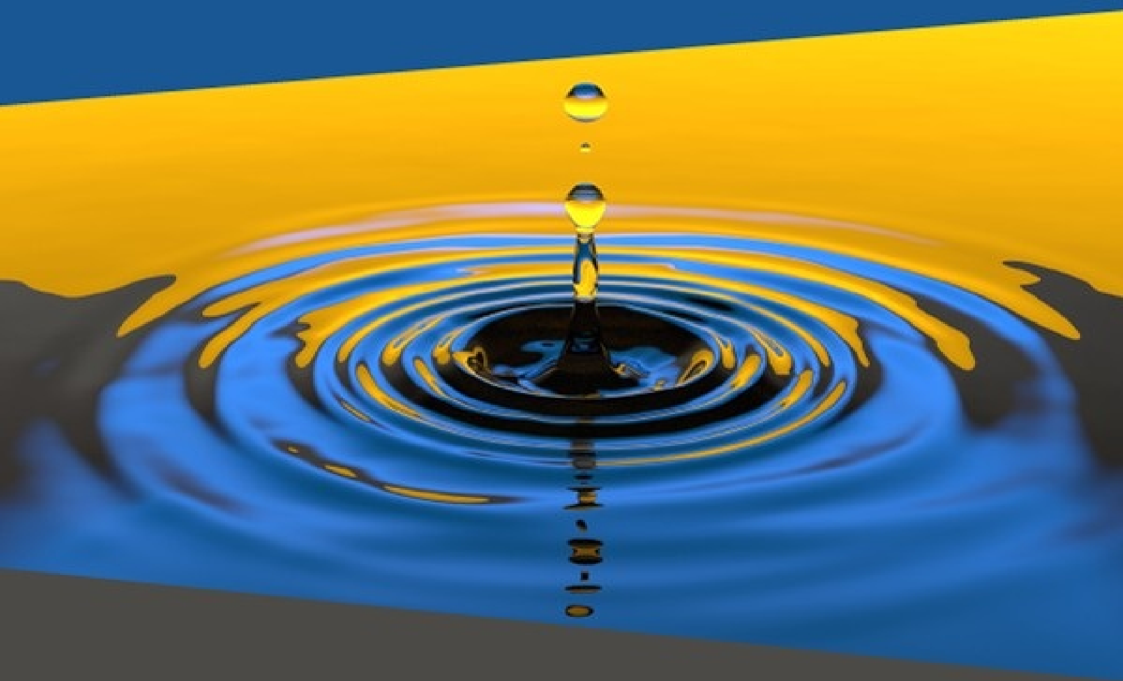
General Principles of Psychotherapy



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General Principles of Psychotherapy

> The therapist's ultimate commitment to the welfare of his patient governs and directs his therapeutic interventions toward what he understands to be ultimately in the patient's best interests. This principle implies that the therapist always uses his best therapeutic skills to promote and accomplish for his patient the most effective course of treatment (2, p. 364).

Definition and Scope

Broadly, psychotherapy can be described as a mutual therapist-patient endeavor to investigate and understand the nature of the latter's mental distress for the purpose of providing relief from his suffering. The suffering may take the form of attitudes, feelings, behaviors or symptoms that are causing difficulties; the major purpose of psychotherapy is to produce changes in the person which will enable him to maintain a more stable and less painful adaptation to himself and the world around him. Although psychotherapy mainly focuses on the source and manifestations of the patient's difficulties, maladaptations or psychopathology, it need not restrict itself to the healing of the psychological illness per se; rather, it may simultaneously aim for the individual's growth, that is, the attainment of his maximum mental health or best human potential.

It should be pointed out that numerous forms of psychotherapy are being practiced today, with different and often conflicting conceptualizations about the fundamental nature of man and his mental ills, therapeutic processes or change agents, the requirements of the doctor/patient relationship, and the primary techniques and methods that are utilized. Often, each tends to exclusively emphasize either dynamic or behavioral or experiential aspects of treatment (1, Chapter 1). Other more common dichotomies include insight versus supportive therapies; the treatment of psychotic versus neurotic patients, inpatients versus outpatients, etc. However, in reality, these approaches are rarely categorical

distinctions. Therapeutic boundaries in actual practice can and do overlap. Thus, if these aspects of the psychotherapies were integrated, the common ground of psychotherapy would currently refer to the treatment of mental and emotional disorders based primarily on verbal (and nonverbal) communication (2) within the context of a special therapeutic relationship be tween two persons, wherein the one seeking help is the recipient of affective experiences (catharsis, abreaction, etc.), behavioral regulations (ad vice, control, etc.), and cognitive mastery (insight, explanations, etc.) in relation to his presenting and/or underlying problems (3).

More specifically, psychotherapy as defined above represents a theoretical midpoint of psychological treatment within a large and varied *continuum* of clinical approaches and techniques. While the focus is on general principles, the actual practice of psychotherapy is further delineated by descriptions of two hypothetical endpoints of psychotherapeutic treatment—intrapsychic conflict resolution within the context of a fantasized and frustrating transference relationship; and adaptation to current reality within the context of a real and gratifying therapeutic alliance. (Approaches emphasizing each goal will be elaborated upon in the last section of the paper.)

Theory of Mental Functioning

Basic psychotherapeutic theories have as their working concepts the dynamic, genetic, structural, economic, developmental and adaptive nature of mental functioning. In brief, man's affects, thoughts and behavior reflect the expression and transformation of his innate instincts, and more crucially, their repression, as well as the ways in which man defends himself (and adapts) in the face of his moral standards and the demands of external reality. Not only is man a product of inner conflicts—that is, both subject to and resisting against a reservoir of impulses largely inaccessible to his conscious self—but he is also a product of his environment, his learned or unlearned behaviors, values and beliefs which he has acquired through identifications, conditioning and training.

Beyond these unconscious determinants and internal and external alterations through learning, man strives not only for stability, but for self-determination, growth, and authenticity; at the same time, he seeks to find some meaning and purpose in life.

There are no procrustean therapeutic beds in which the patient should be fitted. The therapist must formulate an independent therapeutic rationale and working hypothesis for each patient undertaking psychotherapy.

Diagnosis and Assessment

Psychotherapy is applicable to a large and complex range of emotional disorders, including a variety of situational crises, personality disorders, neuroses, reconstituted psychoses, psychoses, and chronic mild organic condition. The categories in most current use are described in DSM III.

However, in establishing the therapeutic assessment and plan, a good clinician should avoid the simple attachment of one of the above diagnoses to the patient, since this often prematurely relegates him to a fixed position within that diagnostic label and may produce closure on how the patient is subsequently viewed and treated. Not only do few patients really fit DSM categories, but often this expedient but clinically limited method of assessing illness offers little of practical psychotherapeutic value. Psychotherapy-oriented diagnosis and assessment in a more constructive sense attempt to emphatically portray the patient and his inner world, his strengths as well as weaknesses, his capacities for health as well as illness. Throughout the therapeutic process, therefore, the therapist reexplores and refines his diagnosis by carefully observing the patient’s interactions, his relationship to himself and others, his adaptability and accessibility for particular therapeutic interventions.

Psychotherapeutic Objectives

Psychotherapy can have any or all of the following goals: 1) relief of immediate crisis, 2) reduction or removal of symptomatology, 3) strengthening of defenses and integrative capacities, 4) resolution or rearrangement of underlying conflicts, and 5) modification of personality organization towards an adaptive and mature functioning.

Based upon the therapist's ongoing assessment of the particular patient, objectives may be modest, restricted, narrowly focused short-term goals, such as reduction of specific symptomatology, brief problem-solving, crisis intervention, or achievement of limited insight into a well-circumscribed area of conflict, or longer-term objectives such as a reduction in the intensity of conflict, rearrangement of defensive structures, resolution of therapeutic dependence, and modification, or, at times, even resolution, of basic and unconscious conflicts. In some cases, where the immediate need is to sustain the patient during a particular crisis or period of stress, the major aim may be to provide a supportive relationship. Supportive efforts can be of brief duration or may extend over a long period, particularly with patients whose capacity for therapeutic work and for adequate functioning without a sustained therapeutic relationship is limited.

Of course, goals set at the beginning of therapy may be—and, indeed, must be—modified or replaced by new ones as therapy progresses. In most instances, the patient should participate in the setting of goals. Both therapist and patient should be aware that the aims of treatment are subject to change throughout its course, and that either overestimating or underestimating the goals of treatment at any one time is not irrevocable. Overrating the patient's capacities may place undue pressure on him during treatment; on the other hand, settling for modified objectives may result in difficulties for the patient later on and necessitate additional therapeutic work at that time.

The Psychotherapeutic Relationship

Psychotherapeutic change invariably occurs within the context of an

interpersonal relationship between the patient and therapist. In fact, some approaches focus almost exclusively on the therapeutic relationship (i.e., it is the subject and object of analysis); others focus primarily on the patient’s life situation and only secondarily on the therapeutic relationship per se. Three significant aspects of the therapeutic relationship in psychotherapy are: 1) real-object relationship, 2) therapeutic alliance, and 3) transference relationship.

Real-Object Relationship

The calm, interested, helpful and empathic attitudes of the therapist are essential for providing a warm and understanding milieu which will enable the patient to undertake the tasks of treatment. This milieu also serves to maintain the patient's contact with objects and with reality, constituting the real-object relationship.

The primary task of the therapist here is the establishment of trust. In his initial contact, the therapist offers to fill the needs of the patient through the possibility of being understood and begins to develop a mutual interaction and rapport that will allow the patient to view him as a constant, reliable, and predictable person. The therapist also supplies to the patient certain moral standards and values. These are not usually expressed directly; rather, they are implicit in the character and behavior of the therapist—that is, it is “not so much what the therapist says or does as what he is” (4, p. 243). The therapist is a model for identification by the patient, while providing the necessary gratification from a real object during the therapeutic encounter.

Therapeutic Alliance

Any successful therapeutic venture requires the close working together of two minds—the therapeutic alliance. This essentially involves the conscious, rational, and non-regressive aspects of the relationship between patient and therapist. It means “that the therapist aims at forming a real and mature alliance

with the conscious adult ego of the patient and encourages him to be a scientific partner in the exploration of his difficulties” (4, p. 72). The therapeutic alliance is based on the mutual explicit or implicit agreement to work together according to the requirements of the therapeutic situation.

This therapeutic alliance is an essential part of the therapeutic process. One of the major tasks of the therapist is to foster its development and to indicate to the patient that it is necessary for the psychotherapeutic work of observation, evaluation, judgment, reasoning, and reality-testing in relation to the material revealed in the sessions.

For the maximal development of this working relationship, both therapist and patient must be capable of controlled ego-splitting in the service of the treatment (5). That is, there are times when the real-object relationship between the patient and therapist would interfere with the therapeutic alliance; there is need to oscillate between the two. To accomplish both tasks, the therapist must judiciously set up a barrier against the patient’s need to revert to the real-object relationship because he wishes to remain gratified by the therapist. The matter is further complicated because certain aspects of the working relationship are real. The patient learns real things about the therapist both in and out of the office, and the therapist behaves in a real and human way toward the patient (6). Therefore, the reality of certain aspects of the treatment relationship, as well as its place in the formation and maintenance of the therapeutic alliance, must be understood by both partners, If both the real-object relationship and the therapeutic alliance are properly handled by the therapist, they can constitute useful and complementary parts of the treatment situation.

The Transference Relationship

How well the therapeutic alliance has been established determines in large measure the therapist’s use of transference as a therapeutic tool The real object need of the patient, satisfied by the former relationships, is deliberately

frustrated by the transference relationship. The deprivations produced by interpretations of transference result in loss of gratification and comfort from an infantile object relationship. The patient is confronted with the pain of his warded-off affects and conflicts and is required to think and begin to deal with these.

Only under certain circumstances should the therapist focus upon and encourage transference feelings: when he feels that such regression will not impair the patient's reality-testing, i.e., his capacity to distinguish reality from fantasy; when the therapeutic alliance is sufficiently established to withstand the frustration entailed in confronting the transference resistance; and, finally, when the therapist's time commitment allows him to assist the patient in working through and resolving the transference dependency.

In summary, the real-object relationship, the therapeutic alliance and the transference relationship between patient and therapist must be carefully balanced at all times as an essential part of treatment.

Psychotherapeutic Techniques

No technique is therapeutic in itself. The choice of a particular therapeutic approach for a specific human disturbance at a particular time is crucial. Each technical step must have a conceptual rationale adapted to the specific patient, and the therapist must leave room for flexibility from his own hypothetical standard. In short, a good clinician must be able to calibrate the use and timing of his therapeutic instruments.

The therapist's capacity to listen attentively and empathically is indispensable. He listens not only to the patient's manifest content, but also to the latent, unconscious meanings. Observation of the patient, with sensitivity to what he means as well as to what he says, provides the foundation for therapeutic endeavor. Upon initial evaluation, the therapist must indicate clearly

to the patient what his needs for treatment are and clarify proposed purposes and limitations of that particular form of treatment. This should include a statement about what is expected of both parties—their respective roles and relationship—in order to define as explicitly as possible the nature of treatment. The establishment of regularly scheduled appointments is a necessary, albeit obvious, requirement. The frequency with which a patient is seen will depend upon his specific needs (e.g., the nature of his psychopathology, capacity to maintain the therapeutic relationship, etc.), the nature of his particular treatment, and goals considered.

Once treatment is initiated, it is necessary for the therapist to encourage the patient to verbalize his thoughts and feelings despite inherent difficulties in doing so. For this purpose, the therapist at times may need to be fairly active—by asking questions, guiding the patient to focus on certain material, and responding calmly as the patient finds ways of expressing his thoughts and feelings. Here, the issue of whether and when a patient should sit facing the therapist or lie down on a couch may arise. This decision must be based upon consideration of what will be most facilitating to the particular patient. While some patients find it easier to verbalize emotional material when they are not facing the therapist, the couch may be threatening to other patients. In either event, the potential for regression of the patient must be carefully assessed.

Therapeutic techniques are naturally dependent upon, and inextricable from, the therapeutic relationship. (See section on The Psychotherapeutic Relationship.) The therapist should continually reinforce the therapeutic alliance between himself and the patient, while gauging how much regression the patient can tolerate at any one time. Essentially, the development of excessive transference reactions should be prevented. In this regard, some important and necessary defenses should be left undisturbed, and others supported and strengthened. When to stabilize the patient’s defenses and when to confront them; when to frustrate the patient and when to gratify him; and when to focus on real events and relationships and when to encourage transferential

manifestations—these are inevitable questions to be asked by every therapist throughout the course of treatment.

The therapist has a variety of potential techniques at his disposal, whose purposes may be explanatory, cathartic, or directly educative. Interpretation (of transference, resistance, repressed conflicts) is often considered to be the major psychodynamic tool. The therapeutic path must be carefully paved by a series of steps in order for interpretations to have their most elucidating effects. In this regard, the roles of confrontation and clarification are critical. Confrontation refers to requiring the patient to discern or face the particular mental event to be investigated; clarification refers to placing the same event in sharp focus, separating important aspects from insignificant ones. Interpretation then goes beyond manifest material by assigning an underlying meaning or cause to the event or phenomenon in question. In offering interpretations, the therapist must pay careful attention to the way they are presented, including the actual wording, the timing, the sequence and the dosage.

Interpretations should deal with the psychological realities of the patient, that is, his specific individual experiences in relation to a conflict. They should go from manifest or current connections to progressively more latent material—from what is accessible or partially accessible to what is unknown. The patient should be relatively removed from an anxiety-provoking emotional experience before an attempt at interpretation. A premature interpretation may backfire, in that it may increase the patient's resistance to insight rather than further it. Finally, the interpretation should be reintroduced at various junctures throughout the therapy; it may be that only after several doses can an interpretation become integrated completely into the patient's understanding.

The therapist may also wish at times to use techniques which can be considered essentially non-interpretive, that is, which may serve to block or lessen insight rather than facilitate it. Foremost in this regard are: *abreaction,* which may still be used but is not felt to bring insight directly; *direct suggestion*

or advice, which is only useful to the extent that it is openly acknowledged and analyzed within the therapy setting; *manipulation,* allowable only to the extent that it can be brought into the explorative arena and does not occur without the ultimate knowledge of the patient; and the *deliberate* or *conscious assumption of roles or attitudes* that create an unanalyzable situation by their very nature.

In addition, some patients (or all patients at some time) may need to be directly instructed in matters pertaining to their life outside of therapy, e.g., the nature of certain reality events and relationships—at work, at school, at home. Such educative interventions may interfere with access to depth material, but they contribute to the patient’s defenses and enlarge the scope of his ego.

Descriptions of Two Psychotherapeutic Parameters

Emphasis on Transference and Intrapsychic Conflict

This hypothetical end of the psychotherapy pendulum aims at major changes in the patient's adaptive functioning and personality organization and relatively firm resolution of intrapsychic conflicts. Applicability of such an approach is felt to require some degree of the following characteristics: the capacity for therapeutic alliance—that is, a reasonably well-integrated ego and some ability to relate effectively; sufficient resourcefulness for effective therapeutic work; the capacity to sustain therapeutic regression and to master the resulting anxiety; the capacity to maintain the distinction between fantasy and reality; and the capacity to form a transference (2).

This form of exploratory or depth psychotherapy can play an effective role in treating a large range of psychopathology, although the patients best suited to this approach are those suffering from neurotic conflicts and symptom complexes, reactive conditions, and the whole realm of non-psychotic character disorders. It is also the treatment of choice for patients with borderline personalities, but the management of these patients’ regressive episodes may

require occasional modifications of this approach.

The patient is seen at least twice a week, preferably more, for 50 minutes each time, in the therapist's office. Typically, it is an environment with minimal extrinsic intrusions in order to create conditions of relative sensory deprivation. This serves to maximize the evocation of repressed memories, free association, uncensored content of the patient's life material, dreams, etc. The crux of this method is the analysis of transference, which comprises the major instrument of the psychotherapeutic treatment as well as its major obstacle.

The therapist maintains the development of transference by judiciously frustrating the patient and avoiding gratifying his wishes, and by remaining relatively removed and anonymous. His basic therapeutic stance is as a deliberately dispassionate observer and reflector of the patient's feelings. The encouragement of transference reactions results in inevitable resistances to this endeavor, which must also be overcome (e.g., interpreted) as part of the treatment. This frustrating stance, in conjunction with the high frequency and regularity of contacts between patient and therapist, encourages an essentially regressive process and tends to increase the intensity of feelings within the treatment situation. In contrast to psychoanalysis, however, a full-blown transference neurosis should be prevented from developing; interpreting the transference as resistance is attempted only partially and in strictest accordance with the needs and capacities of the patient; further, the therapist does not attempt to completely resolve the original conflict.

The ultimate goal of therapy is, of course, working-through, which refers to the repetitive, progressive, and elaborate explorations and testing out of the interpretations and resistances to them until the presented material has become fully integrated into the patient's understanding. This is perhaps the most time-consuming aspect of dynamic psychotherapy. Although the major portion of such therapeutic work occurs within the therapist's office, working-through necessarily includes the tacit work done by the patient outside of the therapeutic

hour.

Emphasis on Therapeutic Alliance and Adaptation to Current Reality

Patients who require such an approach are those whose ego impairment is considerable, whose basic conflicts are of the more primitive and narcissistic types, and who are highly unlikely to tolerate further regression. The patients who fall into this group may be psychotic, especially those in remission, borderline cases, or patients with severe characterological problems, whose potential for decompensation is high. Treatment aims at the reconstitution and stabilization of the patient s functioning. This process may require short-term involvement or a relationship extending over a considerable period of time.

The therapeutic posture of the therapist essentially is dispassionate, but must be relatively active. He offers himself in a firmly but gently authoritative way to be a protective, supportive, and real object to the patient. He is generally accepting of the patient’s dependency rather than trying to explore or change it. Thus, the nature of the therapeutic relationship differs in emphasis from the model which focused upon the transference relationship, in which the therapist serves primarily as a surrogate ego, a constant object that the patient can rely on. Throughout the therapy, the focus is upon the establishment and maintenance of rapport and a good therapeutic alliance.

Since conflicts over the patient’s attachment to the therapist may develop, the intensity of therapeutic involvement can be minimized by limiting the frequency and duration of psychotherapy visits. In addition, minimal interpretation of intrapsychic conflict is attempted, and non-analytic efforts are made to influence the patient directly through advice, encouragement, reassurance, direct suggestion, inspiration and active persuasion.

This stabilizing type of treatment aims to support the patient’s defenses and provide controls for his overwhelming anxiety or destructive impulses. The

least amount of frustration and deprivation is imposed upon the patient, especially in terms of not having to relinquish the therapist as a source of real object gratification. In attempting to supply stability, the therapist seeks to mobilize the patient's presently available adaptive resources and strengths. One approach is an examination of stressful aspects of the patient's environment, whereby he may then be advised as to how to lessen these stresses or increase his capacity to cope. The therapist may also supply stability by providing ego support. This can be accomplished by guiding the patient in differentiating reality from his inner distortions, validating, where possible, the correctness of the patient's perceptions and thinking. In addition, the therapist may allow the patient to use temporary displacements (transferential, projective or introjective) (7). Education and information also strengthen the patient's ego by enlarging its scope.

In such therapy, the therapist may wish to use extrapsychotherapeutic means. He should consider medication and/or hospitalization to temporarily help the patient to control his behavior, or to remove him from excessive stimulation which may be contributing to a crisis reaction or stress and causing the patient to decompensate. The therapist may also utilize family and group approaches as adjunctive therapeutic measures. The inclusion of the family can serve to reduce the stresses on significant persons in the patient's living situation, allowing them to collectively participate in the establishment of a less conflict-ridden environment.

With a supportive group approach, concrete efforts can be made to reduce disturbances in interpersonal relationships by providing information and direction with regard to everyday problems of living. The multiplicity of transference opportunities may be beneficial for the patient to test out more effective ways of relating to others; he may also be directly trained in certain social skills which can be rehearsed within the course of therapy, as well as tested in outside real-life situations, and then reviewed in subsequent sessions.

Finally, it is certainly possible in working with these patients to tap intrapsychic conflicts and transference, as long as the individual's abilities and limitations are kept clearly in mind.

In conclusion, the prior section has elaborated upon two hypothetical ends of a psychotherapeutic spectrum. These alternate modes of intervention are by no means antithetical. In actual practice these emphases should overlap and, in the best of all possible therapeutic worlds, complement one another.

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