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On Becoming and Being a Therapist

To become a therapist is a strange choice. How could one choose to spend one's time with people whose defining characteristics include unhappiness and getting along badly with others? There is no single or obvious answer to this question but common antecedents (some of which played a part in my own choice) include one's personal difficulties (being a therapist as self-cure), a history of being caretaker to one's own family (needing to be helpful to feel good), a difficulty in getting in touch with one's own deeper feelings (seeking vicarious knowledge), and finding a safe form of intimacy (therapy as being in control). Such observations are likely to provoke dismay in would-be patients, for how can the blind lead the blind? The dismay is fed in part by the idealizing opposite wish (that therapists would be perfect human beings) but it cannot be dismissed as entirely unreasonable for, while it is true that even a fairly neurotic and imperfectly resolved person can be a therapist, the task being a professional one of providing certain conditions and understandings rather than one of showing the way, it is also true that a therapist will be better to the extent that he has achieved insight into, and resolution of, his own personality. The fact that his original motivation was in part "neurotic" or partly unconscious does not mean that a therapist should withdraw from the field, for most life choices of any value are similarly charged. In most jobs, however, these irrational and often unconscious motives can go unexamined, but for the therapist awareness is essential: in the course of his training, in addition to seeking intellectual understanding of his work, he needs to examine himself and come to know the meaning of his choices as fully as possible. Without this, a therapist dominated by the need for self-cure may use his patients to fulfil his own needs or a therapist needing to feel helpful may resent his patient's independence, or may transfer to his patients the mixed feelings stemming from his helpful, but perhaps unconsciously resented, family role. The vicariously exploring therapist may be a poor judge and guide to the person inhabiting the psychic desert he is interested in, while a therapist needing to control or to remain inviolate and detached can seem unhelpful

or persecutory to his patients. Self-knowledge and a critical examination of his therapeutic work are therefore essential, and must be sought through therapy and supervision.

This view is one derived from psychoanalysis and finds its fullest expression in formal psychoanalytic training, which has come to be characterized by many years of personal analysis. This training requirement is enormously expensive in both time and money, and the decision to pursue it, and in doing so to commit oneself to a particular ideological position, should not be taken lightly, or before a period of wider based experience and training. It is to this more general basic training, which may lead in various directions, that I shall now address myself.

BASIC TRAINING

There are three interrelated skills required of the therapist. The first is to arrange his meetings with his patient in ways that enable him to find out what he needs to know about the patient, and which enable the patient to hear what he has to say. The establishment of this situation is partly a technical matter of times and places but depends eventually on the therapist's human qualities; in particular on his ability to anticipate and recognize the patient's anxieties and to communicate his own general concern and interest. The second skill is to be able to make sense of the information he gathers from the patient's account and from his relationship with the patient. The third skill is to know how to use all that he learns in the service of the patient's care. The second and third tasks, while still requiring the human ability to sustain a relationship, in addition require concepts and skills. As in so many of the issues discussed in this book, which aspect receives emphasis in training depends upon the theoretical orientation of the training programme, although recently broader-based programmes have become more available.

SUPERVISION

Early in his basic training, the trainee therapist using basically interpretive methods should start giving therapy to a well-selected case under close supervision. Such supervision has two elements: technical and personal. The technical part consists of discussion of what is said and done, and of the reasons for what is said and done in terms of the therapeutic method and of the theory being applied. The personal part involves the careful consideration of all those attributes of the trainee which are manifest in his therapeutic work, both those that are helpful and need encouragement, and those that are unhelpful and need examination. To make this possible, the supervisor needs to establish a stance that has something in common with the accepting and non-judgemental attitudes of the therapist, and in doing so he also acts as a model. But he has to do this while, at the same time, making it clear that it is the trainee's responsibility to tell all he can about what goes on between him and his patient, accepting that his own part in that will be scrutinized

and is open to criticism. In so far as a trainee's personality is expressed in his work, it is a professional, not a private matter, and open to comment. The same rule or expectation can apply to group supervision, whether by a senior or jointly with colleagues. It is from the experience of such constructive, but often painful, sharing of his work, that the would-be therapist may begin to change and may also come to face wider issues for which he may seek personal therapy.

Supervision, combining technical and personal elements, is the foundation of traditional training in interpretive methods. Two additional approaches offer valuable, different opportunities for learning. Video-tapes of actual sessions, either exemplary interviews by experienced workers or, probably most effective, of the trainee himself, offer the chance to recognize useful and revise unhelpful forms of intervention. An even more flexible and economical method, allowing fuller exploration, is role-playing. The trainer can play the role of a patient he has treated himself in a group training situation, in which group members in turn conduct the interview (including "replays" using different interventions). The interview is broken off at intervals,

(a) to consider how effectively it has enabled the patient to reveal himself, which provides training in interviewing skills,

(b) so that the group reflects on the material and begins to make sense of it in terms of the theoretical concepts being taught,

(c) to enable the group to consider on that basis what interventions and treatment strategies are appropriate.

While reasonably experienced trainees can present their own cases in this way, (and this is an interesting variant on conventional supervision and gives a powerful sense of being the patient), inexperienced therapists, or those presenting cases only seen for a short time, cannot play sufficiently coherent roles. If the trainer plays the patient, however, he can select cases and manipulate interactions in ways that highlight the particular issues he wishes the group to consider. This very flexible method involves the participation of the whole group and is surprisingly subtle, often evoking, for example, transference and counter-transference feelings that can also be considered.

Assuming that the trainee's first experience has been in individual work on a basically interpretive model, he will need to get some training and experience in cognitive/behavioural approaches, some experience of group work, and some experience of family and marital work. These different experiences will be accompanied by instruction in the appropriate theoretical backgrounds of behavioural psychology, the cognitive therapies, and the different theories of group and family functioning. Group work and family work may further expose the trainee to a consideration of his own characteristics through forms of self-exploration such as group membership and sculpting, experiences which may facilitate important personal changes, sometimes more effectively than individual therapy pursued out of routine obligation.

COUNTER-TRANSFERENCE

A therapist's response to his patients combines rational judgements, perceptions, and styles of address reflecting his particular background, and also factors deriving from his particular history of which he is not aware. The need is to understand both general assumptions and strategies, and to recognize problems that are due to factors that are inaccessible because of defence mechanisms. The quickest way to self-understanding is to be exposed to the reflections of others who do not see possibility circumscribed by what we see as self-evident. The patterning of our individual responses by our higher-order schemas can be pointed out to us, and often accepted without difficulty, and this can enable us to extend, modify, or make allowances for, our particular assumptions. We may also be confronted with ways in which our defences interfere with accurate understanding. Some of these may yield to the effects of good supervision and the confidence that follows upon developing competence, just as patients become less defended as they gain control and understanding, but therapists in training will benefit from individual and/or group therapy.

As well as learning to see more clearly and respond more accurately, we can learn to recognize and use our idiosyncratic responses as diagnostic tools, translating our personal irrational responses to patients into news about the patient. One example often cited is that of the clenched fist in the pocket, said to be diagnostic of hysteria, but in fact all such responses are quite idiosyncratic and our job is to learn what our own particular responses mean in terms of what the patient is doing, or seeking to do. If we can manage this, we can often, without having consciously to articulate the connection, respond in a way that seems intuitive to what the patient is doing, or trying to do, and does not yet know about.

THE TRAINEE PSYCHOTHERAPIST

The therapist who manages to obtain a training of the kind of breadth and depth suggested above should have a reasonable degree of self-knowledge and a flexible therapeutic approach. From this he might choose to continue to work on a broad front, or to pursue a chosen special method. The advantages of a general initial training over a narrow approach based upon one theoretical model or confined exclusively to group, individual, or natural group settings is, I hope obvious. The disadvantages are those to do with identity and support in that there is at present no one theoretical system and no all-embracing institution able to unite those seeking to work in eclectic or integrated ways. However, by the end of a few years of training and experience, a therapist is likely to have acquired an extensive system of understanding and to have undergone a fair amount of personal change, on the basis of which he will have chosen forms of work that match his personal style. The field is wide enough to house happily a wide range of temperaments and ideologies and

there is obviously no single model of the good therapist. We may all aspire to become like the mature, ideal parents, supervisors, or therapists we had, or wish we had had, combining the wisdom of age with the energy of youth, uniting "masculine force" with "feminine understanding", knowing when to open a new question and when to point to a solution, capable of always giving enough and never too much; but meanwhile, we can begin to have some confidence in our offer, and some awareness of our limits. The incorporation into our therapeutic work of some form of evaluation of progress, such as a periodic review of progress with patients in relation to predetermined aims, provides the best basis for making an accurate assessment of our effectiveness, and is a protection against complacency.

MAINTAINING THE CONDITIONS FOR THERAPY

Having considered the process of becoming a therapist, I will move on to some questions of practice, by discussing what conditions are required by therapists for their work, and what conditions they should provide for their patients.

The first requirement for the therapist is that the nature of the act be sufficiently understood by his colleagues. Junior staff in training, in particular, have to learn to insist upon space and time free from interruption to see their patients, and the right to seek supervision and perhaps personal therapy. Later on, pressures upon services being considerable in most circumstances, the disposition of time between long-term and short-term work, between treating cases, or teaching or supervising others, between consultation and therapeutic work, can be problematic. Psychotherapists, with their particular concern for the private and individual, often handle their social, professional, and political relationships badly, and become isolated and vulnerable as a result. Moreover, their isolation and narrowing of attention to the detail of clinical work does not serve the interests of the population of potential patients well, as is evident from the heavy concentration of psychotherapy resources upon middle-class patients. Other pressures are self-generated, perhaps as a result of unresolved omnipotence. Doing therapy is inevitably tiring, but how tiring depends upon the kind of work being done and on the ease one has with oneself in doing it. The therapist should try to adjust his workload within the limits of his resource, giving time and energy to thinking and reading and to living his own life. The worst solution is to limit the extent of one's availability during actual patient contact; I believe we could often do better to spend less time with patients and more time thinking about them. The dangers of settling down to a routine, with the therapist a passive sponge or uninvolved chess-player in relation to the patient, is greatest in open-ended, unfocused, interpretive therapy and reduced in the integrated approach I advocate, with its greater variety and openness.

The control and definition of the therapeutic process itself is a more complicated issue. Where the therapy is confined to the use of active and didactic methods the principles are not too difficult to enunciate, being determined largely by pedagogic considerations. The therapist needs to explain clearly what he offers and should

provide it reliably and skilfully. The use of a broader approach, involving the consideration of assumptions and strategies and working to overcome dilemmas, traps, and snags, may similarly demand no more from the therapist than the type of scaffolding function referred to in Chapter 6 but, as transference may occur and may either interfere with treatment or add a new dimension to it, it is my view that the conditions offered and sustained by the therapist must be seen in the light of this metaphoric transaction.

Once that is accepted, then the guiding principle behind the therapist's control of the therapeutic situation is clear. He must recognize that, whatever goes on will have, as well as its obvious and surface connotation, a possible meaning in terms of the patient's self-identity and strategic scripts, especially with respect to those of which the patient is only incompletely or uncomfortably aware. It is the therapist's responsibility to recognize and clarify these meanings with the patient; rather than allowing the patient to evoke a confirmatory response, he uses the transference as a learning experience.

Those who accept that transference is a central issue in therapy may still apply this recognition very differently. Disagreements about the therapist's role may be described in various ways; one distinction is between those who stress the personal encounter between therapist and patient, and those who stress the professional nature of the contract. Laing has written extensively on the crucial importance of the human connection between patient and therapist, but in terms of practice it is not always clear what the implications of this are. Lomas (1973) makes it clearer but, in doing so, appears to disclaim any professionalism at all. The more establishment figures, on the other hand, would be closer to the position of Strachey, discussed earlier, and would regard any departure from the opaque, interpretive stance, as offering more reality than the patient could bear, and as being likely to feed into unconscious conflict and delay the progress of analysis. As, despite this view, many psychoanalysts occupy themselves with brief psychotherapy and recognize that the implications of this include a much greater activity and visibility on their part, this issue is clearly far from being resolved. My own view can be summarized as follows:

(a) The human relation between patient and therapist is an unequal one.
(b) It is directed towards the patient's needs.
(c) Because of the vulnerability of the distressed patient and because of the power of the transference, the therapist must accept responsibility for the control of the relationship.
(d) Knowing how to control and how to utilize this relationship is a professional skill.

In establishing the terms of therapy, the therapist exercises and sets up the conditions of his control. How this is done will be a matter of personal style; it may be done stiffly or informally, implicitly or explicitly, but it needs to be done clearly and not foggily. The control, which is the frame within which therapy proceeds, has two main purposes: the defence of the therapist and the defence of the patient.

Therapists must defend themselves against the pressures of their patients, some of whom at least are likely to feel desperate, to be manipulative, and to have difficulty in acknowledging the needs of others. The therapist's patience and his ability to turn these pressures into understanding is possible only because his degree of exposure to his patients is limited. This control is exercised in the first place by making the terms of the contract clear; the psychotherapist makes the offer of a regular meeting of a certain duration in his office for the purpose of talking about the patient's problems, and he undertakes to be present as an attentive and skilled helper. Moreover, although his is a human presence, the agenda does not include *his* life, *his* personality, or *his* problems. The therapist must be prepared to give the reasons for the terms he sets, but cannot basically offer to compromise with them. This confined, well-bounded offer is a relief to most patients, and frees them for the work of therapy. It is an annoyance to others, but this feeling, as much as any other, can be accepted and openly discussed and it is probable that it will throw some light on the patient's life problems.

How opaque as a person the therapist is, or chooses to try to be, is a matter of theory and of style. Most therapists working in brief and more active therapies will not deny their patients all gestures of concern or all evidence of their own personalities, but limits on personal exposure and involvement are still necessary. The dangers of being a charismatic presence are obvious enough: cure by persuasion or inspiration is likely to be unstable. The possibility of sexual exploitation of patients whose transference involvement may include powerful, and often partly sexualized dependency, is also obvious. The inequality of roles; the unequal vulnerability, and the fact that such transference feelings reflect poorly assimilated, unresolved childhood feelings for parents would make any sexual response on the part of the therapist exploitive in general, and specifically antitherapeutic. The dangers of a calculated degree of human availability as opposed to invisibility are less obvious. Provided the therapist is cautious in the pace at which he becomes visible, making this judgement on the basis of the early meetings with the patient and the patient's history, I believe that the advantages of a reasonably human presence outweigh the possible costs, and such a therapist will still attract the range of transference reactions available and necessary for the patient's progress. Neurotic people are plagued by the tendency to repeat the same errors over and over again, and they will do so with a visible and present therapist, given half a chance. It is also clear, as I have argued earlier, that the personally invisible, withholding therapist is not a neutral presence, he is a very powerful and controlling one.

However the therapist resolves the question of how present to be, he must remain in control of the agenda of the meeting and must always turn it back to the issues on which the therapy is being conducted. Patients will sometimes ask about the therapist's private life, although they do not always really want answers. Such direct enquiries can sometimes be answered or an answer can be refused on the grounds of one's right to privacy, or partial answers can be given; whichever is done, the reason for the question's being asked can also be explored. A rigid stance on this question can lead to silly power struggles and guessing games, which should be avoided. As therapy proceeds and the patient comes to differentiate between the metaphoric transference relationship and the working relationship more clearly, and to see the therapist in a less clouded way, there is a shift in the direction of greater equality and openness but, up to the time of termination, the agenda must always remain the patient and his problems.

The therapist who does not solve the problem of his visibility by adhering to the conventional analytic prescriptions of minimal exposure, and who does not strictly limit all communication to occasional interpretations in a 50-minute session, will still need, as much as will the rule-follower, to take note of everything that happens between him and his patient, and to look for evidence of transference and counter-transference. I have argued earlier that the inclusion of active methods in the therapy does not prevent the emergence of transference, and I have expressed my belief that a patient's capacity to use transference interpretations to abandon restrictive and defensive strategies is often enhanced rather than reduced by such activity.

SOME DIFFICULT TECHNICAL ISSUES

Any therapist working on weekly or less frequent sessions needs to consider ways of easing, and ways of speeding up, the process of therapy. I would like to consider three specific questions at this point. Should the therapist allow telephone or letter access to patients? Should therapists ever touch their patients? Should therapists ever reveal their counter-transference? Each of these is essentially a professional question, but none is simply resolved.

The question of giving patients telephone or writing access is largely one of the therapist's own needs. It is particularly likely to arise in therapy with long intervals between sessions, or at times of interruption in therapy. Telephoning represents a major intrusion on the therapist's life and should be kept to a minimum, but there are times of crisis or of angry transference when it is only humane to give patients access, in order that they may confirm that the therapist is still with them and alive. Writing letters is less intrusive, and for some patients represents a way of saying things which cannot be said so clearly during the session. I personally, therefore, do not put restrictions on this (as is clear from the letters quoted in this book), believing that such communications are often valuable. What is communicated in such letters should be discussed at the next meeting with the patient. As with any other act, the patient's use or abuse of telephoning or writing may itself need to be understood in terms of the problem being treated, and the transference.

The issue of physical contact with a patient is seldom discussed, and needs discussing. To suggest that any contact at all might take place arouses fears of sexual exploitation or of inducing dependency, and challenges the more general taboos on physicality which dominate western culture. The simple answer is never

to permit it but that is not, in my view, always the correct one. There are occasions in therapy, for example, when patients first fully feel the extent of their despair or loss, when not to take a hand or put a hand on a shoulder is inhumane. Even if such gestures are misjudged, and many patients have extremely awkward feelings about their bodies, their response may be more illuminating than their non-response or unexpressed response to a non-gesture would have been. Anne's anger, reported earlier, is a case in point.

Jane

Jane, a woman of forty, had sought treatment for phobic symptoms. These were related to a long-term unacknowledged depression. Jane became flustered when, after a very painful session, I took her hand as she was leaving, and at her next visit she talked about how important that gesture had been in helping her understand the extent of the prohibitions of her childhood. She wept as she recalled an occasion when her younger brother, of whom she was very fond, had returned from a long stay in hospital. She had sat by him, just wanting to be near, and sometimes touch him, but her father had said, "Leave the lad alone, won't you", and had made her sit on the far side of the room. At later sessions she referred back to the occasion of my taking her hand as having been a critical moment in her understanding of one source of her depression.

One further issue needs to be discussed. Knowing and clarifying the transference is a central task of many therapies, and learning about the counter-transference an important part of training, but how far should the counter-transference itself be reserved as a mine of private information at the therapist's disposal and how far, if at all, should it be shared with the patient? Clearly, if the therapist is aware of a response that is simply a function of his own private history, current mood, or unresolved neurosis, his main job is to ensure that this awareness is used to defend the patient against distortions of his understanding or response. Often, however, the responses which patients evoke in therapists are similar to those they evoke in others in the world outside and here an explicit description of the response can be useful. A patient who is being passively uncooperative and withholding, and who is irritating his therapist might be given the interpretation: "I feel you are putting your anger into me." I would prefer something more direct such as: " I find you impossible to get through to today; it makes me feel pretty irritated. I wonder if other people get to feel the same way when you are like this. Can we try to understand what you are feeling?" One may at times share one's own idiosyncratic counter-transference usefully; for example, I know and do not respect in myself a certain vulnerability to the appeal of helpless and hopeless waifs. By recognizing and naming the impulse to give care and protection while, at the same time, withholding it and making it clear that I know such a response to be inappropriate and collusive with a self-diminishing strategy on their part, I offer both an interpretation and a model of controlling an inappropriate impulse, and I convey trust in the possibility of the patient acting differently.

We need always, in judging our acts and non-acts, to try to anticipate and make sense of how the patient understands what we are doing or not doing. If a particular patient becomes the subject of more than the usual variations in our practice or the subject of unusual preoccupations, that is to say, if a particular patient evokes a powerful or confusing counter-transference, we should seek supervision or share the issue with a colleague. Many would argue that strict rule-following by the therapist is the safest path, in that mistakes will be avoided, but that view leaves out the fact that the omissions, the silences, and the inexpressiveness of the therapist are also acts and may also be mistaken.

DISCUSSION

Different school of psychotherapy use very different training methods, but most share one feature: a failure to evaluate the effectiveness of their training programmes by research. Matarazzo (1971), reviewing research in this field, awards the Rogerians highest marks for training evaluation research, in particular noting their widely quoted (and incompletely replicated) demonstration of the relevance of therapist attributes to outcome in therapy (the attributes being accurate empathy, positive regard, and genuineness) and noting the extension of this finding to a similar characterization of successful supervisors. Behaviourists' research in training, also reviewed by Matarazzo, concentrates on the training of new practitioners in problem identification and in the selection of appropriate techniques. Demonstration (role-modelling), supervised treatment, role-playing, and didactic instructions are all used in the training of behavioural therapists. Predictably, psychoanalytic training is the least rigorously evaluated. Traditionally, this training combines formal instruction in theory, personal analysis, and the conduct of training cases under close supervision. The role of the supervisor is seen as a matter for some dispute: some see it as primarily interpretive, in which the trainee–supervisor relationship is as much a focus for attention as is the trainee–patient one; whereas others place the main emphasis in supervision on therapeutic procedures and technique. While it may be useful to pay attention to the supervisor–supervisee relationship, one study, using video-recordings of supervisory sessions and relying upon trainees' evaluations as measures of outcome, showed that supervisors characterized as being outstanding were those who focused more attention on the patient and less upon the trainee (Goin and Kline, 1974).

Conventional supervision represents the trainer's selective observations on the edited account of the session presented by the trainee. Kubie (1958) argued powerfully for the greater relevance and learning potential for the trainee of tape-recordings of sessions, which offer a basis both for supervision and for self-monitoring. In training, as in therapy, there are strong arguments for a more comprehensive theoretical base and a more diverse range of training methods. There has been a recent and welcome trend in Britain towards the provision of such

broad-based training programmes (Haldane *et al.*, 1979; Margison, 1980; Lieberman *et al.*, 1978).

The possible harmful effects of therapy have attracted relatively little attention. Active treatment methods are often evaded or resisted by patients, but their potential for serious harm is relatively low. Interpretive methods, on the other hand, where transference plays a large part, can leave patients worse off (see, for example, Bergin, 1966) and the ways in which such harm may be done must be borne in mind. Meares and Hobson (1977) provide a useful discussion of this issue, offering a description of the "persecutory therapist" under six headings. The distortions of the therapist's relationship they describe are often justified by theoretical beliefs. The six features of negative therapist-patient interactions which they identify are summarized as follows:

(a) ***Intrusion*** into the patient's personal space can occur by crude interrogation, by premature intuitive understanding, and by forcing the confession of secrets.

(b) *Derogation* is a term used to cover various ways in which a therapist can denigrate his patient, seriously damaging his self-esteem.

(c) ***Invalidation*** of experience occurs when the therapist does not respect everything that his patient says and responds by explaining away or categorizing, rather than by elaborating and amplifying affects, images, and memories.

(d) The ***opaque therapist***, in attempting to maintain an impersonal neutrality, denies his involvement in a two-person situation with its rhythm of intimacy and distance.

(e) The ***untenable situation*** renders the patient helpless, confused, and unable to explore and learn; it is promoted by lack of clarity about the structure of therapy; by the imposition of impossible requirements; by giving conflicting messages; and by making conflicting demands.

(f) The *persecutory spiral* is an escalating, destructive interaction in which both therapist and patient are, or feel, persecuted. Potent factors are "all-knowing", authoritarian, rigid and sectarian attitudes and beliefs regarding psychotherapeutic theory and technique.

To these various acts of commission, Older (1977) under the title "Four Taboos That May Limit the Success of Psychotherapy" considers common rigidities whereby therapists may fail their patients. The four he considers are, firstly, the fear of any physical contact because of the dangers of sexual involvement and the general difficulty in physical expression in our culture; secondly, the avoidance of embarrassing topics; thirdly, not allowing the noisy expression of emotion; and fourthly, an unwillingness to vary durations of the patient's sessions in response to the occasional patient's need to work through a problem to its conclusion.

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Aids to Self-scrutiny and Self-help

My work as a psychotherapist has evolved over the years in a number of directions. I have become more varied in the methods I use, I have become increasingly explicit about what I am doing, and about the ideas underlying my approach and, in talking to patients, I use the word "work" much more often. Over this period, I seem to find my patients less perplexing and less exhausting, and their changes more predictable and more rapidly achieved. While this could be the result of the accumulating illusions, rather than the skills, of greater age, I prefer to believe that it is because I am better at providing the conditions and concepts that patients need in order to change themselves. In this chapter, I want to describe some of the ways in which people can be helped to think clearly and differently about themselves and to learn new ways of acting outside the therapy situation. Some of these ways may be useful to people not in therapy, as aids to self-exploration and problem-definition.

One of the main threads running through the book has been an emphasis on the description of the aims of treatment as being the revision of self-perpetuating errors or failures in procedures. The value of these descriptions is that they direct attention away from the surface manifestations of symptoms, moods, and unwanted behaviours to the underlying modes of thought and action that perpetuate difficulty.

People do not usually reflect on their procedures in this way, and they often lack concepts with which to engage in such reflection. As I became clearer about these concepts, I found myself sharing them with many patients, and after a time I decided to give to most of my patients, during the assessment period, a "personal therapy file" which described in some detail the ideas I was operating on, and which invited them to apply these ideas to their own difficulties. In such cases, the last assessment session was devoted to a discussion of the aims and methods of treatment, based on what they, in their way, and I, in my way, had concluded over the first sessions.

Not every patient is suitable for this approach; a few make little use of the file and in some cases I do not even offer it, or I give only certain pages of the file,