner of a martyr, and then undermining the person who acts as her host. She appears also to want to capitalize on her plight, by holding forth physical weakness and infirmity as reasons for her avoidance of responsibility.

These patterns become apparent to her during psychotherapy in relation to her husband who she variantly adores, fears, and despises, making for a tumultuous marriage. She learns that while she is driven to submit herself to him as a powerful parental agency, this crushes her assertiveness and fosters feelings of helplessness. Exploration of the genesis of her patterns may show her how her dependency resulted from subjugation by an overprotecting mother, who stifled her independent emotional growth. This knowledge gives impetus to her desires for freedom. She sees how continued pursuit of dependency since childhood causes reflex helplessness and crushing of independence. Such insights are fostered in a nonjudgmental and tolerant treatment atmosphere, the therapist never is represented as an authority who orders the patient to change her way of life.

On the basis of her new understanding much dissatisfaction may be created in the patient with her present life situation. She will also be motivated to experiment with different modes of adjustment. The desire to give up dependency as a primary adaptive technique may, however, be blocked by a fear of, and a contempt for, normal life goals. Anxiety here may mask itself as anhedonia—an indifference to or boredom with pleasures and impulses accepted as valuable by the average person—for, compared with the ecstatic, albeit spurious, joys of neurotic fulfillment, customary routines seem uninspiring indeed. The therapist accordingly engages in a constant analysis of misconceptions about normality in terms of their anxiety-avoidance components.

When our patient, for instance, manifests disinterest in certain people, it may be possible to show her that she harbors contempt for any individual who does not possess glamorous strength and omniscience. She may actually classify people into two categories: those who are superior and who potentially can serve as parental substitutes and those who are inferior and, therefore, are utter bores. The immense narcissism and grandiosity inherent in her attitudes about herself may become apparent to the patient as she realizes how she strives to gain omnipotence through passive identification with a

godlike figure. At this point the patient may become aware of why she refuses to have children. She realizes that she does not want to be replaced as the favorite child of her husband. She does not want to "give" and be a parent to a child, since she herself wants to be that child. She conceives it her right to take from others.

This analysis of anxieties and expectations, and the continued verbalization by the patient of fears and anticipated pleasures, provides increased motivation to attempt a different life expression. But no new patterns can be learned unless the motivation to acquire them is greater than the motivation that promotes the survival of the existing neurotic habits. Therapist activities, therefore, must embrace encouragement of any desires that the patient voices for mental health, emotional growth, and freedom from suffering. The therapist must attempt to undermine the pleasure and security values that the patient seeks from the prosecution of her neurosis. Thus, the therapist may show the patient that the rationale of her dependency need is inescapable if one accepts the premise that she is incorrigibly helpless. While it is true that conditions in her childhood made dependency and related patterns necessary, she now continues to operate under assumptions that are no longer true. Her expectations of injury approximate those of a child. If she analyzes her situation today, she will see that conditions no longer necessitate anachronistic reactions that are so destructive to her adjustment. She is challenged to revise her assumption of life as a repetitive phenomenon that is blackened by shadows of her need for parenting.

PROVIDING A FAVORABLE ENVIRONMENT FOR ACTION

With expanding insights the patient tends to affiliate neurotic strivings with suffering and maladjustment. Their operation and even their appearance begin to evoke discomfort. This provides motivation for their inhibition. Involved in the inhibitory response are incidental stimuli or cues that are associated with the neurotic patterns and that once could initiate them. More and more the patient becomes capable of controlling reactions and of engaging in productive responses.

It may be necessary for the therapist to prepare the patient in advance for any foreseen disappointments that may occur in the course of executing a new response. Thus, if our dependent patient decides that she must assert herself with her husband, she may resolve to do this by asking him

for a regular allowance weekly, from which she can budget her household expenses, purchase her clothing, and provide for certain luxuries. Hitherto her husband has doled out funds whenever she needed to make a purchase, requesting an itemized accounting in order to check on her spending. He has considered his wife irresponsible—an attitude the patient has sponsored, partly out of need to avoid responsibility and partly out of hostility—because she has made many unnecessary purchases. He has for this reason restricted her spending. We may, therefore, anticipate that he will react negatively to her suggestion that he provide her with a weekly sum and that she be entrusted with the family purchasing. Because she has chosen this area as a test for her assertiveness, a negative or violent reception of her assertive gesture will probably mobilize anxiety and result in defeat. She may then suffer a decisive setback in her therapy and perhaps never again dare to approach her husband assertively.

To forestall this contingency, the therapist may ask her to anticipate her husband's reaction when the patient presents her plan. The patient may be fully expectant that her husband's response will be negative. She may then be asked to anticipate her own reaction should he refuse to cooperate. The therapist may even predict for the patient a violent response on the part of her husband and get her to verbalize how she would feel if he became recalcitrant and punitive. Once the patient accepts the possibility that her request may bring forth hostility and once she recognizes that her husband may, on the basis of her past performance, perhaps be justified in his refusal to trust her management, the therapist may encourage her to approach her husband on a different basis. Discussing with him the need for practice in making herself more independent, she may suggest that he allow her to assume greater responsibility in the handling of finances. However, since even this prudent method of presentation may be rejected, the patient should be prepared for a disappointment. What is accomplished by this tactic is that the patient is desensitized to failure and musters the strength to cope with an absence of rewards for her new responses.

In many patients insight is translated into action without too great activity on the part of the therapist. In some patients, however, considerable activity may be required before therapeutic movement becomes perceptible. Although the therapist may have been more or less passive during the first two phases of therapy, this phase necessitates more energetic measures, and greater pressure and confrontation because of the patient's reluctance to face anxiety.

In occasional instances role playing may be efficacious, the therapist taking the role of the individual with whom the patient seeks to relate on different terms. Or the therapist may suggest that the patient assume the role of that individual, while the therapist takes the part of the patient. The patient, in addition to building up immunity to rebuffs, enjoys in this technique an opportunity for emotional catharsis. The therapist is, in turn, possessed of a means of making the patient aware of one's undercurrent feelings and responses. If the therapist does group psychodrama, the patient may be introduced into the group while continuing to be seen on an individual basis too.

Conferences with Family Members

An element often overlooked in the resistance to getting well is the impact of the reactions on the patient of significant other persons. The patient's interpersonal relationships are bound to change as the shackles of the neurosis are broken by the patient. The threat to the existing family balance will mobilize defensive attack and withdrawal maneuvers on the part of those with whom the patient is in close bond and who are threatened by change. Often this creates such turmoil that the patient will block off progress and perhaps retreat to former patterns of interaction, only to be rewarded by a return of symptoms. The therapist may imagine that it is the therapy that is ineffective, an unhappy thought that the patient may well instigate and sustain. By being constantly on the lookout for possibilities of retrenchment into former behavioral patterns, the therapist will best be able to explain failure of progress as a form of resistance. This phenomenon is most clearly apparent in children, adolescents, and young people who live closely with their families, particularly those who are withdrawn and schizoid. Therapy in releasing independent or rebellious activities in the identified patient may create a crisis in the family homeostasis.

Family therapy with the significant others present may be very successful where the related persons are not too emotionally disturbed. Where an adult patient lives in a close relationship with another person, like a spouse, the person is bound to react with anxiety when the patient threatens to upset present routines. Thus, the mate of our female patient with the dependency problem will probably regard any change in the patient in her striving for freedom as an assault on his own rights. He may then

attempt to undermine the patient's treatment.

Surmising such a contingency, we might find it expedient to arrange for a talk with the spouse. The consultation will have to be secured with the knowledge and even cooperation of the patient. One or several conferences with the spouse can often make the difference between success or failure in the patient's initial effort at a new response. Once the spouse sees the rationale of the new plan of action (and senses that he is not being blamed by the therapist), and he realizes that his own problems and needs are being taken into account, he may voluntarily cooperate. Even hostile reactions of the patient may be tolerated by him, if he is alerted to the possibilities of such reactions. In our dependent patient, for example, an interview may be geared around the discussion with the husband of what he has noticed about his wife. Any troublesome attitudes and behavior mentioned may then be pointed out as manifestations of her problem of lack of assertiveness. In order for her to overcome this problem, which is so crippling to her adjustment, including her marital adjustment, it will be necessary to give her an opportunity to grow. Even though she may make mistakes, the husband is enjoined to exercise tolerance, since this is how people learn and grow. It would be better for her to make a few mistakes, for instance, in the way that she budgets her allowance, and to help her to learn through her mistakes, than to let her continue in her present state of turmoil.

Obviously, in order for the husband to adjust to the patient's assertiveness, it will be necessary for him to master some of his own needs that are being satisfied by the patient's passivity and dependence. A fear for his own masculinity, and/or a compulsive striving for superiority and power may demand that his wife relate to him as a subordinate. Consequently, the husband may have to experience a therapeutic change himself in order to allow his wife to exercise assertiveness in the relationship. He may go through an emotional crisis before this happens, even though he appreciates the purpose behind the plan as explained to him by the therapist. Naturally the husband's dynamics would not be thrown at him during an interview because he would most certainly reject the interpretations. Rather he may be told: "I know this is asking a good deal from you to let your wife experiment. You may not be able to do it, many people can't." This challenge may be enough to get his cooperation.

The following excerpt from a session with a woman whose dependency problem resembled that of the hypothetic patient we are considering as an example illustrates this point:

Pt. And Sunday morning I was in church and I got a little nervous. Then when I came home, my husband started acting funny, wanting to go here, wanting to go there. I told him I thought he didn't really want to go anywhere. He brought up a lot of things. All of a sudden I looked at him and saw hatred on his face, and my mind stopped working. He said, "You care more about the doctor than you do me." He acted very jealous, and I got upset.

Th. I see.

Pt. And in the last few months we had been getting along so well. You know I just am never going to go back again to what I was. I got upset at his attitude and wanted to throw something at him, but instead I turned it on me. I cried and tore my hair. He got me so angry, I lost control. I don't want to live with a man I have to appease. I told him he is a mean man and that I would leave him.

Th. And then what happened?

Pt. He got upset and cried. He told me it was his fault. He said he always was this way and that he could see he was wrong. Then I started feeling sorry for him. Then I got mad at him. I don't think I can stand him. He's brutal and mean. He isn't happy until he sees me groveling on my knees. Then he's happy. Maybe I'm not the woman for him. *(pause*)

Th. But you *could* assert your rights. You *could* define what you feel your rights to be.

Pt. But I have. I don't see what I did to aggravate him. I know he has a problem in wanting to treat me like a slave. Maybe someone else could stand it, but I can't. And I told him and threatened to walk out. *(pause*)

Th. So what happened then?

Pt. Surprising. He broke down and cried. Then he said it was all his fault. He said he could see how he treated me, that it was all his fault. He said he didn't know how I could stand it so long. He said he would try to treat me more like an equal.

There are many instances in which improvement in therapy of one marital partner results in increasing emotional disturbance of the mate. Indeed, a disturbed adaptation of the patient may be a condition necessary for the equilibrium of the mate. Thus, a husband, domineered by a power-driven wife, may satisfy masochistic needs under a domain of tyranny. He may be unwilling to give up his masochistic indulgences and adjust to an atmosphere of cooperative equality brought about by the wife's improvement through psychotherapy. Or a frigid woman, receiving treatment, may make sexual demands on her impotent husband who will then develop strong anxiety. Where the mate of the patient has good ego strength, he or she may possibly be able to adapt spontaneously adjusting to the new demands presented by the patient toward a healthier adjustment. The outcome of psychotherapy in one partner then will be emotional improvement in both members. However, it may be necessary for the mate of the patient to receive psychotherapy also where spontaneous improvement does not occur. Conjoint

marital therapy and even family therapy, including as many involved members of the family as possible, may be in order.

Adjusting the Patient's Environment

Where the patient's environment is disturbed, it may have to be altered before insight can adequately be translated into action. Thus, if there is undernourishment, shabby physical attire, bad housing, and other consequences of a subminimal budget standard, which are outside of the patient's control, a community or private agency may have to render assistance. An individual who is living with a brutal or neurotic parent or marital partner may be unable to achieve adequate mental health until an actual separation from the home is brought about. Domineering parents who resent their offspring's self-sufficiency may cause a patient to feel hopeless since compliance seems to be a condition for security.

The majority of patients are capable of modifying their environment through their own actions, once the disturbance is clearly identified and the proper resources are made available to them. Occasionally the adjunctive series of a trained social worker may be required, especially with children and patients with weak ego structures. The therapist, with the help of a social worker, may materially alleviate certain problems by simple environmental manipulation. This is particularly the case where the people with whom the patient lives are capable of gaining insight into existing defects in the family relationship. Such factors as favoritism displayed toward another sibling, lack of appropriate disciplines and proper habit routines, the competitive pitting of a child against older siblings, overprotective and domineering influences of the patient's parents or mate my sometimes be eliminated by proper psychoeducation. Correction of sources of discord and tension frequently is rewarded by alleviation or disappearance of symptoms.

Such situational treatment, while admittedly superficial, can have definite therapeutic value and may permit an individual to proceed to more favorable development. Often family members become so subjectively involved with the problems of the patient, so defensive and indignant about them that they are unable to see many destructive influences that exist in the household. An honest and frank presentation of the facts may permit intelligent people to alter the situation sufficiently to take the strain off the patient.

It must not be assumed, however, that all situational therapy will be successful, even when gross disturbances exist in the household. Frequently the family is unable or unwilling to alter inimical conditions because of severe neurotic problems in members other than the patient or because of physical factors in the home over which they have no control. Here the social worker, through repeated home visits, may start interpersonal therapy that may bring the family around toward accepting the recommendations of the therapist. The worker may, in specific instances, render material aid to the family, or may assist in the planning of a budget or a home routine. Direct contact of the social worker with the family may reveal that others need attention or therapy.

Another function that the social worker can fulfill is to make available to the individual the various church, school, and neighborhood recreational facilities. Persons with emotional problems frequently become so rooted to their homes, out of a sense of insecurity, that they fear outside contacts. Establishing a relationship with and introducing the patient to groups outside the home may start a social experience that becomes increasingly meaningful for helping to release forces that make for self-development. A day hospital, day-care center, or rehabilitation unit are often of great value.

In cases where the destructive elements within the family are irremediable or where the individual is rejected with little chance of eventual acceptance, it may be necessary to encourage the individual to take up residence elsewhere. Temporary or permanent placement in a foster family or rest home may be essential. Although there is evidence that such change of environment rarely has an effect on deeper problems, residence in a home with kindly and sympathetic adults may serve to stabilize and to give the individual an opportunity to execute in action the insight learned. The most significant factor in changes of residence is the meaning that it has to the patient. If the patient regards it as another evidence of rejection, it can have an undermining rather than a constructive influence. Instead of getting better, the patient may regress to more immature patterns of behavior. Above all, the patient must be adequately prepared for residence change or placement and should look forward to it as a therapeutic experience rather than as a form of punishment.

Caution must, however, be exercised in effecting drastic and permanent changes in the work or home situation, and thorough study of the patient is essential before one is justified in advising anything that may recast the patient's entire life. This applies particularly to problems of divorce and separation.

Many married patients seek therapeutic help while on the crest of a wave of resentment that compels them to desire separation or divorce. Mere encouragement on the part of the therapist serves to translate these desires into action. The therapist should, therefore, always be chary of giving advice that will break up a marriage unless completely convinced that there is nothing in the marital situation that is worthy of saving or until certain that the relationship is dangerously destructive to the patient and that there is no hope of abatement. This precaution is essential because the patient may completely bury, under the tide of anger, positive qualities of the mate to win sympathy from the therapist or to justify the resentment felt toward the mate.

When the therapist is swept away by the patient's emotion and encourages a breakup of the home, many patients will be plunged into despair and anxiety. They will blame the therapist for having taken them so seriously as to destroy their hopes for a reconciliation. It is advisable in all cases, even when the marital situation appears hopeless, to enjoin the patient to attempt the working through of problems in the present setting, pointing out that the spouse may also suffer from emotional difficulties for which treatment will be required. The patient will, in this way, not only be helped, but also the spouse, and constructive features of the relationship will be preserved. It is wise to get the patient to talk about positive qualities possessed by the spouse instead of completely being absorbed by the latter's negative characteristics.

On the other hand, it is undesirable, indeed manifestly impossible, to restrict every patient from making fundamental changes during therapy. Conversion of understanding into action presupposes that the life situation must be altered. The rule that no changes be made during the period of therapy is more honored in its breach than its observance. The important thing is that the patient discuss with the therapist plans to effectuate change *before* making them in order to lessen the possibilities of a neurotic decision, for instance one that may be in service of masochistic self-defeating impulses.

Learning New Patterns within the Therapeutic Relationship

The re-experiencing by the patient, within the therapeutic situation, of early unresolved fears, attitudes, and needs and the proper management by the therapist of these strivings are important means of learning. The patient has an opportunity to work out, in a more favorable setting, problems that could

not be resolved in relationships with early authorities. The new patterns resulting are gradually absorbed and become a part of the patient's personality.

For this to happen, the therapeutic situation must serve as a corrective experience and must not repeat early disappointments and mishandlings. The patient while motivated to grow and to develop within the relationship, is hampered by anxiety, residual in expectations of hurt from domineering, rejecting, overprotecting, and punitive authority. This is why the therapist must not be tempted by the patient's unprovoked attitudes and behavior to repeat the prohibitions, penalties, and retribution of authoritative figures in the patient's past. Should the therapist respond in this way, the patient's convictions that authority is not to be trusted will be reinforced. No modifications of attitudes can occur under these circumstances.

Realizing that the patient must verbalize or act out unreasonable strivings in order to get well, the therapist will have an opportunity to react to these in an entirely different way from that anticipated by the patient. The therapist acts in a warm, accepting, and nonjudgmental manner. These attitudes inspire the patient to retest the original traumatic situation. The patient does this anticipating hurt. If the therapist, by virtue of understanding and the ability to remain objective, can avoid repeating the punitive and rejecting threats, the patient may be helped to live through in a new setting crucial experiences that should have been resolved as a child. The therapist will constantly have to interpret to the patient the latter's expectation of hurt, and to help the patient to realize that the circumstances under which one failed to develop security and self-esteem were peculiar to a disturbed childhood.

This will call for a high degree of mental health on the part of the therapist, whose own value system is bound to incorporate many of the judgments and arbitrary attitudes residual in the culture, which, incorporated in the parent's attitudes, have crushed the patient's growth.

Within the therapeutic relationship itself, therefore, the patient is helped to find a new and healthier means of adjustment. A virtue of the working alliance is that it acts as a prototype of better interpersonal relationships. It fosters the patient's faith in other people and ultimately in the self.

One way that the working relationship is utilized is to battle resistances to action. It is sometimes necessary to encourage patients to face certain situations that have paralyzed them with fear. Utilizing

the relationship as a fulcrum, the patients may be urged to experiment with new patterns while observing their responses. A program sometimes may be planned cooperatively with the patients, the therapist occasionally making positive suggestions. While advice giving is best eschewed, the advantages and disadvantages of alternative courses of action may be presented, the patients being encouraged to make a final choice for themselves. Thus, if a patient wants the therapist to make the decision on an issue, the therapist may ask, "What do *you* feel about this?" Possibilities of failure, as well as anticipated reactions to entering into new situations may be explored. The patient may be cautioned- by such statements as, "It isn't easy to do this" or "This may be hard for you." A method of stimulating action is to confront the patient with the question, "What are you doing about this situation?" whenever dissatisfaction is expressed by the patient on his or her progress.

Even with these promptings the patient may shy away from executing actions that threaten to promote old anxieties. If the initiative is put in the patient's hands, a stalemate may result. Although an analysis of resistances may encourage a cautious step into dangerous territory, the patient may need a gently firm push by the therapist before boldly approaching a new activity. In phobias, for instance, the patient may have to be strongly urged to face the phobic situation, on the basis that it is necessary to learn to master a certain amount of anxiety before one can get well. Where the relationship with the therapist is good, the patient will be motivated to approach the situation that seems dangerous with greater courage.

Success and pleasure in constructive action constitute the greatest possible rewards for the patient. Occasionally the therapist may indicate approval in nonverbal or in cautiously phrased verbal terms. Conversely, whenever the patient fails in an attempted action, sympathy, reassurance, encouragement, and active analysis of the reasons for the failure are indicated. The patient may be reminded that the difficulty has been present a long time and that one need not be discouraged if one does not conquer one's trouble abruptly. The patient may be given an explanation such as the following: "You know, an emotional problem is often like a hard rock. You can pound on it with a hammer one hundred times without making any visible impression. The hundred-and-first time, however, it may crumble to pieces. The same thing happens in therapy. For months no visible change is present, but the neurotic structure is constantly being altered under the surface. Eventually in therapy, and even after therapy, signs of crumbling of the neurosis occur."

Eventually the rewards of positive achievement and enjoyment issue out of the new and healthy patterns themselves. Surcease from suffering, reinforced by joys of productive interpersonal relationships, enable the patient to consolidate gains.

Adjunctive devices are often helpful during the action phase of therapy. These include the prescription of tranquilizing drugs, to help master anxiety associated with attempting new tasks, as well as hypnosis, self-hypnosis, and behavior therapy. (See Chapters 51.)

ILLUSTRATIVE CASE MATERIAL

The following is a portion of a session in which a man with a personality problem of dependency, submissiveness, passivity, and detachment indicates how he has put his insight into action and asserted himself.

Pt. There has been a great change in me. I haven't felt this way in my whole life. And it has been going on for weeks.

Th. Is that so?

Pt. Yes. Of course, I used to have spurts of good feeling for different reasons. Once I felt as happy as a lark when I was about 13. I had had eczema for years and x-ray treatments took it away. I felt grand for a short time. And then I felt wonderful when I met my wife, but it lasted only a short while. But all these things came from external causes. The way I feel now seems to be coming from inside of me. All my life I seem to have been a zombie, really dead, because I carried inside of me all sorts of standards of other people. I was like an automaton. If you would press a button, I would react in a certain way. I never had a sense of myself.

Th. Mm hmm.

Pt. Things have happened these weeks, which I think I handled well, and my reactions were good too. I have never had a prolonged period like this. Several times I'd say to myself, "I wonder if I can keep this up?" People mean different things to me now, you know. They are not powerful and threatening. My daughter was operated on at the hospital, for example. I regarded it in a sensible way. I said, "It's a minor operation. I'm concerned about her, but it's a simple thing and nothing to be upset about." I used to have a whole string of emotional responses that go along with illness. Now my wife has this worrying but that was instilled in her by her mother. So I had to go along handling various things with her feelings which used to suck me into a trap before and arouse guilt feelings in me.

Th. I see.

Pt. So she started to hammer at me a few days before the operation to see to it that the room in the hospital was a good one, that there was a television set there, and so on. Now this is a good hospital, I know, but their policy is annoying. I know they have a program, and you could stand on your ear and get nowhere by ordering them around. So I said to my wife, "I'm not going to follow out your directions and do this and do that because I don't

think it's right. Everything will go smoothly." So I did it my way, and everything went smoothly.

Th. Previously how would you have done it?

Pt. To tell you this is a revolution is an understatement. I'd always appease my wife like I did my mother. I'd do what she said without questioning it. This time I did what *I* wanted, and I felt no guilt. I had a sense of power. Everything went smoothly. When I got to the hospital, my wife was frantic because they gave my daughter a rectal sedative and she expelled it. The nurse was all confused and didn't know what to do. Then they called for her to go to the operation. I said, "I won't let her out of the room until she is properly sedated. I don't care if they get the whole hospital on my head; I'm just not going to do it." And I did this with ease. There was nothing to it. Before this I would say, "Look, I'm making these people wait, and so forth, and so forth." So the intern came up and gave her a sedative. They called the surgeon who agreed that the child shouldn't come down until she was sedated. (*laughs*) Everyone was chewing their nails, but I stuck to my guns. Not that I was unreasonable, but I did stick to what I felt was right.

Th. And things came out well?

Pt. Better than well. It's like a miracle. To think how fearful I was, before therapy, to take a stand with anybody. Especially, I wasn't able to be firm with my wife. When I got home, though, my wife started on me and said that I should have acted more cooperative. That burned me up because that questioned my stand. I told her calmly (*laughs*) that I had sized up the situation and felt this is what had to be done, and the proof was that things turned out well. Even if they didn't, I was sure I was doing the right thing.

Th. I see.

Pt. I then realized that my wife was under a strain, and I told her I was sorry if I talked rough to her. And then she said, "Yes, you're sorry," sarcastically. I said to her, "Look, I said I was sorry. I'm not going to crawl; I'm not going to stand on my head or any goddamn thing." And I didn't feel any anxiety or any guilt or anything. This morning my wife was as happy as a lark, as if nothing had happened.

Th. That made you feel you could take a stand and nothing bad would happen.

Pt. I just brought that up to show that I wasn't drawn in; I felt I was right and I wasn't going to try to dope out my wife's neurotic reactions to things and turn myself inside out trying to please her. I felt wonderful about this. So that was that.

Th. Yes.

Pt. I get a lot of resentment now at certain women mostly, and say, "Why did I have to knock myself out for years? What's so great about them? They are just people, and there are plenty of them around. Why were women so important to me?" I know what it springs from, and it seems so crazy to me now. (*laughs*)

Th. What *did* it spring from actually? *[testing his insight]*

Pt. Well, I would say that there were many factors involved and the picture becomes clearer; my whole life becomes clearer all the time. I would say it all started out, leaving psychologic terms out, with getting a terrible deal with my mother—she killed me. She must have acted in such a way that I was terribly uncertain of her love, and I must have gotten the feeling that if I didn't do exactly as she wanted me to do, she wouldn't love me anymore. And there was no approbation given to me as a person. I became a thing. I became something that

was used as a ground for other people's neurotic problems. My mother, on the one hand, being defeated in her life, used me to a point of smothering me with affection, which, I have a feeling now, covered a lot of repressed hostility and a lot of rebellion against being a mother. My father, on the other hand, showered on me his own lack of confidence as a man. He impressed me with what a man should be, that when he was with people, he wouldn't let them get away with anything. If a cab driver said anything to him, he'd beat him up. He had a tremendous temper. He'd say, "You got to fight; don't take anything from anybody." He never gave me any affection. He couldn't. I think he has a lot more qualities than my mother, but he is very compulsive in the matter, as shown by the fact that he couldn't be warm. He was compulsive about his own work and emphasized to me not to procrastinate or put off tomorrow what could be done today. The approbation came from getting good marks in school. That was the big thing.

Th. Yes.

Pt. So, I grew up with two big areas that were involved—the love area with my mother and the work area with my father. And then, in addition to that, my mother presenting the picture of what a bastard an aggressive man is. My father was a bastard, she said. "I love you," she said, "so don't be a bastard to me. If you do certain things that I don't like, then you are a bastard to me." So I grew up that way with no confidence in myself, no feeling about myself as having worth. The only worth I had was getting good marks to please my father and giving in to please my mother. So with one thing and another I started to crack up.

Th. What happened with your wife?

Pt. She became a mother, and the same thing would have happened with every woman. No matter what the woman was, she was irreplaceable because I had no confidence I could get another woman.

Th. How would you say your attitudes are now in that respect?

Pt. Well, I would say, number one, I know they are not irreplaceable. I think I use sex in an abnormal way. First, it was to prove being a man and to get this feeling of being approved and accepted by a woman like my wife, which after a while stopped working because it proved nothing. So I feel now they are not irreplaceable. I know they have problems, and I don't have to get involved in their problems. I don't have to be sucked in again into being an automaton who is prey to their whims. Pleasing a woman, no matter what her problems, is good as long as it is a reciprocal thing; but doing it just to please her becomes detrimental to the relationship. I suppose in our culture women are more insecure than men and have problems; but I don't have to get involved in their problems. I also have learned that making a woman insecure by making her feel uncertain about you is not the answer. Because, while it works temporarily to incite her interest, it breaks up the relationship after a while.

Th. So that you feel your attitudes are altogether more wholesome.

Pt. My, yes. I realized that my feelings and my needs are just as important as the woman's. All this time I've been making an intellectual exercise about resolving conflict. Instead, the drives I feel now are healthy and good. After all, if it's a fifty-fifty proposition; you can't be too submissive and you can't be too aggressive. I feel a lot more strength within myself. I feel more alive and more vital. The reactions of other people don't matter as much as my own, or I'd say better that my reactions are equally important as the opinions of other people.