6

Teaching, Learning, and Therapy

Normal learning involves the successive revision of schemata in the face of new external situations or in the service of elaborated aims. In the neurotic patient, or other failed problem-solver, the process has gone wrong at some point. In the present chapter, we will consider in general terms the relation of theories of learning and teaching to psychotherapy, and compare the practice of teachers and therapists, before proceeding to a detailed consideration of the practice of psychotherapy in the ensuing chapters.

What patients have to do is to learn new ways of going about their lives, so that they no longer create trouble for themselves, fail to realize their aims, or suffer from symptoms. This is a learning task to do with the solution of ordinary, or sometimes unusually difficult, life problems. As such, the learning involved in therapy is learning in the precise areas where learning has been unsuccessful. Ordinary problem-solving (see the review of numerous studies by Heppner, 1976) involves a number of stages, summarized as orientation, problem-definition, the generation of alternative solutions, decision-making, and testing out. This sequence can be seen to parallel the procedural sequence described in the PSM. The particular problems of the patient, compared to those of the pupil, stem from his history of failure and from the self-perpetuating errors discussed in the last chapters, which mean that, while a pupil is in principle ready to face the task of learning, a patient is more likely to see himself as ill, unhappy, the victim of circumstance, guilty, or as a failure, rather than as a potential problem-solver.

The therapist as teacher must take account of these special circumstances, but he may still see his task as similar in many ways to that of the tutor, as described, for example, by Wood *et al.* (1976). These authors describe the tutor's role as the provision of "scaffolding", which they define as involving the following acts:

(a) Recruitment: the tutor has to enlist the problem-solver's interest in, and adherence to, the requirements of the task.

(b) Reduction in degrees of freedom: the tutor simplifies the task by reducing

the number of constituent acts required to reach a solution.

(c) Direction maintenance: the tutor gives encouragement and prevents premature satisfaction with incomplete solutions.

(d) Marking critical features: the tutor notes the most relevant aspects of the problem.

(e) Frustration control: these authors note that there should perhaps be some such maxim as "problem-solving should be less dangerous or stressful with a tutor than without", a remark which could be transferred to therapy without revision. They also note the risk of creating dependency.

(f) Demonstration: the tutor may model the solution to a task by enacting an idealized version of the acts to be performed.

It is at the stage of recruitment and orientation that the therapist must exercise skills not required of the teacher; in some way or other he must transform the patient's account of distress into accurate descriptions of procedures needing revision and of problems capable of solution. How this reframing is done will depend upon the orientation of the therapist, and on the kind of intervention proposed. Thus, the behaviourist will describe the problem primarily in terms of behaviours shaped by outcomes, the analyst in terms of conflicts between drives and defences, the existentialist in terms of meanings and purposes; whatever framework is offered will have a transforming effect upon the patient's own definition of his difficulty, and will serve to recruit him to the appropriate form of treatment.

It is clear that the redefinition of problems and the orientation of patients towards their solution is a major part of the therapist's work, and one which distinguishes it from the work of teachers. In order to be able to carry out this function, the therapist must avoid premature structuring of the things the patient tells him, and must avoid responses that serve to sustain the patient's conflicts or to heighten his destructively critical self-judgements. The therapist must learn to attend to what is said and to what is not said, and to recognize from the pattern of communication the assumptions serving to shape the account given by the patient. In his non-critical, open, exploratory attitude, and in his acceptance of contradiction, he both arrives at his understandings and offers to the patient a model of a constructive form of self-scrutiny. In all these ways, the second stage of the procedural script model is being attended to, and the negative ways in which reality and possibility have been construed by the patient are being revised. Very often, this process frees the patient's capacity to proceed, and he may generate and test out new forms of action without further help, but therapists of some persuasions will offer direct guidance at this stage also.

In the approach proposed in this book, the patient's account will be considered in terms of the PSM, and insights will be shaped with the patient, emphasis being placed upon the identification of those processes which are serving to perpetuate the blocking or diverting of aims, and which are preventing learning. As this is done, and to do so is not a mechanical procedure, the patient will be helped to see how his troubles are derived from his patterns of thinking and acting, and he will learn to see

his task as being a revision of these thoughts and acts, while at the same time he is being provided with concepts and methods which can make this revision possible. Many problems are manifest only indirectly, i.e. they may not have been identified by the patient and they may not be accessible to the patient's conscious introspection. However, a great deal that people do at the tactical level is patterned in a fairly obvious way by strategic or self-identity scripts which they themselves cannot articulate, but which the therapist can infer fairly easily. The early identification and naming of these higher-order scripts and the identification of the defences, traps, dilemmas, and snags that represent faults in these scripts enable patient and therapist to start work on revising patterns of thought and action. At the same time, the patient can be recruited to further diagnostic work on himself by being instructed in self-monitoring, as will be described in more detail later. The patient's work in these respects should, in my view, be sustained by by the therapist's continued support and encouragement, and by his sharing the conceptual framework being used. His assistance in pacing the rate of change, and his provision of realistic evaluations of progress are also helpful. In this, the therapist is acting in ways directly parallel to the scaffolding function of the teacher, described above.

In the course of this process, which takes place in the early stages of treatment, the support offered to the patient by the therapist's presence and by the understandings gained will often reduce anxiety and defensiveness, and access to feelings and the exploration of the personal meanings of past and present experiences becomes freer. This ability to feel and engage in looser associative thinking can be encouraged by the therapist's attention and understanding; permission or encouragement to think in this way is helpful to many people in our culture where reason and logic are seen as superior thought forms. While I have known many patients who remembered with gratitude certain schoolteachers as having encouraged this kind of thinking — usually teachers of literature or art — it is clear that most teaching does not nourish it.

There is one more important difference between teacher and therapist. The therapist must be aware of the way in which problems are not just reported by the patient, but may be enacted by him in his relationship with the therapist. For some patients, the crucial learning experience of therapy is how this enactment (the transference) is experienced rather than how it is described.

DIFFERENCES BETWEEN THERAPISTS AND TEACHERS

While the therapist's role has many parallels to that of the teacher, there are important differences which imply that certain conditions are necessary for therapy. These can be summarized as follows:

(a) The therapist avoids judgement or premature structuring of the material in order to make exploration possible, while he provides enough structure to make the patient feel safe enough to proceed with the exploration.

(b) He generalizes and reformulates as problems the difficulties of which the patient complains. This task involves making translations, investigating the meanings of symptoms, moods, and unwanted behaviours, and in most cases looking at these in terms of underlying, often conflicted, assumptions.

(c) He helps the patient recognize, explore and name his experiences.

(d) The therapist challenges assumptions and questions terms, and may suggest alternative strategies while leaving the patient free to elaborate his own alternatives as far as possible.

(e) He is aware of, and may make use of, the way in which the patient's relationship with him can be seen as a paradigm or metaphor of aspects of his difficulties.

In this brief account of therapist as teacher, I have assumed that the therapist is able to discern and name the patterns of difficulty in ways which enable him and the patient to generate alternative ways of acting. The experienced therapist can often do this quickly; he is in the position of Socrates when he was eliciting from his slave-boy the proof of the theorem by Pythagoras concerning the square on the hypoteneuse. Socrates was able to extract the correct solution of the theorem from his slave-boy because he was himself in possession of the proof and was therefore able to ask the appropriate questions. On other occasions, however, the therapist may be in the position of Socrates as imagined in a parable offered by Gilbert Ryle (1979); a Socrates who, on the following day, commenced upon a similar elicitation of proof of a different theorem from the slave-boy, only to realize that he had forgotten the proof himself. The slave-boy reminded him of the previous day's successful questioning, but Socrates was forced to acknowledge that, having forgotten his destination, he was not able to be a guide on the journey. Psychotherapy in the style of the first Socrates is often satisfactory, for "well-charted teaching can occasionally ... dispel ignorance"; but the task may be the more difficult one of finding new solutions to unknown problems which, in Gilbert Ryle's words is "trying out promising tracks which will exist, if they ever do exist, only after one has struggled exploringly over ground where they are not." The therapist can show his support for this exploration and can offer metaphors for the journey, but he cannot provide the map. Fortunately, most patients can explore for themselves, once their self-perpetuating blocks on changing have been identified and challenged.

PERSONALITY CHANGE AND EMOTIONAL LEARNING

I have suggested that, in so far as the changes sought in therapy are conceptual, the therapist's skills in conducting therapy are an extension of those of the teacher. Therapy enlarges what the patient knows, both knowing that (i.e. his understanding of himself and his experience) and knowing how (i.e. his capacity to organize his acts and pursue his intentions). Whether such changes can be called changes of personality is a somewhat arbitrary question. Some aspects of personality are clearly pretty stable, and probably largely determined by inheritance, but much of what we call personality is the manifestation of habitual strategies employed by a person in

his familiar environment. Both situational change and psychotherapy can lead to radical modifications in these latter aspects.

Neurosis is often referred to as emotional disorder, and the aim of therapy is often described as emotional learning, and hence the emphasis on thinking in this book might be seen to be missing the point. However, emotions are based directly upon the personal meanings that we accord to our experiences, and a thinking/feeling dichotomy is not a helpful one. A common aim of psychotherapy is the relief of emotional distress but the term "emotional learning" is too vague for this process. The various components of what is so described can be categorized as follows:

(a) A better capacity to recognize and label correctly one's emotional responses. Examples here would be the clarification of the difference between emotions and appetite disturbances in the patient with anorexia, or helping people recognize feeling states that were not named or not permitted in their childhood homes.

(b) Linked with this, difficulty in knowing or permitting emotions may be related to false predictions about what would happen if they were to be expressed. A therapist can help here by evoking and permitting the expression of such emotions, by noting their occasions in the patient's reports, and by a consideration of what forms of expression are appropriate under what circumstances. For some patients, better control over inappropriate expression of emotion may be an important aim; for others, the need may be to know and show feelings more spontaneously.

(c) Another aspect of emotional learning consists of recognizing how far unwanted emotions are the result of one's thoughts, actions, and imagination rather than changes in circumstance.

(d) Psychotherapy, by encouraging a general increase in the patient's ability to know what he wants and a greater ability to act effectively to get it, leads to more positive and fewer negative emotional experiences.

(e) Linked with this, therapy can overcome the general inertia, helplesness, and depressed mood which stem from the recognition of one's own ineffectiveness, and can relieve the anxiety that follows the recognition that one's thoughts and acts are out of control, through the development of a clearer, more positive and effective sense of self.

Taking these points together, therefore, emotional learning turns out to consist of an improved capacity to perceive and construe experience accurately and to act effectively, areas of learning which are the focus of the integrated approach proposed in this book.

DIFFERENT APPROACHES TO THERAPEUTIC LEARNING

The therapist as teacher is faced, in an extreme form, with some of the basi difficulties that face any teacher operating above the level of rote learning and drill. Learning requires the elaboration of new concepts and new skills, and these cannot be simply transferred didactically; they have to be acquired in action by the pupil. Such acquisition is only possible if the discrepancy between the experience offered

and the pupil's existing capacity to cope with it is neither too small (for then there is no need to change) nor too large (for then new experience cannot be assimilated at all). The teacher has the advantage that he can control the rate of exposure to new experience, although he is also faced with the severe temptation to be to the pupil only what Socrates was to the slave-boy, denying the pupil the experience of successfully "discovering new tracks" for himself. The therapist, on the other hand, has no control over the size of the discrepancy between the patient's needs and his capacity, and is usually faced with somebody already overcome by repeated failure to solve his problems, or locked in ineffective but familiar modes of part-solution. How much support, and what form of support, the therapist should offer, in trying to help such a patient, is a difficult question. The different answers given to this question serve to differentiate very sharply between psychoanalysis on the one hand and the cognitive/behavioural approach to therapy on the other.

The psychoanalytic reluctance to offer more than reliable availability and interpretation is designed to save the patient from the slave-boy's fate. The more active therapist, on the other hand, is unashamedly Socratic, and many use even drill, while paying considerable attention, like good instructors, to the appropriate pace and order of exposure to new experience. The psychoanalytic position reflects a high ideal and would seem to offer the least threat to the autonomy of the patient, and the greatest opportunity for enlarging his sense of his own nature and capacity. For some patients, especially those who have a very diminished or undeveloped sense of their ability to order or control their lives, this very inactive holding and the permitting of this exploration is probably uniquely effective. There are, however, others — and I suspect they are the great majority of patients seeking therapy — for whom this degree of passivity and this principled refusal to guide is frustrating, and may serve to inhibit rather than to enhance the patient's capacity for self-directed exploration. The provision for patients of concepts which they can use to link and make sense of their behavioural problems, the instructing of patients in ways of thinking about their dilemmas, the planning with patients of programmes to change and control their thinking and behaviour, can all lead to a rapid restoration of morale, a loss of anxiety, and to an extension, therefore, in their sense of control and safety. It is my experience that these more active therapeutic approaches, used early in the course of psychotherapy, do not inhibit and may in fact enhance, the patient's capacity also to engage in self-directed, unstructured exploration.

DISCUSSION

To conclude this chapter, the basic assumptions of cognitive, behavioural, and psychoanalytic therapists concerning the nature of the effects which their interventions produce will be reviewed.

Cognitive models of learning

The metaphor of the "scaffolding" function of the teacher is drawn from a study of how children were helped in a block assembly task (Wood *et al.*, 1976). This work was an illustration and extension of the position described earlier in *Towards a Theory of Instruction* (Bruner, 1966). Mahoney (1974) has applied cognitive theories of problem-solving to the field of behaviour modification, arguing that the neglect of cognitive processes by behaviourists had restricted their therapeutic effectiveness; he emphasized the need to teach patients accurate self-evaluation and to encourage the generation of multiple solutions. Training in self-instruction and self-regulation characterizes the cognitive therapy described by Meichenbaum (1977) and by Goldfried (1979). The process of "systematic rational restructuring" is described by the latter as having four stages:

(a) Helping clients recognize that their self-statements mediate emotional arousal;
(b) Helping clients see the irrationality of certain beliefs.
(c) Helping clients understand that their unrealistic self-statements mediate their maladaptive emotions, and
(d) Helpfing clients to modify their unrealistic self-statements.

In terms of the PSM this approach aims to influence assumptions about one's worth and predictions about one's capacity, and about the responses of others.

Behavioural model of learning

The essential assumption in behaviourism is that behaviours are shaped by outcomes, and the manipulation of outcomes is the essential teaching device. The two best validated behavioural methods for inducing change are exposure *in vivo* for phobias, and exposure and response prevention for compulsions. The effects of these treatments can be interpreted in terms of the PSM as being ways of altering the subject's predictive evaluations, whereby an expectation of danger or failure is modified by the experience of surviving graded exposure or the non-acting of a compulsion. Rehearsal in imagination, although described in conditioning terms, is essentially a cognitive procedure, as Lang (1977) argues. This author also argues for a cognitive ("information processing") analysis of fear, and suggests that what is activated in treatment, whether by rehearsal or by exposure, are "propositional structures". He suggests that "in many practical contexts the emotional image is less usefully conceived of as an internal process, and more valuable when construed as a preparatory set to respond . . .". In this view, rehearsal in imagination is therefore allied to cognitive restructuring as being concerned with how the subject sees the situation, understands the meaning of it, and anticipates the effects of his response to it. In terms of the PSM it represents an approach that influences both the subject's predictions and his assembly of means.

The psychoanalytic model of change

What is largely missing from these cognitive and behavioural accounts is any consideration of the effects on learning of conflicts between intentions and self-

judgements. For this we have to consider the very different accounts of change given by psychoanalysis. Freud avoided the use of the word, and the concept of, "cure"; his accounts were either depressive as in "the transformation of hysterical misery into common unhappiness", or abstract as in "to strengthen the ego, to make it more independent of the superego, to widen its field of perception and enlarge its organisation, so that it can appropriate fresh portions of the id" (Freud 1933). The main agent in this process of altering the balance of power in the intrapsychic world is the transference, and the detailed discussion of it will therefore be postponed to Chapter 9.