colleagues, and involvement with other people's work, then there is immense interest and satisfaction to be had from the utilisation of the most sensitive and informative of all psychological instruments.

10

Instructions, Constructions, Interpretations, and Strategies

In the last three chapters, the selection of patients, the setting up of therapy, the establishment of its goals, the place of active methods, and the use of the transference have been considered. It has been argued that therapists must know how to create a situation in which patients can reveal their troubles and know how to make sense of, and reframe, these troubles. Beyond this, they need to have certain practical skills at their disposal which they can teach patients to use in the pursuit of self-knowledge and self-control, and they should be familiar with and, in some contexts, able to use, the transference. In the present chapter, further attention will be paid to what therapists say and do, and to the question of planning the strategy of the treatment.

It should be emphasized at this point that, in my view, psychotherapy involves more than techniques: it is the skilful use of the human encounter. The development of closely specified treatment methods and the production of standard treatment manuals have served to introduce some rigour into the field of training and outcome research, but such treatment packages, fortunately, are still delivered by human therapists of all shapes and sizes, in very different contexts. In my own practice, while drawing upon some of the specific techniques of cognitive and behavioural workers, I never conduct therapy on lines restricted to any one such approach, and the foundation of treatment is always a sharing with the patient of my overall understanding.

The aim of a therapeutic programme is to obtain maximum impact with minimum means. One of the main contentions of this book is that this is best achieved by the early elaboration of treatment goals in the form of high-level explanations or hypotheses about the patient's self-perpetuating faulty procedures. In this, the approach differs from both psychoanalysis and behavioural therapies, where the emphasis is more upon detail: in psychoanalysis, through attention to the minutiae of recollection, fantasy and the transference; in behaviourism by the careful microanalysis of small units of behaviour. In both these approaches,

recovery is seen as taking place through a process of generalization. While such detailed attention has its place, especially during the diagnostic phase, the relabelling or reconceptualizing of a problem-maintaining procedure, especially one expressing (although often in many detailed manifestations) a high-level self-identity or strategic script, can free the patient and enable him to alter his behaviour and experience over a wide range, in ways less immediately dependent upon the therapist. I believe that the power of such explanations has been underemphasized. Any act and any understanding that demonstrates or enlarges the patient's capacity to control his life will be therapeutic; but the impact of such gains will be greater to the extent that their relation to central procedures is clear. When the utilization of a concept, or the trying-out of a new way of acting in a small-scale context, is understood to be an application of a general understanding about procedures, the successful small-scale evidence serves to modify the whole class of procedures of which it is a member. Mathematics teachers impart principles, and then set their pupils problems which are to be solved using the terms set out, thus enabling their pupils to make the necessary strategies their own, but they do not set problems and expect the pupils to generate the principles themselves. Patients who are demoralized by making consistent errors in solving their problems surely deserve the same kind of help.

Once a set of overall hypotheses and goals has been developed with the patient, identifying his procedural faults, the therapeutic method can be similarly jointly considered. A few patients will need to work primarily in the transference; but for the majority, the agreed goals and hypotheses will form the basis for continued exploration, in which both active methods and interpretation may play a part.

The cognitive/behavioural techniques appropriate for most neurotic patients are not complicated and do not usually demand a highly detailed behavioural analysis or programme. Self-monitoring, instruction in relaxation and rehearsal in imagination, programmes for graded exposure to overcome avoidance behaviours, and the use of paradoxical intention, can all be described briefly and, with the help of written instructions, patients can be taught to be come their own behaviour therapists. In so doing, they may also gain a more concrete sense of the relationship between acts and outcomes. Patients with highly elaborated behavioural problems or those with suitable types of difficulty who fail to respond to a combination of simple approaches and the general understanding being offered, should be referred for specialist behaviour therapy, but they are a small minority of most neurotic populations.

The active technique of most general use is self-monitoring. Any individual whose symptoms or unwanted behaviours are intermittent, or variable in intensity, can carry out self-monitoring during the assessment phase, with advantage. The minimum gain will be the collection of details of diagnostic importance; often patients report their depressed and self-attacking feelings more explicitly in these writings than they do verbally. Many patients find that monitoring brings to their attention the unrealistic nature of their thoughts, and this commonly enables them

to distance themselves from them, recognize their recurrence more quickly and, in time, gain more control over them.

In terms of the PSM, active methods are effective by altering maladaptive assumptions and evaluations, and by correcting associated trap behaviours. The focused work done on the basis of the dilemma, trap, and snag formulations – identifying blocks to relearning – is effective by increasing the accuracy and sophistication of the patient's self-evaluation, so that his hitherto accepted maladaptive assumptions and strategies become identified by him, relabelled as problems, and opened to modification. While most patients can recognize the truth and relevance of these reformulations (at least provided they are well-rooted in the information provided by the patient and are not a product of the therapist's theory or of his fantasy) many need time to explore and grasp fully their implications and some will, in this process, elaborate or revise aspects of them. This further exploration and elaboration may be assisted by various forms of imaginative exploration and by the more traditional forms of interpretive work which draw upon psychoanalytic theory and involve, in particular, attention to the transference and to dreams.

Even when active methods are used, most of the time spent with the patient can be devoted to discussions of current life situations, of memory, fantasy, and of the transference, and the form of sessions can be left largely unstructured, and determined by the patient.

The sense of control gained by the early provision of a general explanatory framework, and by the early experience of increasing control over symptoms and behaviour, assists the patient in the task of abandoning restricted defensive strategies of thought or action, and serves to support, rather than interfere with, the work of dynamic therapy. Such an assertion does not essentially contradict the psychoanalytic view that the aim of therapy is to extend the power of the ego, but it would nonetheless be regarded as inappropriate by most workers in the psychoanalytic tradition, even by those working in time-limited therapy, where the need for therapist activity and goal specificity are acknowledged. The conventional wisdom rests upon the polarization of regressive–reconstructive and repressive–constructive treatments. Conventional psychoanalytic treatment, in this view, offers regressive reconstruction and is hence virtuous in that it does not impose solutions on the patient; whereas active methods are repressive–constructive and, even if effective, are not virtuous. The assumption that the only way to strengthen the ego is to induce its temporary (i.e. for up to 5 or 7 years) regression in the relationship with a powerful analyst, is paradoxical and requires more evidence in its favour than has been provided so far. Active methods, and the interpretation of the transference in non-regressed patients, do not impose values or solutions on patients, and it is wrong to describe such methods as repressive. The provision of concepts and cognitive skills to patients allows them to pursue their own solution and frees them to explore and re-assess their strategies and to pursue

their own aims on their own terms. If the large explanatory theories developed at the start of treatment turn out to be wrong, or wrong in detail, their revision by the therapist and patient together is a useful enterprise and a good learning experience; if they are more or less right they offer a powerful means to the patient of revising ineffective procedures.

By the time assessment and the joint consideration of method has been concluded, therapeutic change will usually have commenced and a therapeutic mode satisfactory to patient and therapist will have been established. The patient has said, in effect, "These are my troubles and this is who I am." The therapist has answered, "This is how I understand what you say. This is how I see how things go wrong. These are the ways I think I can help you. These are the things you can begin to do." In terms of the PSM, the possibilities of the therapeutic situation have been clarified, the nature of therapist and patient roles have been established, the therapist's belief in his own and in the patient's efficacy has been conveyed, and there has been some discussion and some trying out of alternative means, usually with some positive evaluation of the effects.

SHARING UNDERSTANDINGS WITH THE PATIENT: CONSTRUCTIONS

In psychoanalytic terminology, constructions – or reconstructions – represent the more or less elaborate linking up of hypothesized events in infancy and childhood with current difficulties. This reconstruction is genetic, that is to say it seeks to make sense of what is now experienced in terms of the meaning system derived from the earlier stage. The status of such construction is, of course, hypothetical: "Only the further course of the analysis enables us to decide whether our constructions are correct or unserviceable" wrote Freud (1937), but the "assured conviction of the truth of the construction ... achieves the same therapeutic result as a recaptured memory."

Memories, in the cognitive view, can be reconstructed but never recaptured; moreover, as memory is a store of schemata organizing perceptions, understandings, and actions, the revision of this store, whether by rewriting the past by way of a recaptured memory, or by the use of a serviceable (but perhaps not necessarily "correct") construction will affect the current system of scripts.

One of the major differences between time-limited psychoanalytically based therapy and the time-limited cognitive analytic therapy that I am proposing, revolves around these constructions. The emphasis of most psychoanalytic workers is on the interpretation of the transference around specific events. While such interpretations may sometimes be the main form of treatment, most patients, in my experience, gain considerable early relief and control from the early presentation of more general constructions of their self-perpetuating ineffective scripts. These formulations do not set out to be genetic reconstructions, although they may draw upon historical data; the emphasis is upon identifying current, self-perpetuating, negative procedures.

It is not the patient's history, *per se*, that interests the therapist; it is the conclusions that the patient has drawn from it.

INTERPRETATIONS

Interpretations are understandings of specific incidents or experiences. Sandler *et al.* (1973) write as follows:

> ... it would appear that therapeutic change as a consequence of analysis depends, to a large degree, on the provision of a structured and organised conceptual and affective framework within which the patient can effectively place himself and his subjective experience of himself and others.

Interpretations are ways of making explicit sense of a patient's particular experiences, including those aspects which are incompletely known and recognized by him. The subject matter of interpretation is any reported situation, memory, fantasy or dream, and the patient's behaviour towards the therapist. Interpretation can involve translating hints, disguised statements, or symbols offered by the patient; it may include noting contradictory or conflicting elements in what is being presented, and will often involve noting what is *not* said and *not* done as much as what *is* said and done.

It is usually implied by psychoanalytic writers that the patient's inability to understand fully the meanings of his own acts and communications is necessarily due to the operation of defences. I have argued earlier that patients' failures to name their higher-order scripts, which are serving to pattern individual acts, may be based on no more than the easily remediable lack of appropriate concepts with which to name them. It is for this reason that the early provision of broad, accessible constructions is of such value. However, transference interpretations become of crucial importance when the transference relationship illustrates the enactment without resolution of the issues named in the basic dilemma, trap, and snag formulations, and it is particularly clarifying where the more primitive and disorienting processes of projection and splitting are manifest.

The conventional form of giving an interpretation is somewhat tentative, the aim being to avoid suggestion. There are, however, many occasions, particularly in brief therapy, when it is quite appropriate to argue, confront, and suggest. For example, a patient crippled by harsh, self-judgemental scripts, who can accept and understand the need to mitigate unjustified attacks on the self, may learn more, and faster, if one is prepared not just to interpret the evidence for a "harsh superego", but to provide detailed suggestions on how to improve self-care. In doing this, one must be prepared to justify proposed acts in terms of equity and justice; one must be prepared to argue forcibly with the assumption formed by the patient's history, and one should be prepared to define the values on which the suggestions rest, in order that the patient can choose whether to accept or resist them. In terms of the PSM, one is attending in this way, not only to the patient's biased reading of the situation and to his destructive self-identity judgemental scripts, one is also helping with the

generation of alternative methods of proceeding and modifying negative self-efficacy assumptions by enhancing his capacity for self-care.

Such active interventions are usually ways of challenging undermining, negative self-judgements. Sometimes, however, the naming and challenging of self-prohibiting scripts is not adequate, and in that case additional help may be required in the interpretation of what, in psychoanalysis, would be called "id drives", i.e. suppressed aims to do with sex or aggression. Difficulties in the expression of feeling that stem from self-punishing inhibitions are often experienced in ways that can be described as dilemmas (e.g. feelings are *either* totally controlled *or* chaotic). In such cases, the elaboration of effective forms of alternative action can be a great help. The transference may provide the patient with his first experience of a feeling that is both acknowledged and contained, but he may also be helped with detailed consideration of his procedures in other relationships. The ability to act on the basis of feeling demands both that feelings be acknowledged and permitted and that their expression is under control.

DREAMS

One particular focus of interpretation that played an important part in the evolution of psychoanalysis is that applied to dreams. The following example illustrates the use and interest of dreams in therapy.

Rachel

At the end of the first assessment session with Rachel—a young woman who had incompletely recovered from anorexia nervosa, who seemed over-controlled and out of touch with her feelings—I asked if she dreamt and suggested that one could sometimes find out about oneself by considering one's dreams. During the night before her second session, she dreamt for the first time for two months; in this dream, she was forced to work all day at a boring job in order to pay for her studies which she was obliged to pursue at night. This illustrates many of the reasons that make dreams of interest to the psychotherapist: the fact that she remembered the dream and the timing of it expressed co-operation or compliance, while the content of the dream with its heavy burden of nightwork told of a more complaining response. Rachel is further described in Chapter 12.

The interesting thing about dreams is that they are made up by the dreamer. The remembered dream is inevitably an edited one, for most dream images are muddled and vague, and it is in our "effort after meaning" (Bartlett 1954) that we put structure upon them. In that process of putting structure, we will select certain meanings and suppress others, a process that becomes more marked still when we communicate the dream to another. The recounted dream, therefore, is a conflation of the original images and the meanings applied to them; but the fact remains that both the images and the editing are the product of the dreamer and can convey

news about him. Thinking about a dream and trying to explore what other possible meanings the images might have often reveals ambiguities and can illuminate the underlying conflicted meanings in the person's mind.

In the context of psychotherapy, the dream becomes a communication to the therapist. What is dreamt, and how it is told, will be related to the stage of therapy and to the transference relationship with the therapist. The value of dreams lies precisely in their basic vagueness and in their apparently unbidden quality, which allows the patient, in some degree, to disclaim responsibility for them, and therefore to present aspects of himself that are not fully or easily acknowledged. Moreover, especially for some creative dreamers, the way in which thoughts or ideas are expressed can often be in a highly condensed and symbolic form. Discussion of a dream with a patient, therefore, is an opportunity for the therapist to extend and to share subtle understandings, while simultaneously showing his acceptance of the contradictory and "forbidden" aspects of the patient's thoughts and wishes. Many dreams, of course, cannot be understood, and indeed some seem to be transference challenges defying understanding, but the establishment of the use of dreams in therapy, in which the transference implications are explored in relation to the patient's problems, can be a considerable aid to progress. In order to demonstrate some aspects of dreaming, we will return to the two patients, whom we have followed through the book, Anne and David.

Anne

Anne discussed dreams on four occasions during the first phase of her therapy. The ninth session followed the first interruption in therapy, during which she had in general managed rather well, and had felt much more in control. Half-way through the period she had a dream in which she was in a mental hospital under my care: I had been taking her pulse and arranging an electrocardiogram, and she thought to herself, "It can't be a mental hospital, it must be an ordinary one". Then she thought, "Oh, oh, he's just doing the cardiogram in order to placate me. It really is a mental hospital all the time." This dream illustrates, but does not extend particularly, our understanding of Anne's fear of mental illness and her mixed feelings and mistrust of me during my absence. That session ended with the discussion of mealtimes at home, terrible occasions of immense tension, at which she had been required to get meals ready as a sign that she loved her mother, eat them quickly, not talk to daddy, and when she had finished eating, get up immediately and wash the dishes. At the next (tenth) session, she came with a dream continuing these "oral" preoccupations. She and her siblings had been kept for years in a garage, and they were thin, like the photographs of starving children used to obtain support for Oxfam. In the dream, she and her siblings had escaped, but the others had been too weak to keep up with her. Father had chased them but had been unable to reach the roof that she was on, and she finally escaped to a neighbour's house. There, she found her father, but now she had a pistol in her hand; she fired at him but it was only a toy pistol, at which point she just patted him

on the face. Anne was able to see how the early part of this dream represented a fuller recognition than she had been able to give before to the deprivation of her early years. As a result of the dream she had been able to talk much more openly with her husband and had discussed how, before her acute symptoms had come on, she had felt a number of strains in herself, and between them, which they had not been able to discuss at that time. The dream also conveyed a deep ambivalence towards her father (and probably to me). The siblings who failed to escape could represent her actual siblings who were still living at home, or could represent that part of her which was not yet free. The conventional, and probably appropriate, interpretation of the pistol as a penis symbol was not discussed.

At her fourteenth session Anne told of a dream in which she was in a building somewhere between a supermarket and a prison, with her mother, and by an enormous effort she had managed to squeeze herself out through a crack in a locked door. She had then taken shelter in a bar (with a barman in the background), where she gathered strength in order to go to the bookshop where she was to meet her husband. The first part of this dream seemed to express her sense of excape and struggle; the second part, the bar and the barman, stood for the shelter and refreshment of therapy, and the bookshop rendezvous was, perhaps, a reference to the tendency towards intellectualization she shared with her husband. When I commented on the last point she said that the day before they had had one of the most effective and freeing rows that she could remember.

The seventeenth session of therapy had been marked by initial blankness, and then by a surprising and painful experience of direct sadness during which she cried, although she had very quickly dried the tears away again. She had been in and out of a depressed state following that session. Shortly before the eighteenth, she had a dream, located in one of the houses the family had lived in when she was a child. There was woman there, not recognizable, who was dying of a heart attack, who later in the dream transformed clearly into her mother. Her mother was screaming at her: she had been trying to get the ambulance but could not get the address right. The scene shifted to another of the family homes, and her mother was shouting at her father in a way that reminded Anne of the jealous scenes which had recurred during her adolescence. Anne called out three times to her father, "Why don't you leave her and come and live with me". This dream was followed by a lot of painful recollection of family scenes. The end of the dream gives expression to a feeling which had never been consciously acknowledged; it seemed to support my feeling that her anger with, and mistrust of, me, early in therapy (see Chapter 4) had, as I had suggested, a basis in denied wishes for closeness to her father and older men.

David

David was aware that he dreamt quite a lot, but he had a more or less deliberate policy of not attending to dreams because he was worried that to do so would contribute to his bad sleep. In the course of his brief therapy he reported a dream on one occasion, in the third session. He was driving an open car with Patricia, and in

front of him saw a similar car which spun round and drove back against the traffic; he saw that this car was driven also by himself and was being chased by another car, and the car he was in joined the chase also. There was a crazy ride across uneven country, and then the second car crashed and the car he was in ground to a halt at the foot of a rubbish dump; rubbish began falling down all round them, and Patricia complained that he was failing to protect her from it. This dream seemed to contain many of the aspects of David's emotional response to his situation (see Chapter 5) but I was unable to make very much sense of it beyond that; perhaps for that reason he did not bring any more dreams.

DISCUSSION

Evidence of the helpful effects of combining behavioural techniques with psychodynamic psychotherapy is provided by a number of authors in Marmor and Woods (1980). Of particular interest to the argument I am putting forward is a paper by Segraves and Smith in this volume, describing simultaneous treatment of patients by a behaviour therapist and a dynamic therapist. Three case histories are given. The two therapists confined their interventions to the terms of their respective theoretical positions. It is evident from the case histories that the emergence of transference issues and the recovery of important memories and understandings occurred specifically in relation to the progress of the behavioural therapy and in the context of the patient's relationship with the behaviour therapist. The working through of such issues was left to the dynamic therapist. Other authors in Marmor and Woods report the use of combined methods by single therapists, which is clearly more economical and perhaps less confusing for the patient. Olds (1981) reports the effectiveness of introducing active techniques (rehearsal in fantasy, record-keeping, paradoxical intention) in accelerating psychoanalytic therapy. Planning of such treatments would obviously be easier if the dynamic and behavioural methods, currently based upon quite different theoretical models, could be related in the single cognitive model which I am proposing in the PSM.

For many people, the distinction between active and interpretive methods in therapy is equated with that between superficiality and depth. The concept of depth is psychoanalytically derived, referring to the infantile stage at which the patient's trauma or developmental failure occurred ("early" implying "deep"). As regards therapies, Cawley (quoted in Brown and Pedder, 1979) suggests a three-level classification from:

(a) the most *superficial*, consisting of the patient's unburdening of his problems, ventilation of feelings within a supportive relationship and discussion of current difficulties with a non-judgmental helper;

(b) *intermediate* (overlapping the above and the deeper level), consisting of clarification of problems within a developing therapeutic relationship, confrontation

of defences, interpretation of unconscious motives, and transference phenomena; and

(c) *deep*, consisting of exploration and analysis through repetition and remembering and reconstruction of the past, regression through less adult levels, and resolution of conflicts by re-experiencing and working through.

This classification is based upon an implicit equation of the depth of the difficulty and the depth of the treatment, and reflects the belief that really fundamental change demands analytical treatment. This view, in turn, conflates the belief that adult difficulties are historically-determined, especially through the persistence of unintegrated conflictual issues dating back to infancy (which is clearly often the case), with the assumption that regression and resolution through re-experiencing (the psychoanalytic three Rs) is the only route to recovery. It is here that the cognitive-analytic approach I propose parts company with the traditional psychoanalytic one. The reports that active methods are slightly better than interpretive ones for patients with more serious disorders (Sloane *et al.*, 1975), that profound dynamic changes can follow minimal therapy or life events (Malan *et al.*, 1975), and that in practice at least one analyst (Balint) was both active and didactic when treating an ill patient with focal therapy (Strupp, 1975), argue against the orthodox position and there is no really satisfactory support for the belief that full-scale analysis produces more profound changes than shorter methods (see also Appelbaum, 1977). This does not mean that it may not offer some people a valuable and desired experience.

The fact that our present understandings are built upon our historical experience is true; thought and memory are, in an important sense, indistinguishable. But we continue to elaborate and refine our understandings and strategies without having to dismantle the whole structure and start again (not that we can, anyway, start again in any real sense) and in my view it is the obstacles to such elaborations and refinements that are the proper targets of psychotherapy.

The tactical implications of this view are important. Instead of consigning patients to the superficial approaches of ventilation and non-judgemental chat, we can offer all patients a reframing of their troubles by identifying the obstacles to change and, at least in some areas and aspects of their difficulties, we can try out the effects of teaching relevant skills. For some, this approach can profoundly influence their lives; for others, the correction of old assumptions and strategies may require to be dealt with through some form of transference work, although this can usually be relatively brief and need not involve regression.

One must assume that there are some patients for whom the experience of full-scale analysis for 4 or 5 hours weekly for several years, with the development of a regressed transference, is necessary; but the analytic literature provides little guidance towards the recognition of such patients, the basic conviction seeming to be that it is the ideal treatment for all able to pay for it. The refusal to countenance active methods is in no way a necessary corollary of the model of mental processes proposed by psychoanalysis; it is based rather upon tradition and faith, and upon a

system of training whose primary aim is the preservation of this tradition. Perhaps therapeutic methods, as well as training, have as one main function the defence of the purity of theory and tradition?

Schafer (1978) proposes that the distinctive features of psychoanalytic treatment are as follows:

> First, psychoanalysis is the consistent attempt to understand the analysand's reports of private and public psychological events, especially in the transference and resistance, as actions that are susceptible to interpretation and re-interpretation. These reports are considered . . . as actions, some of which underemphasize agency and others of which overemphasize it. Second, the psychoanalyst develops a focus on the archaic, more or less bodily and unconsciously maintained, meanings of these actions, and third, the analyst states these meanings in terms of conflictual, sexual, and aggressive wishings and imaginings, and in terms of those relevant infantile zones, substances and situations, which seem to threaten or enhance the self and others in relationships.

The first of Schafter's points defines for me the essential nature of interpretive psychotherapy; the second and the third refer to psychoanalytic theories of infantile development which may serve to inform the analyst and will help enlarge his understanding, for example of metaphor or of symptoms, but how often, how far, or in what sense the psychotherapist needs to *focus* upon these archaic meanings and state them in terms of "relevant infantile zones" etc., seems very uncertain. I suspect that for most patients full recovery is possible without this, and that in many cases the induction and interpretation of the regressed transference is unnecessary and possibly disabling. At least one has to accept that evidence to contradict this belief is largely lacking.