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SOME PRINCIPLES OF GENERIC PSYCHODYNAMIC PSYCHOTHERAPY

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MINDSPAIN

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Some Principles Of Generic Psychodynamic Psychotherapy

A Primer For New Psychotherapists



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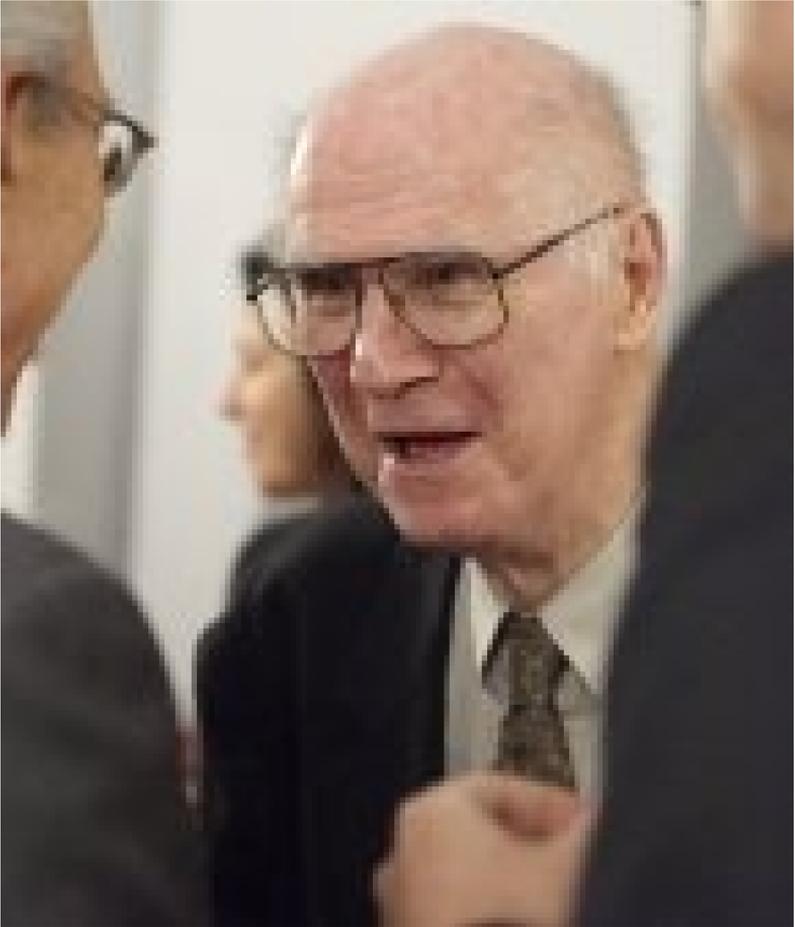
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Herbert J. Schlesinger, Ph.D.

Introduction

SOME¹ PRINCIPLES OF GENERIC DYNAMIC PSYCHOTHERAPY

First: Consider the question, “For which patient is this Generic Dynamic Psychotherapy² suitable?” Answer: For any patient within (or outside of) any of the DSM diagnostic categories who is disturbed by what we might consider to be the generic psychological disorder, distress that follows from an unresolved (and perhaps irresolvable) intra-psychic conflict. Although it may have to be employed somewhat differently for patients with various diagnosable conditions, it is **not** a specific treatment for any condition. **Neither is it** a treatment for the existential conditions (e.g., poverty, abuse, unemployment or discrimination) from which many patients in the public sector suffer, and it is **not** a substitute for social action to remedy those existential conditions, although it may be suitable for the conflicted state of mind that results from or is complicated by such existential conditions. In addition

¹ Not exhaustive.

² The term “Generic Dynamic Psychotherapy” implies that these principles are expected to apply across all patients regardless of official diagnosis or presenting complaint. They may need to be adapted to the particular needs or peculiar circumstances of individual patients and to classes of patients, e.g., diagnostic groups.

to profiting from the specific effects of treatment with generic psychotherapy, the patient may derive much good simply from becoming involved in a sound relationship with a “caring other,” which a would-be therapist ought to be capable of offering prior to obtaining the training offered in this seminar. “What are we treating” is a basic topic we should take up in class and return to frequently. If we do not continually consider what we might reasonably expect psychotherapy to remedy, we will invite treatment failure.

Although the treatment has no protocol and no “rules” or “frame,” it is guided by the cultural, i.e., conventional, expectations of proper patient and therapist behavior in a professional relationship. This is not to ignore that the clinic or agency in which you work will have some rules or “frame” to govern the conditions of treatment. “Generic psychotherapy” may be used within such ground rules, but does not require them. We will discuss the advantages and disadvantages of imposing a “frame” of rules on the patient vs. working without any, and how to work effectively and ethically within a larger social system (e.g., hospital, clinic or correctional institution) that imposes rules that govern how you work.

Second: Some characteristics of Generic Dynamic Psychotherapy – The treatment is open-ended but is expected to last no longer than is necessary to accomplish its goals. The beginning patient probably will have some expectations of psychotherapy that could be called goals. However, goals are not a fixed target. New goals often emerge in the course of therapy and some original goals may be discarded. We must discuss the concept of appropriate goals for therapy and distinguish the goals appropriate for therapy from the life goals of the patient. Family members and society may have different ideas

about what they expect you to accomplish. We will discuss the practical matter of how to focus on goals in therapy, and what it means to accomplish them or to approach them.

The treatment resembles ordinary conversation and largely is about what comes to the patient's mind. A better label for this psychotherapy than "Generic" might be "Conversational," by analogy to a Berlitz course in Conversational Spanish. The basic assumptions are that what troubles the patient will appear in that conversation, that the patient will want the therapist to understand his troubles, and wants the therapist's help in relieving them. By confirming these assumptions the therapist "**privileged**" to enter the psychological world of the patient and to be guided by the patient's agenda rather than imposing the therapist's agenda.

Third: How does this treatment help, that is, how does it bring about psychic change? Research and clinical experience tell us that the main therapeutic factor in all forms of psychotherapy is the quality of the therapeutic relationship, a matter that has been taken to be equivalent to the term "**therapeutic alliance.**" This term is much vaunted by some therapists and researchers and is much criticized by others as over-simplifying a complex matter, for example, as something one either has or does not have. In this seminar, we will regard the therapeutic relationship as the field in which therapy takes place, and in our case discussions, we will evaluate the balance of the transference and non-transference aspects of the relationship in each of the items below so as to be able to offer the increment that therapeutic skill can add to the salutary matrix of the helping relationship.

Given these characteristics of Generic Psychotherapy, the following "principles" apply...

Principle #1

The patient is always right.

A. However poorly his ideas or behavior fit with consensus or the “real world,” we assume they are coherent with a personal system of thought and an emotional context; probably one not yet seen clearly by those outside the system. **It is the therapist’s task to help figure out how the patient is RIGHT.** That is, what are the premises that would make the patient’s stance logically, if not factually, correct? In other words, the therapist’s task is to figure out the context in which the patient’s thinking and behavior would make sense. Consider, it doesn’t take special training to see how the patient is wrong in his thinking and unwise in his acting, and it isn’t usually helpful to point out how and when the patient is wrong; everyone before you has already tried that.

B. A corollary: **The patient is doing the best he can**, considering his limited understanding of the premises underlying his painful situation, the limits of his awareness of social (consensual) reality, and why his efforts to make things better don’t work.

Principle #2

These ideas lead to the sub-principle that the **therapist works with what the patient is doing rather than what he is not doing**, which has as a corollary, **“The clinical material is what the patient does, not just what the patient says.”** Speech is only one of the modes of communication used by all of us, including our patients. Most often, patient speech is tendentious, not merely communicative; it is intended to act upon the therapist, to get her to do (or not do) something to, for, or about the patient. One of our therapeutic intentions is to help the patient upgrade expressive actions and “action language” into symbolic speech. We will discuss this version of “interpretation” and other versions in class.

Principle #3

It is not usually stressed sufficiently that all of us, including the persons who present for psychotherapy, have an idiosyncratic sense of social reality. As most of us are from the same general “culture,” it is easy (and usually wrong) to assume that we have the same sense of reality as our patients. That assumption must be checked with every new patient and whenever necessary during treatment. Many of our patients show disturbed reality-testing, at very least a disturbed appreciation of social reality. This disturbance, which derives at least partly from early experience, shows up most clearly by distorting the patient-therapist relationship, distortions we summarize with the term “transference.” The immediate point is that the therapist should not assume that the “reality” the patient reports and in which he behaves is the same as that of the therapist; **it is the responsibility of the therapist to attempt to discover the nature of the psychological world in which the patient lives.** The patient may be “right” in the sense of Principle 1; that is, he may be behaving consistently with respect to his idiosyncratic sense of social reality. You may expect that when patients improve, their sense of reality will change.

Principle #4

Many if not most of the patients you will encounter in the public clinics are additionally disturbed in their basic cognitive functioning as a function of their particular emotional disorder, particularly schizophrenia or conditions in the schizotypal spectrum, including borderline conditions, and to a lesser and different degree, in the bipolar spectrum. Even when no longer “psychotic,” the patient’s cognitive functioning may still be sub-optimal. **Early in your work with the patient, it is essential to evaluate the kind and degree of impaired cognitive functioning because it will determine how you will have to interact with the patient to enlist the patient’s cooperation, his understanding and his willingness to try out new ideas in action.** In the psychotherapy of patients who regress easily, including some “borderline” patients whose sense of self (or identity) we presume did not develop fully at the developmentally appropriate time, the patient may feel invited, or permitted, or required to identify himself with (i.e., merge with) the therapist and thereby lose his own identity. Also, the therapist may seem to invite or permit more dependency than is useful for the patient or the therapy. It is likely that we will encounter several examples illustrating these issues in class. The principles

PRINCIPLE #4

in items 5 - 9, below, about keeping interventions simple; no more than one idea at a time, about gauging one's next intervention based on the patient's response to the previous one, and refraining from interrogating the patient apply particularly to such patients.

Principle #5

S **tart at the surface** (and stay there!). Mainly, keep your eyes (and ears) on what is going on between patient and therapist. Consider that process (in “shorthand,” “the transference”) to be the “surface.” **Consider first the function of what the patient is telling you**; what are the patient’s intentions at the moment; what is he trying to accomplish or prevent by what he is telling you, and especially, “**Why now?**” Subtopics include: **address affect before content, defensiveness before wish, and possible origins only when the patient seriously asks, “Where did that come from?”** Remember that the patient creates the “transference-figure” using you (the therapist) as the modeling clay. Transference is an expression of procedural memory and is enacted, not just spoken. As therapist, you will be treated as a composite of figures from the patient’s history as well as from your actuality. If you are not clear about what transference means and what it includes and doesn’t include, raise your question in class. Ditto about countertransference.

Principle #6

Preserve your split between participant and observer or, in this context, as transference object and therapist. When you find yourself “stuck” without any useful moves or feel therapeutically impotent, you should understand this unpleasant feeling as telling you that for the moment, you have lost your “therapeutic split” and have become reunited (i.e., fused) with the transference object. Rather than realizing that the patient is addressing the transference-figure (i.e., not you as therapist), you may want to reject the unflattering attributions as offensive and feel you have to defend yourself against slander! Alternatively, the patient may be feeling helpless and has managed to evoke the same feeling of helplessness in you so that both of you feel you have no moves left. Consider too that you may have allowed yourself to become a party in the patient’s story rather than a listener to it. Try to use this information to restore the split and regain your sense of personal safety, a position from which you can help the patient. The same considerations apply when the patient idealizes you in ways that make you feel uncomfortable.

Principle #7

A corollary to Item 6: the patient telling you his story (narrative point of view) most likely will be a good story teller. Like Aristotle and any other good listener, the therapist will tend to suspend disbelief, will insert himself into the story, and will experience the events narrated as if present while these events are unfolding. Note my shift in tense; the story time is now although the events took place then while the eager listener finds himself involved now as if he were there then. It is important to keep in mind that **the therapist's attention should be mainly on the patient's intentions, i.e., mainly on the story telling** (i.e., to whom [transference figure] is the story being told and why is it being told (to him/her right now?). What does the patient expect the transference figure to do? Consider that the content of the story may refer metaphorically to the treatment situation.

Principle #8

When intervening, consider that as in architecture, **“Less is more.”** The main idea is to **“Keep it simple”**; no more than one idea to an intervention; if you offer the patient half an idea, it may be better than offering a whole idea. First, modesty should encourage you to offer your ideas as conjectures rather than as certainties. Additionally, in line with our general purpose to promote the patient’s sense of agency, we want to encourage the patient’s active curiosity about the matter. Finally, if you offer half of an idea, you are entitled to hope that the patient will “catch on” and complete the idea if it resonates with his understanding; perhaps he might even take credit for the discovery. If, as often happens, the patient doesn’t “get it” or if he disagrees, all the better; then you should listen for (but rarely will hear) the patient’s better idea. Consider the patient to be an ally in this search for personal truth. In general, **keep your interventions brief — laconic, evocative, and empathetic.**

Principle #9

Psychotherapy is not a form of interrogation. **Questioning, especially repeated or relentless digging puts the patient into the position of a respondent who has to figure out what you “really want to know”.** If the general goal of psychotherapy is to increase the patient’s sense of agency, why make the patient into a respondent? Your interventions should facilitate the patient’s activity within the session, e.g., look for a show of curiosity and willingness to elaborate his story with useful detail. You will need to distinguish between detail that increases understanding from detail that mainly serves to fill the time and to keep the therapist from being active. This defensiveness is not “wrong,” and should not be thought of as “resistance” to the treatment; it tends to occur when the patient is not feeling safe, and if you understand it so, you should address the patient’s sense of safety as the issue of the moment in treatment. See also item 8.

Principle #10

A **bout questioning in general?** If there is something you believe you urgently need to know, first ask yourself what you would do with the information if you had it right now. Then ask yourself, if the information is essential at that point, why hasn't the patient told it to you, and deal instead with the withholding rather than attempt to get around the patient's purpose by demanding the missing information. Consider that it might make sense for the patient to withhold the information (i.e., to withhold it from the transference object). See item 1. again.

More on questioning: If you have a conjecture that is less than certain and you want to convey your uncertainty, rather than hiding your uncertainty behind a question you could put your notion affirmatively but tentatively, e.g., "Perhaps," . Questioning requires the patient to enter into your frame of reference when you should be trying to work within the patient's frame of reference. These points amplify item 1. and will need much discussion.

A further thought on questioning: How to reconcile this advice with the situation at the beginning of treatment when the patient, as when entering any treatment situation, may expect to be queried about his reasons for seeking help and his history?

We will discuss this seeming contradiction in class.

Principle #11

The main platform for **psychotherapy is (i.e., should be) a safe place for the patient to say what is on his mind.**

The therapist should keep at least one eye on whether the patient is feeling safe, and if not, to address that issue before others. The relationship between therapist and patient is the most important therapeutic element in psychotherapy, to which our seminar will aim to add a bit of skill. **Respect so called “resistance” as something the patient is doing for himself rather than against the therapist or against the therapy.** If it is against anyone, it is against the transference object. Go with “the resistance,” not against it. Think of the pendulum as an analogy; it cannot swing far before it has to swing back; if you want to keep a pendulum swinging, go with it, i.e., push it lightly when it is moving away. The main immediate purpose of the therapist is to help the patient continue to communicate (not necessarily in speech; recall, the patient has several modes of communication). The patient who responds by becoming silent, or by looking away, or by putting his head down is telling you something important about his/her current state, not just withholding something.

Principle #12

Psycho~~pathology~~ (i.e., pathological thinking) is maintained by relatively automatic repetition of defensive maneuvers, particularly by automatic patterns of thought that tend to pass unnoticed by patient and therapist. If you can catch one of the automatisms flitting by and repeat it aloud, slowly and thoughtfully, it will give the patient a chance to hear himself and permit self-criticism. Occasionally, you may hear something like, “Well, it seemed to make sense when I said it, but it doesn’t when you repeated it.” **In general, slowing down the pace of conversation promotes self-critical awareness.**

Principle #13

Rarely does a single (correct) intervention seem to accomplish much; that is, it will seem to generate “resistance,” i.e., caution and a wish to return to safety (because it implicitly threatens change as well as possibly provide some relief.) It is important to follow up your interventions. To put it figuratively, **it matters less what you say first than what you say next**, that is, how you deal with the patient’s response to your intervention. **There is no such event as “the patient did not respond,”** only that you weren’t alert to what the patient did do after you spoke (or after you didn’t speak when the patient expected you to), and you didn’t realize that was how the patient responded. In your follow up, go with the patient’s feelings first. See items 2. and 4. A corollary: The “here and now” point of view does not mean that what is past is unimportant but rather that your focus should be on what is happening now; if past events are being remembered, the memory is now and it is influencing the patient’s state now. Remember: therapeutic change happens now, not “some day.” Pay attention! Particularly the so-called borderline patient (and others not so well organized) may change instantly (i.e., seem to rise several developmental levels) when you respond empathetically at the regressed level of his presentation.

Principle #14

Some **intimations of progress and change** that therapists tend not to notice are the formal indications that a “phase” of therapy has ended. (See Schlesinger, *Endings and Beginnings* for definition and discussion). These indications imply ending in the sense that the problem that has preoccupied the patient seems to have lost saliency. They may include some accomplishment that the patient fails to mention, or a shift in the transference, or a change in the patient’s engagement in the therapy or with the therapist. The patient seems more interested in taking up a new topic or perhaps considers quitting therapy. Another phase may be about to begin. We will discuss these matters more closely in the second semester in the context of ending and termination. However, in both semesters, to repeat, it is important to **remember that therapeutic change is happening now, not maybe some day if only the treatment would last long enough**. Only occasionally, is it useful to call the patient’s attention to the fact that he is changing, perhaps to help him understand mixture of feelings of appreciation and pleasure that are dampened by more obvious sadness about loss. Remember, most patients do not come to psychotherapy to change; they would prefer other things and people to change to make them

feel better. For the few who would like to change, remember that even change that is welcome involves some loss (e.g., loss of a familiar symptom, or inhibition, or excuse from responsibility, or loss of the therapist's interest). Although the sense of loss belongs to the total experience and we would like the patient to appreciate it as such, the loss does not have to wipe out the gains, which might happen if the patient is more fearful of loss than eager to have the advantages that might accrue from changing. Sometimes it is better not to remark on your observation that the patient is changing until the patient notices it, and then comment on the emotional quality of the self-observation. It depends on the meaning of changing to the patient. (review item 4.)

Principle #15

You can understand patient's "stories" directly, that is literally, and also and more usefully, metaphorically. Like Aesop's fables, they may refer to matters that politically are too delicate to address directly, such as negative aspects of the relationship with the therapist. **Much good work can be done by staying with the patient "in the metaphor."** Usually, there is no need to "interpret", in the narrow sense of "translate," such as, "What you really mean is!" That kind of reductive and patronizing translation tends to abort the process, i.e., tends to stop the patient from communicating further. Rather, think of interpreting as a process of gradually enhancing meaning and watch how the patient's thoughts build toward enriching his understanding. It may become too uncomfortable when the patient notices that his thoughts and feelings have been drifting toward the therapist; then the patient is likely to change the topic. Sometimes, when the patient begins to sense that he has been speaking metaphorically he will interpret it himself, perhaps in the projected form of, "I guess you think I am referring to you." It is much better to allow the patient to do this rather than to do it for him. One can make it easier for the patient to include the therapist safely by couching one's remarks in an "**umbrella**" formulation, one that covers the personnel in

the metaphor and others, e.g., when responding to a patient's veiled accusation that he is being misunderstood, "Yes, I can see how easy it would be to jump to that (wrong) conclusion" In general, avoid reductive pronouncements, e.g., "What you really mean is ..."

Principle #16

Sooner or later, a supervisor will grow weary of hearing you tell about your patient's misbehavior and tell you that **you ought to set some limits**. Indeed, you may become fed up with (what you take to be) the patient's uncooperativeness in the face of your good intentions. What to do? First, it would be better to understand what the patient is doing, what you are doing and not doing, and why you and your supervisor are annoyed. A review of these Principles will suggest that the patient is telling you something by his behavior that you would rather not understand at all, or if you do get the gist of his thoughts, you would that he put them into civil speech! You might think that it is all very well for me to regard this misbehavior as communicative, but my supervisor says I have to do something about it and soon. We will discuss this dilemma in class when you have an example to illustrate it. In the meantime, consider as a Principle that **the only one you can set limits on is yourself**. As a therapist, you have no power over the patient other than the power attributed to you via transference, and that attribution is the root of the problem you are facing; the patient has knocked you off of your seemingly safe platform as benign but aloof therapist and is demanding that you (**as transference-figure**) take an unpleasant, dangerous, or unprofessional action,

and you are unwilling to go along (countertransference). The examples you will provide will give us the opportunity to see that for the therapist, “not doing something,” is as much an action as “doing it;” both compliance and refusal are on the action dimension, and you have become caught up in the very conflict the patient is re-enacting. How then to apply the Principle above?

Principle #17

Another way of looking at the idea of setting limits is to ask if there are patient behaviors that are inconsistent with obtaining psychotherapy, such as aggressive or sexual moves against the therapist, (or others, e.g., minors), or suicidal acts (or threats). Are there circumstances that require the therapist to deal directly with the patient's behavior in addition to (or instead of) considering it a communication in action to be understood like any other communication?

Principle #18

In many a treatment, the not-so-smooth course may erupt (or stagnate) into what your supervisor may call an **impasse or stalemate**; that is, the outer forms of therapy may prevail but nothing therapeutic seems to be happening, or perhaps the scene has become chaotic. In the instance of stagnation, an explosion might seem desirable; in the instance of an eruption, a demand that limits must be set will be heard. As in item 14., you will want to understand what the patient (and therapist) is communicating via this (mis-) behavior. Consider that the patient is telling you that he has run out of words to say that he is afraid to go on and also is afraid to lose you, and that this noisy or quiet interruption expresses just that fear and is a way to prevent dangerous movement. In the boxing ring, the equivalent would be a clinch; **a defensive maneuver to keep from getting hurt or hurting.**

Principle #19

Think about how you will end this episode of treatment from the very beginning of the treatment. Ending always implies separation and loss, and these feelings are among the most painful of human experiences. You should have learned how the patient has dealt with previous losses and separations. Watch at the endings of phases for the degree of discomfort about changing and improvement; do they imply fear of losing the therapist? Try to help the patient end each episode of treatment as a “mini-termination” by identifying and helping the patient work through the implications of abandonment and loss that accompany progress. Even if the patient will go on with another therapist, he will be better able to make a fresh start if you have helped him deal openly with the separation from you. (see *Endings and Beginnings*)

Principle #20

Perhaps you will think that this point should have been first on this list. Even though it may not be the first order of business in psychotherapy, you should **pay particular attention to the “precipitating event,” the matter that “caused,” or at least is blamed by the patient’s for his distress and often is given as the reason for coming to treatment.** It is not the first concern of the therapist because, **no matter what brings the patient to your office for a first visit, when he gets there (if he gets there, i.e., many intended first visits are cancelled) YOU are the problem,** you are a stranger of unknown power and possible danger to whom the patient feels he has to disclose all and at once (review item 9. on safety). As a matter of expectable clinical manners, you will make it possible for the patient to offer his theory about what made him come and what seemed to upset his previous equilibrium. At the same time, you will be observing his behavior; **listening to how he tells it;** is he eager or reluctant to tell his story. Does he tell it in the most general terms so that you can sense no personal meaning, or so full of minor detail that you lose track of the theme, or might even fail to notice that left out the important details. Keep in mind; it is not the blamed “event” itself, whether sudden calamity or expectable loss, but the **meaning**

the event had for the patient that is disturbing. Remember too, for most first therapy appointments in clinics, the patient was first seen in “evaluation” some while ago and then waited for “assignment.” Consider that the patient you are seeing is not the same person who called the clinic in the first place; you may be at a beginning point, but probably he is in the middle of things. What led the patient to the clinic in the first place and what was the (therapeutic) effect of the “evaluation?” Much of the fall seminar will be concerned with this transition and its meaning.

Principle #21

In the second semester, after a review of the other “Principles” we will focus on items 13.– > and deal with the issues of how to end an episode of treatment to obtain maximum benefit for the patient. **We will discuss the many ways in which patients (AND THEIR THERAPISTS) end treatment (and end other important relationships) and distinguish TERMINATION as form of ending in which the parties attempt to deal with the emotional aspects of ending and separation rather than seeking a painless way of saying “good bye.”**

Principle #22

Consider that at the end of your stay most clinical agencies will be satisfied if you noiselessly “transfer” the patient to an incoming therapist. Not good; you must learn to appreciate and foster the richness of feeling that often accompanies separating – both for the patient and therapist. We will discuss how to make elective even such scheduled endings as when you rotate off service, and **we will discuss ending by “terminating” treatment as most desirable when that mode fits the patient and the circumstances**, how to tell if it does fit, and how to do it. Only those endings should be referred to as a “termination” in which therapist and patient have dealt with the welter of feelings about separation and loss and the fantasy that he will lose the gains if he doesn’t stay attached to the therapist. Consider that, if left to themselves, **patients will tend to end an episode of psychotherapy in the way they have dealt with other important separations, motivated mostly by the wish to avoiding experiencing the pain of separation.**