Treat or Treatment

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If I have seen a person in therapy or analysis who did not actively wish to uncover a trauma of some determining sort, I do not remember who. There is something deeply satisfying about the "aha!" of "So that is it!" Freud's theories would not, I think, have gained the acceptance they did had they not initially been rooted in the idea of a forgotten childhood trauma. Even now people like Jeffrey Masson reinstate the view that it isn't that there wasn't a trauma, it's that the bad people stole it away.

But there is another basis: It is Why may I seek therapy but others not? Have I actually been chosen, or am I thrusting myself upon the world in a disorderly and unmannerly fashion? This is the survivor guilt for attempting to be among those who flourish.

If this question is not taken up, people have a difficult time feeling it is all right to be sick or get well. They will, accordingly, require of the therapist again and again to reassure them: "It is all right, no one else might know it, but we know how tough times have been—even if there isn't a traumatic incident by which to prove it."

This reassurance becomes a source of gratitude (where otherwise envy may have reigned), and there is no doubt that people do better for therapists who inspire such gratitude. Feeling better is not to be despised.

But feeling better has an ambiguous relationship to "getting better," which for a while involves feeling if anything rather worse. The question is whether or not the patient can be assisted toward suffering instead of merely guiltily, angrily, or masochistically feeling pain. This, in turn, has a good deal to do with the therapist's capacity to suffer—to endure and allow pain without romanticizing it as something inflicted.

There might be something to be said for finessing the issue altogether, by making a close and systematic study of the inner person a routine part of life.

Seelsorgers: Take note.

The series of encounters of which psychotherapy is comprised constitute an intricate transaction. At the same time, the "success" of the transaction is neither so commonplace nor so absolute that students of the subject have been willing to stop trying somehow to isolate factors in psychotherapy, hoping first to distinguish the active from the inert ingredients and then to refine those they believe will bring about success.

Various practitioners, theorists, empiricists, and methodologists have come to favor one or another of the ingredients above the others. Eysenck, for example, has supported the candidacy of Time itself. His studies, matching groups of therapy patients with controls, have persuaded him that Time does make a difference in people's lives, though not always; and if psychotherapy also makes a difference, although not always, then the time spent in it, he argues, may be the prepotent ingredient.

This conclusion, not unnaturally, has failed to commend itself to psychotherapists, who propose nominees of a somewhat different character. Chief among their candidates are Insight, Social Learning, the Corrective Emotional Experience, and Frustration. To take the last first, supporters of the Frustration hypothesis argue that since so many of the people who enter psychotherapy do so as a last resort, having given preference to such environmental alterations as changes in job, spouse, life-style, or geographic location, their discovery that therapy too provides scant compliance with their wish to remain as they are at last evokes a shift in motivations that occasions personal change.

The Corrective Emotional Experience advocates represent a more complex hypothesis. Part of their thesis rests on the assumption that people who become patients have suffered deprivations in the course of their lives. Hence, the course of treatment is organized around judicious doses of the missing experiences. But only some of what is prescribed falls into the TLC genre, for example, Carl Rogers's "Unconditional Positive Regard." There is also a disciplinary side to the supplements; this is leveled against what are viewed as overdoses of previous indulgences. The Behaviorist school of treatment has simplified the Corrective Emotional Experience position to that of providing rather concrete rewards and punishments in order to tempt or coerce patients toward or away from particular configurations of behavior.

The Social Learning hypothesis has found its current zenith in the Sensitivity Training and Encounter group experiences. In these, the participants' behavior at the outset is exposed to increasingly candid responses, while at the same time each is encouraged to experiment with new ways of experiencing himself and of conducting relationships. Individual psychotherapy is also viewed, by those who nominate Social Learning as the active ingredient, as resting largely on the role model of the therapist and in a series of feedbacks from him concerning the socially functional adequacy of the patient's behavior.

Then there are those who hold for the Insight candidacy. Their thesis is that the patient is benefited primarily by coming to know and understand the reasons for his reactions and behavior. The assumptions here are that people act as if things are true that are not, that these beliefs—for all they motivate behavior—are unconscious, and that their revelation enables motivations to be modified.

The Insight hypothesis comes from, and remains the cornerstone of, classical psychoanalysis. But quite typically in the psychoanalytic situation, though interpretation is the primary occupation of the analyst, Time,

Frustration, Social Learning, and the Corrective Emotional Experience all have a part to play. The two participants both require time, and timing is an important contribution of the analyst. Frustration brings conflicts to the fore, particularly over resistances. The therapeutic alliance, whereby the therapist often quite actively attempts to interest the patient in reflecting upon and considering what is taking place, is developed quite as much by what the analyst exemplifies as by what he occasionally counsels or cautions the patient about. So Social Learning has its part as well. Finally the analyst's reliability, consistency, and the fact that he can be trusted to serve no other cause than the elucidation of the patient's conflicting motivations, comprise essential contributions toward a corrective emotional experience. Stauncher proponents of the Insight thesis, however, argue that Insight via interpretations is the active ingredient and the others are either relatively inert—designed mainly to hold interpretation in suspension (I use the term in the pharmaceutical sense)—or essentially catalytic.

If therapists have their beliefs about what the therapeutic situation must consist of, so do patients. Not one of the nominees I have discussed so far is a candidate of the therapist alone. Each of the hypotheses mentioned has been put forward with some urgency and in varying degrees of explicitness by every patient I have encountered or whose therapy I have supervised. However, when studied one by one, and especially when taken as something to understand in some depth, the preferences of individual patients are not easily susceptible to generalization. And it is very much to this problem that Strupp, Fox, and Lessler (1969) have addressed themselves in their book *Patients View Their Psychotherapy*.

The authors report on two studies they conducted of ex-patients' retrospective experience of the encounter and current appraisal of benefits received. The first study involves people who underwent long-term, privately conducted psychotherapy with relatively more experienced therapists; the second, people who had clinical care of shorter duration with psychotherapists in training.

The research itself has a number of shortcomings, some of which the authors are the first to acknowledge. It is, first of all, a questionnaire study, and such studies, asking for verbal professions of attitude, rarely present an accurate —and never a balanced—picture. Second, the questionnaires make extensive use of rating categories of the "extremely much" to "nothing at all" variety, and the responses to such formats may more accurately reflect the way people *use* categories—some having a penchant for the extreme, others for middling statements—than the viewpoint held on the item as such. Third, the items by their nature make the meaning of the response equivocal, as for example: "I often had the feeling [my therapist] talked too much." Too much for what—for what he had to say? For

my ability to listen? For my own sense of what I deserved? For my relative opportunity to talk? Clearly, the "fact" could be affirmed or denied for such a multitude of reasons that we cannot really know what in fact the situation was. Finally, and most to the issue of the favored ingredient, there is the shortcoming inherent in the research itself. The authors, as they have every right to do, focus almost exclusively on the ex-patients' retrospective view of the *therapist*, and not, as the title implies, of the therapy. In so doing they get the results they ask for—for example, that the therapist is the key factor in the process and outcome of the therapy. He may be; but, equally, he may not be: the fact is that we cannot know, and in this the data presented and much of the discussion offered by the authors could substantially, if unintentionally, mislead.

The artifactual nature of research findings in studies of psychotherapy are, of course, far from exclusive to Strupp, Fox, and Lessler. But it does not help, I think, when they follow up what I read (and shall presently quote) as the key finding of their researches with: "Clearly in this instance, as in certain others, the patients' reports cannot be taken at face value" (p. 117). This is too much like the old conundrum about the man who says he is a Cretan but that all Cretans are liars for a research report on a serious study. May the authors really have it both ways?

The central finding of both studies, and the one to which the authors take exception, is this:

> A positive attitude toward the therapist proved to be closely related to success in therapy, irrespective of how that success was measured. Patients who rated their own therapy as successful described their therapists as warm, attentive, interested, understanding and respectful. Furthermore they perceived the therapist as experienced and active in the therapeutic situation. Patients rated highly successful by their therapists have a similar description by the therapist. These patients were less likely to report intense anger toward their therapists than were their less successful counterparts, who also tended to report uncertainty about the therapist's attitude toward them. (p. 116)

That the authors wince at this ("We do not subscribe to the view of psychotherapy as the 'purchase of friendship,' although this is what the patients obviously wanted, and, if their reports are taken at face value, to some extent received" [p. 117]) is understandable, but in another sense. They too have their nominees for active ingredient: "The therapist teaches and the patient learns.... As teacher (or substitute parent), he dispenses rewards and punishments and employs a variety of psychological techniques for helping the patient achieve greater autonomy and self-direction. Once he—the patient—has deeply experienced and recognized the error or foolishness of his ways ('insight'), he may gradually modify his behavior" (pp. 2-3).

But even if we discount the possibility that a central finding may be a methodological artifact and fly in face of the authors' wish to disown it, we are left with yet another problem. Ex-patients, we learn, seem to favor the "good

therapist"—that is, the warm, attentive, active, kindly therapist—as their candidate for the ingredient that makes the difference. But do they deem or dub him so because he has proved helpful, or has help indeed burgeoned from his kindly behavior? Or is it that both a sense of being helped and a friendly view of the therapist has followed from yet a third or fourth factor? This, as well, we cannot know.

Confronted by the presence of so little of the known, we might well be tempted to drop the subject and harvest vineyards of greater certainty. On the other hand, since we have been dealing in candidacies all along, it can do no harm to add one more.

Let us take it, then, that the person of the therapist is regarded by these ex-patients as a factor of signal importance—that he *was* the therapeutically active ingredient. And, further, that when he is "good," patients feel and act benefited. Can a hypothesis be drawn to account for this?

The Corrective Emotional Experience advocates will have little trouble adducing theirs, and it may be that the "finding" does support their theory. But there is at least one other hypothesis that suggests itself. It is that a therapist is imbued with goodness at least partly to the extent that he meets his patient's more particular requirements of him—*whatever* these may be.

Consider, for example, a young woman who was briefly a patient of mine. She held a profound and most urgent conviction that nothing could benefit her but some kind of massive assault of nearly annihilating proportions. Though she was partially prepared to allow me to help her explore and come to understand this conviction, she could not feel at ail satisfied that this process would be of any use. When after two or three weeks she chanced to learn of the phenomenon of electrical shock treatments, she decided that these and only these would do. As it happens, electrical shocks are not among my own favored candidates as therapeutic agent, so I instead renewed my attempts to enlist her help in the mutual exploration of her convictions I had in mind. Far from regarding this effort of mine as kindly, she clearly began to view me as cruel, cold, misguided, and even brutal, a category she had previously reserved for her father, who, no doubt relieved by her removal of this painful view from him, thereupon arranged for a practitioner of the science to administer a course of thirty-six treatments.

It is not the extremity of the example that I wish to emphasize, but its particularity. Not all people are so particular about what benefit must consist in as was that young woman. But all people have their convictions if they are not to be gripped by a Kafkaesque experience. I do not mean by conviction at all what has been called "faith,"

though for people in whom faith is expectant, faith reposed will work wonders. Faith, then, is but one such expectation, as the need for assault is another, and fancies about the contents of a pill or the color of a pill others still. A conviction about the properties of rewards and punishments or about the value of a psychoanalysis is also an expectation in search of reciprocation. So it is that there is no ingredient proposed by empiricist, methodologist, theorist, or therapist that has not been put forward, albeit on a more naive basis, by one or another of the patients I have come to know.

Those practitioners who attune themselves to a close consideration of the views of their individual patients recognize such convictions as part and parcel of the transference. For when examined with care, these convictions reveal the patient's deepest preconceptions of what went wrong in his life, what needs to be set right, and what it will take from the therapist for the patient to get from talk to sufficiency and defect to wholeness.

It cannot be surprising, therefore, that even when simply in the presence of an experience that complements their expectations, people feel benefited. Thus one can quite agree that, as Strupp, Fox, and Lessler note, it was more the who and the what, than the how and the why, that the ex-patients in their studies drew from their therapies. But to regard this as something questionable—as if instead of seeking enlightenment, as they were supposed to, the patients merely basked in the sun and came away with a good tan—is to carp. For, as they also point out, the majority of ex-patients studied entered therapy after suffering from such complaints as "dissatisfaction," "lack of purpose," and the like—complaints which the authors sum up as a "generalized unhappiness and estrangement" (p. 57). Such people, not unnaturally, want above all to *feel* better. And they quite typically hope to accomplish this either through a restoration of a once better experience, or by having the therapist offset the internal sources of their unhappiness. This is thus *their* candidate for psychoactive ingredient. If these wishes are fulfilled, they can and do feel benefited. Feeling benefited, moreover, they will often act with the increased vigor and temerity which in turn elicits reciprocal conferents from life. This expansive cycle exponentially increases the sense of benefit.

To be sure, such cycles can all too readily unwind again once the patient has left the source of therapeutic beneficence. This may be particularly true if the patient's response to the divergences that inevitably accompany the basic concordance are not treated with in some depth. One might assume just such a failure to make the tensions a focus of the therapy in those ex-patients in the study who were angry in therapy and remain so since. There is much to be said, then, for offering a treatment instead of a treat.

And yet it is hard to think why the simple benefits of a largely concordant encounter should be despised. But despised they are. Though therapists traditionally speak of "termination," not completion, and remind their unready-feeling patients that they will still be there if needed, the culture of psychotherapy shares with the culture-at-large a belief that therapy should be a once-in-a lifetime proposition. Special circumstances withstanding are indeed the exceptions that prove the rule. But why *should* "cure" be a forever-more attainment? Why *do* therapists of the persuasion represented by the authors struggle and strain to press on their uninterested patients an education that isn't wanted? Especially when this impingement may well interfere with the benefits concordance can offer? I suggest that much less can often do more than quite a lot—when the circumstances propitious for more enduring goals are wanting.

These circumstances derive from a concatenation of factors neither widely found nor easily catalyzed. Patients, for example, who want quite simply to feel better, by virtue of what they receive in the way of kindliness from their therapist, may need to return for refresher course after refresher course before they feel ready to tackle the question of why their psychic metabolism is such that good experiences fail to stick to their ribs. Surely one way *not* to catalyze this ready disposition is for the therapist to press on the patient a treatment more oriented to the pursuit of the ideals in his ideology than to the capacities and objectives of his patient. Psychotherapy, with us as we now recognize it for at least a century, is likely to last a while longer. Its usefulness to people will doubtless increase. But there can be no less doubt that the degree to which its contributions increase will closely follow the extent to which ideologies are expunged from its practice—and study.

REFERENCE

Strupp, H. H., Fox, R., and Lessler, K. (1969). *Patients View Their Psychotherapy*. Baltimore: Johns Hopkins University Press.