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Examining the Variables That Are Common to Most Therapies

The Compleat Therapist

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Examining the Variables That Are Common to Most Therapies

It is not that we do not have enough ideas about the best way to help people to change; we have too many. The prevailing movement in the field today is toward reconciling the differences between diverse approaches and finding their common factors. This trend has been shaped by several phenomena: (1) research findings indicating that a few core elements are at work, (2) a proliferation of eclectic points of view, and (3) sociopolitical pressures to develop a unified professional discipline (Goldfried, 1982b; Wogan and Norcross, 1985).

In spite of pressures both within and outside our profession to show a unified front, it is surprisingly difficult to find agreement about what effective therapy should be like. In a survey of therapists' beliefs about what constitutes good practices, there were only 2 items out of 83 in which there was agreement by more than 50 percent of respondents: that it is all right to break confidentiality if a client is homicidal, and that offering or accepting a handshake is appropriate (Pope, Tabachnick, and Keith-Spiegel, 1988). Although the focus of the study was on ethical rather than technical practices, it nevertheless points out the difficulty we have in coming to a consensus about anything.

A Consensus on Critical Moments

There is optimism for the future that we are getting closer to a consensus regarding what are "good" and "bad" moments in therapy. Lazarus (1986, p. 167), believes that the hope in our profession lies in the integration of all the disciplines and theories into a technical eclecticism that draws on universal principles of what works consistently: "All effective therapists must straddle the fence between science and art. In a patient with bipolar affective disorder in a florid manic phase, psychopharmacologists have demonstrated that lithium carbonate, alone or combined with neuroleptics, is strongly indicated. The *art* consists of persuading the patient to comply with the medical prescription, as well as addressing intrapersonal factors or interpersonal networks that might require attention."

Indeed the scientific and artistic foundations for psychotherapy come together not in theoretical structures, but in a consensus of certain practices. In a survey of therapist beliefs about optimal professional practice, Mahoney, Norcross, Prochaska, and Missar (1989) found a convergence of perspectives. Although the 500 psychologists who participated in the study represented the full range of theoretical perspectives (approximately 25 percent psychoanalytic, 15 percent behavioral, 10 percent humanistic, 13 percent cognitive, 32 percent eclectic), there was some agreement about what interventions consistently facilitate client change. According to the participants, all effective therapists foster hope in their clients' expectations, provide support and encouragement, and clarify feelings, thoughts, issues,

and themes.

As much as we might disagree with one another over philosophical issues, most therapists do follow customary procedures when confronted with certain specific situations. For example, the process for completing a mental status exam has become virtually standardized, as have assessment procedures for determining suicidal risk. Therapists of virtually all allegiances share a common belief in the utility of certain testing materials.

There are also certain events or moments in therapy that would be considered significant by almost all practitioners. They may be viewed as especially meaningful because of their relationship to successful outcomes, or because they are turning points in the direction that therapy takes. Usually there is some agreement between client and therapist that indeed something important has happened. It can be a “felt sense” that something has changed. There may also be behavioral evidence, characterized by increased intensity in vocal quality, accelerated activity, energy, expressiveness, and involvement (Rice and Wagstaff, 1967). These are magic moments. They are events in which things forever seem transformed.

From research and from many theoretical approaches, Mahrer and Nadler (1986) synthesized a list of “good moments” in therapy that are found in the work of most practitioners. These include the following themes, which

are illustrated with representative client statements:

1. *Revealing significant material about self.* "I've never really told anyone before about the way my father would act when he got drunk. Even now, when my family gets together, we pretend like it never happened."

2. *Sharing personal and meaningful feelings.* "I know it doesn't make sense that I would be so devastated, but ever since I got the report about my low sperm count I just can't pull myself together. It means I'll never be able to have a part of me living in my child. It's so damn unfair after everything else I've been through! I feel so angry I could explode!"

3. *Exploring issues that have previously been warded off.* "When you pointed out a few weeks ago how self-obsessed I was, that I couldn't get out of my stuff long enough to appreciate anyone else's position, I felt hurt and misunderstood. But I think you are absolutely correct: I *have* been reluctant to look at how self-centered I am ."

4. *Demonstrating a degree of insight into the meaning and implications of behavior.* "I've been blaming my parents for me being late to school — as if it's *their* job to wake me up every morning and get me ready. The truth is that I use them as an excuse for my troubles in a lot of areas we have been looking at. Yes, they fight a lot. Yes, they don't set limits with me the way they probably should. But it's my problem, and only I can do something about it."

5. *Being highly expressive and vibrant in communications.* "I can't *believe* he called me. ME! I *never* thought he even noticed me. But he called — Can you believe it? This is *so* incredible! I just want to hug you, I feel so happy."

6. *Sharing strong positive feelings toward the therapist and the way things are progressing.* "You've helped me *so* much. I can finally stand up to people like never before. I don't feel like anyone can push me around anymore — not my kids, my ex-husband, or my boss. And yet you've helped me to retain the softness and sensitivity that is so important to me. I can't thank you enough."

As I read over this list of "good moments" in therapy, I feel a little wistful: they do not happen often enough. We wait weeks, sometimes months, before we see evidence of these signals that things are progressing. And for every good moment in therapy to which we could agree, there are also some perfectly awful moments as well — when silence drags on forever, when a client becomes abusive, when appointments are canceled without explanation.

If we can agree on which manifestations of client behavior are generally good or bad, the next task is to try to identify what is likely to facilitate desired goals. In a review of factors across all therapies that account for significant client progress, Lambert (1986) calculated the percentage of improvement that is a function of each variable. The most important single

variable, accounting for 40 percent of significant growth, Lambert labeled "spontaneous remission." This includes all those factors that are part of the client's natural functioning, ego strength, developmental and homeostatic mechanisms, and social support. Another 15 percent of improvement results from placebo effects, which Lambert prefers to call "expectancy controls" because of their specific rather than nonspecific influence. So far, then, we have over half of generic psychotherapy's positive effects accounted for by client variables that are encouraged and facilitated by the clinician: expectations, resources, and developmental processes.

Once we get into the actual psychotherapy, about 30 percent of its effects are the result of common factors — such universal mechanisms as catharsis, empathy, trust, insight, modeling, warmth, and risk taking. Finally, only 15 percent of improvement is attributable to any specific interventions or techniques that are part of a particular treatment modality. This, therefore, helps to explain why the specifics of what we do seem less important than the more general principles we follow that are common to most therapeutic systems.

Karasu (1986) has conceptualized the specific techniques of different schools of therapy as belonging to one of three general change agents that are shared by all models:

Affective Experiencing. Whether it is called catharsis, emotional arousal, experiential activities, or the expression of feelings, all therapies deal with and process emotions. Behavior therapists would use flooding techniques. Psychoanalysts would use free association. Shared dialogue, role playing, bioenergetics, or any one of a hundred other techniques would also access the same material and accomplish similar goals: the identification, clarification, and expression of feelings.

Cognitive Mastery. There is also an intellectual insight component to most therapies in which clients explore the reasons and motives underlying their difficulties. There is great diversity, of course, in the way this area is addressed, with psychoanalysts using interpretation, behavior therapists preferring thought-stopping, existentialists exploring personal meaning, and cognitive therapists attacking the belief systems directly. Nevertheless, almost all therapists give some attention to what and how clients think about themselves and their life predicaments. Almost all therapies try to alter clients' perceptions of self and the world.

Behavioral Regulation. The third change agent is not within the exclusive province of behavior therapy alone. Any focus on behavior — giving direct feedback, identifying problem areas, selectively reinforcing desirable responses (even if they are only shared feelings) — are examples of how even a client-centered clinician would deal with behavioral dimensions.

These three general points of agreement among most effective therapists are only the beginning of what may be considered a consensus. The balance of this chapter is devoted to addressing more specifically many other factors that are common to the work of most effective therapists. While hardly an exhaustive treatment, this discussion does represent a summary of those factors that we can be reasonably sure most practitioners would agree are significant. These include supportive elements within the context of the therapeutic relationship, processes that lead to self-awareness and exploration, and variables that all ow the therapist to influence the client's perceptions and behavior.

The Therapeutic Relationship

Of all the elements we might name, none receives more attention — both in theory and in practice — than the alliance between client and therapist. It is the glue that binds everything we do and the context for every intervention. A productive, open, and trusting relationship is, quite simply, the single most necessary prerequisite for effective psychotherapy (as we currently know and understand it) to take place.

The Relationship as the Basis for All Effective Therapy. The existential or humanistic therapist places primary emphasis on a relationship with the client that is supportive, authentic, nurturing, caring, accepting, trusting, and

honest. All other types of clinicians — regardless of their espoused allegiances or belief systems — also spend some time developing a relationship that they consider to be necessary for anything else they might do. Most contemporary psychoanalysts, for example, no longer maintain the strict neutrality that was originally advocated by Freud, but rather seek to establish a more authentic encounter (Messer, 1988). And even those orthodox practitioners who do believe in maintaining a degree of distance so that transference feelings are not compromised still believe that *their* relationship with a client is central to the analytic work that follows. Behavior and cognitive therapists will also now readily acknowledge that their interventions are likely to be more effective if implemented within the context of a relationship that is trusting and open (Wolpe and Lazarus, 1966; Goldfried and Davidson, 1976; Arnkoff, 1983; Linehan, 1988). I recall at ending one of Albert Ellis's "road shows" during the 1970s and listening to his very strident presentation on the values of rational-emotive techniques while ridiculing Carl Rogers's emphasis on the therapeutic relationship, which he considered mostly a waste of time. He told us that therapy should be businesslike, direct, rational, and logical, concentrating on incisive confrontations of irrational beliefs.

When I volunteered to be a "client" for demonstration purposes, I discovered that although I felt better after my therapeutic experience, it was *not,* as Ellis promised, because of his rational-emotive interventions. What

helped me more than anything in dealing with the impending death of my mother was Ellis's caring and warmth. Ellis — a caring and warm clinician? He had always seemed so cold and analytic to me from afar. But even before an audience of hundreds on a stage, I could feel that, for those few minutes, I was the most important person in the world to him. I could feel his support and his acceptance.

Yes, he quibbled about the language I was using to describe my plight. And yes, I did find his different perception of what I was experiencing helpful — but those techniques had a lot less impact than he thought they did. It was because I felt close to him, because I felt he cared about me, that I was motivated to listen to whatever he had to say to me, and I was willing to try thinking differently about my mother's death.

Qualities of Effective Therapeutic Relationships. The therapeutic relationship in rational-emotive, psychoanalytic, behavioral, or humanistic psychotherapy includes many of the same characteristics identified by Rogers (1957) in his influential paper on the subject — that is, a degree of acceptance, respect, and caring. From their review and analysis of the literature related to process variables that operate in therapy, Orlinsky and Howard (1986) further specified the qualities of the therapeutic bond between client and clinician. They found that the relationship is most helpful when it consists of the following: (1) an intense investment of energy by both

client and therapist that is unrelated to any specific techniques or activities employed; (2) a reliance on roles in which the client demonstrates evidence of self-expressive attachment to the therapist and the therapist demonstrates an active collaboration in the process; (3) good personal contact, including a degree of mutual comfort, mutual trust, an absence of defensiveness, spontaneity, and reciprocal understanding; (4) sufficient support and goodwill to permit challenges and confrontation without jeopardizing the stability of the relationship.

Orlinsky and Howard (1986, p. 336) summarize their findings with the observation that the personal chemistry between therapy participants is not unlike the world of molecules — in which some are attracted to one another, some are repel ed, and some form a bond, depending on their properties: "Our conception of the therapeutic bond is intended to be analogous to a chemical bond. Some elements form very strong and stable combinations; others react with explosive energy; others do little more than prevent each other from occupying the same space at the same time."

Moustakas (1986) has described the essence of effective therapeutic relationships as consisting of three facets: Being In, Being For, and Being With. The first process, *Being In,* is synonymous with pure empathy: it is the experience of entering into another's body and mind, knowing and feeling what is going on inside the other. It is being open and responsive to whatever

pours forth from the client, with a complete absence of judgment, evaluation, or analysis. It is the therapist's presence experienced by the client as all-embracing and accepting.

Being For is, on the other hand, not a neutral posture — for the client clearly feels the therapist's presence as an ally and advocate. With this support for him or her as a person, even if not for a particularly dysfunctional aspect of self, the client feels the impetus to pursue the arduous path that lies ahead, knowing there is an experienced guide along for the journey.

Being With encompasses the two previous processes, but involves recognition of the intrinsic separateness between two people. That is, while the therapist can try to understand, to enter the client's world as a companion and promoter, he or she will always retain part of his or her own identity. It is client and therapist fully engaged with one another — sharing and exploring together — but sometimes seeing things quite differently. "Being With certainly means listening and hearing the other's feelings, thoughts, objectives, but it also means offering my own perceptions and views" (Moustakas, 1986, p. 102).

Reciprocal Bonds. In their evolutionary theory of psychotherapy, Glantz and Pearce (1989) have made the compelling argument that the reason why all therapy works is because it satisfies a basic need for human contact and

engagement. We are a species of tribespeople who, for thousands of generations, clung together in bands — roaming the earth, camping out on the plains, living in caves, creating settlements. We are biologically equipped and naturally endowed to function in a world in which each person lives as part of his or her tribe, takes care of everyone else, and is in turn nurtured by all other members of the group.

Psychotherapy was born at precisely the time in human history when our tribes were disbanded, its members scattered across the globe. No longer do most people live where they were born, surrounded by their extended families and those who have been interconnected to their heritage. With these bonds disintegrated, with people separated from their kin, with families and tribes broken up through recent "inventions" of divorce, job relocation, and transportation that makes migration so easy, many, if not most people, hunger for closer affiliations to others.

The basis for all therapy is the establishment of a relationship that satisfies the client's need for nurturance, affiliation, and closeness to another. This is true not only for traditional individual psychotherapy but for the innumerable derivatives that evolved into various support groups. In the United States alone, each week over fifteen million people at end 500,000 different groups for alcoholics, overeaters, sexual addicts, abused children, disease sufferers, single parents, gamblers, women, men, and cross-dressers.

“All of a sudden, people are pouring back into churches and synagogues with a fervor that hasn’t been seen since the ’50s. It appears that a great religious revival is sweeping the land — until you examine the situation a little more closely. Then you’ll notice the biggest crowds today often arrive in midweek. And instead of filing into the pews, these people head for the basement, where they immediately sit down and begin talking about their deepest secrets, darkest fears and strangest cravings” (Leerhsen, 1990, p. 50).

In their essence, all support groups and forms of therapy create a surrogate environment that resembles the nurturing, supportive alliances of our heritage. They satisfy the millions of years of genetic programming that motivates us to survive based on the ability to form reciprocal bonds with others. Born without fangs, claws, or great speed or strength, humans have to rely on their wits and their sense of community. We are thus born with the intense drive to inspire trust and find it in others, even if, now separated from our tribes, we are doomed to frustration.

The great majority of clients, in addition to their presenting complaints, suffer from this need to connect with others. Once the supportive bond has been established between therapist and client, any number of different methodologies that follow are likely to be useful.

Self-Exploration Processes

Catharsis

When Freud and Breuer first collaborated in the 1890s on their new procedure called the *cathartic method,* little did they realize they were onto one of the greatest discoveries ever made about human nature. After Freud relinquished hypnosis in favor of his "talking cure," he learned that by simply allowing people to talk about what is disturbing them, they felt better after releasing repressed psychic energy.

Freud, as a neurologist, was fond of biological metaphors to explain psychological phenomena. Thus the notion of catharsis, or the release of psychic energy, comes from observations related to organic physics. Einstein pointed out that even inorganic matter is a form of radiant energy that is released as heat and light when there are small differences in mass (Zukav, 1979). Translated into human metabolic functioning, this means that the body maintains a precise energy balance. When energy input (food sources) is greater than energy output (exercise), body weight increases. The surplus energy available must be dissipated in some way, even if it is in the production of fat cells. This analogy of dissipating surplus emotional tension is the basis for understanding the cathartic process.

Now, all practitioners today may not agree with Freud's explanation for why catharsis processes work, but they would certainly not dispute the value of allowing clients to relate their stories with all associated pent-up

memories, feelings, dreams, images, and ideas. Regardless of whether a practitioner believes in the existence of the unconscious, the libido, or the mechanisms of repression, there is, nevertheless, a fairly universal endorsement of allowing clients to express themselves freely, to share their feelings about their experiences and perceptions, to blow off steam, as it were. And apart from any other interventions that are employed — that is, despite what is actually done with the material elicited during catharsis — all therapies share the view that it is helpful to facilitate emotional release.

It is therefore a common strategy of most practitioners to encourage clients to tell their stories about how they got them selves into their present predicament. As a primary or secondary component of this process, clients are also stimulated to share their thoughts and feelings about what has occurred. And as a result, several things are likely to happen: (1) they experience emotional arousal, (2) they become aware of thoughts and feelings that were previously buried, (3) they feel better as a result of releasing tension, (4) if they are permit ed to tell their story without detecting critical judgment in the listener, (5) they feel less shame and more self-acceptance about what transpired, and (6) they feel closer to the person they have confided in.

The value of catharsis is one of the few operative variables in therapy on which almost all of us can agree. Some clinicians use catharsis explicitly as the

core of their work, facilitating the revelation of disguised as well as conscious material. Other therapists have enough respect for what this process can do not to interfere with its natural progression in sessions. We all allow our clients to talk, to speak whatever is on their minds without fear of ridicule or condemnation. And we are thus all witnesses to that magical transformation that takes place in which the client, on unburdening himself or herself, walks out of our office with a lighter step.

Consciousness Raising

Prochaska and DiClemente (1984b) identify consciousness raising as the most frequently applied process of change that is used in some form by virtually every therapeutic system. That is, the object of some part of the work is to increase the client's level of awareness about some dimension, whether this is done through feedback, guidance, or education. This information is then internalized and used as an aid in generating insight, facilitating decision making, or initiating action.

One psychologist feels that everything she does with clients — focusing, structuring, interpreting, reflecting, confronting, even establishing a therapeutic relationship — is done primarily to help them expand their relationship with themselves. She describes this phenomenon as it was played out with one client:

Jan was twenty-four when I began working with her two-and-a-half years ago. She sought help for bulimia, which she had since high school, and was then actively engaged in binge-eating and laxative abuse. She also was struggling with male relationships and was attracted to men who would not meet her needs. She had tried to at end college unsuccessfully while working as a physician's assistant. Jan was very frightened but willing to engage in an alliance with me.

In addition to fostering a safe and supportive relationship with Jan, I encouraged her to establish a relationship with *herself.* I did this by assisting her to access her feelings and the well-preserved conflicts underlying her behavior. We spent time exploring the impact of her father's early departure and m other's desperate clinging to Jan and two older sisters. We traveled into her self-image, her sexuality, her "shadow," her spirituality, her experience of self, others, and life. At every step, I remained with her in every sense of the word. As our relationship has evolved, I have also disclosed more of who I am.

Today Jan is free of bulimic symptoms, involved in a warm, loving relationship with a man for over a year, and just enrolled full time at a university to pursue a degree in physical therapy. She attributes her evolving transformation to the journey we embarked upon, a venture that called her to the self she is still becoming.

The language and concepts that are part of this description of consciousness raising are quite alien to the experience of many therapists. Nevertheless, the same notion of introducing clients to ideas that we believe are helpful to them, and increasing their awareness of how they function in the world, is a fairly universal mode of operation. Certainly, not every therapist would agree that raising a client's consciousness or promoting self-discovery are sufficient conditions for change to occur, but there would probably be little argument that it often helps facilitate progress of the action

stages. Clients will feel more motivated to initiate changes in their lives if they understand how and why these changes are helpful and what in themselves is sabotaging their goals. Therefore, all but the most radical of Ericksonian practitioners (who echo Milton's sentiments that insight is distracting and even dangerous) will agree that some degree of self-exploration is generally helpful.

Patterns of Influence

In addition to those aspects of generic therapy that are supportive and largely insight oriented, there are also a number of factors that are designed specifically to influence the client's self-perceptions and behavior. These include such things as impacting the client's expectations for treatment, creating healing rituals designed to heighten constructive beliefs, actively reinforcing self-enhancing actions, and facilitating tasks that are likely to produce desired objectives. Of special significance are those actions the therapist takes to promote greater self-acceptance.

Most therapies teach people to change what they do not like about themselves, and to accept what they are unable or unwilling to change. No matter what the client shares, what he has done, what he thinks or feels, he will still see the same impassive, all-knowing, all-loving face communicating total (or near total) acceptance. To the client who has just revealed he has evil

thoughts, wicked fantasies, or has committed terrible acts, the therapist of almost any theoretical school will nevertheless respond in a calm, carefully neutral manner. The client may expect horror, outrage, scolding, disapproval, and disdain, and indeed it is possible the therapist may be feeling some of this internally, but what will show on the outside is utter serenity. No histrionics. No vomiting in revulsion, as the client may well have expected.

This unconditional acceptance has a profound effect on the client riddled with guilt, shame, and self-loathing: "If this person who seems pretty bright and together doesn't think what I said was a big deal, and believes I am a reasonably nice person, maybe I am all right after all." The experience of feeling accepted by another, no matter what one says or does, leads to being more accepting of oneself.

It is not a deliberate effort on the part of any therapist to initiate a plan of promoting self-acceptance in the client; it is quite simply one of the pleasant side effects that happens during the therapeutic hour. Long ago, we stopped arguing with one another about a few principles that have now become universally practiced. Prominent among these is the notion that it is highly desirable and generally helpful to listen with an open mind, to suspend judgment and criticism, and if not to unconditionally accept *everything* about the client, then at least to accept him or her unconditionally *as a person,* even if we may only conditionally accept certain aspects of the client's behavior.

Placebos and Positive Expectations

The essence of effective therapy is the clinician's unwavering belief in his or her capacity to promote healing and the ability to inspire this faith in others. Frank (1973), Fish (1973), and Pentony (1981) have all advocated that inspired positive expectancies are the primary ingredient in most change processes. To the extent that the therapist can help clients believe they are going to feel better and improve their lives as a result of staying in treatment, the more likely the results are going to be satisfying.

Internists often give relatively inert medications to their patients accompanied by confident predictions of how helpful they will be, and are not the least bit surprised to find that they worked just as they anticipated. Surgeons have also found that their patients tend to do much better if they are convinced the scheduled operation will indeed relieve their suffering. And all professionals realize their effectiveness is based, to a large extent, on their clients' positive expectations and trust in their competence.

A universal aspect of therapeutic practice is the establishment of a setting and aura that fosters belief in the process. All great practitioners exhibit an image of authority, wisdom, and confidence. They have decorated their offices carefully, adorning them with symbols of power (diplomas, licenses, a thronelike chair) and wisdom (books, manuals, file cabinets). They dress the part of the authoritative doctor or informal confidant, depending on

the image that is believed to be most desirable. They appear at ease, comfortable, secure, as if they know exactly what they are doing. They act like they have been doing this for a long time and they are pretty good at it.

And the "it" doesn't matter much. Whether the interventions are medical, systems, or family oriented, or whether they are cognitively, behaviorally, or affectively based — if the therapist believes with all his or her heart they will work, and can convince the client they will work, then there is a great probability they will indeed be helpful.

In a major work summarizing the current research on placebo effects, White (1982) found that regardless of what medical procedure is used — surgery, medication, physical manipulation, or talking — 55 percent of therapeutic effects can be attributable to suggestion. While once the placebo was conceived of as a distraction and nuisance, Wolberg (1986) states that if capitalizing on a person's belief system can have such a profound influence, much of what all professional helpers do is to promote the natural healing of the body and mind. We send inspirational messages by both subtle and direct means — that whatever the client presents is nothing we have not seen before nor anything we cannot deal with. The fact that we are busy signals that others must be getting something from what we are doing. Our dress, style, and trappings all testify that we are qualified experts sanctioned by the state and profession. And perhaps more than any other single thing that we

do that is helpful to clients, is that we believe in them and we believe in ourselves. We believe in the process of therapy. We are in the business of instilling hope.

Uses of Ritual

Every system of change makes use of rituals that are designed to attract and maintain the client's attention as well as to make the healing magic appear more powerful and impressive. Fish (1973) finds these rituals to be the basis for much of the placebo effect that maximizes positive expectations in all therapies. On an even grander scale, Campbell (1972, p. 43) has found that the function of all ritual "is to give form to human life, not in the way of a mere surface arrangement, but in depth." Based on his exhaustive study of mythology throughout the ages, Campbell believes that the use of ritual provides a needed structure to life, a symbol of order that repeats our most instructive themes.

The master of the Japanese tea ceremony uses ritual to perfect the harmony between the natural world and the human art form. Rites of passage for birth, death, marriage, or adolescence serve to ease the transition from one life stage to another. Rituals of religion, fertility, burial, or warfare provide a degree of comfort because of the power they have come to symbolize. The hypnotist uses rituals to induce an altered state of

consciousness that is more susceptible to influence and change. The behavioral therapist also uses certain operant rituals to reinforce target behaviors. The technique of systematic desensitization, for example, is an organized ritual in which clients list their greatest fears, organize them in a hierarchy, and then face them one at a time after undergoing other rituals of deep breathing and relaxation training to induce an altered state.

There are rituals we use with every client to help them make the transition from the outside world to the unique rules of interaction that operate inside our office. For instance, we begin most sessions with certain inviolate rituals: the greeting at the door, the walk down the corridor, the selection of seats, the invitation to begin. Similarly, there are rituals that guide the ways we close our sessions, as well as those that facilitate transitions from one subject to the next, or from one mode of operation to the next.

Moustakas (1981, p. 24) describes the uses of rituals in his work with children. In one case, he was especially struck by the power of ritual as a way to make contact with an uncommunicative child:

> One of the most magnificent experiences I have ever had in therapy was with Barbara, diagnosed as schizophrenic. Since early childhood she had been humiliated, taunted, and called hunchback because of severe spinal curvature. My usual ways of beginning therapy were ineffective. She sat quietly, silently, numb to nearly all of my interventions. One day she arrived looking weary and unhappy. She asked for a cup of tea. From this simple request a process of therapy was initiated which resembled a Japanese tea ceremony — a series of rituals each containing a special and

> unique meaning, beginning with the quiet preparations and culminating in the slow, savoring drinking of the tea. At these times, when Barbara spoke, her words were not edgy or agitated. She communicated different aspects of her life and described her relations with the people she encountered during the week. On the whole she lived as a recluse, and rarely left her home. Our weekly meetings became the pivotal point of her life. In mysterious ways our rituals awakened her and she began having regular contacts with others in her neighborhood.

Therapeutic rituals are designed, through their elegance and symbolism and power, to facilitate an altered state of consciousness that helps the client to remain more receptive to the therapist's influence. The most basic of interventions involves simply persuading the client she or he really has no problem. When this strategy is embedded in ritualistic patterns, such as adopting an authoritative manner and tone of voice the client has come to associate with wisdom and expertise, influential effects are multiplied.

A twenty-year-old man arrives at the office obviously distraught and embarrassed. He eventually sputters out that he believes he may be gay, and since this realization, has been seriously considering suicide. When pressed as to how he arrived at this conclusion, he told a story of having spent the night with his girlfriend for the first time. Since both of them were virgins, they consumed quite a bit of wine to appease their mutual apprehension. When it came time to consummate the act, the young man discovered to his horror that he was unable to maintain an erection. His girlfriend, who was also quite inexperienced and insecure regarding her sexuality, became

terribly frustrated and went into a rage, accusing him of being a homosexual. On three subsequent occasions he was also unable to become physically aroused.

The healing ritual became a simple matter of explaining that alcohol inhibits sexual responsiveness and that failing to get an erection occasionally was quite normal. He was then reassured the problem would go away on its own if he would just relax — which *it* did, after *he* did.

For this, or any intervention, to have much effect, it must be couched within the context of the therapist's rituals. In the
previous example, the simple information and reassurance became immediately helpful because of the therapist's ability to create rituals that inspire trust and confidence so that the client would allow himself to be influenced by what he heard.

Learning Principles

All psychotherapy is an educational process that facilitates learning about self and others. Consistent with such models, therapy follows certain sound principles that operate consistently. Learning can be defined as any relatively enduring change in behavior that is not due to instinctual drives, natural growth and development, or temporary states induced by drugs or fatigue (Hilgard and Bower, 1975).

Reinforcement. If reinforcement is more broadly defined as support for some ideas and behaviors as preferable to others, then it is clearly a mechanism that is part of all therapeutic endeavors. The behavior therapist has in mind quite another idea, seeing reinforcement as the application of token economies, contingency contracting, punishment, or variable interval schedules to increase or decrease the frequency of target behaviors. However, Garfield (1980, p. 107) makes the interesting point that "the therapist tends to positively reinforce those responses on the part of the patient which he views as desirable, and to not actively reinforce or extinguish those responses which he deems to be undesirable in terms of therapeutic goals."

This concept is easily observed in the phenomenon that Freudian clients dream in Freudian symbols, Jungian clients dream in Jungian symbols, and behavioral clients report that their dreams do not have much significance at all. In another context, it may be readily observed that the client-centered therapist becomes more responsive (and therefore reinforcing) when clients share authentic feelings, the rational-emotive therapist deliberately and inadvertently reinforces the use of certain phrases and concepts, the psychoanalytic therapist gives selective attention to processes that are believed to be most significant, and so on. In short, when we like what clients are doing or saying, we let them know it. All "unconditional positive regard" means is that we should avoid the use of punishment when clients say things we do not want to hear.

Truax (1966) discovered, after analyzing Carl Rogers's behavior during interviews, that he was definitely more reinforcing of some client behaviors than other. Through the use of verbal acknowledgments and head nods, Rogers was quite effective in shaping the style in which the clients communicated, and even the content they focused on. This is true of all other therapies as well : we tend to reinforce clients, nonverbally and verbally, unconsciously and directly, when they use the concepts we have introduced, or act in ways we believe are more fully functioning than their previous maladaptive patterns.

Habituated Responses. In Seligman's (1975) model of learned helplessness or Dollard and Miller's (1950) notions of acquired neuroses, the assumption is made that clients have learned to be dysfunctional, and so it is possible to break these bad habits by learning alternative ways to think, feel, or act. Most therapies make use of the idea that fears, anxieties, and other symptomatic behaviors are adaptive in the sense that they are learned patterns of coping that have certain undesirable side effects (such as the present discomfort). It is usually proposed in some way that it is possible to act differently and to learn alternative responses that are more self-enhancing.

Acquiring New Information. Learning involves the input of new information that is useful to the organism. A component of each therapy

system involves providing such knowledge when it is needed. This can take the form of providing general information about human nature (explaining a normal developmental stage of growth), about the process of psychotherapy (explaining the concepts of resistance or transference), about concepts relevant to the client's presenting complaint (telling a metaphorical tale), or other functions that are situation specific (offering guidance about where other information may be found). There is a part of every therapist's role in which he or she becomes a source of knowledge and information.

Transfer of Learning. Behavior becomes maladaptive when people attempt to generalize their actions from those few instances when it is functional to many other places where it is not. The client who is highly intellectual and analytic, who finds these talents useful to him in the financial arena, encounters only frustration when he tries to apply these skills in arguments with his wife when she does not feel acknowledged and heard. Much of marital therapy is necessarily pragmatic, because in order to break long-standing patterns of interaction, participants are encouraged to transfer their learning from sessions to their lives at home. This is also true for all helping approaches in which clinicians urge their clients to apply each week what they have learned in their therapeutic encounters.

Rehearsal. Most therapies contain some segment of rehearsal, in which clients are encouraged to practice new ways of thinking, talking, feeling,

acting. They then receive some degree of feedback from their therapist that is likely to be helpful when they attempt to apply what they have learned to the outside world. This is not only true in the behavior therapies, but also in those that are exclusively insight oriented. Clients practice, at first tentatively, concepts and ideas they have recently understood to see if they are indeed valid. They may have just heard they are perceived as timid and so try to act more assertively in sessions. They have just examined an aspect of how they relate to authority figures (including the therapist) based on how they were treated by parents. They begin experimenting with more mature, less deferential communication styles. If they like the results they get while rehearsing with their therapist, they will hopefully apply what they have learned to other relationships.

Discrimination Training. Clients are often helped to distinguish between those behaviors that are helpful in one setting or situation, such as the world of commerce, but not necessarily in another, such as the world of love relationships. As part of the introspective process most therapies offer, some work is devoted to heightening awarenesses of when and how certain patterns operate. Clients are thus taught to discriminate between: (1) things they have done, thought, or felt in the past and things they are experiencing in the present; (2) aspects of themselves that are self-defeating versus those that are self-enhancing; and (3) specific instances in which certain strategies are most likely to be useful.

Task Facilitation Apart from the learning principles just mentioned, there are also many tasks that are usually completed in order for lasting change to occur (Rice and Saperia, 1984). The therapist's job is to aid the client along this path — by offering guidance, support, and direction when and where they are needed. Some of the tasks that are completed as part of the therapeutic process are illustrated in the following case.

Andrew, at age thirty-nine, has been in therapy most of his life. Although extremely bright, attractive, and personable, he feels stuck and hopeless. He lives with his m other, who has enmeshed him in a web of dependence he has never been able to work his way out of—even with the assistance of a half-dozen different helpers in the last decade alone. His mother, too, has been in therapy for quite some time. In fact, at one point, Andrew confided with a snicker, his mother was seeing three different therapists each week without any of them knowing about the others' existence. "If my mother has all those therapists bamboozled, how am I ever going to escape her clutches?"

Each time Andrew would enroll in graduate school (he had tried law school, medical school, and two chemistry programs) or began a new job (numbering in the dozens), his mother would sabotage his efforts by bribing him to come home. By now, he was more than depressed; he was thoroughly *beaten* — without any hope for the future.

His many therapists had attempted a number of reasonable approaches over the years — and he had tremendous insight into his mother's parasitic behavior as well as his own passive-dependent tendencies. He could spout the jargon of psychodynamics, existential philosophy, and a few other systems so well that it
took me a few weeks before I became convinced he was not a therapist himself (sent as a spy, I thought in a moment of paranoia, by some professional board to test my competence).

Here was a case when insight alone had not done the trick. Clearly, some sort of structure was needed to help him regain his confidence and hope by making steady progress toward some ultimate goal.

We started small. Very, very small. Since his dependency was maintained by the complete financial support he was receiving from his mother (each Monday morning he would find an envelope in the bathroom loaded with crisp bills), he began to withdraw a token amount to return to his mother with the cryptic note: "I don't need this much." Eventually, he was able to gradually increase the amount he returned, infinitesimally lessening his dependence.

We worked on task facilitation in a number of other areas as well. Since he was not at all ready to stick with a regular job, he served in a volunteer

capacity that required a one-year commitment in writing. He contracted to at end a lecture series, moved on to taking a noncredit class, and finally actually began a graduate program. And all of this he kept a secret from his mother. By the time she did realize how independent he was becoming, he felt strong enough to neutralize her attempts (which by now he could easily identify as such) to sabotage him.

It is not usually my way to work in such a structured, task-oriented style. In Andrew's case, however, structure was *exactly* what he needed to improve his morale and sense of accomplishment.

There are other, more subtle tasks that are also included in most therapeutic processes — requesting clients to give vivid and complete descriptions of their problems, including antecedent events; asking clients to make connections between present concerns and associations with other life themes; and most important, helping clients to take risks by experimenting with new ways of thinking, feeling, and behaving. In fact, most therapies concentrate on creating a climate that is safe and secure enough for clients to experiment with alternative ways of functioning. Once freed of the fear of judgment and ridicule, once involved in a relationship with someone who is supportive, nurturing, and accepting, it feels safe to try doing things that may be awkward.

Therapy, almost by definition, implies the release of patterns that have been maladaptive in place of others that may be more fully functioning. The client initially enters treatment tentative, insecure, vulnerable, hesitant to take risks or try something new. Therapy often represents a last-ditch effort to get help when all else has failed. Like a battered child, the client flinches at the prospect of opening himself or herself up to more hurt, pain, and rejection. Only slowly, with the therapist encouraging and gently prodding, does the client start daring to be different. One step forward. And then wait to see what disaster lurks ahead. All seems clear. Another baby step. Still another. Until, finally, the client can walk, even run, without the need for further support.

More specifically, therapists are interested in helping clients to experiment with the following:

- When confronted with situations that you would usually avoid, face them with courage, and apply what we have been practicing together.

- When you catch yourself feeling self-inflicted misery, rather than wall owing in your suffering, *do* something to change the way you are reacting to what is happening around you.

- Whereas normally you would let this person or situation get to you, try something different, *anything* other than the way you typically react.

- Previously, you have viewed the events of your personal history as having limited you in the options you have for the future; the next time you will remind yourself there are other ways you can think about what you lived through, and thus other ways you can choose to act in the future.

- Ask yourself what you have been most strongly avoiding in your life — which conflict, confrontation, or unresolved issue — and force yourself to deal with it.

- You have been reluctant all your life to try anything that you cannot be perfect at, and so you have missed out on a lot of opportunities you could have enjoyed or profited from. You will look for situations you can jump into, knowing you will feel inept in the beginning, but realizing that even if you do not live up to your expectations, you can still learn a lot.

We could, perhaps, list a hundred other injunctions by therapists that encourage greater risk taking and experimentation on the part of their clients. The objective of these efforts is to help people to stop doing things that they know will never work, when they feel too powerless or frightened to consider other options. We are all attempting to shake things up a bit.

Demolition Stage

After the Apollo astronauts had tried everything in their power to fix a million-dollar Hasselblad camera on the blink, an expert at Mission Control in

Houston yelled out in exasperation to the ship circling the globe: “Kick the damn thing!” Which they did. And it promptly began to function. As therapists, we are also trying to help the client by “kicking the camera,” that is, by shaking things up a bit so that things will fall together differently than they were before. We do this with every probing question we ask, every interpretation or confrontation we make. We are pushing the client to consider other alternatives, to expand the boundaries of what was considered possible.

Most therapies do, in fact, have what Schein (1973) call ed a “demolition stage,” in which the client is first confronted with the fact that current life behaviors are not working very well. Clients begin to feel more and more confused and dissatisfied with present levels of functioning. They become more vulnerable in the therapy and are deliberately encouraged to do so. Dysfunctional character defenses are demolished through the persistent exploration by the therapist of the client’s resistance, reluctance, passivity, and self-defeating behaviors.

When the demolition stage has been completed, the client truly believes, as he or she surveys the rubble around him, that it is futile to continue the previous course of action. The client may as well try something else.

Pentony (1981) believes that this demolition stage common to most

therapies is necessary to prepare someone for lasting change. Once clients are at the point where they have given up previously maladaptive patterns that they now believe are useless, they are ripe for considering alternatives that include new perceptions of reality, new strategies for coping, new ways of thinking and interpreting one's life situation and what one can do about it.

How to Operationalize Commonalities in Clinical Practice

It is one thing to believe that there are certain variables and processes common to most therapeutic approaches; it is quite another, however, to apply these understandings to clinical practice. Let us assume, for example, that many of the elements mentioned in this chapter — notably the therapeutic relationship, the placebo effect, catharsis, and various learning principles — are in fact part of most helping systems. Further, let us assume that these variables are supported empirically by a number of studies attesting to their influence in promoting significant and lasting client changes. Operating pragmatically, then, what use is this knowledge for the practitioner?

Perhaps the greatest significance is that it helps us to focus our attention more clearly on which curative elements are most powerful, while filtering out those extraneous factors that are somewhat less important. Though only a casual football spectator, I heard a television commentator

explain the dramatic improvement of a young quarterback's performance. Not unlike the work of a therapist in action, the quarterback must attend to a thousand different variables allay once — the positions of both his and opposing players, the time left on the clock, the wind direction, the playing surface, the history of what the teams have done before, what the opposition might be planning, what his own capabilities are, contingency plans, and so on. In addition, he has to memorize several hundred plays, or possible scenarios.

The commentator explained that once the coach decided to simplify the playbook to less than a dozen options, the quarterback was able to relax more and concentrate instead on how he could improvise variations of these few plays according to his reading of the everchanging situations. I felt immense relief when I heard this explanation. It made instant sense to me that in my own work in therapy, I often feel overwhelmed by the number of "plays" that are available to me at any moment in time. I sometimes spend so much time analyzing the situation, sorting through options, and trying to remember what I am supposed to do in this situation that I miss a lot of what is going on. Like the quarterback with an overly complex playbook, I am so concerned with selecting the "right" choice that I am frozen into inaction.

I am then reminded of this metaphor: there are not really a thousand different plays, only a few good ones that go by different names. And I begin

to ask myself silently: “What is it that *really* matters? Being with the client, listening hard. Being myself, as much as I can, without meeting my own needs. Letting the client know how I am processing what is happening. Reading accurately how the client is responding to my interventions. Just let the client be and do what he or she feels is right. Set limits when appropriate. Reinforce healthy behavior. Be supportive. Again. Be *really* supportive. Let him or her know how much I care.”

With fewer but more consistent and potent “plays” at our disposal, therapy is more focused. Just as the young quarterback becomes seasoned and slowly adds more variations on the few themes he has mastered, so too can we expand our options. This quality — the ability to reduce complex situations to their essences — is only one of the many traits that are consistently found in the “compleat” therapist.

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