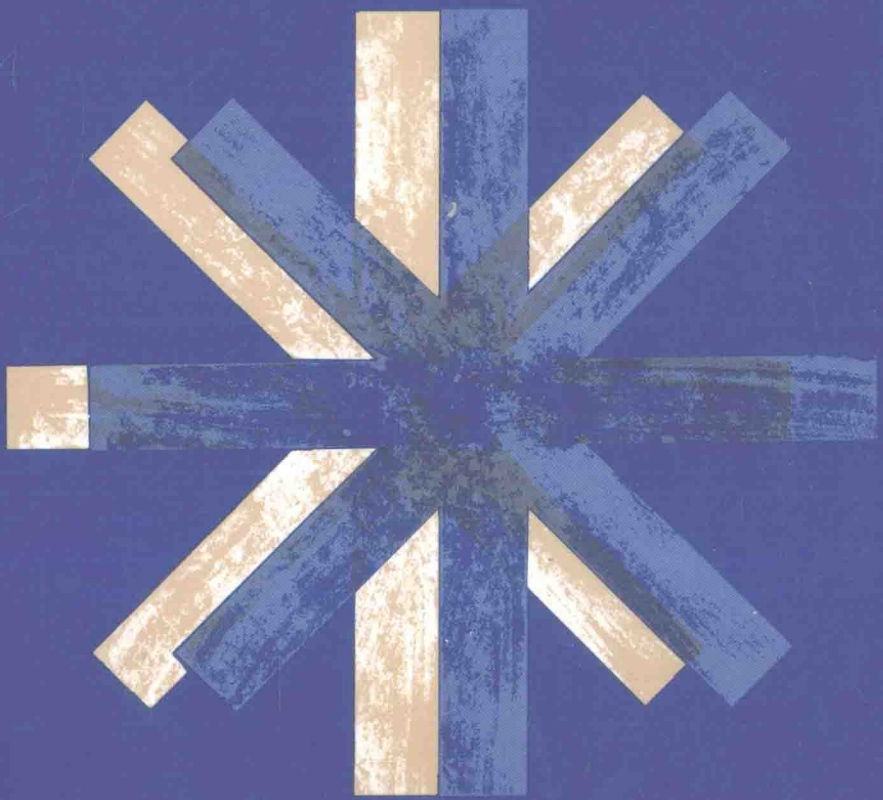
HILDE BRUCH, M.D.

LEARNING PSYCHOTHERAPY

Rationale and Ground Rules



"A masterpiece of succinct and clear statements about the major and fundamental issues of psychotherapy."

—Otto Allen Will, Jr., M.D.

Learning Psychotherapy

RATIONALE AND GROUND RULES

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Preface

The process of learning psychotherapy is lifelong: an interminable task of creative reappraisal, of studying both failures and successes with the same objectivity and readiness to learn. A therapist cannot increase his professional expertise through repetition of what he has done or been taught before. Each new patient must be approached as what he is, a stranger whose anguish and problems are unprecedented and unique; the challenge is to approach him in a special way, geared to his particular situation. This very alertness to the newness of each therapeutic encounter permits the mature therapist to use past experience as well as present ignorance in a constructive way.

These advanced achievements of psychotherapy may be a faraway goal, but it is one that needs to be implied in the learning process from the very beginning. This book addresses itself to the beginner who is for the first time confronted with the task of functioning as a psychotherapist. Learning psychotherapy is the core, the very heart, of the psychiatric residency. Over the past few decades the field of psychiatry has broadened considerably, encompassing a variety of new tasks which are usually ill defined and demand different, often contradictory, approaches and attitudes. Even with all these changes, becoming an effective psychotherapist has retained a central position. It is the only way

residents can learn in depth about the complexity of human beings; such knowledge can then be applied to other treatment modalities, not only in intensive dynamic therapy.

Psychotherapy itself is in such a state of flux, and the concept has been broadened to such an extent, that nearly every professional interaction between two people, or groups of people, is referred to as "therapy." Psychoanalysis and its offspring, dynamic psychotherapy, have come under attack as being too time-consuming and expensive, and not suitable for all patients; the one-to-one relationship has been criticized as representing an outmoded "medical model" of psychiatry, out of step with modern concepts of a "social model." Most of these criticisms reflect a lack of understanding and knowledge of the essential tasks of intensive psychotherapy.

It is correct that dynamic psychotherapy makes great demands on therapist and patient alike, not only in the expenditure of time and money but in the intensity of personal involvement, in the need for introspection and willingness to be unsparingly honest and to face unpleasant facts. It demands the readiness to reexamine one's motives and attitudes toward life, and to use this understanding responsibly to take new action. That this treatment is not readily available, or even suitable, for the many does not make it less valuable or indispensable for those who can and do benefit from it, for those who find it the only way of obtaining lasting relief from their self-doubt and sorrow. Undoubtedly, many people in quandaries can benefit from some of the current streamlined, get-well-quickly approaches. Yet there are many others who require deeper self-understanding and stimulation for genuine inner growth, and they can achieve this only through individual psychotherapy. The tragic fate of patients who are reduced to powerlessness in the depersonalized setting of psychiatric hospitals that use only standard prescription of the treatment in vogue, with no relevance to the individual's needs, has been noted over the ages.

Psychotherapy addresses itself to the inner difficulties that interfere with an individual's ability to cope with the tasks and stresses inherent in human life. Students often ask what psychotherapy really is, and how it accomplishes favorable change, particularly when the available time is limited. I should like to define it here as a situation where two people interact and try to come to an understanding of one another, with the specific goal of accomplishing something beneficial for the complaining person. Though patients come to psychiatrists with a multitude of problems, I shall consider their difficulties here, in a gross oversimplification, under the heading of one common problem: the sense of helplessness, the fear and inner conviction of being unable to "cope" and to change things. This feeling can be recognized as an essential issue in every situation, though in widely varying degrees. Patients often expect, and so do beginner psychotherapists, that psychotherapy will solve their problems and make them happy, or at least less dissatisfied. If this occurs, it is a fortunate side effect. It is not in our power to make people happy, but we can be of assistance in making them at least to some degree more competent in evaluating realistically what troubles them so that they can learn to react appropriately to their problems and find relief from their sense of impotence.

And how is this achieved? In every form of psychotherapy several processes go on simultaneously and serially: by *listening* effectively to what the patient has to say, you may make him feel he has been heard and understood; by summarizing and *reformulating* what you have heard, you may help him take the first steps toward clarifying and reducing the underlying confusion that complicates his life; finally, by a more objective assessment of his resources and by *presenting alternatives,* you may help him arrive at a point where he can take action, no longer so helplessly caught in his anxieties and victimized by circumstances. These are the essential tasks of both short-term

and long-term therapy, in whatever elaborate form it is practiced. Treatment itself is the process through which a patient develops new mental tools so that he can manage his life in a more realistic way, less distorted, less burdened by misinterpretations and repressed emotions.

I shall attempt here to review what I have observed while supervising the first efforts at psychotherapy of medical students, psychiatric residents, social workers, and interns in psychology, and also the work of candidates in psychoanalytic training who already had extensive experience. Much was learned from my work as consultant to practicing psychiatrists who asked for an evaluation of patients who seemed to be untreatable. In spite of the widely different level of expertness, there have been amazing similarities in basic problems that were recognized as interfering with therapeutic effectiveness. The difficulties usually rested in preconceived notions and convictions, gleaned from previous teaching or reading, that were not appropriate for a particular patient and interfered with the therapist's open-minded assessment of the treatment needs.

Most of the examples used to illustrate various points have been taken from the records of patients treated by residents, including some from my own residency. Though they were chosen as presenting typical problems, no generalized deductions should be made from them when dealing with another patient; in spite of apparent similarity, there is always need for individual modification. Psychodynamic understanding implies an approach to the underlying problems of each person appropriate for his particular development and needs. Only in this way will therapy be effective and reality-oriented. Such individualization is also an important aspect of the learning process. Each therapist needs to develop his assets and abilities in a way that is meaningful to him. With the development of more sensitive and deeper self-understanding he will learn to use the human rela-

tionship in an individualistic but still planned and disciplined way.

One great difficulty in the process of learning is the fact that theoretical principles and so-called techniques are often transmitted and received through stereotyped tradition-bound instruction. Probably each experienced therapist has developed a working theory and method of his own, what he actually does in the privacy of his office. However, the way he uses these personal concepts in his work with patients usually goes unstated, and what gets into print are variations on the officially accepted theories, expressed in standardized terminology. So I shall attempt a more direct personal approach here: to give some general principles underlying effective psychotherapy, within a broad theoretical frame, and to spell out some of the actual factors that help or hinder the beginner in the process of learning psychotherapy.

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When Strangers Meet

"A journey of a thousand miles begins with but a single step." This old Chinese proverb may well be applied to the psychotherapeutic journey. However long it takes and no matter how involved it becomes, it does begin with the initial interview; what is experienced then and there may well determine the course of therapy. It may start auspiciously, with a promise of mutual rapport and understanding. Though many difficulties will arise as treatment progresses, this basic feeling of having been understood may well sustain the patient when the going gets rough. Just as in a physical journey when the inattentive and doubting may stumble and then limp along hesitatingly and with distress, so it may happen that there are misunderstandings in the initial contact, no reassurance to the patient that the therapist has grasped what troubles him. Unexpressed doubts and anxieties will interfere with the therapeutic process and slow things down. If things miscarry altogether, the trip is off; the patient will not return. If he cannot avoid it, as when he is hospitalized, he will remain hostile, suspicious, and uncommunicative. Such negativism is not always due to poor motivation or paranoic attitudes of a patient, but not uncommonly it is related to some unfortunate experience on first contact, where he might have felt that he was dealt with as "a case" or that the therapist

did not respect him and appreciate his problems as those of a suffering human being.

The beginner is in an unusually difficult position. When a psychiatrist is established in his own practice, or has a position of prestige and authority in an institution, patients are specifically referred to him, usually with some words of praise about his special abilities. In contrast, the beginner is an unknown quantity, and a patient's reaction and the development of trust in him as a therapist are much more dependent on what he experiences in the first treatment session. Fortunately, though, in his need and desire for help a patient is ready to endow the future therapist with special competence and ability for understanding.

FIRST REACTIONS

Both the therapist and patient bring their own personalities and past experiences to the therapeutic encounter, although the therapist, let us hope, has some greater awareness of the hidden factors and fewer anxieties about what lies ahead. Whatever the overt reason and manifest symptomatology that bring a patient into a psychiatrist's office, the therapist must be motivated by the wish to be of use to the patient and to understand him, and to give him the opportunity to express himself openly and freely. Whatever he has heard about his patient-to-be, or read in the sometimes voluminous case history, when the first interview finally takes place he does well to remember that this is an occasion where two strangers meet, with both having to take the first tentative steps to learn to know one another. It is a time of mutual assessment, though there may be only limited awareness of the interplay of many subtle emotional factors. How the initial interview turns out depends on the patient and his problems, how he presents himself, how he perceives or misperceives the situation, but also on the therapist's open-mindedness, his

awareness of himself and his feelings and reactions, his confidence in what he is doing, and his sensitivity to the patient's need for help and understanding.

The official task of the first interview is to get acquainted, to obtain a brief history of the patient's problems and difficulties, to form a tentative diagnostic impression, and to give some kind of formulation of the basic issues and possible treatment goals. It would be presumptuous to pretend to gain a clear, let alone complete, picture of a patient's difficulties. But it is helpful to say a few summarizing words about what one thinks the bewilderment or apprehension or anger is about. I find it useful to make some comment with a positive meaning, implying that I can conceive of the patient in a different mode, not as anxiety-ridden or depressed, suspicious, and desperate, but as a functioning person with the capacity for trust and self-confidence. A simple question might do it: "When did you last feel comfortable (or confident) about yourself?" Or one might ask a mother who has filled the whole session with a long list of her child's shortcomings and her own tribulations, "What do you enjoy most about Johnnie?"

The beginner may be too anxiously preoccupied with gathering as much information as possible and thus may focus too mechanically on getting definite answers to his many questions. In this way he may miss the all-important purpose of a first interview, namely to establish the possibility of meaningful exchange. This requires a free-flowing expression not only of words but of sentiments that convey the promise of mutual trust. Whatever the content of the discussion, another process goes on simultaneously, that of sizing one another up in terms of one's own emotional reactions. As in all important relationships, an immediate flood of feelings is aroused on first contact, which may be familiarity and liking but also remoteness or definite dislike. The alert observer will pay attention to what it is that arouses

such positive or negative feelings, and whether they are fleeting or of a depth that might interfere with the development of intimacy that is a prerequisite for therapy. Feelings of liking and disliking are based on the numerous, often imponderable personal expressions and qualities that make up the total nexus of one's own background and development. An experienced therapist will disqualify himself with a face-saving explanation, without hurting the patient's feelings, and will refer him to another therapist when he notices such feelings of dislike in himself, or even when he fails to experience some sense of empathy, of potentially sympathetic understanding of the patient's problems. The beginner does not have this freedom of choice, nor the sense of definiteness about his own reactions. One way he gains experience in the training period is to learn about the range of his reactions and interactions with a great many different people. Under observation and scrutiny, he may find it difficult to admit any negative feelings in himself. As in all other relationships, it is the hidden and unacknowledged feelings that may cause trouble and interfere with the honest and open exploration of feelings and reactions as they develop in the course of therapy.

ASSESSMENT OF A STRANGER

Many of the basic issues that come up with a new patient are similar to experiences we have had throughout our lives when meeting new people and getting acquainted with them. When we meet a stranger we take in, without thinking about it, many small details about him, and we form some immediate impression of the sort of person he is, by the way he walks or dresses, his facial expression, tone of voice and gestures, eye contact or its avoidance. We automatically draw some conclusions, which may or may not be correct; we also may or may not be fully aware of them, but they find a counterexpression in our own responses,

gestures, tone of voice, alertness of remarks, and so on. It is often these nonverbal messages which account for our feeling comfortable or uncomfortable when we meet a person for the first time.

If the therapist tries too hard to exclude such life-long patterns of reaction behind a stereotyped professional facade, the whole exchange may become artificial and stilted, lacking in spontaneity and warmth. An important aspect of one's development as a psychotherapist is your becoming acutely aware of the range of your own reactions and feeling tones. This reaction may also be of importance in forming a diagnostic impression. European authors continue to speak of the "praecox feeling"; on analysis this proves to be the examiner's uneasiness when the customary responses in verbal and nonverbal communication with schizophrenics do not occur. The feeling of being drained or exasperated and bewildered, which many therapists experience during conferences with the parents of schizophrenic patients, has proved an important guidepost in exploring the confusing climate and style of communication of such families.

THERAPEUTIC PURPOSE

The therapeutic interview differs from the ordinary social contact in one important respect: it is an encounter with a definite *purpose,* namely that something of positive value and constructive usefulness for the patient should come out of it. I find it useful at the outset to state this implied purpose in some explicit way, in particular if a patient finds it difficult to talk about himself. How the initial interview turns out depends, of course, on many circumstances. It will be different for a hospitalized patient who may be there against his will and who finds himself assigned to some stranger called "his therapist"; he may rebel against divulging his innermost and often frightening thoughts and feelings to this stranger. Even a patient who

appears in your office on his own may find it a difficult task to confide in a complete stranger, and the neophyte therapist may ask himself, "Why should he trust me?" Direct verbal assertions—"You can tell me everything"—will disclaim by their very pompousness the subtle reassurance the patient needs and which is given in nonverbal expressions of warmth and sympathy, and by careful questions and comments that reveal a willingness to understand.

The patient is in the help-seeking role, and though he may resent the very fact of having admitted that he is not able to handle his own affairs, he usually arrives with the hope of finding support in his efforts to leave outworn patterns behind, and thus is determined to tell it all. He endows the therapist with qualities of special knowledge and authority, and this is quite independent of the age, sex, and experience of the therapist, which facilitates a patient's being open and confiding about what troubles him. Whether or not this first confession of difficulties develops into something that has the elements of a beginning therapeutic alliance depends on whether he undergoes the emotional experience of having made contact, of having found a sympathetic and understanding listener.

KEEPING THE INTERVIEW GOING

Though patients vary greatly in their readiness and ability to talk—some pour out their endless complaints without giving the listener a chance to get a word in edgewise—the more common problem is how to keep the interview going. After the first statement of what troubles him the patient expects guidance on what he should talk about, and the therapist should supply it through carefully formulated comments and questions. This is where one's *general* grasp of an individual's difficulties, and the quality of one's understanding of psychopathology, makes a great difference. Without a general familiarity with the phenomenon, one

does not know what to look for and may miss the point completely. Still, rigid preconceived notions may guide one in the wrong direction and lead to irrelevant questions. I shall give a general outline of modern concepts of personality development in the next chapter.

The closer one's comments and questions relate to what the patient has expressed as troubling him, the better the interview will progress, with increasingly confidential elaborations and often a visible relief of anxiety. If on the other hand a tense beginner, perhaps with a case conference in mind, throws unconnected questionnaire-like questions at a patient, the more likely it is that the patient's tension will increase and that he will withdraw and become uncommunicative. Usually this type of questioning represents the beginner's puzzlement about what a relevant comment might be. Through attention for what one is doing, and open-minded supervision, this inexpertness gradually corrects itself with time. The process will be aided by the therapist's freedom to draw on his human resources, on his general education and the range of his reading, and by developing flexible theoretical concepts of human development.

SOCIAL AMENITIES

As stated before, a therapeutic session resembles ordinary social interaction in the exchange of words and the observations of all the culturally determined forms of beginning and ending a conversation. The same basic principles of showing respect and courtesy apply. The first step in meeting the stranger who comes to you as a patient, of course, is to introduce yourself and to greet him. However disturbed or reluctant a patient may appear, you should introduce yourself so that you are sure your name has been understood, and you should also ask the patient's name and how he likes to be addressed. I personally have grave misgivings about the habit of addressing an adult patient by first name right