Issues in Psychotherapy

William G. Herron · Sheila Rouslin

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WILLIAM G. HERRON
St. John's University
and
SHEILA ROUSLIN
Lehman College,
City University of New York

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To

Jane and Aaron

Introduction

This book evolved through the years from many discussions among the authors and other psychotherapists. While the content varied, the themes of these discussions remained essentially the same. In the practice of psychotherapy, issues are encountered for which the therapist is largely unprepared; the issues are subsequently evaded. This lack of true solution troubles the therapist, because the consequences are potentially far-reaching and deleterious to the therapist and to the patient. Why are some issues in therapy not more completely resolved? There are a number of interrelated reasons.

There are realities in the field of psychotherapy which impede clear solutions. The most obvious and general is the nature of the subject matter, namely human behavior; but, interwoven with the realities is the fact that these issues touch upon the self-involvement, or narcissism, of the therapist—and this often arouses strong reactions.

Many problems have low visibility. When they do come into view, there is a personal, problematic, and controversial quality about them which the therapist might suppress or repress. Unfortunately, the issues themselves are often suppressed or repressed as well. While there are articles and books to some degree concerned with these matters, the issues we will discuss are not the customary and frequently encountered ones of technique, process, and theory addressed in most books on psychotherapy.

We are concerned with ongoing issues that are potential and actual hazards for every practitioner but which are generally ignored. Such a reaction is a hallmark of some disruption in the therapist's self-image.

Any patient problem that is threatening to the therapist is crucial in many ways. They are encountered by most therapists, whether in training, practice, or teaching. They are disturbing and personally discomforting and so are usually avoided. Yet they require as complete a resolution as possible, so that psychotherapy may continue effectively. So far, however, the resolutions are much too idiosyncratic, and too often hardly meet a criterion of really solving the issue. Such a situation provides little or no assistance to the general field of psychotherapy or to most psychotherapists. It also results in a great deal of ineffective, even damaging "therapeutic" encounters because the therapist really does not want to consider what may be happening.

While one can be sympathetic to the results of having an issue arise between the therapist and the client, no purpose is served, and much harm may be done by simultaneously wishing the problem did not exist, and then making the wish come true by going on with the therapy as though there were no issue. Many issues are unconsciously ignored and so do not come into the therapist's awareness, while others are treated with far less significance than they deserve. Most therapists *intend* to be effective, but the burying of personally distressing issues, of which the patient may be aware in varying degrees, is not doing the job well. The therapist retains his or her narcissistic composure while the therapy suffers or collapses.

Therapists learn to expect that patients will be difficult from time to time. They also realize that, depending on a variety of factors, such behavior can be a sign of progress or a problem for the therapy. What therapists do not expect are their own difficulties connected with being psychotherapists, and they are reluctant to look at these openly. We are not suggesting that therapists do not engage in self-examination. Quite the contrary; and if the therapist's orientation is psychoanalytic, many of the issues would involve countertransference, which is certainly supposed to be resolved by the therapist. Other orientations have different ways of conceptualizing the therapist's reactions. Of course all have considerable latitude with regard to determining just what is and is not a "therapeutic reaction." But more important, the issues, in whole or in part, can go unrecognized, or the self-examination process, whatever it may be called, can be merely descriptive rather than an explanation leading to constructive action. The point is that there is serious neglect, and therapists are reluctant to do enough about it. So, while narcissism is a prominent topic in the literature on psychopathology and treatment, it is the *patient's* narcissism and self-absorption that get most of the attention, not the *therapist's*.

We are by no means removed from the natural reluctance to engage in self-examination. Writing this book involved a considerable and continual struggle with that reluctance. Yet we are convinced that frank and open discussion of troublesome issues is essential to the effectiveness of the psychotherapies. As practicing psychotherapists for more than the past 20 years, we are increasingly attuned to the problems all therapists face. They may be ashamed, perplexed, disturbed, lonely, angry, and a host of other unpleasant states. These problems need to be solved for, or by, the therapists, yet their training has not really prepared them to do this, regardless of their parent disciplines or orientations. The thrust of the field of psychotherapy has been that such problems ought not to arise. If they do, which of course is the case, it is the therapist's responsibility largely on her or his own, to somehow get rid of them.

"Somehow" is very vague. For example, supervisors often point out problems to their supervisees, and then offer as the potential solution, "Work that out in your own analysis." Well, what if the "working out" takes a long time, or is only partial or does not occur at all? What happens to the therapist, the patient, and the therapy during this attempted "working out?" As another example, a well known analyst has stated that in regard to therapist behavior, "rudeness has no place in psychoanalytic therapy." But what if the analyst is indeed rude, and not just once, and has repeated difficulties in changing such behavior?

These examples are indicative of the issues we explore in this book, namely the insecurities, misunderstandings, and perplexing motivations coexisting with such positive and welcomed therapist qualities as empathy, dedication, and well-timed interventions. We focus on behaviors and events that are "not supposed to happen" in psychotherapy, yet do, and we talk about what therapists can do when such painful things occur.

Our presentation is an intermingling of personal experience and clinical and research literature, and has at its core the conception of narcissism in the personality

of every therapist, and how that may be misused, or it is hoped, made effective. In broad terms, the *self* of the therapist appears to be the issue that could spawn all the issues, and could resolve them.

As the book was conceived we felt its impact would be greatest if we limited ourselves to a certain number of issues that struck us as particularly in need of attention. They are not thought of as the only issues of significance, nor do we believe that all therapists would select them as the most important issues to be discussed. What we do believe, however, is that they are indeed important issues for *all* therapists, and that most therapists have had, or will have, their struggles with them. These are also issues for therapists of all disciplines and persuasions, but not all therapists will agree with our statements. In that sense the book is designed to be provocative. We hope all therapists will read this and think more about how they use themselves, and wonder if indeed they could become more effective, even if their way is not ours. We also welcome the responses of therapists to our contentions.

The issues discussed are definition of psychotherapy, aims of psychotherapy, behavior of the therapist, occupational hazards, therapists' narcissism, contracts, therapists' termination motives, therapists' fantasies, personal meanings of being in private practice, and what is personally involved in being a "good" psychotherapist. The presentation changes as the book proceeds, in accord with the content covered and the discussion of the appropriate use of the therapist's self. The first three chapters are deliberately more formal, with considerable use made of empirical research, because it is available and appropriate to the subject matter. A balanced presentation is preferred over a primarily subjective conception. In these areas there is considerable material upon which to draw, and we combine empirical and clinical data to make inferences. It is clear in these first three chapters that there are problems appearing to be outside the therapist's obvious control. These problems make definition, goal description, and patient–therapist interaction difficult. The patient is one of these "outside" factors that can prohibit or prevent solution, and this deserves appropriate recognition. It suits certain therapist needs to "not be that concerned," and to take as inevitable reality what they could have a more prominent role in changing.

The fourth chapter is more personalized and informal, making greater use of clinical opinion and experience, yet maintaining a continuity with the evidence as compiled in the preceding chapters.

At this point we will describe what is covered in the book, thus illustrating the particulars of our total conception. This should enable the reader to understand why we began where we did, where we are going in the development of the book, and our hoped-for conclusion, stimulating a definite improvement in the quality of psychotherapy through the medium of changing therapists' perceptions and actions.

Our starting point is that the field in its very essence, its definition, is tentative. Our concern is that many therapists do not like to face this inexactitude, so that efforts to alter it are inhibited. Some feel it has a universal definition, and therefore there is no problem, while others embrace the vagueness as a method of protecting themselves from responsibilities to their clients. Therapists must learn to define what they do.

Another concern is that definitions of psychotherapy, particularly if they find their way into legislation and/or insurance contracts, tend to designate *who* are the psychotherapists more precisely than what is involved in the process of psychotherapy. The control aspect of such designation is enormous, and all the disciplines have become embroiled in struggling to be designated as a provider of psychotherapy. With people coming out of the woodwork to call themselves psychotherapists, it is obvious that standards of competence are essential. But psychotherapy

is not the fiefdom of a single discipline and there is no value in chauvinism by profession in this field. The solution is in the creation of an independent profession of psychotherapy.

Of course that lies in the future, and we are in the present. Although the problems of defining psychotherapy are quite visible, psychotherapists *must* define it. Our thrust is to recognize the problems of definition, yet also show that some definition is necessary. All therapists must be prepared to understand and to explain to their clients what it is they actually do. In turn therapists then need to integrate the probable narcissistic injury such explanation can bring, rather than hiding with dexterity when it comes to the very basic issues.

The next issue, which clients often voice as their major concern, is whether therapy will help them? Therapists have to be more exact in regard to what the patient can expect by entering into psychotherapy, which is also a problem inextricably linked to definition. We first discuss in general terms the categories of the psychotherapies and their goals, and we move from that to the very large body of research on the effects of psychotherapy. We synthesize the results of the research efforts, while repeatedly making the point that all psychotherapists ought to pay more attention to research results. Our conclusion is that indeed psychotherapies affect clients, but not always positively, or the way the clients thought when they started, and certainly not all of the time. Many therapists find such a conclusion unappealing, and so will ignore the research results or seize on certain aspects to get rid of particular clients in the name of "good therapy." We stress the need for therapists to allow research results to appropriately influence their work, which generally they seem not to do, and the need for relative specificity of treatment, which is also often ignored unless the therapist is looking for a way to avoid treating a patient.

We raise the question of what makes therapy effective, and consider what a number of the major schools of therapy claim they can and will do for patients. Stress is placed on society's growing demand for accountability and the therapist's need to be as specific as possible with the particular client about what may or may not happen as the result of any designated course of psychotherapy. We conclude with our own explanations to our clients of the aims of our type of psychotherapy. In the process of discussions about goals, we make repeated notice of the role of the therapist, which becomes the subject matter for Chapter III.

Here the relative degree of importance of various therapist behaviors is discussed, based on synthesizing the empirical research on therapist variables. These include personality factors and demographic factors, such as race, sex, and social class, as well as the matching of patients and therapists. In particular we discern the positive effect of the good psychological health of the therapist. We then consider ways in which some therapists exploit their clients, and we muse about the fit, or lack of it, between the therapist's professed theory and actual practice. Thus foundations are established for the discussion of therapist behavior, and a number of interrelated occupational hazards can be considered.

In so doing one operates more out of an experiential base than a research one. There is a central narcissistic dynamic underlying the image of the therapist as a person, an expression of his or her selfhood as the therapist wishes it to be felt and perceived. For all psychotherapists, the "doing" of psychotherapy always involves certain problems, most of which have certainly received very limited attention, in research or otherwise. First we look at what the therapist brings to the therapy, and from this conclude that the doing of therapy affects therapists in various ways that definitely merit attention and remediation rather than the more usual varieties of resignation and accommodation to their presence. Our focus is on therapist fatigue,

the therapist's relationships outside of therapy, and therapists' attitudes about money. We stress the need for a greater understanding of the "hard work" of being a therapist, using examples of our own experiences in these areas.

We have provided evidence for the confirmation of a personality constellation of most therapists that so frequently entraps them. This is the general occupational hazard of narcissism, and we focus on this in Chapter V. We particularly demonstrate its operation in the obsessional personality, which is common among psychotherapists. The concept of narcissism is a recognizable and understandable one to therapists of all orientations, but it tends to be most often used as a psychodynamic construct; and so our explanation of its operations is primarily in psychoanalytic terminology. The therapist's behaviors can be features of his or her narcissism, illustrated through such activities and feelings as control, fear, anger, ambivalence, detachment, and demanding helpfulness. After identifying the problem and considering clinical examples, we raise the possibility of a "healthy narcissism" in the therapeutic relationship.

The range of narcissism, and in a broad sense, how the therapist can relate to the patient, brings us, in Chapter VI, to the issue of how therapists and patients "contract" to have a certain relationship. Contracts do exist, with their assets and liabilities, but our particular concern is the distinction between rational and irrational contracts. Most of the material contained in the literature has been with the former, while the irrational contract, which we consider the more influential for the course of therapy, has often been overlooked. We stress the need for its recognition, giving examples, and work our way into the useful conception of a "therapist–patient" alliance operating in the service of the therapy, yet largely unconscious. We discuss the appropriate recognition and use of this alliance, as well as harmful misconceptions by therapists about contracts.

In Chapter VII we face a controversial possibility resulting from one or more of the therapist's narcissistic manifestations. When we discussed the fact of an alliance we implicitly raised the question of the ending of the therapist–patient relationship by the therapist. Of course therapists and patients both make decisions about the ending of therapy, but our interest lies in why therapists terminate the process. It is often for reasons of the therapist's that are not necessarily related to the health or improvement of the patient. Perhaps for many therapists and their patients, therapy would be best conceptualized as having an unlimited duration. Countertransferential elements, the particular brand of therapist needs filling a great part of his or her fantasy, become striking in our consideration of the therapist's motivations for termination. They then take us into the broader territory of the therapist's fantasies, which is the subject matter of Chapter VIII.

Here we connect the concepts of narcissism, fantasy, and countertransference. The last concept gets a large amount of our specific attention, though within the framework of fantasy, particularly narcissistic fantasy. First we consider the therapist's ability to be aware of personal fantasies, and then the role of fantasy in countertransference. There is a general outline of the development and definition of countertransference, illustrating its application with clinical examples, plus a useful classification of countertransference responses. Then we move into the more general use of therapist's fantasy in psychotherapy. The need for an increased recognition of this is pointed out, which leads to Chapter IX where fantasy and fact may or may not match each other, but fantasy is certainly prominent. The dynamics and pragmatics of the private practice of psychotherapy are discussed.

The main concern in Chapter IX is with the relatively neglected area of the therapist's psychodynamics in regard to practicing psychotherapy independently. Pragmatic issues are mentioned, but to illustrate personal, intrapsychic concerns

of the therapist, since these are the principal issue. Such a focus is consistent with the central role played by narcissism and its derivatives. The movement into private practice by therapists can be conceptualized in developmental terms, particularly through understanding the symbiotic bond and separation-individuation phases as they originally occur, and as they are repeated throughout the therapist's life. The problems of narcissism as indicated in specific manifestations of anxiety, aggression, and guilt appearing as the therapist enters private practice are discussed. These feelings are seen as inevitable, and we stress the need for recognizing and managing them effectively, and indicate some possibilities for doing this. Such discussion leads to the necessity of a true self-accountability, which is an integral ingredient of healthy narcissism. We then move into Chapter X where views on the "good" therapist are offered.

At this point of the book, the last chapter, we briefly summarize the issues discussed. Our conceptualization of the good therapist is a relative one, namely an effective person who is "good enough," and we amplify our conception of healthy narcissism to show how that is a major element in the identity of the good therapist. The increasing concern with narcissism in the psychotherapeutic field could bode well for the improvement of the field, provided sufficient emphasis is given to the narcissism of the therapists. In this vein there are a number of ways to develop the reality of the concept of the good therapist. These propositions are the effective creation of a profession of psychotherapy, an appropriate integration of research and practice, and especially the incisive, yet expanded development of the self of the therapist. This last proposition requires significant concern with the therapist's value systems, cognitive activities, and personal/interpersonal behaviors. These matters have been addressed before, but they have been neglected, to the detriment of all concerned. Such neglect is certainly not in the best interest of therapists. Our concerns are not without precedent, though we address them in a rather unique way. Our hope is that the concerns are universal, and that numerous clinicians from all disciplines involved in psychotherapy will read this book. We then hope they will develop a new awareness leading to beneficial changes for the therapists and their patients.

Acknowledgments

While we collaborated on this book, speaking as a definite "we," the acknowledgments will be best expressed in an individual way. So, first Sheila Rouslin will express her gratitude, and then William G. Herron will express his.

After finishing the book I found myself reflecting on how it came into being. In the process it became clear that there were a number of persons involved, directly or indirectly. I am indebted to my coauthor, who knew me well enough to properly time a proposal that we write together what we had been formulating independently for a number of years. For that I am grateful, and also for the realization throughout the writing that indeed we knew and respected each other's unconscious more than we had consciously considered. It was and is an unspoken communication, and our friendship has deepened because of the experience.

I will be forever grateful to my mentor, Hildegard E. Peplau, who set the example of rigorous scholarship and clinical expertise. In so doing she influenced my entire career. She was one of the first and only persons who knew what to do with my rebelliousness and intellectual curiosity. At about the same time, I met Joseph Geller, who was to become my analyst and my friend. I have been guided by his unusual perception, his unending patience (except when it ends), and his beautifully complex, obsessional mind. Truly, without his "good enough" mothering and provision of a flexible "holding environment" I would have been unable to find and harness those qualities I brought to him. In addition, in many ways, for years he has lived through the material in this book with me.

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I would especially like to thank Aaron Welt, my partner and friend, who has taught me so much about initimate relationships. He has groaned and grown with me through the writing of this book.

Sheila Rouslin, October 1980
New York, New York, and Ridgewood, New Jersey

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Finally, my special and unparalleled gratitude goes to my wife, Mary Jane Herron. She taught me how to live.

William G. Herron, October 1980
Woodcliff Lake, New Jersey, and Jamaica, New York

About the Authors

WILLIAM G. HERRON received his Ph.D. degree in clinical psychology from Fordham University and is a graduate of the Adelphi University postdoctoral program in psychotherapy and psychoanalysis. He is a Professor in the Department of Psychology at St. John's University, Jamaica, New York, and in private practice in Woodcliff Lake, New Jersey. He is the coauthor of *Reactive and Process Schizophrenia* and *Contemporary School Psychology.*

SHEILA ROUSLIN earned her M.S. degree in psychiatric nursing from Rutgers University. Currently she is in private practice in New York City and Ridgewood, New Jersey. She is an Adjunct Lecturer at Lehman College, City University of New York, a contributing editor of *Perspectives in Psychiatric Care,* and the coauthor of *Group Psychotherapy in Nursing Practice.*

Contents

main seeing its enormous, confusing expansion—and move from that to the question of whether a definition of any utility can be created. The major attempts to do this have been through exploring a possible unifying concept for psychotherapies. The difficulties inherent in this are also illustrated.

There is another common approach, that is, sticking to a particular psychotherapy, with the smallest possible deviations. Admittedly there is no purity even in this, since "deviations" do occur, but psychoanalytic and behavioral therapies are used as homogeneous cases in point. Neither gets high marks for clarity. At the same time, there are the possible advantages of faith in the specific process for both therapist and client, and the probability of making some inroads into definition via specificity.

Finally, we explore the issue of competence, suggesting the formation of a profession of psychotherapy, and offering our own imperfect explanation of psychotherapy.

DEFINITIONS

Polatin, in 1966, attempted to provide a road map for treating psychiatric disorders, in which specific disorders were to be matched with specific therapies. In the process he offered the following definition: "Psychotherapy is a form of treatment in psychiatry relying essentially on the verbal communication between therapist and patient and on the interaction between the personalities of therapist and patient in a dynamic interpersonal relationship, whereby maladaptive behavior is altered toward a more effective adaptation, relief of symptoms occurs, and insights are developed" (p. 41).

What is unsatisfactory about this definition? First, there is marked disagreement in the field as to whether the techniques in psychotherapy should be considered "treatment," or "education." Then, "in psychiatry" is a restrictive phrase implying at the least that psychiatrists are the vast majority of the stockholders in the psychotherapy corporation. At the most, this highlights the controversy about who indeed is a psychotherapist (as opposed, some would say, to who should be a psychotherapist). By law in New York state, as one illustration, a number of major groups of professionals are licensed to do psychotherapy, independently, which is the key word. Psychiatry is only one of these groups.

The emphasis on verbal communication could be disputed because it excludes nonverbal procedures. Also, words such as "interaction," "dynamic," and "maladaptive" are subject to a number of interpretations of their meanings. Finally, the goals of adaptation, symptom relief, and insight could be argued as to both meaning and scope.

Admittedly this definition was proposed in 1966 and we are looking at it from the perspective of another fourteen years of the ongoing development of the field. These years have not made the definition unrecognizable, yet it certainly would not now get anything approaching universal acceptance, nor would it have even in the sixties. In a recent attempt at tracing the history of psychotherapy, Ehrenwald (1976) broadly depicts it as mental healing. In historical order this includes magic, philosophy, religion, and science, with overlaps in approximations in the time frame, and, currently, psychosocial components that mitigate the emphasis in a scientific approach aimed at rational insight. The problem of definition is painfully evident in the preface of Ehrenwald's extensive book. He states: "Psychotherapy on the contemporary scene seems headed in all directions at once" (1976, p. 5).

If anything, it used to be easier to define because there was less knowledge and less variety. Orne recognizes this in attempting to describe psychotherapy for the *American Handbook of Psychiatry*. He even begins by asserting that, "It is fair to ask

why psychotherapy (which after all is often described as old as man himself) has failed to develop a readily transmitted body of cumulative knowledge that can ensure the competence of its average practitioner" (p. 4).

He then substantiates the difficulty of having an "acceptable" definition. While citing a number of definitions, his conclusion is that all are inadequate, based either on their overinclusiveness or on their failure to make essential distinctions. In practice he sees psychotherapy as being used in a broad sense, which includes a host of "treatment" procedures, and in a more circumscribed way. The latter is considered the majority viewpoint by Orne, and "refers to a method designed to alleviate specific difficulties through the use of specific therapeutic procedures practiced by highly skilled professionals" (p. 7).

This is a relatively safe definition, imparting general information that is accurate, but the use of "highly skilled professionals" would be met with some arguments. First, there are the supporters of the peer self-help psychotherapy movement who want to eliminate professionals, and are part of a somewhat larger movement to deprofessionalize psychotherapy. Then, there is considerable disagreement among the professionals themselves as to what constitutes "highly skilled." This is a crucial concern, as illustrated by Orne's comment that "psychotherapy is defined more by *who* does it—by the role relationship and the training of the therapist" (p. 5).

Wolberg (1977), in his third edition of the comprehensive *Technique of Psychotherapy,* offers this definition, "Psychotherapy is the treatment, by psychological means, of problems of an emotional nature in which a trained person deliberately establishes a professional relationship with the patient with the object of (1) removing, modifying, or retarding existing symptoms, (2) mediating disturbed patterns of behavior, and (3) promoting positive personality growth and development" (p. 3).

As with the other definitions, this also has limitations. Wolberg admits the need for elaboration, and attempts it with regard to "treatment," "psychological means," "problems of an emotional nature," and most of the other components of the definition. Yet in so doing he espouses definite points of view that are not universally accepted, for example, the elimination of somatic modalities as forms of psychotherapy, or stressing the emotional nature of problems in contrast to emphasizing social factors.

While preferring his own definition to other ones, he nonetheless lists thirty-six other possibilities that reflect disagreement on technique, process, goals, and personnel. Thus a sampling of definitions indeed verifies the point made earlier regarding the unsatisfactory nature of any existing definition of psychotherapy. The next question: Why such a problem?

THE DEVELOPMENT OF PSYCHOTHERAPY

It seems accurate to date the beginnings of "formal" psychotherapy (or "scientific" psychotherapy, or what most professionals would call psychotherapy today) in the nineteenth century with the advent of psychoanalysis. At that time psychotherapy was a fairly circumscribed entity in terms of most of its components—treatment procedures, treatment agents, and problems to be treated. But it did not stay that way.

Instead, growth in a number of areas occurred, more or less at the same time, although they tend to be interdependent. There was a marked increase in therapeutic tactics, moving from hypnosis and free association to the addition of virtually hundreds of different procedures designed to produce behavioral changes. Along with this, the range of problems to which psychotherapy was applied increased. First, the type-of-symptom problems expanded from one neurosis to character problems and psychoses. Since then, there has been a trend to help the healthy be healthier, so that in