

THE TECHNIQUE OF PSYCHOTHERAPY

GENERAL PRINCIPLES OF PSYCHOTHERAPY

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General Principles of Psychotherapy

No single mechanism or theory can explain what happens in successful therapy. A variety of factors, specific and non-specific, are coordinately operative. Some theorists believe that therapy essentially is a relearning process where old destructive patterns become extinguished and new constructive behavior learned through conditioning tactics and sustained by reinforcement. There are others who avow that psychotherapy is effective because it supplies the patient with a second chance for personality development, but this time with an empathetic surrogate parent who makes up for the deficits of the original developmental period. To some, psychotherapy provides a corrective emotional experience within the matrix of a good therapeutic interpersonal relationship, which is more or less actively manipulated to avoid the mistakes of the past. To some, the seeds of change are latent within each individual requiring a mere accepting, warm, nonjudgmental relationship to sprout into blossoms of maturity. There are many other theories of why psychotherapy works, probably because so many different factors account for change in different patients. Actually theorists, espousing a special point of view, appear to select a single item out of a field of multiple responsible agencies, all of which are undoubtedly operative at one time or another.

When we try to examine the processes of change in therapy, we find that they contain many hypothetical assumptions that are difficult to subject to experimental validation. This is largely because the therapeutic interpersonal relationship on which psychotherapy is based embraces sundry variables that do not readily lend themselves to measurement. It is consequently difficult to apply to an evaluative study of psychotherapy the precise principles on which scientific method is based—namely, an unprejudiced compilation of facts and information, the formulation of reasonable hypotheses, the retention of objectivity in observation, and the retesting of findings with an attempt to reduplicate results. For the most part, descriptions of psychotherapeutic technique reflect the personal values and convictions of the observer. The clinical attitudes expressed are more pragmatic and empiric than they are scientific.

It is perhaps for these reasons that psychotherapy has been regarded by many as an art rather than

a science. One may justifiably consider the ability to establish and maintain a relationship with a patient a form of artistry, since it is dependent on certain personality factors with which some therapists are more highly endowed than others. Yet conceding that psychotherapy, at our present state of knowledge, is less a science than an art, certain basic principles must apply as in any other art of which an understanding is crucial to its effective practice. Without a disciplined application of these principles no amount of artistic endowment can inspire good psychotherapy.

Another factor that makes a study of any psychotherapeutic method baffling is the confusion of broad basic techniques with the unique personal ways in which they are implemented. In psychotherapy, as in any other art or partial art, we are confronted with the phenomenon of a highly personalized style that is employed in the medium of a particular method.

An analogy may illustrate this point. Students learning to paint will be aided greatly by studying fundamental techniques of painting and general principles of composition. They will also derive much in observing the methods of painters who have achieved proficiency in their work. Their art instructors will help them to master blocks and ineptitudes in putting fundamental techniques into practice. As they gain confidence in themselves, their training will blend with individual personality assets, such as creativity, sensitivity, and originality, and, out of this amalgam, they will develop their own styles of painting—a preferential mode of symbolic representation and a unique use of color and texture. They will still operate within the broad framework of the fundamental techniques, but their finished products will be their own, different from those of their teachers and colleagues who have been exposed to the same kind of instruction.

In psychotherapy, students will be helped also by studying general principles and techniques—such as the conduct of an initial interview, the establishment of a working relationship with the patient, the determination of the dynamics of a neurosis, the promotion of activity toward therapeutic change, and the termination of therapy. They will be benefited by observing how trained psychotherapists execute these procedures. Like the artist, they will need to function under supervision, in this way becoming aware of their deficiencies that interfere with the putting into practice of what they have learned. As their experience grows, they will fuse the supervisor's method with their own working mode, introducing new elements and modifying others, until they develop their own style of therapy. They will

still follow the broad principles of technique, but in a manner that is uniquely their own.

A broad structure of therapy must take into account this factor of spontaneity of style in the psychotherapist. For without spontaneity, therapists are truly handicapped in relating to their patients and in allowing their intuition to help them grasp the dynamic forces that are operative during the treatment process.

DYNAMICS OF THERAPEUTIC CHANGE

Before describing a structure of psychotherapy that provides for this kind of flexible framework, it may be helpful to consider the dynamics of psychotherapy in terms of an example of what happens to the typical individual who is exposed to a reconstructive psychotherapeutic approach. Modifications consonant with reeducative and supportive therapies will be considered later.

When average patients enter into therapy, they are usually bewildered, confused, and upset by what is happening to them. Their symptoms seem more or less dissociated from the matrix of their life. Consequently, they are confounded by attempts to investigate in detail aspects of their experience that they consider irrelevant to their complaint factor. Not realizing that their symptoms stem from deep problems of long standing that are presently being reflected in disturbances in relationships with people, patients expect rapid results. In this respect they are rather like the obese patients who want the physician to remove, in 2 weeks, the excess weight that has taken 10 years to accumulate, while at the same time refusing to exercise or diet. Patients seek to retain fixed ways of dealing with people and situations, which provoke and exaggerate their symptoms, while demanding that the products of their disturbed way of living be quickly extirpated.

With this in mind, patients desire to relate to the therapist in the traditional way that patients utilize physicians. Patients demand some kind of immediate dramatic help or, in their helplessness, the performance of a miracle by means of a mysterious nostrum or formula. Patients hopefully conceive of the therapist as an omniscient authority who will palliate their suffering and expeditiously lead them to health and personal success. The sicker the patients the more likely they are to consider therapy a conjuring trick. Operative almost from the start are intercurrent forces of the placebo element, emotional

catharsis, and suggestion that may serve to bring the patients to temporary homeostasis. These subsidies, however, are generally short-lived, and more substantial therapeutic interventions will be needed to control the continuing symptoms.

It may require a great deal of perseverance on the part of the therapist to demonstrate to patients that their symptoms do not occur at random but are exacerbated by definite life situations that involve their attitudes toward people and their estimate of themselves. Before progress can be made, however, it will be necessary to achieve the realization that symptoms are not independent manifestations; rather they are representations of problems of which there is only partially awareness. Once patients accept the idea of continuity between their symptoms and certain other problems within themselves, they are more capable of abandoning hopes for immediate symptom relief by some spectacular performance on the part of the therapist. Motivated by the discomfort of their symptoms and the desire for more fulfilling lives, they will enter into deeper inquiries into themselves and the multiple forces impinging on them from the outside.

Soon the patients will comprehend that symptoms fluctuate, often depending on some happenings of daily life and on certain difficulties encountered in interpersonal relations. Awareness of these facts will tend to divert the emphasis from their immediate complaints. As soon as this occurs, the first basic step in therapy will have been taken.

To bring patients to such an understanding, however, may prove to be more than an ambitious undertaking. The patients are habituated to themselves, their character traits and attitudes. These are so "ego-syntonic" that the patients can only perceive them as an incontrovertible everyday component of life. The possibility that their behaviors are abnormal may not only be unacceptable but also unbelievable. Nearly all neurotic people assume that their own particular pattern for living is average, if not universal. If they do recognize themselves as variant, then that in itself is regarded as a special attribute, contingent upon the possession of a unique constitution and the existence of external conditions that offer them no other course than the one they are pursuing.

It is this attitude that makes for obstinate resistance to change. The patient cannot readily be persuaded to see that he or she projects attitudes and fears without actual basis. In the course of therapy,

however, the patients may gain an understanding that what they once assumed to be normal may actually be unusual. Clues to their fundamental difficulties will be pieced together for them by the therapist. The unique relationship that has developed between the patients and the therapist will help them to accept interpretations of their behavior and their symbolic life as revealed in their verbalizations, dreams, and fantasies.

No better way exists of bringing patients to an awareness of their problems than by actually living them through in the therapeutic situation. Sometimes patients will develop and show the same kinds of unreasonable impulses toward the psychotherapist that they have displayed in important previous relationships. The long period of conditioning that makes the individual's patternings a part of the self inspires continuing repetitive and compulsive responses. The patient is usually unaware of reasons for his or her irrational responses, such as development of attitudes of an unusual or destructive nature toward the therapist that cannot be suppressed. The therapist here becomes the target of the patient's neurotic projections. Patients may, for instance, submit themselves, render themselves defenseless, or become martyrs. They may struggle with a need to be victimized so that they can criticize the therapist. They may identify with the therapist, or tear the latter down in fantasy, verbally, or by aggressive acts. They may strive to cash in on submissiveness by toadying to the therapist while at the same time burning inwardly with indignation. They may be paralyzed in relationships and take a thousand precautions before expressing themselves, so as not to offend. They may compete with the therapist and try to outshine him or her. They may strive to crush whatever atom of individuality persists, if they believe the therapist will be good to them and protect them. They may resent intrusion into their private fantasies and express disguised or open hostility. These and countless other attitudes may unfold as the therapeutic process proceeds.

Such behaviors are important clues to underlying impulses and strivings, which when provisionally interpreted provide a good chance to examine pivotal problems while reexperiencing them. This potentially enables the working through of the dynamics of one's reaction patterns in the relationship with the therapist. Under these circumstances the various defense reactions and resistances, which are directed against inner fears and strivings, become apparent to patients, not as theories but as real experiences, and they are gradually enabled to gain insight into their inner impulses and motivations—the source of some disturbing symptoms.

Identifying significant patterns may greatly surprise the patient and may be countered with resistance, for basic adaptational patterns are being challenged which, though unsatisfying and productive of anxiety, constitute for the patient the only known way of life. Moreover, there are many hidden spurious gains and benefits that patients derive from their neuroses that they will refuse to forfeit. Debilitating as some symptoms may be, many of them serve a protective purpose in the psychic economy. To give them up threatens exposure to inconveniences far greater than anything that the patients already suffer. They will, therefore, in an exasperating way, tend to obstruct their own progress.

The exact form of resistances will depend to a large degree on the kinds of defenses that patients customarily employ to avert danger. They may feel helpless, or hopeless, or hostile or they may get discouraged, inhibited, fatigued, or listless. They may succumb to irritability or to contempt for the therapist, or they may develop feelings of being misunderstood. Some patients may become forgetful and fail to show up for appointments, or they may manifest depression and complain incessantly about their health, presenting a vast assortment of physical symptoms. They may express suspicions regarding the therapist's intentions or training or political convictions as a possible justification for halting therapy, or they may try to disarm the therapist with strong professions of praise or devotion. They may even evince a forced and artificial "flight into health."

Thus it seems that patients do not entirely want to get well. What they want is a magic recipe from the therapist whereby they may retain their neurosis but be stripped of any suffering. They want to be dependent, yet secure and strong within themselves, or they wish to detach themselves, to keep their freedom, yet at the same time to form successful and gratifying relationships with people. They will resent the attempt to change their way of life significantly, and, in order to hinder the therapist, they will continue to erect impediments to the treatment process.

Counterbalancing resistance, however, are the values that patients inject into the therapeutic relationship and the respect that they have for the therapist's opinions and judgments. A powerful ally is also operative in the spontaneous urge that exists in all persons for health, development, and creative self-fulfillment. Utilizing whatever opportunities that present themselves, the therapist attempts to dissipate resistances by constantly interpreting them to patients in relation to their content, their manifestations, and their function. The exposure of the therapist's defensive operations leads patients to

a gradual understanding of their conflicts and character drives and of the vicarious satisfactions derived from them. In this way patients learn to comprehend many perverse gratifications, to countenance unconscious fears, and to master the anxieties that prompt neurotic coping mechanisms.

Realization that a bulk of their responses are not justified by present-day reality, but are residual in past conditionings, is an important step in getting well. Nurtured is a desire to explore more thoroughly the meaning and origin of various drives and attitudes. Most patients have a long past history that goes back to crucial formative experiences in early life in relation to important intimate figures, particularly parents and siblings. Traumatic conditions centered around feeding, toilet training, sexual curiosities, desires for approval and status, and other important biologic and social needs are often discovered as the sponsoring agencies of current defenses. In properly conducted psychotherapy awareness dawns that attitudes toward the world are built up from early experiences with the world. Such needs as sexuality and assertiveness have become, as a consequence, inhibited or distorted in expression. Impulses such as anger cannot gain an acceptable adaptive outlet. Patients learn that they carry within themselves expectations of the same kind of frustration and injury that they experienced in early years. Some present-day patterns are understandable in the light of anachronistic expectations. The patients may be able to remember or to reconstruct the situations in early childhood that are at the basis of their expectations.

Sometimes patients will repeat, in their relationship with the therapist, their most traumatic early experiences and perhaps revivify archaic attitudes and feelings that were originally engendered in their dealings with parental or sibling figures. Such transference manifestations usually reflect circumstances that patients failed to master as children, which were responsible for deep anxieties and deviations in character formation. Because the relationship with the therapist is unique in its protectiveness, fearsome past happenings, once too great for immature adaptive capacities, may now be reanimated and faced again with not too shattering anxiety.

Each successful effort, though minor, will both punctuate the handicapping influence of neurotic defenses and inspire a wish to meet life on new terms. The crippling anxieties that conditioned former reaction patterns are in this way progressively mastered. When at last patients are able to liberate themselves from ghosts of the past, the world becomes a bastion of hope: feelings of security expand;

interpersonal relationships become freer, unhampered by dependency, aggression, or detachment. Basic needs and demands are emancipated from anxieties that impede their materialization.

Roughly, reconstructive therapy may be divided into two phases. The first aspect involves an *uncovering process*, during which patients become aware of impulses, fears, attitudes, and memories that have interfered with wholesome relationships with the world and people. The second aspect is *reeducative* and consists of an elaboration of new and adaptive interpersonal patterns. Social reintegration does not occur automatically. It is a slow reconditioning process, necessitating the establishing of fresh habit and reaction patterns to displace outmoded destructive ones.

The uncovering period of treatment proceeds as rapidly as the individual is capable of tolerating anxiety. This makes possible the gradual yielding of repressions. During therapy ego strength increases as the positive relationship with the therapist consolidates. But the patient constantly strives to ward off a close relationship out of fear of arousal of strivings hitherto kept in suspension and out of awareness. The patient displays resistances to the therapist as a defense against what he or she believes will lead to liberation of intolerable anarchial impulses. These impediments must be dealt with firmly and constantly before the patient begins to appreciate that he or she can handle conflicting feelings and attitudes.

The reeducative phase of therapy is usually even more prolonged than the uncovering phase. Established patterns of behavior are changed with great reluctance— the revelation of the unconscious conflicts that initiated them is only the first step in this change. Patients fight desperately to hang on to habitual values. They continue to show resistance even when they have become aware of the extent to which they are at the mercy of disabling inner fears and strivings. They continue to reject insight as an alien force, although it finally comes into its own as they gain glimmers of understanding of their repudiated drives. Intellectual insight alone, however, does not divert them from their customary reactions. It does permit them to gain a foothold on new interpersonal pathways. This support is, however, tenuous, and they retreat constantly before the onslaught of their neurotic demands, which, though known to them, continue to persist with dauntless vigor.

Slowly, against great resistance, alterations occur in patients' behavior. It becomes less and less motivated by irrational needs and increasingly relegated to fulfillment in mere fantasy. Yet, though

blatant neurotic patterns vanish, shadows of them persist and come to life sporadically. It is as if the balance of power keeps shifting from old established ways to the as yet rudimentary new.

A further development in the maturative process is inherent in the recognition of the incongruity of customary defenses and drives. Patients slowly come to regard them as irrational elements that they would like to eliminate from their lives. A battle then ensues between their desire for change and the urgent forces that compel them to resume their old neurotic actions. After a period of strife, more or less prolonged, a remarkable change occurs in the inner dynamics of the personality. Habitual impulses, which have functioned compulsively or which have been accepted as an inevitable part of life, are alienated from the ego. Even though these continue to emerge, the individual responds to them with more and more reluctance, refusing them their original hold. Coordinately there is a reorganization of interpersonal relationships and a more realistic reintegration between the self and its past experiences. Signs of abandonment of compulsive patterns are registered in a sense of inner peace, happiness, security, and absence of neurotic suffering. These positive gains serve as resistance barriers to old neurotic attitudes when the latter try to force individuals into their previous modes.

With expanding emancipation from their past, patients become more self-confident, assertive, and expressive. They accept as their right the making of salutary choices and decisions and the establishment of new values. As the ego of patients expands, the superego loses its force and tyranny. Patients appreciate joy in living and the experiencing of fruitful productivity. Finally, they no longer require help from the therapist, and the world itself becomes an arena for gratification of fundamental needs, which, prior to therapy, they felt to be utterly beyond their reach.

MECHANICS OF THERAPEUTIC CHANGE

Therapeutic change is brought about in the medium of the patient-therapist relationship. Through verbalization patients become aware of the forces within themselves that produce their symptoms and interfere with a successful adaptation. On the basis of this understanding they then proceed to 7. challenge those designs that interfere with their adjustment and to substitute for them mature patterns that will gratify basic biologic and social needs. As they abandon archaic fears and liberate themselves from paralyzing past forces, they achieve a progressive mastery of their environment, the ability to relate

better with people, and the capacity to express their impulses in a culturally accepted manner. The function of the therapist during this evolution is as an agent who catalyzes change, helping patients to resolve resistances to maturity.

Breaking a successful treatment process down into component parts, the following sequences are usually encountered:

1. The patients, concerned with their symptoms and complaints, elaborate on these.
2. The patients discuss upsetting feelings that are usually associated with their symptoms.
3. Patients believe that their feelings are related to certain dissatisfactions with their environment and that they are inescapably controlled by a mysterious turmoil that ranges within them.
4. Along with their feelings, they recognize patterns of behavior that frustrate them, are repetitive, and compulsive. Soon they appreciate that some of these patterns are responsible for their tension. This causes them to doubt their value.
5. As they become aware of how dissatisfied they are with their behavior, they begin to try to stop it; yet they find that it persists in spite of themselves.
6. Patients slowly perceive, then, that their behavior serves a function of some sort and that they cannot give it up easily. Indeed, they find that their patterns repeat themselves in various settings, perhaps even with the therapist.
7. If they have the incentive to explore their operations, they discover that some have a long history, going as far back as their early relationships with their parents, siblings, and other significant personages.
8. Gradually they discern that they are influenced by occasional impulses and feelings akin to those present in them as children. They fathom that by carrying over certain attitudes into their present life they are reacting to people as facsimiles of past authorities.
9. With great trepidation patients begin to challenge their early attitudes; progressively they inhibit automatic and repetitive behavior patterns, slowly mastering their anxieties as they realize that fantasied dangers and expectations of injury do not come to pass. In the therapeutic relationship, particularly, they show change, especially in their attitudes toward the therapist.

10. Patients begin to entertain hopes that they are not the weak and contemptible people who have constituted their inner self-image, that they actually have stature and integrity, that they need not be frustrated in the expression of important needs, and that they can relate themselves productively to people.
11. This causes them to resent all the more the devices that they customarily employ, which are products of devaluated feelings toward themselves and their devastating fears of their environment.
12. Slowly patients experiment with new forms of behavior that are motivated by a different conception of themselves as people.
13. Finding fulfillment in these improvisations, patients become more and more capable of liberating themselves from old goals and styles of action.
14. Growing strength within themselves contributes to a sense of mastery and produces healthy changes in their feelings of security, self-esteem, and their attitudes toward others.
15. Patients liberate themselves more and more from anxieties related to past experiences and misconceptions. They approach life as a biologic being, capable of gaining satisfactions for their inner impulses and demands, and as a social being, participating in community living and contributing to the group welfare.