Cognitive Therapy and Research, Vol. 4, No. 3, 1980, pp. 271–306

Some Views on Effective Principles of Psychotherapy

INTRODUCTION

The argument has been advanced by several writers in the field that with increased experience, therapists tend to become more similar in their actual clinical practice. It has been suggested that there exists a "therapeutic underground," which may rarely appear in the literature, but which nonetheless reflects some common observations among well-seasoned clinicians as to what tends to be effective. If this indeed is the case, then such commonalities are likely to shed light on some very significant principles of change, as they have managed to emerge in spite of the theoretical biases inherent in each of our varying orientations.

In looking for common themes, it is not being suggested that there are no real differences among varying theoretical approaches. The conclusion that "we all do the same thing" would represent a gross oversimplification. Nonetheless, a search for common principles can be of immeasurable help in advancing the effectiveness of our therapeutic procedures.

Toward the goal of searching for common principles, a group of prominent therapists were asked to comment on their observations of what

[1]Because this is a multi-authored article for a special issue of the journal, author reprints are not available. Information about purchasing this special issue can be obtained from Single-Order Sales Department, Plenum Publishing Corporation, 227 West 17th Street, New York, New York 10011.

0147-5916/80/0900-0271$03.00/0

they believed to be the underlying principles or clinical strategies associated with the therapeutic change process, particularly as it was relevant for nonpsychotic patients/clients. We were primarily interested in having them share the results of *their own personal experiences and observations as clinicians.* Clearly, it was assumed that what they believed to be the most effective ingredients in psychotherapy would be heavily determined by their theoretical and philosophical orientations. Nevertheless, theory often allows us ample room to vary in what we do in therapy, so a fair amount of individuality was certainly expected. This is precisely what we were trying to get at, namely, their own personal conclusions, as determined by the interplay of their clinical experience, theoretical orientation, and knowledge of research findings.

Representing varying backgrounds and theoretical orientations, the therapists that participated in this project were as follows: John Paul Brady, Gerald C. Davison, Paul A. Dewald, Gerard Egan, James Fadiman, Jerome D. Frank, Merton M. Gill and Irwin Hoffman, Walter Kempler, Arnold A. Lazarus, Victor Raimy, Julian B. Rotter, and Hans H. Strupp. Each of them was asked to respond to the following set of questions:

1. What is the role played by new experiences provided to the patient/client in facilitating change?
2. To what extent does offering patients/clients feedback on their thinking, emotions, and behavior facilitate therapeutic change?
3. In what way do you see the therapist–patient/client relationship as contributing to the change process?
4. How have you used language/cognition/awareness in facilitating change within the therapeutic setting?
5. What clinical strategies or principles of change do you believe to be common across all therapeutic orientations?

In answering these questions, the respondents were asked to make every attempt to avoid use of theoretical concepts. As a useful guideline, it was suggested that they imagine that these questions were being asked of them by an uninformed layperson, who was intelligent but unaware of any theoretical jargon. It was also emphasized that these questions be answered in light of those conclusions drawn from *their own personal experiences and observations* of what tended to work with the majority of nonpsychotic patients/clients. Their responses to each of these questions are outlined below.

Marvin R. Goldfried
Associate Editor

1. WHAT IS THE ROLE PLAYED BY NEW EXPERIENCES PROVIDED TO THE PATIENT/CLIENT IN FACILITATING CHANGE?

JOHN PAUL BRADY: I regard new experiences, that is, experiences of the patient since treatment was initiated, as critical to favorable change. It is only by behaving differently, trying out new responses to old situations, that the patient can hope to alter habitual maladaptive ways of responding. This is true whether the new ways of responding were simply discussed with the patient verbally or whether they were tried out in therapy through role playing or through actually entering situations with the therapist and behaving differently under his guidance and urging. Of course, the therapy itself may be considered "new experiences." However, I suspect these are not as drastically different from other experiences the patient has had as is generally believed. What may make therapy as new experience useful is the accompanying explanation or interpretation of the therapy-experience; that is, the patient perceives the experience in a way in which he has not perceived previous interpersonal communications. Of course, there are some highly structured therapeutic techniques, such as systematic desensitization and its variants, that may provide relatively new experiences because of their carefully programmed and structured nature.

GERALD C. DAVISON: I have absolutely no doubt that this factor is absolutely crucial for therapeutic change and that, indeed, it cuts across all therapy orientations. The subtle questions have to do with the *nature* of new experiences as well as with the way such experiences are brought about.

In my own clinical work, I view the therapy situation as one in which the client can try out new ways of thinking, feeling, and behaving both within the therapy relationship (that is, to myself) and outside the consulting room.

My belief is that clients build up over time a set of expectancies about what the world holds for them, what they are capable or incapable of doing. These beliefs about the future may come from a variety of sources, not all of which are important to uncover, in my opinion. But what remains critical is that the client encounter situations (actual, analogue, or symbolic) in which he or she has behaved in a predictable way, but in one way or another is induced to behave differently, to look at the situation differently, or some such thing.

As for *how* such experiences are created, I sometimes cajole clients into trying out something new, and sometimes become more heavy-handed under certain circumstances.

PAUL A. DEWALD: In psychoanalysis and psychoanalystic psychotherapy, new experience plays a crucial role in facilitating change. However, the experience occurs primarily in the two-person field of patient and analyst, and the analyst maintains a relatively circumscribed and constant form of neutral participation. The therapeutic situation and technique are designed to promote a return for the patient of earlier and at times forgotten forms, organization, and levels of behavior previously experienced toward key persons during the patient's earlier life and development. Progressively, these are reactivated and are felt and expressed toward the analyst (transference and transference neurosis).

The patient, however, maintains an adult perspective, while simultaneously experiencing childlike or infantile feelings states, wishes, and fears. These lead him to expect of the analyst responses similar to those that occurred or were fantasied in connection with earlier figures. By maintaining the neutral participant observer stance, the analyst provides the patient with a new experience of acceptance, understanding, and help in coping with conflicts and feeling states. The patient simultaneously experiences at a childlike level the old conflicts and feelings, as well as the new therapeutic experiences *at the same level of childlike regression.* The adult rational and self-observing portion of the patient's personality must then integrate and reconcile the other two levels of experience.

Another new set of experiences for the patient are those of being treated with attention and respect by a parental figure who does not seek to impose upon the patient his own values, behavior patterns, or demands, and who instead encouraged independence, autonomy, and freedom of choice in regard to value systems, self-awareness, and the experimenting and practicing of new behavioral responses to old conflicts.

GERARD EGAN: If clients have problems in living and if counseling can be seen, at least in part, as a problem-solving process, then new experiences are called for throughout all the therapeutic steps (see my answer to question 5). Each step calls for some kind of new experience.

I believe that new experiences are critical in facilitating change. New experiences together with new perspectives on self, others, behavior, and environment constitute the challenge dimension of the helping process. Counseling without support is destructive, but counseling without challenge is effete. Through new experiences clients learn that they can live life differently and more fully wihout being destroyed. "I am not as fragile as I see myself or as some others see me." Some of these new experiences take place inside the counseling relationship; others take place outside but are set up and supported by the counseling sessions themselves. For instance,

clients find out that they can talk intimately about themselves, whether to one other person in individual counseling or to a number of others in a group situation, without being destroyed. New experiences introduce clients to dimensions of developmental tasks that they are handling poorly, overlooking, or running away from. For instance, a client can learn that she can let down her guard and experiment with various ways of being intimate with others without surrendering values that are important to her and without being swallowed up by others. Most clients I see are "out of community" in some way and need to establish or reestablish some kind of community. This cannot be done without new experiences. Group counseling can be a start but cannot take the place of community "out there." Developmental tasks such as autonomy, intimacy, and identity and the ways in which they relate to one another can be discussed forever without having any impact on the ways in which clients live their lives. New experiences rather than just new ideas are the essence of the challenge dimension of helping.

JAMES FADIMAN: Without new experiences, there is no change. The central experience is feedback without blame. To be accepted not only for what one has been but for what one is becoming is an ongoing revelation.

Beyond therapy, the critical new experiences occur during moments of testing the insights acquired in therapy. Unless these tests occur, nothing (useful) has been gained but insight.

Except for those clients who are in therapy as a hobby, or those who use it as an ironclad defense, the surprises that occur are the core of the experience.

I wish it was my canny wisdom, understanding, and clarity that makes the differences. However, it is only after the client does something that is novel, something outside of therapy, that the insubstantial excitement of understanding is transformed into lasting change.

JEROME D. FRANK: In a sense, all psychotherapy is a new experience in that it provides the patient with a relationship with a helping figure that differs from previous ones and uses procedures that are not part of daily living. A powerful therapeutic force with many clinic patients is being taken seriously and being encouraged by a prestige figure to express their feelings for the first time in their lives. I have seen a patient abandon a socially crippling monosymptomatic delusion of many years' duration simply on the grounds that the doctor seemed genuinely interested in her and encouraged her to talk. Other experiences that may produce change directly through their novelty are arriving at a startling new insight, which causes a shift in

the patient's perceptions, or being challenged in a novel way by other members of a therapy group, thereby eliciting a new response.

Much of the therapeutic power of innovative psychotherapeutic procedures, as with new medical and surgical procedures, lies in their novelty, which stimulates patients emotionally, thereby increasing their susceptibility to the therapist, and arouses their hopes.

MERTON M. GILL and **IRWIN HOFFMAN:** There is little doubt that the therapist's personality and his manner of relating can often provide the patient with a new and beneficial interpersonal experience. However, we are convinced that it is of great importance that the patient be encouraged to verbally explicate the details and nuances of his experience of the relationship, including those aspects of it that seem to be new. First of all, sometimes what appears to be new experience turns out, upon critical reflection, to be a new edition of something old or to conceal something about the nature of the therapist's influence that both the patient and the therapist are inclined to deny. Secondly, even when the experience stemming from the effects of the therapist's involvement is entirely positive and genuinely new, there is much to be gained by coupling it with the special new experience that comes with direct communication about the relationship. We believe that changes that are brought about by this particular, unique kind of new experience in the therapy involve a maturation of the patient's reflective self-consciousness as a social being. These changes are likely to be the most far-reaching and enduring. The experience in the therapy increases the patient's self-awareness, which in turn modifies the way in which he experiences and copes with outside situations. These modifications lead, in turn, to new outside experiences, which further consolidate what has been achieved.

WALTER KEMPLER: If by "new" experiences you mean that something happens *within* the person that has not previously occurred—though they may have been through the same scene many times before and said the same things in it before—then yes, new experiences are our essential aspect of changing. When I quit smoking many years ago, I said, as I had said many, many times before, "This time I'm really finished." And as I said it, I experienced my saying it differently and knew I was finished. There was no "new experience" that I could identify outside of me. I was simply ready. Outside circumstances—situations—old and new experiences also lead to qualitative changes.

A therapeutic act is one that supplies the other—whether intentional or fortuitous is not significant—with a presence that enables the other to take the next necessary step. This ingredient, this catalytic agent, has infinite variations. One patient described my attitude toward a given issue (pain) as "not giving a damn," and from that perspective of *his* drew the

needed courage to make his next move. Another saw me as "really caring," while yet another described the catalytic agent in my presence as my "willingness to be vulnerable and let it all hang out." Another came unstuck when I was "wrong and told off." The descriptions are endlessly assorted.

ARNOLD A. LAZARUS: By definition, without "new experiences" there can be no change. A successful treatment outcome will reflect a wide range of "new experiences"—new thoughts, feelings, and behaviors, new improved ways of communicating with others.

There are data demonstrating that therapeutic change usually follows methods that are *performance-based.* Purely cognitive or verbal methods are often less effective. I therefore deliberately provide a series of performance-based "new experiences" for my clients to transact or put into effect. At the start of each session I customarily ask, "What new or different things have you done this week?" If the answer is "None!" one can be quite certain that little (if any) progress will have been made. Effective therapists, in my estimation, manage to persuade their clients to take calculated emotional risks. They inspire and encourage them to do different things and to do things differently.

Most people who consult therapists are in an unsatisfactory rut. Their restricted or faulty thinking limits their freedom of choices so that their actions, feelings, sensations, creative outlets, and personal relationships are often conglutinated. Only "new experiences" can provide the flexibility and the reinforcements they require.

VICTOR RAIMY: Almost everything I do in therapy consists of trying to provide the client with new experiences so that he can gain new perspectives on himself and on himself in relation to significant others. Such new experiences or new perspectives are intended to help him to detect and change his misconceptions.

For me, the new experiences form a continuum from the explanations or questions I employ to try to modify the client's thinking directly, through the small experiments I conduct within the interview in which the client can observe his own reactions, to the specific and concrete homework assignments where he can obtain further and often more elaborate feedback about his own reactions and misconceptions in real life.

In my experience, straightforward questioning of the client directed toward helping him to discover and deal with his relevant misconceptions can be an extremely powerful and new experience in bringing about change. In complex, emotional problems where the client is inhibited in discussing his often ambivalent thinking, the process can frequently be speeded up by asking him to close his eyes and imagine that the significant other is present but mute; the client then tells the imagined person what his "feelings" are

toward him. Homework assignments outside of the interview can also be helpful in providing the client with new perspectives.

All three kinds of new experiences—interview discussion, imaginary interactions within the interview, and self-observed interactions in real life—can provide the client with insight, which I define as recognition of a misconception.

JULIAN B. ROTTER: If one accepts the idea that a new thought is a new experience, then of course, all change follows from new experience. The person may or may not be aware of the new experience or the connection between the new experience and the changed behavior. If the question is being asked in the more restrictive sense of new experiences outside of the therapy room, it makes a great deal of sense from the point of view of social learning theory that such new experiences be heavily emphasized.

According to the social learning theory,[2] a change in the potential occurrence of any behavior is a function of (1) a change in the expectancy for a particular reinforcement to occur as a result of the behavior in that situation and/or (2) a change in the value of any particular reinforcement that is expected to occur in that situation. Consequently, any new experience that changes either expectancy or reinforcement values will change behavior.

While insight into the origins of behavior or insight into the future consequences of behavior can be highly significant for some patients, it seems reasonable that it is important for all patients to try out new behaviors in their present life circumstances and to discover for themselves whether or not they are more adaptive. It seems apparent from the frequent relapses following therapeutic gains (clinically and experimentally established) that the gains produced in the therapy room often do not generalize to outside circumstances. Generalization proceeeds along a gradient and if the therapist is seen as a social agent, he or she is typically much different from others, and the patient's behavior in relationship with the therapist is likely also to be different.

There is no special technique, no special method, no mysterious process that is presumed to accomplish therapeutic change. Verbal discussions, trying out new behaviors, suggestion, and a change in one's life situations all can lead to behavioral change. The major problem is one of suiting the method to the patient so that change is accomplished efficiently and beneficially. It is the therapist's job to get the patient to try out new behaviors or to seek out new environments or, in the case of children, to

[2]Rotter, J. B. *Social learning and clinical psychology.* Englewood Cliffs, New Jersey: Prentice-Hall, 1954; Rotter, J. B., Chance, J., & Phares, E. J. (Eds.), *Applications of a social learning theory of personality.* New York: Holt, Rinehart & Winston, 1972.

help produce such new environments; but it is ultimately the patient's choice as to whether to maintain the new behaviors and/or try to control his or her environment himself or herself.

HANS H. STRUPP: Basic to all forms of psychotherapy, whether or not it is acknowledged by the theory to which the therapist subscribes, is the patient's experience with a human being who, for better or worse, becomes a "significant other." Psychotherapy works because (a) all human beings have a strong tendency to "transfer" patterns of interpersonal relatedness[3] from the past to the present, and (b) this transference tendency can be utilized by the therapist to bring about a "corrective experience." Thus the essence of psychotherapy is interpersonal learning, a new significant experience (*Erlebnis*) that, if all goes well, modifies basic aspects of the patient's patterns of relatedness in ways that are called therapeutic.

With reference to (a), Freud's discovery of the universal transference tendency was revolutionary. He demonstrated that human beings learn their most basic patterns of relatedness from care-givers (usually the mother) in infancy and childhood. These internalized experiences form the "deep structure" governing experiences with significant others later in life. The fundamental reason for the pervasiveness of early learning experiences (particularly those pertaining to the receiving and giving of affection that form the substrate of the person's self-image and self-concept) is the small child's biological and psychological dependency on powerful adults. As a result, injurious early experiences (e.g., inadequate mothering, death of a parent, birth of a sibling) that are beyond the child's mastery become the source of conflicts and maladaptive patterns of behavior that tend to repeat earlier traumas.

With respect to (b), the therapist's attitude of understanding, respect, warmth, and acceptance promotes the reenactment of earlier difficulties in interpersonal relatedness. The therapist is helpful by providing a certain amount of genuine nurturance and by refusing to reenact the complementary role unwittingly assigned to him or her by the patient. Furthermore, by making explict the conflictual and maladaptive patterns emergizing in the patient–therapist relationship, the therapist enables the patient to restructure his or her experience in more adaptive and satisfying ways.

[3]By patterns of interpersonal relatedness I mean characteristic and often stereotyped ways in which a person relates to significant others. Such patterns become apparent particularly in situations that are affectively charged and that activate engrained (overlearned) tendencies of relating to care-givers and authority figures. Patterns of relatedness are often suffused by unconscious fantasies and contradictory strivings. They also tend to repeat traumatic experiences and are frequently troublesome because of hostile components that are experienced by the patient as ego-alien.

2. TO WHAT EXTENT DOES OFFERING PATIENTS/CLIENTS FEEDBACK ON THEIR THINKING, EMOTIONS, AND BEHAVIOR FACILITATE THERAPEUTIC CHANGE?

JOHN PAUL BRADY: A common practice of psychotherapists (including myself) is to label a bit of the patient's thinking, emotional responses, or behavior with the expectation that the patient will understand himself better and that this will facilitate favorable changes in these three interrelated aspects of psychological functioning. A hazard of this strategy is that the therapist may not correctly identify or interpret the patient's thinking, emotions, or behavior. Another hazard is that the patient will become defensive or offended by the therapist's interpretations. Although I find this strategy useful at times with selected patients, I do not find it a major treatment strategy. In general, I think it is more useful for the patient to identify recurring patterns in his thinking, emotional reactions to certain situations, or characteristic behaviors under particular circumstances and label them himself. Of course, the therapist may indirectly facilitate this process by eliciting the required self-reports from the patient and judiciously asking whether he can identify a recurring pattern and whether a given pattern is adaptive or satisfying.

GERALD C. DAVISON: Over the past several years my clinical practice and beliefs have changed in the direction of acknowledging more and more the importance of what we call feedback to the client. The therapist is in a unique, socially sanctioned situation to tell the client things that other people are unlikely to tell, such as how the client comes across to people. Often I will use myself as a barometer of what other people are likely to feel or think in reaction to the client. (The role of interfering biases by the therapist is obvious.)

All human beings, but perhaps especially those who are deeply troubled, do not have a terribly good idea of how they affect others by the way they think or act. I have often told clients that the therapy situation is a rare and treasured opportunity to learn things about themselves; I do this deliberately to further enhance the legitimacy of things that I will tell them about themselves.

PAUL A. DEWALD: In psychoanalysis and psychoanalytic psychotherapy, feedback is offered primarily in the form of verbal interventions. These are designed to bring to the patient's attention behavior patterns or meaning inferred regarding the patient's verbal communications of which the patient is not consciously aware. To the extent that such verbal feedback to the patient increases the patient's own self-awareness and allows the patient to recognize previously unconscious fantasies, emotions, and conflicts, as well as the ways by which the patient has previously sought to

avoid awareness of those mental processes, such feedback is a precursor for facilitation of behavioral change. Interpretation or other forms of feedback alone do not create change. Change occurs as the result of how the patient responds to and uses the feedback offered by the analyst.

GERARD EGAN: If new experiences constitute the "machinery" of behavioral change, then feedback is the oil that keeps it running. Feedback must pervade the entire process. *Ongoing* feedback is critical. Without reliable and valid feedback no one, including the counselor, knows whether the helping process is working. One of the tasks of counseling is to help clients discover sources of ongoing feedback in their lives. There are two very practical issues—the source of feedback and the content.

Initially, the counselor is the principal source of feedback. As soon as possible, however, clients must be taught to give feedback to themselves and to find in their environment natural sources of feedback. Again, group counseling offers a beginning since clients can get feedback immediately from peers in the counseling session itself.

Feedback on what? The answer to this question describes the *content* of feedback. Since I see counseling as a humanistic problem-solving process and the helper as a consultant to this process, the stages of the problem-solving process itself tell me what kinds of feedback are important. Accurate empathy, which is useful throughout the helping process, is a kind of feedback itself. However, clients need direct feedback with respect to (a) how clearly they are understanding their problems and needs, (b) whether they are developing new, problem-related perspectives, (c) the realism of their goals, (d) the comprehensiveness of their program census, and (e) the "fit" of programs chosen to their style and resources.

Of course, feedback is critical in helping the client evaluate the helping process itself. *Clients* need feedback to answer the three evaluation questions I have listed in my response to question 5.

JAMES FADIMAN: Feedback is offering a peculiar sort of mirror in which clients can observe their reflections. I focus on one or another aspects of peoples lives to encourage them to take one step beyond their normal reactions to their situation.

A story is told of a cat who complained: "What ingratitude there is in this world! Here I am offering free lessons in catching mice and not a single rabbit has signed up." Outside of therapy and special teaching situations, people are free to be satisfied with the cat's perception of the world.

To be able to examine one's preconceptions—one's filters against experiencing reality—is useful. Keep in mind that the cat's evaluation is accurate *and* incomplete. Feedback leads to completion.

JEROME D. FRANK: Any intervention that brings into conscious focus behaviors that are more or less out of awareness is potentially helpful.

Whether or not it actually motivates the patient to change depends a good deal on how it is presented and on the therapist's attitude. For patients who perceive themselves as victims of others' behavior, an especially useful form of feedback is that which clarifies how the patient's behavior or attitudes elicit these reactions. By discovering how they contribute to the difficulty, patients come to realize that they also can do something about it, thereby increasing their sense of competence. Through this kind of feedback the patient discovers that he or she is not a helpless victim of circumstances but has more control than he or she realized. Included in feedback should be the therapist's indication of his or her own reaction to the behavior in question, especially if it arouses the reactions of unfriendliness, boredom, or rejection that the patient experiences from others in daily life.

An aspect of feedback that does not depend so much on the therapeutic relationship is bringing to the center of attention maladaptive habitual behavior or words that are largely out of awareness. As with biofeedback of physiological processes, this helps patients to gain conscious control over them.

MERTON M. GILL and **IRWIN HOFFMAN:** The kind of feedback we find most effective takes the form, primarily, of tentative interpretations designed to further the process by which the patient becomes aware of and speaks openly about his experience of the relationship. On the whole, we do not favor feedback in which the therapist reveals his own personal reactions to the patient as a means of facilitating change. There may be some exceptions when the therapist is confident that all observers would similarly assess the patient's behavior. Otherwise, there is too much risk that in the process of revealing his own reactions the therapist will take on the mantle of a judge and neglect a joint exploration of how the patient experiences the interaction. Such joint exploration entails a special kind of dialogue. On the one hand, the perspective of the patient, which is subject to self-deception, is complemented by the outside perspective of the therapist. On the other hand, interpretations offered by the therapist are continually checked against what the patient finds through his own introspection.

While change in all psychological therapies depends on the relationship, therapies differ in the degree to which the patient's experience of the relationship is itself explored and explicated. There are barriers to the patient's free communication of his experience of the reltionship. To a significant extent the patient's inhibitions are related to what he thinks the therapist is prepared to hear and accept without reacting defensively or in any other adverse ways. One of the most compelling demonstrations of the therapist's receptiveness occurs when he recognizes and interprets the patient's hints about or disguised allusions to his experience of the relationship, including his impressions of the therapist. These interpreta-

tions should be offered as hunches to be affirmed, modified, or denied by the patient, never as fact.

WALTER KEMPLER: We do not "offer feedback" as a mirror or an apparatus. We are, and are seen as, living. We "feed back," filtering through our own perceiving and our voice, manner, attitude, posture, and how we are valued by the receiver are all part of the return arm of the process. "Feedback" is reminiscent of the old nonsense called the "objective" interpretation—both are fiction. We are speaking of our personal responses, or a variation of personal response in which we urge patients to reconsider what they have done or said. It can be done in many ways—by repeating it; with video replay; by asking, "Do you mean . . .;" by exclaiming, "You must be kidding!!"; by declaring, "That's absurd." How the therapist reacts is important, as is relevance and timing. But let's not pretend the impossible and sterile neutrality that I suspect is intended in the term *feedback.*

ARNOLD A. LAZARUS: Frank, forthright, and honest feedback is a rare commodity. Social protocol often demands a degree of tact and diplomacy that hinges on hypocrisy. Even good friends are often loath to provide one with honest feedback lest the other person take offense. And when loved ones do offer feedback, their perceptions are bound to be biased and may often be questioned. Therapists, on the other hand, are trained observers who can hold up a "psychic mirror" and allow clients to see things about themselves that might otherwise go unnoticed.

Feedback alone, without providing alternate (more adaptive) reactions or responses is limited. Errors in the client's thinking, emotions, and behavior may be clearly articulated in a supportive and empathic manner and still lead nowhere. "Thank you for the feedback. I see exactly what you mean, but I don't know what to do about it." Thus, while corrective feedback is often essential, it is rarely sufficient. The client needs to be able to accept the feedback, validate and integrate it; and finally, he/she needs to be taught to translate it into new actions and transactions.

VICTOR RAIMY: Verbal feedback that graphically encapsulates a client's misconception about himself or his relationships is for me the "therapeutic act" *par excellence.* In the well-known *Gloria* film in which Fritz Perls tells Gloria that she is a "phony," he immediately captures her attention, focuses it upon a misconception that interferes with her interpersonal relations, thus throwing into sharp relief her faulty assumption that she behaves toward others in a rational, genuine fashion.

This instance of uncomplimentary feedback is only an extreme example of how I believe most progress in therapy occurs. Ordinarily the therapist provides feedback when the client has not been able to grasp the

significance of his expressed thoughts, emotions, and behavior. Reflections, interpretations, and confrontations are all designed to provide feedback that enables a client to examine his thinking more critically, thus helping him to correct whatever misconceptions are affecting his adjustment. Similar feedback can also be provided for the client by asking him to observe his own behavior, thoughts, and emotions during new experiences arranged by the therapist within or outside of the interview.

Most of the feedback I verbalize is in the form of tentative questions in order to give the client as much latitude as possible so that he can concentrate on the content of the feedback itself without having to deal with the therapist's implied attitudes at the same time. I also try to phrase such feedback as graphically and tersely as possible in order to set it off from the often confused (for the client, particularly) dialogue of the interview.

JULIAN B. ROTTER: This question can be restated in two questions: (1) To what extent is it typical that patients are not aware of their behavior, thoughts, emotions (states of the organism)? The usual criterion for awareness is the ability to verbalize, and it is clear that there is a great deal about the patient's own behavior and ideations that he or she cannot verbalize, although there is also much that he or she can verbalize. Being able to describe one's own behavior, ideas, and emotions, including one's "true feelings," does not necessarily lead to therapeutic change, although it may facilitate it.

One problem is that feedback or insight is often incomplete. For example, the client's responses to a parent are extremely complicated, varying from situation to situation and involving a considerable variety of potential reinforcements, not only love and hostility. Broad, over-generalized interpretations (reflections) often are not convincing to the patient because he or she is aware that something is missing.

The greater limitation, however, is that such insight or awareness alone is not enough. It can only lead to therapeutic change when satisfying alternatives are available to the client.

The further question is: Is such awareness necessary? I think not. If the patient can learn alternative behaviors and find them satisfying, he or she can adjust quite well without being aware of what he or she is doing, thinking, feeling at all times, just as the rest of us do.

HANS H. STRUPP: In keeping with the foregoing conceptualization, patients benefit particularly from therapist comments ("interpretations") that place their current troublesome patterns of relatedness, particularly those with the therapist, in the context of major themes of their life history and thus highlight the anachronistic, maladaptive, and often self-contradictory character of the patient's goals. The therapist's efforts are consistently aimed at discovering the latent (symbolic) meanings of the patient's verbal and nonverbal communications—in this respect fantasies,

reveries, dreams and other relatively uncensored communications are particularly useful—and bringing them to the patient's attention. Noteworthy here is the universal human tendency to hide painful experiences and their aftermath from oneself, often by fending off (resisting) the person attempting to unravel and understand them. At the same time, the patient's most basic desire (which also provides the "motivation for therapy") is the wish to be accepted and understood.

Therapeutic change is basically structural change; that is, the patient learns to reorganize beliefs about himself or herself, the intentions and behavior of others, and the patient's feelings and behavior in interaction with others. Such reorganizations occur most dramatically and probably most lastingly in the context of *aroused affect,* provided the *nature* and *timing* of the therapist's interventions are "right." In other words, the patient must be in an optimally receptive state in order to benefit from the therapist's communications ("feedback"). For this reason, efforts by the therapist to promote reorganization, insight, and understanding at other times are probably of very limited utility. In short, the therapist's communications must be geared to the patient's current level of understanding, that is, his or her ability to experience them as meaningful. Therapy tends to be slow because these processes often cannot be hastened, although the therapist can endeavor to keep the patient "on track" by maintaining a focus on major conflictual themes and avoiding excursions into side issues.

3. IN WHAT WAY DO YOU SEE THE THERAPIST – PATIENT/ CLIENT RELATIONSHIP AS CONTRIBUTING TO THE CHANGE PROCESS?

JOHN PAUL BRADY: There is no question that qualitative aspects of the therapist–patient relationship can greatly influence the course of therapy for good or bad. In general, if the patient's relationship to the therapist is characterized by belief in the therapist's competence (knowledge, sophistication, and training) and if the patient regards the therapist as an honest, trustworthy, and decent human being with good social and ethical values (in his own scheme of things), the patient is more apt to invest himself in the therapy. Equally important is the quality and tone of the relationship he has with the therapist. That is, if he feels trusting and warm toward the therapist, this generally will facilitate following the treatment regimen, will be associated with higher expectations of improvement, and other generally favorable factors. The feelings of the therapist toward the patient are also important. If the therapist feels that his patient is not a desirable person or a decent human being or simply does not like the patient for whatever reasons, he may not succeed in concealing these feelings and

attitudes toward the patient, and in general they will have a deleterious effect. There are some exceptions to these generalizations, however. Some patients will feel frightened and vulnerable with a therapist toward whom they feel attracted, particularly if from past experience they perceive such relationships as dangerous (danger of being hurt emotionally). With such a patient, a somewhat more distant and impersonal relationship may in fact be more desirable in that it will facilitate the patient's involvement in the treatment, following the treatment regimen, etc.

GERALD C. DAVISON: This aspect of therapy is of the utmost importance. Even behaviorally oriented clinicians like myself have for some time acknowledged the importance of the relationship. Clients have to trust the therapist to tell the therapist things. Clients have to believe in the therapist to try to new things, to allow feedback from the therapist to have an impact on them, to feel secure about divulging terrible secrets about themselves or others. A relationship that is not a strong one will not encourage the client to explore alternatives and try out new ways of behaving. A technique will not be any more believable to a client than is the therapist suggesting the use of the technique.

PAUL A. DEWALD: As mentioned in questions 1 and 2, from a psychoanalytic perspective the therapist–patient relationship and interaction are crucial to the entire therapeutic process. As the therapy evolves and unfolds, the patient increasingly experiences in a living situation between himself and the therapist the earlier forms and levels of conflict that had produced or contributed to the patient's psychopathology. In this sense the patient–therapist relationship serves as a paradigm of interpersonal reactions and conflicts from which the patient can recognize and observe similar forms and level of conflict with others in his life and environment. The emergence of these conflicts in the treatment relationship offers a "laboratory" setting in which to explore and practice new forms of conflict expression, containment, or resolution, which can then be generalized by the patient to other relationships outside of the treatment setting. Different from other interpersonal relationships, the therapist avoids imposing new solutions or expectations upon the patient, thus supporting the patient's ultimate autonomy. To some extent this interaction also provides the patient with a model for imitation in connection with the work of the treatment and the willingness to tolerate painful or unpleasant emotional and psychological conflict. But if such imitation and identification by the patient with the therapist begins to limit or constrict the patient's autonomy, this is usually dealt with as a form of interference in the achievements of independent self-development and freedom of choice.

GERARD EGAN: I don't like to either underplay or overplay this relationship. I feel, however, that it is too often overplayed. This

relationship does not exist for itself but for the work that is to be done. Very often clients who come are "out of community" in some sense of that phrase. While it is important that they get into community with the helper in order to get about the work of facing developmental issues and the problems in living that face them, it is important that they not get lost in this relationship. When it is obvious that the person coming to me is out of community, one of my objectives from the very start is to help that person find and cultivate human resources in his or her own natural environment. I do not particularly want to become this person's professional friend. One of the reasons I prefer group therapy or counseling is that it demythologizes the role of the helper somewhat and provides a relatively safe forum in which the client can face the issue of relating to others. Even in group counseling, however, I believe that the issue of transferring what is learned in the group to the person's day-to-day environment needs to be tended to from the very beginning.

Certainly the relationship between helper and clients is important in that it gives the latter an opportunity to start from scratch, as it were, and examine precisely how they go about the task of relating to another human being. The helper provides both support and challenge as clients examine their interpersonal style. The skill of immediacy—the ability to reflect mutually on how this relationship is proceeding generally and the ability to take a look at what is happening at any particular moment of relating—is very important for both therapist and client. This, I believe, can be done in a way that contributes to continuing this process in everyday life.

JAMES FADIMAN: The relationship is a mix of blessings and impediments. When the therapist becomes an unrealistic, powerful figure for the client, it can lengthen therapy and obscure the client's concerns. The therapist's support can in itself be what allows fundamental changes to occur, irrespective of the content of the procedures.

I work with individuals and groups often as a consultant, not as a therapist. In that role I listen, interpret, offer feedback, deal with past traumatic events, clarify emotional overreactions, and so on. In these settings the client is encouraged to feel capable. The client is empowered from the beginning and the consultant is always in the place of the one who serves.

In some situations, one-on-one therapy may be an indulgence for the client and an uneconomical use of time for the therapist. Group work often quickly relieves clients of their attachment from the seductive charm of their pathology. As others work, people see a variety of solutions to problems that disconcertingly resemble their own.

I prefer to coach, educate, consult with, and assist people rather than assume the therapist role. My clients are less likely to develop dependency and I am less prone to hubris.

JEROME D. FRANK: This is the cornerstone of all psychotherapy. Without a good therapeutic relationship, any procedure will fail; with it, with most patients, probably any procedure will succeed. (That sometimes computerized self-administered programs may be able to alleviate some circumscribed symptoms is probably only apparently an exception since the therapist–patient relationship was involved in setting up the program and the patient's acceptance of it.) The core of the patient–therapist relationship is the therapist's ability to inspire the patient's confidence in him as being competent and concerned with the patient's welfare. Mere acceptance by the therapist for treatment, then, implies that the therapist values him and believes he can be helpful. This in itself boosts the patient's self-esteem, allays anxieties, and inspires hopes, thereby enabling the patient to become more flexible in his thinking and behaving, to face unacceptable aspects of himself, and to try out alternative ways of behaving and feeling. In addition, hope is probably a healing emotion in itself.

The patient's feeling of dependence on the therapist for help provides the latter with the necessary leverage—that is, it is the reason that the patient accepts the therapist's suggestions, formulations, and procedures. A good therapeutic relationship has been likened to the relationship between an appreciative audience and a performer in that the audience encourages the performer to do his best, and even to excel himself. In this sense, a good relationship also provides a suitable soil for personal growth.

I believe, without being able to document it with scientific evidence, that much of the therapeutic power of the therapist lies in aspects of the therapist's personality, the patient's personality, and their fit, which probably cannot be conceptualized in objective terms.

MERTON M. GILL and **IRWIN HOFFMAN:** We believe that the patient–therapist relationship is the central consideration in the process of change. We prefer to speak in terms of patient's experience of the relationship because we want to dispel any implication that what the relationship actually is can be understood without an examination of how the patient experiences it. We realize that an outside observer can come to fairly good guesses as to how the patient is experiencing the relationship, but we believe the test of any such guesses rests finally on the patient's account of the experience.

It is important to realize that all interventions affect the patient's experience of the relationship in ways that often are not recognized by the participants. When such efforts are left unexplored, there is a considerable possibility that the immediate interaction will be a repetition of an old experience or pattern of interaction. The revival of certain of these old patterns sometimes helps to restore psychological equilibrium and the patient's functioning may well improve. Such change may follow upon the patient's feeling reassured, forgiven, admired, or even punished. If the basis for the change is a repetition that is not recognized, the change may be

precarious, because whatever disappointment disturbed the patient's functioning originally could very well recur and have the same deleterious effects again.

WALTER KEMPLER: Exactly the same as any other relationship contributes. All of us—therapists, patients, people—change according to what happens or doesn't happen between ourselves and certain *powerful* or *influential* or *significant* others, whichever term you prefer, and regardless of how those others are empowered—through one's love, one's respect, or the others' force. The how, of course, contributes to the character of the changing. The ingredient essential in the changing process from my perspective is the presence of a worthy other: someone to be reckoned with, someone one can empower to measure oneself by or to lay oneself in the hands of, the worthy witness who knows when and how to give a hand or point a finger. How does one become the catalytic worthy other? It happens when I am relevant, that is, when I see the persons in a way they have not seen themselves and yet are able to recognize the validity of my perspective, *and* when I am able to deliver that relevance that touches them in a larger way than logically, cognitively, graspable by reason alone—often called "a moving experience."

The term *catalytic* agent appeals to me, for the actual *therapeutic act* is not what we do. We can only provide the context, the inspiring atmosphere, the inviting pointing. It is what the patient says and/or does as a consequence of our catalytic presence that is the therapeutic act—or change-producing behavior. I contribute (it's all through the therapist–patient relationship) to my patients' changing by saying and/or being, interntionally or fortuitously, just what the others happend to need at that moment in order to make their move.

ARNOLD A. LAZARUS: A good "working relationship" (rapport) is essential. A client who distrusts his or her therapist and/or questions the therapist's competence and abilities is unlikely to derive much benefit. An effective therapist provides responsible guardianship, inspires hope, and enables the client to achieve self-mastery. Role modeling is often an essential part of this constructive process—by selective self-disclosure and judicious guidance, the client is enable to "try on the therapist's problem-solving strategies" and then to reshape and mold them to fit his or her own personality and style.

Some therapists maintain that relationship factors embody all the necessary conditions for growth and change. Others play down relationship factors and emphasize methods and techniques. Most, however, would seem to agree that relationship variables are important, often crucial, but are generally insufficient to effect long-lasting positive treatment outcomes.

I notice an interesting variability in the type of relationship different clients tend to form. At one extreme are those who regard me as a loving,

indispensable, profundly significant guru (fortunately, I am able to keep these overzealous enthusiasts to a minimum), and at the other end of the continuum are those who desire a pure "business relationship" with a supposedly competent professional. I would say that the majority of my successful clients have tended to like me (rather than love me) and have considered me competent, trustworthy, concerned, and outspoken. Therefore they were willing to implement my suggestions, which provided the necessary reparative actions, the impetus for risk taking, and the cultivation of new experiences.

VICTOR RAIMY: For many years I believed that therapist characteristics such as warmth and acceptance were of the greatest importance in achieving a therapeutic alliance. More recently I have become impressed with the perhaps greater importance of the therapist's ability to demonstrate concretely his ability to help the client with his specific problems. Acceptance and confort certainly facilitate communication and maintain treatment, but now I believe that "going for the jugular" is even more important then warmth and accepance. The jugular is that complex of misconceptions that accounts for the client's problems. If the therapist can convincingly assess the client's misconceptions and then demonstrate their relevance to the client, a good therapeutic alliance can be established and maintained in spite of major lacks in warmth and acceptance. Distortions of the principle probably account for the financial success and sometimes the therapeutic successes of the quack and the charlatan.

The rationale for this principle can be illustrated in the work of surgeons, physicians, and dentists, who often inflict considerable pain and discomfort yet remain adored if not loved by their patients. Most patients and clients prefer restoration of health to warmth and acceptance, although in some therapy clients, such demonstrations by an established, admired professional may undermine a debilitating misconception.

Since the jugular is often embedded in an emotionalized morass of defensive and conflicting misconceptions that may take weeks to disentangle, warmth and acceptance are the everyday workhorses needed to cement the therapeutic alliance.

I also find that making salient the relevant misconceptions in transference behaviors can be helpful to the client by demonstrating their influence in the here and now.

JULIAN B. ROTTER: The patient–therapist relationship is crucial to the patient's developing an expectancy that alternative behaviors will be more satisfying, either in the present or in the future. The effectiveness of the therapist in achieving this attitude depends upon (1) the therapist's strength as a reinforcer, (2) the degree to which he or she is thought of as being objective, i.e., not having some personal stake in the person's change, and (3)

the degree to which the therapist is perceived as being knowledgeable, wise, and/or skilled. The willingness of clients to accept new ideas, try out what they consider to be risky new behaviors, and give up the hidden satisfactions of maladaptive behaviors is often dependent upon their trust of the therapist and their desire to obtain his/her approval. In group therapy situations, patients may act as each other's therapists and the same principles would hold. It is not necessary that all patients seek the approval or love of the therapist or that all patients consider the therapist wise or that both conditions hold in order to obtain change; but these are clearly very important characteristics of most therapies. Whether it is more important that the patient feel that the therapist is warm, sympathetic, and concerned or that he or she believe that the therapist has a great knowledge of human behavior depends on the patient. Therapeutic change takes place on the basis of a three-way interaction of therapist, method, and patient.

HANS H. STRUPP: Apart from some dramatic exceptions, the patient—therapist relationship is crucial for therapeutic change. This follows from the basic conception that the patient's difficulties and complaints are typically the product of disturbances in earlier relationships. Therefore, the task of psychotherapy is to bring about corrections in the patient's patterns of relatedness by superimposing a new (better) relationship upon internalized earlier ones. The new relationship with the therapist is curative in two ways: (a) it provides a direct experience in living with a mature and understanding adult, and (b) it uses the new experience as a framework within which the kinds of reorganization I spoke of earlier can occur.

In order for a patient to benefit from such an experience, he or she must have had some previous experience with a satisfying human relationship. By the same token, the more deficient, troubled, and destructive the patient's experience with significant others has been the greater will be the difficulties in achieving a corrective experience in psychotherapy. This is the reason therapy often faces an uphill battle and it defines the limits of what can be achieved in a given period of time. Patients with severely disturbed earlier relationships frequently have great difficulty in forming a good "therapeutic alliance" with the therapist, a sine qua non for therapeutic change.

In addition to the foregoing obstacles, a therapeutic relationship is often deficient because of the therapist's shortcomings. Prominent are lack of empathy, understanding, and sensitivity; deficient interest in and commitment to therapeutic work with the patient; exploitative and destructive tendencies, etc.[4] In short, unless the patient can "click" or "hit it off" with

[4]Hadley, S. W., & Strupp, H. H. Contemporary views of negative effects in psychotherapy: An integrated account. *Archives of General Psychiatry,* 1976, *33,* 1291-1302.

the therapist as another human being, limited progress or failure (negative effects) may be expected.[5]

4. HOW HAVE YOU USED LANGUAGE/COGNITION/ AWARENESS IN FACILITATING CHANGE WITHIN THE THERAPEUTIC SETTING?

JOHN PAUL BRADY: Most of the therapy I conduct entails the use of language and includes exploring the way the patient sees himself and his world (cognition). However, the manner in which I do this varies vastly from patient to patient. For example, with some it may entail exploring the manner in which the patient interprets his own behavior and that of other people with whom he comes into contact, including exploring the implied assumptions the patient uses in making such an analysis of himself in the world in which he lives. With another patient, it may entail exploring his fears and by the use of language identifying the environmental cues that seem to elicit it. With still another patient, the emphasis may be upon teaching the patient specific skills for coping better with interpersonal and environmental challenges (overcoming shyness, relaxing in situations that provoke maladaptive physical tension, speaking more fluently by pacing his speech, or reducing anxiety that limits his effectiveness by being more assertive in certain kinds of social situations).

GERALD C. DAVISON: *All* therapy with adults is necessarily cognitive in nature. It is inconceivable to consider a therapy that does not rely on the ability of the client (and of the therapist!) to think, to consider things abstractly, to turn things over in one's mind, and so forth.

Now, whether awareness of the historical origins of one's behavior is necessary is a separate matter, and I do not personally believe that this is always necessary. And yet I must confess that I cannot spell out for you under what conditions it is or is not necessary, nor do I believe anybody else can.

In any event, the obvious truth is that outpatient therapy, at least with nonpsychotic individuals (and probably with psychotic people as well), rests utterly on language and cognition.

But your question asks *how* I use language/cognition, and that is a far more difficult question. The best I can do, without resorting to jargon, is to say that one can replicate virtually the entire range of human experience with language employed in the consulting room. The client is assumed to have the capacity to transform the therapist's language into information that

[5]Strupp, H. H., Hadley, S. W., & Gomes-Schwartz, B. *Psychotherapy for better or worse: An analysis of the problem of negative effects.* New York: Jason Aronson, 1977. Pp. 354.

has an impact similar to actual experience. But language can do more than experience itself, it seems to me, by permitting more abstract consideration of things. It is as if the client is enabled to turn over a geometric figure resting on a table so as to examine its underside, and how it appears to a person sitting across the table.

PAUL A. DEWALD: As mentioned under question 2, the therapist's verbal interventions are designed to enhance and increase the patient's own awareness in regard to the meanings and patterns of his psychic life and experience, providing a bridge between present and past behaviors as well as a bridge between behavior in the therapeutic setting and behavior outside the treatment situation. Such cognitive awareness serves as a precursor for change, providing insight and recognition, which the patient may then use from the vantage point of his adult self-observing capacities to recognize when behavior is rational and when irrational, and thus it serves as a tool to be used by the patient in gradually modifying subjective as well as objective behavior patterns. Insight and cognitive awareness do not by themselves produce change but become tools used by the patient to promote change.

GERARD EGAN: People usually do not solve problems unless and until they get new perspectives on what they are currently doing. The assumption is that the way they see things now is not helping them handle developmental crises or problems in living. They get these new perspectives in basically two ways—by new behaviors (this was discussed in my response to question 1) and by new insights or new ways of seeing things, that is, through language/cognition/awareness. For me, one of the principal functions of confrontation is precisely this—to help clients develop the awarenesses they lack. This can take place in simple ways, for instance, through information sharing. Some people act in self-defeating ways because they lack certain information. It can also take place in more complex ways through various kinds of challenge, that is, invitations to consider less subjective perspectives that are being overlooked. A number of different therapies provide very useful methodologies in this process of challenging. For instance, I use rational-emotive techniques quite freely to help clients develop new perspectives. I think that script analysis developed within transactional analysis is also a powerful tool for developing new perspectives. In the problem-solving model I use, these techniques are most useful when the client must make choices, that is, when he or she must choose issues to be explored, set goals, choose programs, evaluate the helping process, and determine whether to continue or terminate the process. Language/cognition/awareness procedures in conjunction with various forms of behavioral challenge are especially useful whenever a client gets "stuck" in some way. For instance, some clients lose heart when they are trying to carry out programs to achieve need- or problem-related goals. Language/cognition/awareness techniques at this stage can help them

discover the resources within themselves and within their environments that they need to carry on. These techniques are very useful with people with flagging motivation.

JAMES FADIMAN: Every way I can think of, read about, observe, and practice. My task is to establish, on a trial basis, alternative realities for the client's consideration. I often pose an idea or a situation in which a client's usual patterns will not be adequate or even plausible. The tension between those patterns and the demands of a novel problem force alternative possibilities into consciousness.

I might ask a peson to evaluate the Golden Rule, for example, to consider it as a prescription for damaging relationships and demeaning other people. Grappling with this idea allows people to sift rapidly through their knee-jerk morality, their simplistic religious training, their resistance to authority, their capacity for logical thought and perhaps obtain some insight into those behaviors that display self-hatred. Language is the framework, awareness and flexibility the goal.

Language provides me with clues to the nonfunctional portions of a client's belief system. To the extent that a client is stuck, fixated, attached, or neurotic about some beliefs, he or she will benefit from "shocks" or surprises to that part of the system. Language is an ideal carrier for such shocks.

My intention is to reinforce the capacity for change without punishing the need for continuity, for remaining fixated.

JEROME D. FRANK: I try to help the patient become more aware of his patterns of behavior and feelings through identifying their antecedents and consequences and how they express or attempt to cope with motivational states such as anger or fear. It is often useful to relate present behaviors and feelings to earlier ones, or to point out how feelings appropriate to a past situation are reactivated in a contemporary one. It may be particularly useful to view a symptom as a self-perpetuating and self-defeating attempt at communication through which the patient is trying to control the behavior of others without being aware of or taking responsibility for what he is trying to do. Thus the symptom may be an effort to placate another, to win sympathy, or to get the significant other to gratify a patient in other ways.

All these interventions can be seen as in the service of heightening the patient's sense of self-efficacy or mastery through (1) labeling or attributing meaning to subjective states or behavior that had been inexplicable or mysterious, and (2) encouraging the patient to try out the new behaviors toward significant others that follow from the insights he has gained.

MERTON M. GILL and **IRWIN HOFFMAN:** Interpretations designed to promote self-awareness, whether they are addressed to the patient's

experience in the therapy situation or to his experience in outside situations, can be useful and lead to change. However, we find that interpretations addressed to the patient's experience of the immediate interaction with the therapist are likely to have the most impact for several reasons: First, as a participant, the therapist has more intimate knowledge of the immediate interchange; second, what is being examined is also more immediate in the patient's experience; third, the therapist's attempt to make explicit what the patient believed was forbidden to speak of directly, in itself, provides the patient with a new interpersonal experience (see question 1). When the patient is encouraged to examine his experience of the relationship, including the therapist's immediate influence or impact, he has the opportunity for a new interpersonal experience and for new understanding simultaneously. For example, in the very process of discovering, with the therapist's help, what may be the repetition of an old pattern of behavior in the interaction, he finds himself engaged in an interaction that is different from any he has experienced before. Thus the kind of insight that we want to promote is inseparable from the type of new interpersonal experience that we think is the most powerful facilitator of change.

WALTER KEMPLER: *Language*—my words come deliberately, carefully, and quickly—before I can think about them. I use words, thoughts, phrases for impact, not for understanding, as a rule—in or out of therapy.

Cognition—sometimes offered as a map to provide courage to take the trip. Also, sometimes when I'm tired and worthless as a therapist and not quite aware of it, I offer cognitions.

Awareness—I "use" my awareness to shape my witnessing and pointed reactions. If I believe the other needs encouragement, harshness, clarification, challenge, my silence, my talking—whatever—I tend to become it. My awareness and its consequent behavior changes from moment to moment, sentence to sentence, and is usually not in consonance with what the other believes is needed from me at that moment. Through my awareness and behavior I incite behavior that leads to change; awareness (theirs) may or may not follow. If it does, it may not correspond with mine and that's as it should be. Cure comes through what the other does, says, discovers. I avoid preempting that with direct disclosures of what I am aware of.

On occasion, and as a last resort, I sometimes provide my awareness and have seen beneficial results. But then it is presented with my personal reaction—often desperation, helplessness, or vulnerability—and I suspect it is my candor rather than the content that carries the impact.

ARNOLD A. LAZARUS: I would like to emphasize again that therapeutic change usually follows methods that are performance-based, whereas purely cognitive or verbal methods are often less effective. Yet to rely

entirely on performance-based methods is to miss the obvious reality that our cognitions and images stimulate our actions. Our expectations and anticiptions determine our behaviors. Thus misconceptions, false ideals, gaps in knowledge, and irrational philosophies may require specific changes in language/cognition/awareness before new instrumental responses (behavior change) can be promoted.

It needs to be underscored that a shift in language/cognition/awareness often *follows* a behavior change. But the present question seems to be addressing those instances where a lack of awareness, semantic errors, and/or irrational ideas lie at the core of a client's problems. In these instances I have found the caveats about "premature interpretations" somewhat misplaced. It is my custom to forge ahead with a didactic repertoire of procedures aimed at correcting self-talk, disputing faulty notions, remedying gaps in self-understanding, and promoting a repertoire of social skills. The art of effective psychotherapy rests heavily on one's ability to convey these verbal inputs in a manner that permits the client to assimilate and integrate them. Otherwise, a change in meaning will not necessarily lead to a change in functioning. In my own therapy, I rely very heavily on the use of metaphors and analogies that permit me to "speak the client's language" and thus facilitate the attainment of constructive ends.

VICTOR RAIMY: All of my efforts in therapy employ language in attempting to discover and modify those client misconceptions that hinder adjustment. This principle aplies to all phases of treatment from the initial effort to modify whatever misconceptions the client may have about my approach to therapy, through trying to discover the relevant misconceptions that maintain his maladaptive behavior, through modification or elimination of misconceptions to enable him to attain the goals he seeks. Since misconceptions are the end product of thinking (cognition), they must exist in the client's awareness. I make no use of unconscious processes as I have not found the construct helpful. I may, however, agree with a client that some of his motives may be unconscious in order to avoid intellectual digressions and arguments.

Some form of thinking, which for me includes manipulation of visual and kinesthetic imagery as well as words, seems to be basic in bringing about constructive as well as destructive changes in behavior. My primary efforts are directed toward helping the client discover those end products of his thinking that interfere with his adjustment to his reality.

The target misconceptions are often entangled in a variety of defensive misconceptions as well as complex confusion. The very frequently encountered ambivalence toward significant persons illustrates the presence of conflicting conceptions as well as confusion. The emotion produced by ambivalence enhances the confusion. Conscious, verbal sorting out of the

conflicts and the confusion can often be facilitated by providing new experiences for the client.

JULIAN B. ROTTER: If it is desirable that any changes in behavior or ideation in response to some specific set of stimuli are to be lasting, generalize to other similar stimuli, or repesent the start of a "benign cycle" leading to other behavior changes, then it is clear that all such changes are enhanced by language. This probably just as much true of relaxation or behavioral shaping procedures as it is of insight therapies. Language enhances generalization.

In psychotherapy based on social learning theory, problem solving plays a special and important role.[6] Such techniques as looking for alternatives, trying to discover the motives and feelings of others, exploring the benefits of taking more risks in trusting others, understanding that one can change his or her environments rather than merely being the victim of them, and consciously exploring the long-term effects of specific behaviors are examples of problem-solving attitudes that can provide the client with the potential to deal with new problems outside of the therapy situation. To develop such attitudes on the basis of nonverbalized experience would take both tremendous control of the client's environment and an enormous length of time. Only by language can such problem-solving skills be developed relatively quickly and be resistant to extinction. This principle holds true for children as well as for adults, although the language and the concepts may have to be simplified, depending upon the age and intelligence of the child. Even where relatively little explanation is made by the therapist, if lasting and relatively generalized changes take place, it is probable that the client himself or herself has verbalized new attitudes. Learning that one does not have to experience anxiety at the sight of snakes or high places may be useful to the client, but it is probably the ideal that he or she can control his or her own behavior that is more important and produces the most beneficial effects. It is through language that a patient can become willing to try out new behaviors and persist through painful therapy because the rewards of the effort have been verbalized by the therapist or the client himself or herself.

Behavioral techniques can often be of considerable use as part of a therapeutic regime. But it is likely that their major value is not in establishing new conditioned responses but in establishing new cognitions.

HANS H. STRUPP: I view the good therapist as an exquisitely sensitive and refined clinical instrument whose major contribution to therapeutic change, apart from the not inconsiderable ability to mediate a good

[6]Rotter, J. B. Generalized expectancies for problem solving and psychotherapy. *Cognitive Therapy and Research,* 1978, *2,* 1-10.

interpersonal experience, consists of his or her skill in being keenly attuned to the inner struggles of another human being. The therapist resonates to the patient's experience and places his or her own reactions (associations, fantasies, affects, comparable experience, clinical acumen) in the service of the therapeutic task. The creative use of language is the major vehicle by which the therapist assists in the production of structural change. The therapist's efforts at understanding are often groping and imperfect.

A brief example may serve as an illustration: The patient, a young woman suffering from a fairly severe borderline condition who had been seen in long-term therapy, displayed morose affect during the hour, complained of being used, exploited, and criticized by her boss, and eventually communicated in highly indirect ways that she had similar feelings toward me. In a preceding hour she had expressed the wish for my vacation to start soon (I had announced earlier my plan to take a brief vacation). Seeing herself as the victim of an impending separation (= rejection), she experienced herself as dependent and needy but also as wishing to be needed and exploited. While the parallel to a comparable experience with her father was clear, she rejected my attempt at interpreting her current experience in the context of the earlier one. However, she was unable to deny her anger and resentment at me—these were empirical data we could both see. It was also clear to her that I had not been exploiting her and that she had distorted her present experience with me in terms of constructions she had unwittingly placed on it. By pointing out these facts to her, I believe I was able to accomplish a piece of therapeutic work. This was made possible by (a) our basically good relationship, (b) her enactment of a previous experience in the presence of affect, (c) the presence of incontrovertible data we could both see, and (d) her willingness to listen and be confronted, albeit in a painful way, with facts that demanded a reorganization of her cognitions and emotional reactions.

5. WHAT CLINICAL STRATEGIES OR PRINCIPLES OF CHANGE DO YOU BELIEVE TO BE COMMON ACROSS ALL THERAPEUTIC ORIENTATIONS?

JOHN PAUL BRADY: It is difficult to generalize about this because no clinical principle seems applicable to all treatment situations. Nevertheless, one might generalize about the following strategies and principles:

a. Development of a therapist–patient relationship, characterized by trust, mutual respect, and positive emotional feelings.

b. Procedures and strategies that will increase the patient's expectation of a positive outcome or benefit from the treatment program.

c. Strategies and procedures that will increase the patient's sense of self-worth, mastery of his environment, and general effectiveness.

d. Related to the above, tactics and strategies that will in fact make the patient more effective in handling certain situations and in overcoming maladaptive fears and help him act in a manner or engage in behaviors that, in his own view and that of others, make him a worthwhile, effective person. This may sound circular but it is an important point. For example, a stutterer will generally speak more fluently if he has more confidence in his ability to communicate effectively. Thus part of the treatment is in fact to improve his fluency rate by whatever means possible. However, it is important that he recognize the increase in fluency as evidence of his greater interpersonal effectiveness. This perception and awareness will further increase his fluency and motivation to change. Thus there is a synergistic effect between actual improved performance in real-life situations and the increase in sense of effectiveness and self-worth.

e. New ways of behaving, thinking, and feeling in therapy, whether through simple discussion, role playing, or the like, need to be practiced in the natural environment to ensure their persistence and generalization, with details of these experiences being brought back to the therapist.

f. The patient should be encouraged to view his behavior, thoughts, and feelings as ultimately under his own control, and must assume responsibility for change in treatment.

GERALD C. DAVISON: A time-honored truth is that much of human behavior is a function of its consequencs. While I hardly adhere to the belief that *all* behavior is regulated in this fashion, it seems to be obvious that at least some behavior is sensitive to its payoff in the environment, or the environment as construed by the client.

I believe also that all therapies—at least sensible ones—help clients introspect about how they *feel* about things, often beyond what is obvious. Therapy, then, requires a fair amount of interference by the therapist and considerable skill in getting the client in touch with affect that is not normally attended to. The Gestalt therapists are at one end of this continuum, behavior therapists using something like systematic desensitization at the other. It is in this way that I myself use "insight."

Another strategy is the "Try it, you'll like it" intervention. The therapist is like a salesperson in a clothing store, encouraging the customer to try things on for size, even if the color and material do not seem right. Clients must be encouraged to attempt something they may never have before considered for themselves, to see how it feels, to consider what benefits and risks it holds for them.

I believe also in the importance of placebo, suggestion. People in pain are unusually open to social influence and to having their expectations directed by the therapist.

Finally, it is my abiding belief that therapy overall is a moral enterprise, that we are society's secular priests, that we basically offer clients a philosophy of life, a set of biases not amenable to empircal test. Most of the time we do so unwittingly, which is dangerous and, I believe, in itself unethical.

PAUL A. DEWALD: In a previous paper[7] I described 10 principles or strategies by which various therapeutic orientations could be compared. Each of the different therapeutic orientations uses these components in its own way, and I see no common strategy that is equally applicable to all forms of therapy.

Even if one looks at this question from such broad vantage points as the therapist's personality or the therapist's faith in his own treatment methods, there are still patients within each of the therapeutic orientations whose responses to treatment are highly variable both within a particular therapeutic orientation and across such orientations.

At the most general level of all might be existence of a relationship between patient and therapist as the setting within which therapeutic change occurs. However, the nature of this relationship and the way in which it is used is highly variable among different therapeutic orientations, and I can see no clinical strategies or principles in this area that unite all therapeutic orientations.

GERARD EGAN: I believe that when any therapist of any orientation is successful, she or he uses, knowingly or unknowingly, a substantial number of principles found in a full problem-soving paradigm. I do not consider something as basic as problem solving as a "therapeutic orientation." But I do see it as a tool for organizing the principles and techniques used in all therapeutic endeavors.

Good therapists, since they are also good problem-solvers or good consultants to those with problems:

- Establish decent, nondependent relationships with clients.
- Help clients explore problems, needs, wants, conflicts, developmental tasks.
- Help clients see which issues are most critical and set priorities.
- Challenge clients to develop new perspectives through discussion and action.
- Help clients set up realistic, behavioral goals related to presenting needs.
- Help clients take a census of possible programs for achieving each goal.

[7]Dewald, P. A. Toward a general concept of the therapeutic process. *International Journal of Psychoanalytic Psychotherapy,* 1976, *5,* 283-299.

- Help clients choose programs best fitted to their own style and needs.
- Support and challenge clients to invest themselves in chosen programs.
- Help clients find resources "out there" to do all the above.
- Help clients in an ongoing way deal with the three principal evaluation questions:

a. Are you investing yourself realistically in goal-related programs?
b. Are the programs helping you achieve the goals you set?
c. Does achieving the goal or goals take care of the presenting need or problem?

Good therapists provide support and challenge for this entire process. They also realize that the process is not necessarily as linear as presented here. As consultants, they help clients move back and foth in this model in ways that are most in keeping with individual needs.

Finally, good therapists help clients make sense out of and deal with the multiple systems of their lives and the developmental tasks that are worked out in the context of these systems.

JAMES FADIMAN:

a. Change is possible.
b. Change is more likely with support.
c. Support is easily offered, difficult to accept.
d. Therapists derive pleasure, even joy, from seeing people change.
e. We all have unfulfilled needs for omnipotence and unconditional love. These needs carry therapists of all persuasions through the boring, difficult, and repetitive times in therapy.
f. Therapists care. It disturbs each of us that people suffer excessively. Even the most mechanistic or messianic therapist hopes that every individual can be helped; that suffering can be lessened, pain reduced, satisfaction increased, and ignorance dissipated.
g. There is an urge, or a drive, toward health, awareness, wholeness, certainty in each of us. It is this drive that facilitates and underlies the success of all therapeutic interventions.
h. Along with the dogmatism and foolishness that permeates every school of psychotherapy, there is a core of humility that allows learning. Any realistic therapist knows that the tools are imperfect, the theories tentative, and the results ambiguous.
i. It is a difficult, distressing, demanding, and meaningful occupation with considerable opportunity for improvement.

JEROME D. FRANK: The common principles of change include:

a. Inspiring the patient's hopes, which may be healing in itself and also encourages the patient to explore him- or herself and enter situtions he

or she has previously avoided out of fear, and to try out new ways of dealing with problems.

b. Providing new occasions for both cognitive and experiential learning.

c. Arousing the patient emotionally, which seems to facilitate patients' susceptibility to the therapist's interventions.

d. Heightening the patient's self-esteem and sense of mastery through attributing meaning to previously inexplicable experiences in terms of a coherent conceptual framework and providing experiences of success.

Most therapies may also "extinguish" dysphoric emotions by allowing the patient to experience them repeatedly in a nonreinforcing or actively supportive context.

MERTON M. GILL and **IRWIN HOFFMAN:** A good relationship is probably a common factor in all successful therapy, whatever the orientation. The therapist must inspire trust, at least enough so that the patient can invest and actively participate in whatever therapy is attempted. When therapy promotes new development rather than merely restoring previous states of equilibrium, it undoubtedly is associated with new experiences occurring either in the context of the therapy relationship itself or in the context of outside situations. New awareness or insight may also be inevitable, at least to the extent that the patient realizes that his old ways of responding are not absolutely necessary and that new alternatives are possible and within reach.

Therapy can be extraordinarily powerful when the three factors mentioned—a good relationship, new experience, and new awareness or insight—are integrated into a single process. This integration can be approached when the therapist and the patient work collaboratively to explore the patient's experience of the relationship. However, even then, there is an inevitable greater or lesser residue of inadvertent interpersonal effects that escape detection and examination.

WALTER KEMPLER: The desire to be of value to another crosses all therapeutic orientations. But what is inherent in all people is neither a strategy nor really a private principle of therapy.

The principle of engaging, of moving toward or in relation to another, is the essential principle in common—essential because it is only in the context of one another that the possibility for change can live.

The most common strategy in common, unfortunately, is the attempt to be more than one is through the use of tactics, techniques, and strategies.

ARNOLD A. LAZARUS: Given the proliferation of several esoteric and radical departures from traditional psychotherapy, is it nevertheless possible to identify unifying constructs or methods that hold true for *all*

therapeutic orientations? Perhaps in a generic sense one can refer to the existence of a viable relationship, even if the relationship is between client and computer. But one element that necessarily transcends all treatment boundaries is the presence of *hope.* Presumably, the analysand who spends years on a psychoanalyst's couch has the hope and expectation that benefits will ensue, just as those who follow the ministrations of Gestalt therapists, behavior modifiers, bioenergetic analysts, rational-emotive therapists, transactional analysts, or whatever, have optimistic beliefs about their therapeutic potential.

VICTORY RAIMY: I suspect that there are four primary principles for producing change that are common across all therapeutic orientations:

a. The therapist's ability to facilitate communication with the client.

b. The development of a therapeutic alliance.

c. The discovery in some fashion of the client's relevant misconceptions.

d. The changing of these misconceptions in some fashion.

Facilitating communication seems to be the *sine qua non* of all therapies ranging from the behavioral through the psychoanalytic.

The therapeutic alliance is necessary to motivate the client to work on his problems, whatever the methods employed, as well as to bind the client to the therapist to ensure his remaining in treatment. The therapeutic alliance is produced by some mix of the therapist's personal characteristics plus his ability to convince the client that he understands his specific problems and can help him.

Misconceptions can be "discovered" in many ways, ranging from behavioral and Gestalt techniques, which concentrate upon the immediate present, to psychoanalytic techniques, which under optimal conditions can trace the same patterns from early life to the present. Inappropriate emotional reactions are excellent clues to significant misconceptions. The same misconception can be made manifest to the client experientially, in the terminology of a particular approach, or in everyday, commonsense language.

Since misconceptions are "ideas" or "conceptions," they can be modified or changed by all the methods that change ideas—by logical explanation, by encouraging the client to examine his own ideas critically, by having the client demonstrate errors in his thinking through contrived or natural experiences, and sometimes by modeling relevant behaviors. Different therapies use different techniques to the same end.

JULIAN B. ROTTER: The variety of techniques that presume to be psychologically therapeutic is indeed great. They range from mediation to constant activity, from anxiety-enhancing to anxiety-reducing, from "deep" insight to massage. It is not clear that anything is common to all of

these methods. However, there are a few things that seem to be true of successful therapy regardless of the method employed. One of these is that increasing the patient's belief that he or she will get better, that he or she will be able to achieve a more satisfying adjustment by doing what is required in the therapy, is related to successful outcome. Consequently, it is probably true that in all therapies the therapist either overtly or subtly uses techniques to increase the patient's expectancies for improvement.

It is also true that in most therapies the therapist's caring attitude and acceptance of the patient as a worthwhile person is an important variable. Such behavior is probably necessary in order to build up the therapist's reinforcement value for the patient and to get the patient to try out new behaviors, consider new ideas, take risks, and expend effort. It also is valuable in maintaining persistence of patients over periods when they do not perceive any positive change taking place.

Of course, from a social learning point of view, what all therapies have in common is that they result in changes in expectancies and reinforcement values and, consequently, changes in behavior potentials. However, the variety of techniques used to accomplish this is extremely diverse.

HANS H. STRUPP: I view all forms of psychotherapy as varieties of interpersonal experiences that promote learning (structural change). For such experiences to be successful there must be (a) a therapist (or a group) who is willing and able to provide such an experience and (b) a patient who is willing and able to profit from it. Obstacles to therapeutic change derive from deficiencies in any aspects of the foregoing specification.

The goal of therapy is to help the patient to think, feel, and act differently. The objective can be reached in many different ways, and I question seriously whether there can be a single technique or set of techniques useful to all patients. Instead, what a particular patient can use is highly idiosyncratic; in other words, psychotherapy must always be tailored to the needs of the individual patient and his or her capacity to profit from it. It is difficult if not impossible to write prescriptions for a meaningful interpersonal learning experience, but the following ingredients seem essential:

a. The therapist must be experienced as genuinely interested in the patient as a person and committed to helping him or her.

b. The "lessons" mediated by the therapist must be experienced by the patient as meaningful and helpful. In the process, the patient must have a consistent experience of mastery and success.

c. Psychotherapeutic learning can only occur in the present; thus the patient's *current* transactions with the therapist are of crucial significance.

d. Since maladaptive learning that brings patients to psychotherapy is typically associated with painful earlier experiences that have not been

properly mastered and integrated, psychotherapy must be aimed at helping the patient with this task. A corollary of this proposition is that resistances the patient places in the path of therapeutic learning must be systematically confronted and resolved.

EDITORIAL COMMENT

We are indeed fortunate to have been able to obtain the pooled knowledge and insights from such a group of prominent leaders in the field. Their responses to these several questions clearly provide us with an important step toward obaining a consensus on clinical principles of change. We hope that further efforts toward this goal will involve ongoing and more direct dialogues among representatives of varying theoretical viewpoints, conducted within a context of cooperative collaboration. And while no attempt will be made here to offer a comprehensive analysis of the material provided by our respondents, a few comments will be offered to highlight some of the more obvious themes that seem to have emerged.

To begin with, one is struck by the very strong emphasis placed on the importance of new experiences in the therapeutic change process, which was referred to as "critical," "crucial," "essential," "basic," and the like. These new experiences have been observed to occur in the relationship between patient/client and therapist, as well as outside of the therapeutic session. Such experiences, according to our respondents, can have the effect of creating changes in the clients' perspective, both toward themselves and toward others. Language was viewed as an important vehicle for facilitating such new perspectives, especially by conjuring up and helping to tie together relevant experiences. It was also noted that a patient's/client's changing perspectives can at times be supplemented by the therapist's feedback. In this regard, several of the respondents reminded us that therapists need to be ever alert to the possibility that their own biases may color such feedback attempts. The therapeutic interaction was also referred to as being "crucial" or "central" to the change process, as it provides patients/clients with a relationship in which they can obtain a new awareness or perspective, a setting in which they can experience a new way of relating to another person, and a place where they may be encouraged to relate differently to others in their current life situation. Also emphasized was the importance of a caring, trustworthy, and confident attitude by the therapist, who encourages patients/clients to become more autonomous and to experience a greater sense of self-mastery.

In any attempt to outline common themes, we ultimately need to look directly at what clinicians from various orientations actually do, with an eye toward detecting themes that get at a level of abstraction encompassing the

diverse techniques one is likely to encounter in the clinical situation. In trying to specify what actually "works" clinically, we need to continually guard against the danger of our theory and research becoming too far removed from the clinical foundations of our generalizations.

Since the relevance of any clinical principle will depend on the particular case at hand, any future dialogues and observations should revolve around the search for common themes that exist in dealing with specific clinical problems (e.g., fears, depression, various addictions, sexual problems). What can emerge from such efforts would be the generation of hypotheses that can serve as the basis for a program of clinically meaningful research. Speaking as a behavior therapist interested in both clinical practice and therapy research, I believe that this is clearly a direction in which we need to go. We invite the readers of this journal to offer their reactions to any of the issues discussed above.

M. R. G.