THE TECHNIQUE OF PSYCHOTHERAPY

WHAT IS PSYCHOTHERAPY?

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What Is Psychotherapy?

Few words in the lexicon of the mental health field are as ambiguous as the term *psychotherapy.* It is loosely employed to connote, among other meanings, helping, treating, advising, guiding, educating, and even influencing. Definitions of psychotherapy are often bridled to fields of disciplinary operation, e.g., psychiatry, psychology, casework, etc., sanctuaries for such characterizations being sought in specialized societies. DifFuseness, in definition, has converted the arena of psychotherapy into a swamp of murky ideas, fostering many divergent theories and techniques. Yet a brief and precise description of therapy is important if no more than to circumscribe boundaries of operation and for purposes of hypothetical construction and empirical study. A comprehensive working definition might be the following:

Psychotherapy is the treatment, by psychological means, of problems of an emotional nature in which a trained person deliberately establishes a professional relationship with the patient with the object of (1) removing, modifying, or retarding existing symptoms, (2) mediating disturbed patterns of behavior, and (3) promoting positive personality growth and development.

This formulation requires additional elaboration.

Psychotherapy is the treatment. No matter how much we attempt to dilute what we do in psychotherapy, it constitutes a form of treatment. Such terms as *reeducation, helping process,* and *guidance* are merely descriptive of what happens in the course of treatment and do not really disguise the therapeutic nature of the process. Forms of intervention other than therapy do exist in the mental health field and will be described later.

Psychological means. Psychotherapy is a generic term covering the entire spectrum of psychological treatment methods. These range from designed maneuvers of the therapist-patient relationship to indoctrinations fashioned to change value systems, to tactics aimed at intrapsychic processes, and to conditioning techniques that attempt to alter neural mechanisms. The repertoire of strategies is thus legion, and formats are varied, e.g., individuals, couples, and groups. They are all, nevertheless, dependent upon the establishment of adequate communication, verbal and nonverbal. Excluded are such modalities as somatic therapies (drugs, convulsive therapy, surgery, etc.) and "trial action" therapies such as occupational therapy, dance therapy, music therapy, psychodrama, etc. that, though psychotherapeutic in effect, are not, strictly speaking, forms of psychotherapy.

Problems of an emotional nature. Emotional problems are diverse, influencing every facet of human functioning. They are manifest in distortions in the individual's psychic, somatic, interpersonal, and community life.

Manifestations of emotional illness are thus multiple, involving the total human being. In view of this totality of disturbance, it is arbitrary and unsound to dissociate psychic from interpersonal, social, and psycho-physiological difficulties, aspects of which are usually concurrent, though not always obvious.

A trained person. In search of relief, the individual is apt to involve oneself in a relationship with a friend or authority. The motivations that prompt such a relationship are disabling symptoms or a realization that one's happiness and productivity are being sabotaged by inner forces that one is neither able to understand nor to control. Sometimes the consequences of this relationship are registered in a restoration of homeostasis, a product of healing forces liberated by the helping process. At other times, particularly when attempts are made to handle the sufferer's emotional turmoil in depth, the relationship may become disastrous to both participants. Dealing most adequately with an emotional problem requires a high degree of skill that may best be acquired through extensive postgraduate training and experience.

Deliberately establishing a professional relationship. The relationship, the core of the therapeutic process, is deliberately planned and nurtured by the therapist.Unlike nonprofessional relationships, which are part of the social nature of man, the therapeutic relationship is a collaborative undertaking,

started and maintained on a professional level toward specific therapeutic objectives. More than one therapist (co-therapist, multiple therapists) may work together.

The patient. An individual in psychotherapy receiving treatment is best called a patient rather than some other designation such as a client. The therapist may relate capably to more than one patient during a session, as in marital or group therapy.

The object is removing existing symptoms. A prime goal in therapy is to eliminate the patient's suffering as well as to remove the handicaps imposed by symptoms.

Modifying existing symptoms. Despite our wish for complete relief, certain circumstances may militate against this objective. Chief deterrents are inadequate motivation, diminutive ego strength,[1] and limitations in the patient's available time or finances. These will impose restrictions on the extent of help that can be rendered and make for modification rather than cure of the patient's symptoms.

Retarding existing symptoms. There are some malignant forms of emotional illness, such as certain fulminating schizophrenic and organic brain disorders, in which psychotherapy, no matter how adroitly applied, serves merely to delay an inevitable deteriorative process. This palliative effect is

eminently worthwhile, however, often helping to preserve the patient's contact with reality.

Mediating disturbed patterns of behavior. The recognition in recent years that many occupational, educational, marital, interpersonal, and social problems are emotionally inspired has extended the use of psychotherapy into fields hitherto considered provinces of the psychologist, teacher, sociologist, religious leader, and lawmaker. Realization that the character structure is involved in all emotional illness has broadened the objectives of psychotherapy from mere symptom relief or removal to correction of disturbed interpersonal patterns and relationships.

Promoting positive personality growth and development. The final use of psychotherapy is as a vehicle for personality maturation. This has introduced a new dimension into the field of psychotherapy—a dimension that deals, on the one hand, with problems of immaturity of the so-called normal person and, on the other, with characterologic difficulties associated with inhibited growth previously considered inaccessible to treatment. Here psychotherapy aims at a resolution of blocks in psychosocial development in order that the individual may aspire to a more complete creative self-fulfillment, more productive attitudes toward life, and more gratifying relationships with people. The goals of psychotherapy thus extend from the limited objective of helping to control symptoms to the liberation of the rich resources of the

human mind from neurotic obstructions that thwart its purpose and stunt its growth.

IS THE MEDICAL MODEL OUTMODED?

Therapists who venture into rendering essential human services in mental health will inevitably find that they must penetrate into zones alien to the medical model. Of necessity, they will have to adapt to concepts and interventions that are more related to the social than to the biological sciences. For example, if one seeks to engage in preventive work or in some forms of short-term therapy, it is necessary to become familiar with the dynamics of social systems and the world of learning and rehabilitative procedures. The information one already possesses of biological and psychological systems will, of course, be fed into these areas in a way that adapts one to the exigencies with which the therapist must deal. Unless the therapist is willing to restrict operations to the handling of a narrow band of problems, models of helping will have to be employed that go beyond training in traditional psychotherapeutic education.

Whether we need to call such types of helping psychotherapy is a moot question. Shall we restrict the word to the treatment of outright emotional illness, or shall we extend it to dealing with behavioral and adjustment

problems that are not conspicuously pathological? A good deal of the confusion about psychotherapy stems from the fact that over the years psychological help has been extended to larger and larger groups of people with increasingly diverse complaints. These range from physiological disruptions of anxiety involving almost any organ, to depressive manifestations, to phobias and compulsions, to psychotic dislocations, to habit disorders, to behavioral aberrations, to interpersonal difficulties, to marital and family disturbances, to educational and work blockages, to sexual malfunctions, to addictions, and to a host of other vexations that can plague human beings. The models most appropriate for the understanding of and the dealing with this plethora of troubles must be spread over a number of fields. Indeed, in the course of helping the same individual we may have to apply information from medical, sociological, educational, rehabilitative, and other sources.

In a way, the term psychotherapy is a limiting one because literally it means *treatment* of mental or nervous disorders. This suggests a restrictive medical model. To encompass all the troubles for which psychological help is sought under the term psychotherapy will necessitate a borrowing from theories and stratagems more appropriate to structures other than medical ones, such as sociological or rehabilitative and learning models. Functionally, this is what has happened over the years, often with protests from professionals in disciplines of sociology, anthropology, psychology, and

education, who resent encroachment of their domains. Actually, psychotherapy should not be regarded as a cormorant intent on swallowing diverse disciplines. It is a *body of procedures* that overlap techniques used in counseling, social casework, education, and rehabilitation, even though its goals may be different.

There are advantages and disadvantages to the medical model per se; but, on the whole, it has a proven utility for a bulk of problems seen by the psychotherapist. It is possible that Third Force psychology embracing humanistic aims, as well as the human growth potential movement, may some day provide a viable alternative. As matters stand today, we have not yet achieved this goal. Substituting for the concept of “mental health-mental illness,” “different modes of coping with life” does not necessarily lead to greater clarification of the many problems with which we have to deal in psychotherapy.

The fact that therapists work within the orbit of the medical model does not mean that they must propel themselves into an absurdly authoritative position, thus perpetuating a parent-child relationship. Authoritativeness is more a product of the personality of the individual therapist than the model that an individual pursues in practice. Nor does it follow that patients need be depreciated by being labeled “sick” or “mentally ill,” thus pinning on them awkward pathological labels. Nor, if we adopt the medical model, need they

be deprived of their freedom or liberty, nor robbed of the option of deciding for themselves their suitability for therapy, nor forced to sacrifice responsibility for their own destiny and the right to their own sense of values, nor prevented from being active participants in their own treatment. The medical model does not necessarily have to restrict the focus purely on disease. Expanded psychological growth and development are within its purview, much as physical hygiene is within the scope of good medical practice.

Merely because our present nosological systems are not entirely satisfactory does not sanction the abandonment of diagnosis that is an essential aspect of the medical model. A proper diagnosis can be helpful to the institution of a rational therapeutic program. For example, violence may appear as a symptom of a variety of causes. It may be a simple behavior problem nurtured by situational dislocations. It may be a habitual ego-syntonic display in a psychopathic personality. It may be a manifestation of failing repressive control in a borderline patient. It may be the expression of a delusional system in a schizophrenic. Or it may be a symptom of the manic phase of a bipolar disorder. Unless a correct diagnosis is established, we may fail miserably in providing effective help. Thus, elimination of violence due to environmental difficulties can be helpful in simple behavioral problems, but it will usually be ineffective in the other conditions cited. Anyone who has witnessed the ameliorating effect of neuroleptic medication in schizophrenia

and of lithium in manic disorders will attest to the value of a diagnostic survey. Violence in a borderline case will require special psychotherapeutic management that might not be applicable to other conditions. Diagnosis can be as important in psychological as in physical problems.

On the other hand, a disadvantage fostered by the medical model is that it concerns itself with techniques of therapeutic intervention that are sometimes dissociated from the daily life of the individual. Diagnosis and pathology, legitimate as they may be in disease areas, are sometimes not applicable to certain behavioral zones. To classify these as normal and abnormal or as symptoms and defenses neglects considerations of background, culture, and life style, which require a different perspective. Moreover, while the medical model has in the past sponsored a limited training perspective, it has rarely equipped trainees to deal with many behavioral difficulties that are disruptive to the individual and the community.

It would seem appropriate then in a comprehensive training program to expand the education of psychotherapists toward a wider understanding of the behavioral sciences and toward the use of a broad range of techniques additional to the conventional psychotherapeutic procedures. Under these circumstances, the therapists would be better equipped to move beyond the boundaries of the medical model toward a more pragmatic commitment to

the spectrum of problems challenging them in their practices.

PSYCHOTHERAPY VERSUS PSYCHOANALYSIS

According to Webster's New Universal Unabridged Dictionary psychotherapy connotes "the application of the various forms of mental treatment, as hypnosis, suggestion, psychoanalysis, etc., to nervous and mental disorders." This generic definition is, in mental health circles, supplemented by a more specific usage of the term in relation to goals and methods of treatment as contrasted with psychoanalysis.

Psychoanalysis aims at a systematic and total resolution of unconscious conflicts with structural alteration of defenses, and the character organization. Psychotherapy is less ambitious, reaching for the practical and less arduously achieved goals of resolving some conflicts, modifying others, and even retaining and strengthening certain neurotic defenses that permit individuals to contain their anxiety and to function. This does not necessarily make psychoanalysis a better kind of treatment than psychotherapy or vice versa. Some patients fail miserably at one and do quite well with the other. The key issue is the proper selection of cases for the two different techniques. Patients exposed to formal analysis, centered around evolvement of a transference neurosis and its resolution through interpretation, will require so many qualifications in terms of personality characteristics, motivation,

available time, finances, etc. that they are relatively few in number. Most patients, on the other hand, will qualify for psychotherapy.

Accepting the fact that psychoanalysis has provided us with concepts and techniques that can lead to the recognition and exposure of conflicts that operate beyond the zone of awareness, what is of concern to clinicians is how useful this information is in treating and resolving emotional problems. Most students are no longer willing to accept psychological theories on the basis of faith or literary elegance. Some are relatively unimpressed with both the pronouncements and achievements of psychoanalysis, moving toward psychotherapy with its active approaches directed at symptom relief and problem-solving. Among the expressed doubts are (1) that psychoanalysis is the best treatment for most problems of an emotional nature; (2) that unconscious conflict is necessarily at the root of all emotional difficulties; (3) that every communication of the patient to the therapist during a session has an unconscious meaning, and that through free association one eventually can reach this repudiated core; (4) that verbal unburdening has a greater impact on the individual than behavioral solutions to a problem; (5) that supportive and educational interventions are temporary and inevitably lead to greater avoidance and repression; (6) that an adequate cure of a neurosis necessitates its duplication in treatment through the relationship with the therapist (transference); (7) that psychoanalytic theories can be validated through either research or careful clinical inquiry; and (8) that

psychoanalysis is the only method through which reconstructive change can be achieved.

The upshot of these questions is that students in progressively larger numbers are doubting the clinical usefulness of psychoanalysis and the need for personal training in psychoanalytic techniques, with the sacrifices of time, energy, and money that disciplined analytic studies would entail.

More insidiously dynamic theory, which is useful in understanding psychopathology, is downgraded and credited with little clinical utility and therefore considered not worthy of study. This is unfortunate since insight into anachronistic coping patterns, so essential in reconstructive treatment, will draw upon certain psychoanalytic concepts such as unconscious ideation, repression, resistance, and the survival in the present of needs and defenses rooted in the development past.

Among some psychoanalysists, psychotherapy is sometimes employed to distinguish a wide variety of superficial supportive and reeducative procedures aimed at more conscious mental processes, from psychoanalysis that supports techniques of "depth therapy" focused on the unconscious. While utilizing methodologies for expediency's sake, which may be condoned under certain circumstances, they consider it a baser metal than the pure gold of analysis. The latter alone of all therapies is targeted at the surviving

nucleus of emotional illness in the residual “infantile neurosis.” Psychoanalysis, they say, offers itself as a technique that may, in the cases where it can be successfully employed, promote maturity by eliminating the infantile neurosis as a source of emotional pollution. Psychotherapy is more modest in its goals. It can help to strengthen the individual’s defenses so as to prevent the infantile neurosis from interfering too much with a reality adaptation. It can also provide guidelines for more competent coping with everyday stress. In this way the individual is better able to live with the infantile neurosis and to make an adjustment that is no better or worse than the normal individual who possesses some neurotic defenses, but never sees the inside of a psychotherapist’s office and still gets along satisfactorily with life and people.

Tarachow’s (1963) differentiation of psychoanalysis from psychotherapy is still serviceable. He considers that in the former “transference, repression, other ego defenses, and resistances are all freely subjected to analysis and resolved,” while “psychotherapy, on the other hand, is a selective, limited treatment in which a rearrangement rather than a resolution of these elements is aimed at.” Furthermore, as more and more defections from Freudian theory have occurred, classical (orthodox) Freudians have tended to claim priority for the term psychoanalysis and to label any derivative neo-Freudian method as psychotherapy. Factional quarrels have accordingly developed.

Since psychoanalytic doctrines have permeated into the fiber of mental health practices and theories, the question of where psychoanalysis belongs is an arbitrary one. A well-trained psychotherapist is usually schooled in analytic doctrines and methods and is capable of applying these as part of the treatment program.

PSYCHOANALYSIS VERSUS PSYCHOANALYTICALLY ORIENTED PSYCHOTHERAPY

A good deal of the family strife among psychoanalysts who adhere to classical theory and those who have deviated in their ideas and methods centers around the word psychoanalysis. Classical analysts claim, with some justification, that the term is being watered down to include stratagems that are not even remotely related to psychoanalysis. They insist that psychoanalysis is restricted to a specific mode of treatment, focused on the unconscious, in which the uncovering of repressed childhood conflicts is achieved through the gradual resolution of resistance. This aim is accomplished through an intensive therapist-patient relationship, insured by frequent treatment sessions (preferably five times weekly) and the employment of the techniques of free association, dream analysis, and the evolvement and "working through" of a "transference neurosis." The latter embraces the projected distortions in the therapeutic relationship of traumatic experiences with early parental figures. The transferential

development is guaranteed best by the employment of passive, neutral, anonymous, and nondirective attitudes on the part of the therapist. This tends to mobilize the most repressed components of conflict (the infantile neurosis) and to permit the patient to work through with a new parental image (as embodied in the therapist) more perspicacious attitudes toward authority, toward oneself, and toward one’s own impulses. Resultant is a modification of the severity of the *superego,* a releasing of the strangulations that characterize the archaic defensive maneuvers of the *ego,* and a freeing of the constructive elements of the *id.*

Since there are patients whose problems, motivations, and life circumstances are such that they are unable to respond to the passive methods of psychoanalysis, and since there are therapists who are unable to function in an anonymous, nondirective, non-authoritative manner, dictated by classical technique, a number of modifications have been devised. Because these serve some patients effectively, the revisions have been proposed as “refinements” and “improvements” over the orthodox procedures. The hard core of psychoanalysts connected with the Freudian school have challenged such modifications, considering them a reversion to preanalytic methods or a blocking of the true aims of psychoanalysis—which deals intensively with the unconscious and the *non-interfering* resolution of the transference neurosis.

When we examine the therapeutic tactics of the schools that advocate

modifications, we do find a diversion from classical aims and techniques of psychoanalysis— such as the institution of activity in the relationship, a reduction in the number of weekly sessions, a substitution of the focused interview for free association, a consideration in the interview of the present rather than the past, the introduction of adjunctive devices, the proffering of suggestions and directives, coordinate interviews when necessary with other family members, and even the restraining of the development of a transference neurosis.

While Freudian analysts generally do not object to these innovations, and even admit that they may serve some patients better than formal psychoanalysis, they do object strenuously to the labeling of these newer techniques as psychoanalysis. Neo-Freudians, on the other hand, object to the narrow definition of psychoanalysis defined by the Freudians. After all, they insist Freud himself defined psychoanalysis as any method that dealt with resistance and transference. Why circumscribe it to a special kind of orientation?

Freud (1952) persistently contended that no person was a psychoanalyst who did not accept the foundations of the theory of psychoanalysis, namely the existence of unconscious mental processes, the recognition of the theory of repression and resistance, and the importance of sexuality and the Oedipus Complex.

Some authorities now employ the term "psychoanalytically oriented psychotherapy" or "dynamic psychotherapy" to those approaches that accept some, but not all of Freud's premises. Others consider a psychoanalytically oriented psychotherapy the modulated utilization of the techniques of psychoanalysis that circumvent or dilute a transference neurosis, and that deal with the understanding in dynamic terms of a limited area of the pathology. However, because the word psychoanalysis carries with it connotations of "depth" and "thoroughness" and because there is still a status and economic advantage in some parts of the country in being known as a psychoanalyst and in doing psychoanalysis, therapists resist debasing their activities with a term that might be interpreted as second best.

Where psychoanalysis ends and psychoanalytically oriented psychotherapy begins has become a matter of opinion. One may remember the fruitless struggle of the American Psychoanalytic Association to establish, through its Committee on Evaluation of Psychoanalytic Therapy, a baseline from which to approach the contradistinction between psychoanalysis and psychoanalytic psychotherapy. The effort bogged down, and a report was issued to the effect that even investigation of possible differences mobilized resistance among the members of the Society (Rangell, 1954).

Orthodox Freudians insist that psychoanalysis presupposes an acceptance of the instinct theory (libido theory) and the primacy of early

sexual conflicts. They contend that deviants of cultural or sociological theoretical persuasions are simply not doing psychoanalysis, even though there is an employment of free association and dreams, a delving into childhood conditionings, an uncovering and resolution of resistance, and a setting up and working through by means of interpretation of a transference neurosis. This position is gradually being softened with the current interest in cognition and "ego psychology," which considers behavior too complex to be accounted for solely by innate psychological events.

There is then a tendency to embrace as psychoanalysis only those treatment processes that (1) are executed by trained psychoanalysts, (2) have as their goal the overcoming of resistances to unconscious conflicts, whatever their nature may be, (3) deal with a continuity of experience back to early childhood, and (4) encourage the building up of a transference neurosis and its resolution through interpretation. Techniques that diverge from these methodologic objectives, and yet employ some of the uncovering procedures for delving into the unconscious, such as dreams, free association, and analysis of resistance and transference (which is not to be confused with the more intense transference neurosis) are best classified as "psychoanalytically oriented psychotherapy," or "dynamic psychotherapy," or "exploratory psychotherapy."

OTHER DEFINITIONS OF PSYCHOTHERAPY

The comprehensive definition of psychotherapy given above has many advantages. However, other explanations of the meaning of psychotherapy exist that may be interesting to review.

The sundry published definitions of psychotherapy agree on one point — namely, that psychotherapy constitutes a form of approach to many problems of an emotional nature. They do not agree on other aspects, such as the techniques employed, the processes included, the goals approximated, or the personnel involved. Typical definitions are these:

1. "Psychotherapy is the formal treatment of patients using psychological rather than physical or chemical agents, principally verbal communication."

2. "Psychotherapy may be defined as the treatment of emotional and personality problems and disorders by psychological means."

3. ''We shall define psychotherapy as any type of professional interpersonal situation between a therapist and his patient designed to help the patient to resolve emotional problems."

4. "Psychotherapy is primarily a transaction between the patient and his therapist."

5. "Psychotherapy is ... a developing transaction between two people, one suffering from some type of distress or exhibiting disordered behavior, the other offering amelioration as part

of his professional activity."

6. Psychotherapy consists of "techniques derived from established psychological principles, by persons qualified through training and experience to understand these principles and to apply these techniques with the intention of assisting individuals to modify such personal characteristics as feelings, values, attitudes, and behaviors judged to be maladaptive or maladjustive."

7. "For a very simple realistic definition, one could say that psychotherapy is the utilization of psychological measures in the treatment of sick people."

8. [Psychotherapy endeavors] "to alter the behavior and change the attitudes of a maladjusted person toward a more constructive outcome."

9. [Psychotherapy alludes] "to the entire collection of approaches attempting to influence or assist a patient toward more desirable ways of thinking, feeling, and behaving."

10. "By psychotherapy is meant the use of measures which it is believed will act upon the patient's mind and thereby promote his mental health and aid his adjustment to the particular problems which have disturbed his happiness or adaptation."

11. "Psychotherapy is a form of treatment in psychiatry in which the psychiatrist, by his scientific thinking and understanding, attempts to change the thinking and feeling of people who

are suffering from distorted mental or emotional processes."

12. Psychotherapy "aims to help the impaired individual by influencing his emotional processes, his evaluation of himself and of others, his evaluation of and his manner of coping with the problems of life. It may also include changing his environment … and simultaneously increasing his potentialities of mastery and integration."

13. "[Psychotherapy includes] a multitude of psychological methods, all having one thing in common—the intent to help a suffering individual through psychological means."

14. "Psychotherapy is a planned and systematic application of psychological facts and theories to the alleviation of a large variety of human ailments and disturbances, particularly those of psychogenic origin."

15. "In general, psychotherapy can be defined as the provision by the physician of new life-experiences which can influence the patient in the direction of health."

16. "Psychotherapy is the art of combating disease and promoting health by mental influences."

17. "[Psychotherapy] connotes the use of definitive psychological techniques designed to relieve demonstrable disturbances in psycho-social adjustment."

18. "Psychotherapy includes all kinds and ways of utilizing psychologic means to achieve beneficial psychobiologic

changes."

19. "Psychotherapy consists of any considered and competent medical endeavor directed toward the improvement of the emotional health of the individual, based upon the understanding of the psychodynamics involved, and of the need of the individual under treatment."

20. [Psychotherapy is the] "treatment of mental or emotional disorder or of related bodily ills by psychological means."

21. [Psychotherapy is] "the use of any psychological technique in the treatment of mental disorder or maladjustment… . The term carries no implication about the seriousness of the disorder … the duration or intensity of treatment, or the theoretical orientation of the therapist."

22. [Psychotherapy is] "an emotional exchange [process] in an interpersonal relationship which accelerates the growth of one or both participants."

23. "Psychotherapy is … a cooperative enterprise for clarifying purposes and modifying attitudes in the direction of greater integrity of personality."

24. "Psychotherapy is a certain kind of social relationship between two persons who hold periodic conversations in pursuit of certain goals: namely, the lessening of emotional discomfort and the alteration of various other aspects of client behavior."

25. “Psychotherapy may be defined as the treatment of emotional and personality problems and disorders by psychological means… . Types of psychotherapy fall into two general groups. One may be described as genetic-dynamic, the other as supportive, suppressive, non-exploratory, or non-specific.”

26. “Psychotherapy: The generic term for any type of treatment which is based primarily upon verbal or nonverbal communication with the patient, in distinction to the use of drugs, surgery, or physical measures, such as electroshock or insulin shock, hydrotherapy, and others.”

27. “Psychotherapy is a process in which changes in an individual’s behavior are achieved as a result of experiences in a relationship with a person trained in understanding behavior.”

28. “In its classic sense, psychotherapy is defined as the restructuring of the malfunctioning personality.”

29. “… psychotherapy is a form of help-giving in which a trained, socially sanctioned healer tries to relieve a sufferer’s distress by facilitating certain changes in his feelings, attitudes, and behavior, through the performance of certain activities with him, often with the participation of a group.”

30. “Psychotherapy is a form of treatment of a client by a therapist for disorders of emotional adjustment, with the purpose of bringing about his readjustment so that he will become more comfortable in his emotions, thoughts, and attitudes, and so

that his social relationship will be improved."

31. Psychotherapy is a "process recurring between two (or more) individuals in which one (the therapist), by virtue of his position and training, seeks systematically to apply psychological knowledge and interventions in an attempt to understand, influence, and ultimately modify the psychic experience, mental function and behavior of the other (the patient)."

32. [Psychotherapy is] "a procedural arrangement between a therapist and patient in which the therapist, by explicit or implicit contract, attempts to improve, by psychological means, conditions and behavior which interfere with the patient's well-being— and which are ascribed wholly or in part to psychological causes."

33. "Psychotherapy: The generic term for any type of treatment that is based primarily upon verbal or nonverbal communication with the patient as distinguished from the use of drugs, surgery, or physical measure such as electroconvulsive treatment."

34. "Psychotherapy in its broadest sense is the systematic effort of a person or group to relieve distress or disability by influencing the sufferer's mental state, attitudes and behavior."

35. [Psychotherapy is the] "use of psychological techniques in the treatment of mental disorders. Psychotherapeutic methods are employed by a trained psychotherapist who helps the

patient by means of verbal and emotional communication."

36. "The science and art of influencing behavior so as to make it (a) more efficient and satisfactory to the individual and (b) more compatible with social norms."

37. Psychotherapy is "a process in which a person who wishes to relieve symptoms or resolve problems in living or seeking personal growth enters into an implicit or explicit contract to interact in a prescribed way with a psychotherapist."

38. "Psychotherapy is an interpersonal process designed to bring about modifications of feelings, cognitions, attitudes, and behavior which have proven troublesome to the person seeking help from a trained professional."

39. "Psychotherapy is a confiding, emotionally charged relationship between a trained, socially sanctioned healer and a sufferer. The healer seems to relieve the patient's suffering and disability ... by a procedure often involving other patients or family members, that is organized in terms of a particular conceptual scheme."

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Notes

1 The term *ego strength* is somewhat ambiguous, but in the sense it is employed here it connotes the positive personality assets that will enable the individual to overcome anxieties, to yield

secondary gains of illness, and to acquire new, more adequate defenses.