INTRODUCTION TO THE TECHNIQUE OF PSYCHOTHERAPY

ABOUT THE AUTHOR

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Soon after he received and M.D. from the University of Chicago (Rush), he was called up for service with the Army Medical Corps in World War II. Returning after five years, he began psychiatric training at New York University Bellevue Medical Center and later, psychoanalytic training at the Karen Horney Psychoanalytic Center in New York City.

After years of private practice in New York and Miami, he was appointed Visiting Professor at the University of Florida and Chief, Mental Health Clinic at the affiliated V.A. Medical Center. He has contributed to professional journals as well as to popular publications. He is the author of *Neurosis Is a Painful Style of Living* (New American Library) and *Euthanasia and Assisted Suicide: Psychosocial Issues* (Charles C Thomas).

He and Rose, his wife for over forty years, live in Gainesville, Florida, with their three cats.

INTRODUCTION TO THE TECHNIQUE OF PSYCHOTHERAPY

Practice Guidelines for Psychotherapists

By

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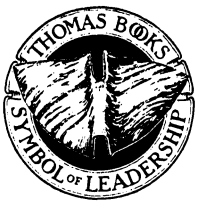
Foreword by

Ronald Alan Shellow, M.D., F.A.C.P., F.A.P.A.



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For Rose

FOREWORD

I met Sam soon after he moved to Miami. It did not take long before the community recognized his talents as a clinician and as a dynamic teacher interested in education for all the mental health disciplines. In a relatively short space of time, he was elected President of the South Florida Psychiatric Society and Founding President of the Behavioral Science Institute.

Mainly, it was as a practitioner, teacher, and supervisor of psychotherapy that I developed the greatest respect for Sam Greenberg. He practiced his own brand of analytic/dynamic psychotherapy. It was based, not slavishly, on the teachings of Karen Horney, but it was mostly Sam Greenberg. His psychotherapy was comprehensive, eclectic, optimistic, practical, and effective. The same year I met Sam, Bernard Glueck–who had been an expert alienist for Clarence Darrow in his defense of Leopold and Loeb–said, "I no longer advise patients to wait until after their analysis to marry. When I first began psychoanalysis, analysis took a few months, and marriages lasted forever. But, now it is the other way around." Sam's treatment was long-term by today's standards, but it did not last forever. His patients got better, and many of them maintained their improvements, after only a few months of psychotherapy.

As teacher and supervisor, Sam listened very carefully to what his students said and did, just as with his patients. Although he indicates in the book that he is not an admirer of DSM-IV (He and I differ on this), he is, in reality, a good psychiatric diagnostician. He tells us how he does it–by having a format in mind, taking a comprehensive history, and a careful, observing examination of the patient. He then advises on how to conduct psychotherapy with various patients and with special consideration of certain problems.

As always, he is free to tell us what he did, by example, to his pupils what to do and what not to do. If a reader speaks with many psychotherapists, he will find most are secretive about what they really do in the privacy of their offices. Sam is not. He tells us what he does

clearly and concisely. He tells us how he conducts psychotherapy. He says it directly, no fuss, no fanfare. Just like Sam Greenberg.

The book is clear enough to instruct, without frightening, a beginning therapist. It is complicated enough to allow the experienced psychotherapist to gain a few "pearls." Some years ago, in an informal consultation, I told Sam of an intervention I had made with a patient. He responded by saying, "If you don't know what to say, you are better off keeping your mouth shut." It was good supervision, and I never forgot it. It is in the book, a little gentler, but it is there.

And, I believe it will help another generation of psychotherapists who practice in an environment of managed care which discourages this type of therapy. I predict that if one follows Samuel Greenberg's psychotherapy, responds to case managers with words similar to those he gives us, and allows results with patients to demonstrate the efficacy, the therapist will get approvals and get paid for helping patients in this way.

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PREFACE

There are now many fine books on psychotherapy, but the author felt that a basic, simply written book, with a minimum of theory, would be helpful to the beginning therapist. This is a practical book and I tell what I do. I have tried to capture the informal tone of an older therapist talking to one who is just starting out. It is a short book, not comprehensive, that includes only the more important issues that I have learned in 40 years of study, practice, and teaching. I learned most from my mistakes, and those of my colleagues.

The emphasis is on individual, dynamic psychotherapy. Once these fundamentals are learned, then technical procedures from the other theoretical approaches that have proven helpful can be added to the therapist's repertoire. There are no pure forms of psychotherapy. In time, each therapist will develop her own style depending on her temperament and training. Some techniques she will follow exactly, modify some and reject others. No therapist can do everything well, nor be comfortable with all patients.

Psychodynamic therapy is the legacy of the psychoanalytic movement. It is known by a variety of names: analytically-oriented, uncovering, expressive, interpersonal, etc. Psychoanalysis made monumental contributions to the understanding of human character and motivation, and to therapy. Unfortunately, the classical technique was rigidly applied and slavishly followed the original experimental model. Even so, it helped many.

Freud has been criticized for the last 100 years, but we are all in his debt for the great contributions: that feelings and behavior may be determined by unconscious forces (what you don't know can hurt you), the crucial importance of childhood, the special importance of sexual development for neurosis, and that dreams are meaningful.

Dynamic psychotherapy is based on these fundamental concepts, but the technique has been modified to conform to the scientific and economic temper of the times. We have learned to use time, and

money, more carefully. A last comment: I use the old-fashioned term *neurosis* instead of the politically correct mental disorder. The DSM's are useful for research and insurance reports, but in therapy we treat a whole person, not one divided into Axes I-V.

S.I.G.

ACKNOWLEDGMENTS

I have been studying all my life and am indebted to many teachers. My patients not only paid me, they also taught me. Most of all, I feel indebted to the teachers and colleagues at the American Institute For Psychoanalysis in New York which was founded by Karen Horney.

I am grateful to many friends and colleagues who have given generously of their time and provided valuable feed back. Especially do I wish to thank Susan Walen, Linda Provus McElroy, Robert Hornberger, Frank Sieka, Ross McElroy, John Kuldau, and Ben Greenberg.

Thanks also to Michael P. Thomas, Virginia Meyers, William H. Bried, and the editors at Charles C Thomas, Ltd. Their help is much appreciated.

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IRREVERENT OBSERVATIONS

The unconscious contains the theories of the analyst.

Meyer Maskin
Late, Professor of Psychiatry,
Emeritus, University of Florida

You always know who the patient is–
he's the one who pays the other fellow.

Harold Kelman
Late, Dean, American Institute for
Psychoanalysis, Karen Horney
Center, New York

INTRODUCTION TO THE TECHNIQUE OF PSYCHOTHERAPY

PART 1
BASIC PSYCHOTHERAPY

Chapter 1

INTRODUCTION

Beginning therapists sometimes ask older ones: "What does a therapist really do?" The answer is: "You listen." This doesn't seem to be a very satisfactory answer; it's so commonplace. Upon reflection, it makes a lot of sense. Therapists are masters of the commonplace, they are professional listeners. This quality of listening is not to be underestimated, it is hard work. It is also rare. Few people really listen to others. We live in a world full of noise, people talking and shouting at each other, but not really listening. Also, in therapy, a unique relationship is developing between the talker and the listener.

The psychotherapist gives the patient her full attention in a setting that tries for a minimum of distraction. She usually doesn't even answer the phone during the session. The therapist wants to learn: what kind of person is this man who wants help?–what is he out for? –what's wrong with him?–what's right with him? She listens not only to the words, but to the person. The therapist tries to put aside her own prejudices and listen with an open mind, no axe to grind. Is the patient frightened, angry, depressed, frustrated, arrogant or burdened by self-contempt? An important result of the process is that the patient begins to listen to himself.

Of course, the therapist does much more than listen. He observes how the patient talks, dresses, moves, and so on. He encourages the patient to speak freely, and he asks questions. He wants to know the story of the patient's life. Above all, the therapist wants to develop a helping, nonjudgmental relationship where the patient feels free to talk about things he never faced before. He is not alone, he has a therapist who also is interested in understanding the things that worry him.

Therapists also help the patient develop insight by their interpretations and, when appropriate, give support, reassurance and advice. We have learned much about human character and motivation in the last

hundred years. While each patient is unique, we can safely assume that he or she shares many traits in common with all other human beings. We don't have to approach each new patient as a research project that has never been done before.

It is wise to proceed cautiously. We don't like to make mistakes at any time, but especially at the beginning, mistakes are costly. Respect the tenacity of chronic symptoms; the patient has not been able to solve them in all this time. Until you know a great deal about the patient, don't rush in with answers to problems which have plagued him for many years. It is safe to assume that behind every question may be a problem. You can say: "We'll try to find out." You can also answer, with a question.

The therapist is not obligated to cure the patient. Depressions, phobias, panic attacks, unhappy marriages, destructive life-styles and all the other symptoms for which patients seek help are usually not resolved quickly. That happens regularly in books and the movies, but rarely in real life. Sometimes, they will not be resolved at all. The therapist is responsible only to see that the patient receives careful, competent treatment. The beginning therapist would like to achieve quick results; it would be reassuring for him. It usually doesn't happen.

DEFINITIONS

A simple definition of psychotherapy is that it is treatment by psychological means. A more formal definition is that of Hans Strupp: "Psychotherapy is an interpersonal process designed to bring about modification of feelings, cognition, attitudes and/or behavior which have proved troublesome to the person seeking help from a trained professional."

Psychotherapy may be with individuals, couples, families or groups. The theoretical approaches vary and carry many designations: supportive, uncovering, expressive, analytically-oriented, interpersonal, cognitive, behavioral "Rational-Emotive," Gestalt, and so on.

In actual practice, there are no pure forms. The therapist adapts the treatment to the patient, what she needs and what she can use. Competent therapists of all the different schools help patients. The therapist keeps her theories to herself; they help her organize the data

for evaluation and treatment, but she doesn't burden the patient with them. Almost all forms of psychotherapy have several elements in common: a supportive and helping relationship, an opportunity for self-expression, and a more constructive way of thinking about problems.

VARIETIES OF THERAPY

There have been a confusing profusion of therapies. This country has had not only junk foods, but also junk therapies. Suffering patients hope for quick relief and have followed many charismatic individuals who have promised better and quicker results. Over the years, we have had encounter groups, marathons, Dianetics, primal scream therapy, "est," Gestalt therapy and transactional analysis, among others. Some of the approaches had merit, many did not, and after a period of popularity, they faded away. Hypnosis and hypnotherapy have limited value in my opinion. The role of the patient is too passive, he is not an active partner in working out solutions to his problems. There are very few therapists who use hypnosis effectively; again this is my opinion.

There are three major approaches of merit: the psychodynamic (also called analytic, expressive and interpersonal), the cognitive and the behavioral. The last two are often combined. There are no pure forms of therapy; in actual practice elements of all are combined. In Behavior Therapy, the focus is on observable behavior, and the aim is to modify current symptoms that interfere with the individual's adaptive functioning. It is based on learning theory and designs individual treatment programs tailored to specific problems. It has been useful in the treatment of phobias and compulsions.

Cognitive Therapy focuses on the conscious reactions of the individual to the upsetting problems. The patient (client) is asked to report on her beliefs, assumptions and expectations about herself, the world and the future. These have been called the "cognitive triad." Therapy proceeds more quickly because the emphasis is on conscious (and preconscious) mental events and current happenings. It does not emphasize dreams nor attempt to bring unconscious material into awareness. Many therapists make effective use of this approach. Analytically-trained therapists would consider it the domain of ego psychology.