BACK

The Elements of Psychotherapy

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'… Much will be gained if we succeed in transforming your hysterical misery into common unhappiness. With a mental life that has been restored to health, you will be better armed against that unhappiness.' (Freud, 1895, *Studies on Hysteria*).

Psychotherapy is a subtle activity, often opaque to outsiders. One definition might be: it is the deliberate and structured use of a professional relationship, enabling an individual to explore, discover and express aspects of themselves that otherwise would remain hidden and troublesome. Certain things follow: this expanded awareness and expressivity can then bring about a fuller, freer, better adapted self and its relationship with others. Put another way, psychotherapy is getting help to understand and express oneself more clearly and fully, so that we are empowered to grow beyond self-limiting or self-defeating patterns. Liberation from such internal traps and tangles, enables us to make choices that are more realistically gratifying and creatively responsive.

These definitions, although probably acceptable to most psychotherapists, are likely to arouse either confusion or scepticism in many medical practitioners. Pragmatically, what can it achieve, and how? When is it most likely to work, and in which form? What is its relevance to medical practice? This article offers some introductory answers to these questions.

Psychopathology

Before the elements of psychotherapy can be understood, it is necessary to survey some of the principles of 'psychopathology': the theory of what goes wrong for individuals, and why. The basics of these are:

1) As infants and small children we are all highly vulnerable, in much need of attention and protection. We probably have a rich, sometimes violent fantasy life, and are unable for some years to subject this to reality-testing (Bowlby, 1971, 1975, 1981; Klein, quoted in Segal, 1964; Piaget, 1952).
2) It follows that the infant and young child are crucially dependent on caring figures for stability, safety, reality-testing and love. Consequently, if these are not forthcoming, the person will grow up with an impairment of his image of self and others. These determine our ability to relate trustingly, realistically and positively; to develop our own creativity and to healthily integrate our most primitive impulses or

feelings (Bowlby, 1971, 1975, 1981; Balint, 1968; Winnicott, 1965). The latter requires an inwardly directed capacity for reality-testing (Rosen, 1962; Schiff, 1975).

3) Some feelings and impulses are very threatening to the conscious self and its sense of integrity. This may lead to 'ego-defence mechanisms', which are involuntary attempts to ward off destabilising internal conflict or distress (Freud, 1936). When excessive, these defence mechanisms may themselves cause problems: 'presenting symptoms', ranging from recurrent relationship difficulties to mental and physical illness (Freud, 1963).

In suitable and motivated individuals, such dysfunctional patterns may be ameliorated or resolved by professional help. This happens by:

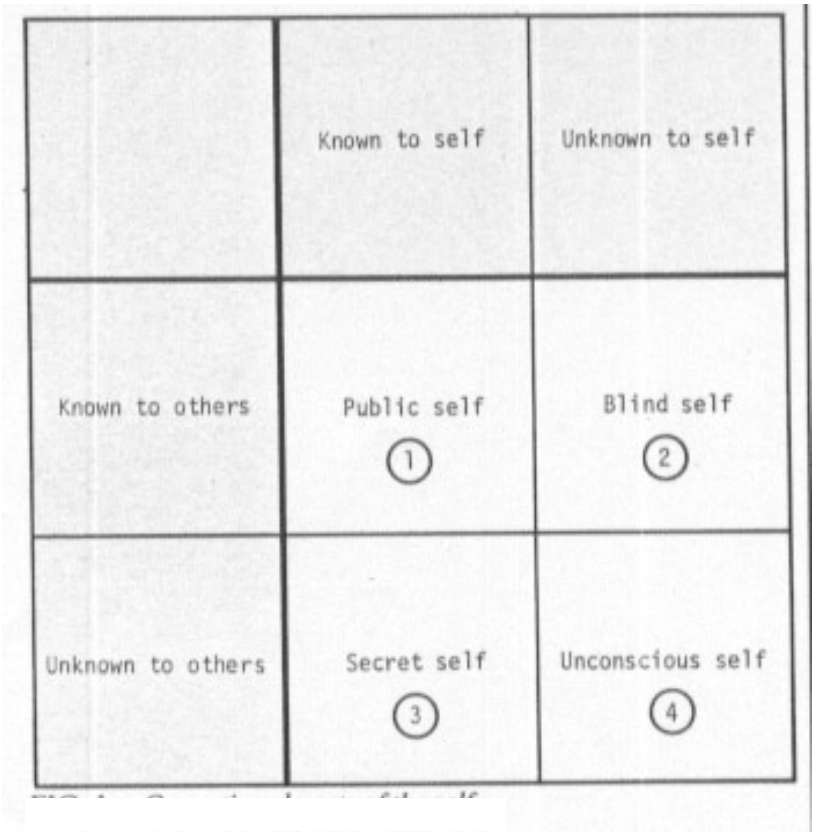
a) Perceiving and understanding the origin and current consequences of such patterns. This is a large part of historical *insight*.
b) Experiencing, within the therapeutic relationship, an encouragement, consistency or caring which was lacking in early original experiences. This can enable *healing*.
c) Acknowledging, experiencing and expressing feelings and impulses that have become fearsome and forbidden for the individual. This unlocking can free the individual for *growth*.
d) Recognizing the distinction between archaic yearnings, frustrations and impulses, and present reality. This kind of operational insight will help an individual navigate the lifelong psychological tasks of *immunity, growth* and *repair* (Perls *et al.*, 1973; Berne, 1961).

The tool of talking

It is sometimes claimed, particularly by those whose outlook is mechanistic, that 'talking can't do any good', or 'you can't change a person's make-up'. In a sense these claims are true, in that words cannot have the same predictable impact on another person, as can a surgical procedure or a drug when the doctor necessarily assumes control over the patient's internal processes. Physical medical treatment is unilateral and hence more controllable than the bilateral process of psychotherapy, where the *dialogue* is at the very centre of its effect. The patient is here far from being a passive recipient; he is an active synthesizer, and ultimately the effectiveness of what is given depends on what he does with it.

Given these limitations, verbal communication can still be immensely valuable when used skilfully and appositely. Its benefits are various and multiple. It can be an antidote to isolation, a way of externalizing internal confusion and thus gaining clarity or a different perspective, a method of de-pressurizing built-up feeling systems and – perhaps most important – a way of forming a *common language* with another person. This latter is an important step to creating a compassionate understanding and acceptance, both of the self and others. Such a common language can only develop, however, when there is a *therapeutic rapport*: this itself implies the conscious wish to develop capacities for trust, discovery and sharing. Some aspects involved in this process are depicted in figure 1 (Luft, 1966).

Figure 1: Operational parts of the self



It can be seen that different styles or levels of psychotherapy can act to bring about different kinds of integration of parts of the self:

- A depressed and isolated man, unhappy with his loneliness, is unaware of the way

he is critical of those who approach him. Other members of a therapy group confront him with this, and he begins to see his contribution to his problem. *Integration of (1) ↔ (2).*

- A woman who is ambivalent about her sexual relationships begins tentatively to talk to her therapist about the misty but intense sexual longings she used to have for her father, about which she still feels guilty and afraid. *Integration of (3) ↔ (1).*
- A middle-aged man, prone to depressive episodes when he feels rejected, tells of a dream, which the therapist thinks indicates his lifelong searching for his father who died when the patient was a boy; the patient denied missing or thinking about him much prior to the dream. *Integration of (4) ↔ (3) ↔ (1*).

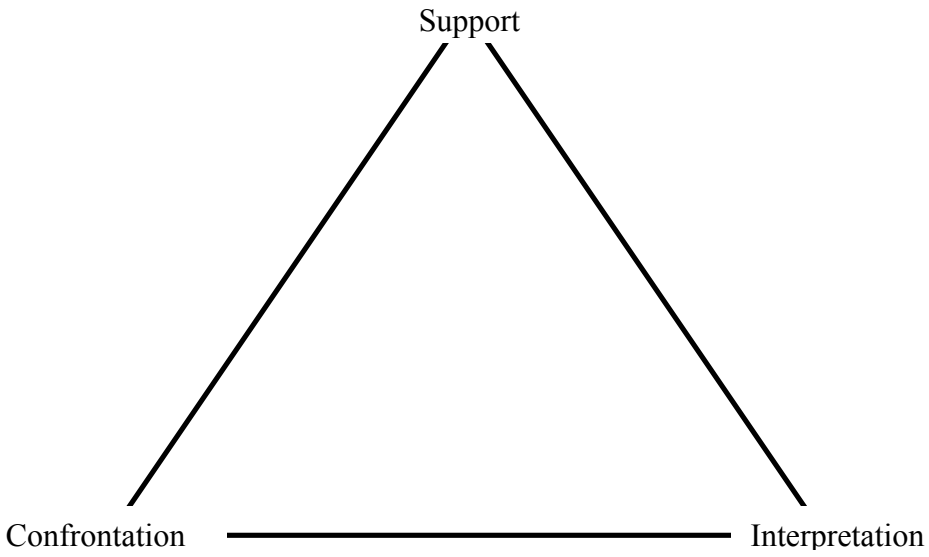
Why do we need to integrate these different parts? In general it can be said that:

a) It is not possible to have mastery of those parts of ourselves of which we are unaware.
b) Relegating distressing and unresolved parts of ourselves to secrecy is likely to seriously limit our capacity for intimate and authentic attachments, and may 'leak out' to produce symptoms.
c) It is only possible to be competent and responsive social beings if we have a fairly clear idea of how other people see us.

Of course, the mere awareness, or expression, of these unintegrated parts of the self does not of itself bring about the required change or integration, but they are essential prerequisites. In much the same way, a map may help us plan a journey, but it cannot bring about the travelling for us. The actual 'travelling' in psychotherapy is a complex matter, involving many different components of resource and motivation, in both patient and therapist.

Almost all psychotherapeutic interventions are some type of *support, confrontation* or *interpretation*. Each of these may be a powerful facilitator when used correctly, but may be damaging when untimely or poorly attuned.

Figure 2 – The therapeutic triad



Support

Support interventions are those that accept the patient as he is, without the pressure for greater awareness or change. It creates what Winnicott (1965) termed 'the facilitating environment'; a *safe base* from which the patient may begin the more difficult task of exploring and expressing material which has not previously been verbalized or shared. It is a paradox of the human condition that often we cannot change the way we operate until we have really accepted ourselves as we are. As a consequence, the therapist must at first accept the patient as he is and support him in his present *modus vivendi*, before other endeavours are undertaken. For this reason many therapists would agree that skilful support is the most basic element in this triad; often, an individual will find his own resources and understanding merely with such help. This is particularly true of those reacting immediately to loss and other crises, and thus is particularly pertinent to the work of the general practitioner. The style of therapy derived from Carl Rogers

(1961) and counselling holds that 'unconditional positive regard' is the most important facilitator in therapy. However, for more severe difficulties such as prolonged grief reactions, or longstanding personality disturbance, a therapy with other components of the triad is called for.

Interpretation

Interpretation helps a patient to make new sense of communicated experience by deliberately introducing associations with previously unlinked experiences and images. In general, it is true to say that there are no 'right' or 'wrong' interpretations, only those that a patient can use within the therapeutic rapport. Thus, an interpretation that may be 'correct' to the therapist but cannot be assimilated by the patient is edifying only to the former and, if asserted dogmatically, will damage the development of rapport. In this sense interpretations should not be 'made' or 'given', but 'offered' tentatively and experimentally. When interpretations are successful they lead to a *deepening of rapport* (Malan, 1979), where the patient feels an increase both in his own understanding and the sense of his being understood, so that he feels safe to explore and share more (Menninger, 1958). Often the most gratifying and facilitating examples of interpretation are also the simplest.

The following two examples illustrate some of these principles:

Example 1

A young woman had been admitted to hospital four times in five years with episodes of mania. Her treatment had consisted mainly of custody and suppression of her symptoms with drugs, evidently with limited and transient effect. On her last admission she exhibited her usual pattern of grandiose thinking and hyperactivity, but the doctor was aware of her eyes glistening. After spending a while with her, he said gently: 'underneath all this activity and bravado, I get the sense that really you're feeling very sad and helpless'. She collapsed and sobbed for several minutes, confirming the doctor's intuition of concealed feelings underlying her 'manic defence'. Later, albeit with pain and difficulty, she developed a sufficient therapeutic alliance with the doctor to explore some of the unarticulated emotional problems generating her episodic illness.

Example 2

A woman in her early forties was convicted of a shoplifting offence and referred for psychotherapy. Six months before her offence she had had a hysterectomy. She was late for her initial interview and the male therapist found her to be 'sexually provocative'; he then made an interpretation to the effect that she had wanted to redress her sexual loss by stealing, first from the shop, and now from him (his time and his penis). She curtly denied understanding of either the remark or its relevance, and did not attend further appointments. This complex interpretation may have been psychoanalytically 'correct', but was untimely and unwieldy: it could not be incorporated into the fragile rapport between patient and therapist, which had only just begun. This woman did not feel sufficiently understood and accepted as she was to be able to use such a comment, which was experienced by her as an attack or derogation.

Confrontation

Confrontation is a term used to describe the therapist's action when he directly draws attention to an aspect of a patient's behaviour, without offering an explanation. Its aim is to enhance *awareness* of behaviour; the way in which he operates and how this may affect others. Generally, attention is focused on what is currently happening. Therefore group and family therapy often utilise this type of intervention because of the richness of interplay between its members, who will act as both confronter and confronted. The therapist's role is then to keep the confrontation within a scope of intensity and relevance that will be tolerable and therapeutic. If a patient is to consider seriously and assimilate the subject of confrontation, he must first feel an adequate sense of care and safety in the therapeutic setting, otherwise he will merely feel attacked. This will lead to an escalation of his defences, rather than the reverse.

Example 3

A middle-aged man complained bitterly and with hurt about his estrangement from his son, who he described as secretive and surly. The therapist noticed his own sense of irritation and exasperation with the patient, who continually, but without apparent awareness, talked across the therapist, and made inaccurate assumptions about him. The therapist gently but firmly pointed this out, adding that this pattern was possibly also true with the son, leading to the painful impasse he had described. Because the man had a

trusting rapport with the therapist, he was able to acknowledge and explore this pattern.

Confrontation is a prominent component of the newer, humanistic therapies such as Encounter, Gestalt and Transactional Analysis. These can be potent catalysts to awareness of present functioning. However, this potency has the capacity to harm, by engendering too much material too quickly for the patient to handle. This caveat leads to the 'Rule of the Therapeutic Triad', which may be stated as: 'For rapport in psychotherapy to be maintained and beneficial, interpretation or confrontation should not exceed the support that is offered to the patient'.

Transference

It has already been outlined how our internal world-image and self-image is fundamentally influenced by our early experiences. All of us, more or less consciously, act from and act-out the kind of adjustments and decisions we made in infancy and early childhood. It follows that we transfer onto others our expectations and fears deriving from that period. If these early experiences were generally good and satisfactorily resolved, this will lead to healthy growth and adjustment. For those who were not so fortunate, the result will be recurrent and continuing difficulties with relationships, and expression and gratification of the self. In such cases it is important that the patient is able to understand what he is *projecting* onto others that hampers him, so that he may be able to grow beyond these ancient repetitions. This field of archaic projections is termed *transference* in psychotherapy and, in the more analytic therapies, is considered the most important diagnostic and therapeutic tool. In these 'deeper' therapies, it is thought to be necessary for the patient to:

1) Experience, in the present, the kind of fears, expectations and fantasies he had as a child and which he now projects onto the therapist (*Evolution* of transference).
2) With the help of the therapist, to understand their historical roots and present way of operating (*Analysis* of transference).
3) Slowly abandon these methods of functioning, by finding newer and more productive ways of relating to the therapist (*Resolution* of transference).

The analysis, or interpretation, of transference may be depicted by another triangle.

Figure 3. The triangle of transference

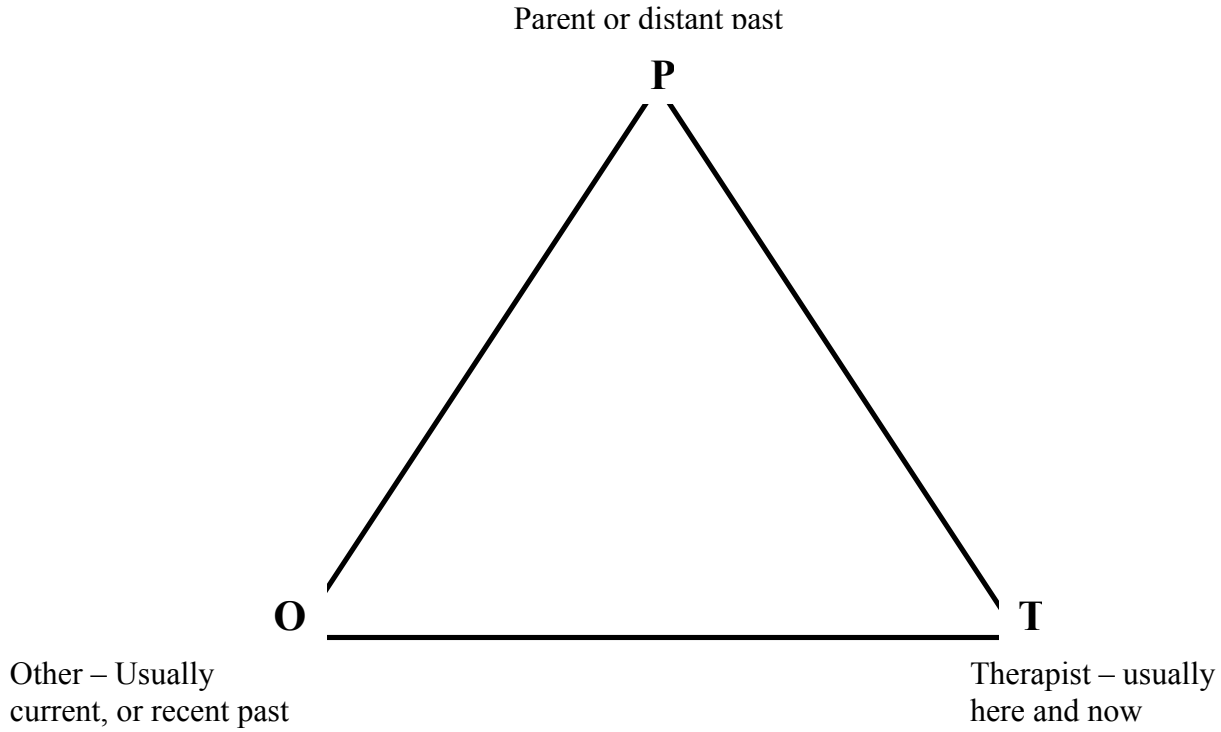


Figure 3 illustrates a scheme whereby the influence of the past may be understood in terms of both the therapy and the patient's current life-situation. For the fullest understanding, links are perceived between all three; at other times more partial insight may be gained by linking any two of the three.

Example 3 *(continued)*

After the middle-aged man understood how he was warding off the therapist, he began to see how he was also doing this with his son (O-T link). The therapist then asked him how he felt when he behaved like this, and then whether he could remember this same feeling when he was very young. The patient then became eager to talk about his fear of domination by others – even his son – and how he attempted to counter this by pre-empting and defining others. He then went on to talk of his relationship with his father and older brother, who he felt exerted a bullying alliance against him. He talked of his recurrent feelings of fear, humiliation and resentment. From this account he began to see how his experiences of the past were being re-enacted both with his son and the therapist (O-P and O-T links), and began to feel less bewildered and powerless in the face of his feelings.

Applicability of psychotherapy

Psychotherapy in its different forms may be helpful for a wide spectrum of disturbance or distress: from disabling life-crises, to chronically unsatisfactory patterns of adjustment or relationships. Always, though, the following are essential for any success:

1) That the individual recognizes that he is not merely a victim of circumstances or faulty biological mechanism, but that he, in some way, is now an *active agent* in his pattern of distress.
2) That he is willing, at least consciously, to pursue the possibility that reflecting on himself and sharing himself, in a professional setting, may lead to a newer and more worthwhile kind of integration and understanding. This is a complex issue, as there are frequently unconscious forces working against conscious motivation – the patient's 'resistance' – when, paradoxically, the distressed mode of functioning is equated with familiarity and security, and is therefore resistant to real examination or change.
3) The patient must be able and willing to tolerate the frustration and pain that often accompanies 'the therapeutic process'. Self-disclosure and acknowledgement of long-buried parts of the self is often difficult and requires considerable investment and courage. It is here that the skill and personal qualities of the therapist can ameliorate the situation. It is also important that the patient understands the metaphorical nature of the relationship; for the care and attention he receives, and the feelings or impulses he has toward the therapist, are at the same time authentic but ritualized within the framework and boundaries of the setting. The patient must have the intent and capacity to 'talk-out', and not 'act-out', his difficulties.

It is the therapist's empathic and professional skills that can elicit, maintain and guide these capacities in the patient. When this happens, there is said to be a strong *therapeutic alliance* between patient and therapist, and they may create a *common language* that unifies the patient's experience of himself and the therapist's experience and understanding of him. The ability to pursue this at the beginning of therapy is usually a favourable prognostic sign, and also indicates the formation of a safe-base from which the patient may experience and work out his 'negative transference' towards the therapist – his covert and archaic fear, envy, anger or resentment – which may underlie

his inability to make trusting or intimate relationships.

Many authors have drawn attention to the caution that should be applied in using psychotherapy in those suffering from severe mental illness, such as psychotic or obsessive-compulsive syndromes, or in personalities with poor social control. It is probably true, however, that these criteria apply equally to these more disabled people, as to the more common (and more easily identified-with) neurotic (Rosen, 1962); that, if a therapeutic alliance can be forged and a common language created (that requires special skill and experience), then the patient may grow away from his disturbed impasse.

Psychotherapy and medicine

Psychotherapy and medicine work from very different assumptions: the former works from the position that the patient must develop his own resources, clarification and self-definition, while the medical model works from the opposite pole; the doctor provides the resources (treatment) and definition (diagnosis). The medical patient may present the problem, but it is soon converted into the language of the doctor who then commands the dialogue (Zigmond, 1982). Psychotherapy, in searching for a common language, cannot therefore be so rigidly defined in its process or outcome; because it has its roots in personal and evolving dialogue, it cannot be 'given' or 'prescribed', and it is probably fundamentally misleading to refer to it as a 'treatment': this word usually implies a passive patient who is cured by an active doctor.

In spite of these apparent incongruities, psychotherapeutic insight and technique has a definite place in helping the medical doctor to understand his own and the patient's behaviour and the meaning of patients' symptoms, particularly when these are not readily diagnosed and treated by conventional means (Zigmond, 1977; Balint, 1956). There are evident limits as to how much psychotherapy a doctor can competently and ethically introduce into his medical practice; he would be unwise, for example, to attempt to help a patient with recurrent relationship difficulties to work through primitive anxieties and conflicts, although exceptionally this is possible. He is, however, well-placed to recognize his patient's anxieties and help him to verbalize them, which is, in itself, often perceived by the patient as an act of great understanding and comfort.

This is particularly so at times of crisis and loss, as the following example illustrates.

Example 4

A 70-year-old man, Mr F, consulted his doctor, complaining that he woke at night 'feeling like my body is on fire, and I get this terrible itching all over, so that I just can't stop scratching'. Routine physical examination and questioning confirmed that the cause was most unlikely to be organic, and the doctor explained this. The doctor, in simple terms, went on to explain that sometimes it is difficult to express or resolve certain kinds of feelings and thoughts. These then upset the body, causing the kind of symptoms of which Mr F complained. The doctor asked Mr F if this made any sense to him and, if so, whether he had any idea of the kind of thoughts and feelings that were troubling him. Mr F replied that his trouble had started soon after his wife had died, of cancer, three months previously, and he wondered if this had anything to do with it. The doctor maintained a warm and attentive silence, which encouraged Mr F to say, 'It's stupid, I know, to be so upset after this time; I should be over it by now', which the doctor softly countered by reassuring him that such a basic loss often leaves a very long wake of disturbed feelings – that none of us ever completely leaves behind the hurt or the sadness from such a loss. At this point Mr F cried, and then talked about his sense of emptiness, and also his hidden regrets. The doctor then asked him if he was also angry that his wife had been taken away, or had abandoned him, leaving him alone – that although it is not 'rational', all of us can feel angry when we lose someone precious. Yes, Mr F agreed, he had at first been angry with the hospital, then himself, for her death; he knew it didn't make sense, but he still felt resentful. The doctor asked if he had talked with anyone about these feelings; 'No, doctor, not like this. People have their own lives to lead. I don't like to bother them'.

After another few minutes Mr F could see that his feelings were inevitable and important; they could only be conjured out of mind by the development of disturbance elsewhere, i.e. his skin. He found, too, that he could begin to share his feelings; his parting remark was simple but deeply felt: 'Thank you so much for listening to me, doctor. It's good to know there's somebody who understands how I feel'.

Comment: integrating the elements of psychotherapy

The example of Mr F illustrates how some of the elements of psychotherapy may be

brought to bear in situations other than intensive psychotherapy programmes. He represented a problem familiar to many doctors who attempt to provide some form of holistic care, and it is arguable that such basic psychotherapeutic skills should be part of their clinical repertoire.

Mr F did not need the kind of prolonged psychotherapy required to help longstanding personality or relationship difficulties, but rather psychotherapeutically enlightened practice. The doctor first of all created a situation, a 'facilitating environment', where a therapeutic alliance evolved. Mr F felt sufficiently supported and trusting to reveal his 'secret self'. The doctor had then gone on to interpret his somatic defence, which enabled Mr F to share his underlying grief and resentment. Because the doctor had shown care and understanding to the vulnerable part of Mr F, the lonely widower would now probably adopt a more tolerant and understanding attitude to his own 'unreasonable' feelings This acceptance could then free him, to heal and find a new equilibrium. It is also important that the doctor was prudent in the use of his interpretations; he refrained from attempting to explore the patient's deeper unconscious where, perhaps, there had been hostile feelings to his wife when she was alive, and for which he now felt guilty. If this were true, it would become manifest later, and to raise this issue in an untimely and premature way would do more harm than good; it would seriously undermine their nascent therapeutic alliance. In this respect one of the most important elements of psychotherapy, as in medicine, is knowing when and where to stop.

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