ANNOTATED PSYCHOTHERAPY

A Session by Session Look at How a Therapist Thinks

RICHARD B. MAKOVER

ROUTLEDGE

"Have you ever wished to observe the work of a therapist first-hand? This comprehensive guide provides a bird's eye view of therapy and the therapeutic assessment process. *Annotated Psychotherapy* is a handy reference and a complete package that offers not only therapy transcripts and therapist evaluative comments but also explanations of key therapy concepts and a glossary of terms. Reading it is almost like having a supervisor by your side as you develop your therapeutic skills."

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"*Annotated Psychotherapy* reveals the therapist's internal dialogue in reaction to patient's statements. The valuable lesson of the book is how the dialogue serves to guide the therapist to adjust the delivery of the psychotherapy. *Annotated Psychotherapy* joins Makover's *Treatment Planning for Psychotherapists* and *Basics of Psychotherapy* to create an essential foundation for educating therapists."

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Annotated Psychotherapy

Annotated Psychotherapy demonstrates how an experienced psychotherapist develops and carries out the right treatment plan through interactions with the patient or client. In these pages, clinicians will find an explanation of everything the therapist says to patients or clients: why they say it, what they intend it to do, how it fits in with the treatment plan for that person, and, importantly, what might have been said that would be better.

Each of the eight sessions are presented in the form of a transcript that shows how a seasoned clinician might conduct the session—what their internal judgments are and what reasoning or rationale they might have for the therapeutic interventions they choose. Discussion sections after each transcript and a glossary provide helpful explanatory material for the key ideas and concepts, making this book an enlightening resource for therapists working and training in psychotherapy, whether their background is psychology, social work, psychiatry, or counseling.

Richard B. Makover, a lecturer at the Yale School of Medicine, developed his psychotherapy concepts in private practice and as clinical director of mental health services at a large health maintenance organization in Connecticut.

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A Session by Session Look at How a Therapist Thinks

Richard B. Makover

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The Moving Finger writes; and having writ,
Moves on: nor all thy Piety nor Wit
Shall lure it back to cancel half a Line
Nor all thy Tears wash out a Word of it.

Edward Fitzgerald, *The Rubáiyát of Omar Khayyám*

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Figure 2.1 Complex Treatment Planning Diagram from *Treatment Planning for Psychotherapists*, 3rd edition, by Richard B. Makover, MD, copyright © 2016 by Richard B. Makover, MD. Used by permission of American Psychiatric Association Publishing.

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All clients/patients and the environments depicted in this book are fictional portraits created for this work and any resemblance to actual places or persons, living or dead, is entirely coincidental.

About the Author

Richard B. Makover graduated from Yale University and the Albert Einstein College of Medicine. After a year as a medical intern, he completed his psychiatric training as chief resident, served as a psychiatrist in the United States Navy and then opened a private practice. He was appointed to academic posts at Cornell University Medical College and at New York Medical College. He served as president of a child guidance clinic and chairman of a program review committee for Connecticut's Department of Mental Retardation. His administrative experience includes chairmanship of a hospital psychiatry department, chief of a neuropsychiatry service, and clinical director of psychiatry at a large health maintenance organization. He has been a consultant in geriatric psychiatry and worked extensively in the field of sleep medicine. Drawing on his widespread clinical experience, in 1996 he proposed a new system of treatment planning. That book, *Treatment Planning for Psychotherapists*, is in its revised 3rd edition. In 2017 he published a textbook, *Basics of Psychotherapy*. He is currently a lecturer at the Yale School of Medicine Department of Psychiatry. He lives in Connecticut with his wife, Janet.

Introduction

A psychotherapist in full-time clinical practice might see six to eight clients a day and carry a caseload of 20 to 30 clients per week.[1] Experienced therapists, although they may be trained in a range of different methodologies, manage this workload by reliance on their basic proficiencies, the group of principles and procedures that apply to generic psychotherapy, the essential competencies that they may employ in a variety of clinical challenges.

This fundamental set of proficiencies is usually concentrated in areas of communication and the analytic examination of patient behaviors, skills that need to be learned during a therapist's years of training. If they are not adequately prepared, however, therapists must hope to hone these skills after their formal education through further study and supervised experience, only to find that those opportunities and the time to devote to them are both in short supply.

Other health care providers are trained, in part, through an apprentice model that allows them many opportunities to observe first-hand how senior experts in their field think about and provide services. A surgeon in training assists at operations. An experienced physical therapist demonstrates procedures to a beginning PT. A student nurse shadows the duties of a registered nurse. Medical students watch residents and attendings perform hands-on treatment. In all these teaching opportunities, the apprentice is:

- Physically present as the care is provided.
- Hears the expert explain the treatment as it takes place.

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- Sees first-hand what is being done as it happens.
- Is able to question the expert in real time.

With these advantages, trainees learn from an experienced practitioner not only what to do and how to do it but when and why it is done.

In behavioral health programs, however, the prospects for apprentice learning are limited. Trainees often have few opportunities to discover how experienced therapists think and how they interact with their clients. They may discuss their own patient/client sessions with a supervisor but time pressure restricts their review to a few key points. They may watch a senior therapist (through one-way glass or on a video) but, as silent outside observers, they cannot appreciate the demonstrator's internal judgments and reasoning or examine the specific rationale for each of the therapeutic interventions.

Consider a training demonstration in which a senior therapist interviews a volunteer client while watched by a group of therapists in training. The observers see the two participants sitting across from one another. They hear the client's monologue and the therapist's responses. They witness the non-verbal behaviors of both participants. Unmeasured, but significant nonetheless, is the effect their viewing of the demonstration has on its validity, the observer effect. Do either of the two participants, both aware of the audience, behave as they would alone? Probably not.

The value of these clinical demonstrations often lies in the global effect on the observers. They may choose to model themselves after the style and the technique exhibited in the interview. They may pick up and store away a particular turn of phrase or interview technique. What they miss, however, is the real-time, moment-to-moment knowledge of what the therapist is thinking or why she or he makes those remarks to the client. What is lacking, in other words, is the most important part of the demonstration, the therapist's cognitive process. Even in the discussion after the interview, the therapist instructor will only be able to provide general explanations for his or her responses to the client and not

the detailed, relevant ideas that lay behind each one. And despite their instructional value most training programs can provide only a limited number of these demonstrations. Inevitably, as therapists graduate and begin their careers even these minimal eyewitness opportunities vanish.

The demonstrations presented in the annotated sessions to follow attempt to duplicate the apprentice experience. The therapy transcripts include immediate commentary that provides access to the therapist's moment-to-moment assessment and decision processes. To lay the groundwork for these transcripts, the next two chapters examine some of the concepts needed to make full use of the annotations. "General Principles of Psychotherapy" discusses the basic principles and practices that support the diversity of therapeutic systems. It includes a discussion of the importance of formulation in treatment planning. "Therapeutic Communication" reviews some of the therapist's specialized communication skills.

The clinical chapters that follow present one or two sessions with eight patients seen by the therapist, Jane. She has been in private practice for ten years. She spends one day a week at a mental health clinic associated with the local hospital where she supervises trainees and also sees two or three patients for individual psychotherapy. She holds a clinical appointment at the nearby university. Her connection with the school enhances her professional standing and it provides opportunities for contact with other professionals. She has an eclectic approach to her work, utilizing a variety of therapeutic strategies based on what she thinks the patient needs and what she feels comfortable in providing.

To avoid clutter, some of the terminology and technical concepts used in the annotations (identified in small caps) are defined in the Glossary. These terms illustrate the diverse nature of modern therapy: they draw on directive, exploratory and experiential treatment approaches used by therapists who want to be prepared to deal with a wide spectrum of patients and their particular problems.

These case examples comprise only a sample of the many life situations and personal problems that therapists encounter. Taken

together, they nevertheless demonstrate many of the common challenges that arise in psychotherapy. Following how Jane thinks about each session will illuminate how a therapist with a treatment plan deals with the moment-to-moment vicissitudes of the therapeutic relationship. Jane is experienced and competent but sometimes she misses a clinical opening or makes a misstep. Readers may learn as much from these occasional oversights as they can when she is successful.

Note

1 What to call the people who seek our help varies among different practitioners. Some prefer the term "client," because it better reflects the collaborative nature of their work together. Given my medical background, the term "patient" occurs more naturally to me, even though I agree that collaboration is essential to any psychotherapy. I use the two terms interchangeably throughout this book.

General Principles of Psychotherapy

This chapter discusses the basic principles, the underlying structure of the variety of behavioral health services that fall under the general heading of psychotherapy. The ideas in this chapter and the next apply to what all the many systems of psychotherapy share in common.

What Is Psychotherapy?

Psychotherapy is the inclusive name for a diverse group of interpersonal services that encompasses a wide-ranging variety of named treatment approaches. One survey, conducted almost three decades ago, documented over 400 different behavioral treatment systems all identifying themselves as psychotherapy (Bergin & Garfield, 1994). Imagine how that list has expanded since! In general, psychotherapy is the service we therapists offer to people who want to improve their future. The past cannot be altered. The present only provides a foundation for modification. We hope our collaborative efforts will help them, going forward, to achieve an enhanced and more successful life.

All those many psychotherapies are united in one common purpose: to offer the prospect of improving problematic behaviors. In some cases, these difficulties have been characterized as a mental disorder (American Psychiatric Association, 2022) or even a mental illness. For many people, however, the problems with which they struggle do not rise to the level of a named disorder, even though the sufferer might have certain character traits or even symptoms that are listed in published compilations of these diagnoses. Recognition of how widespread these

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problems can be has led to the retitling of mental health services as behavioral health services. This revision makes sense because the fundamental purpose of psychotherapy is not to improve *mental* functioning—a slippery concept that is hard to define—but instead to achieve more effective and rewarding behaviors. While other phenomena may shift during therapy—perceptions, feelings, insight, emotional stability, even self-image—they are relevant only if they facilitate the behavior change that defines the desired outcome.

The main difference among these many disciplines, in addition to their theoretical foundations, is where they fall along a continuum of methodological structure. For example, dialectical behavior therapy (DBT) is highly structured and multifaceted (Dimeff & Linehan, 2001), while psychoanalytic psychotherapy is relatively unstructured and widely focused (Marcus, 2002). Each of this multitude of therapies will usually fit into one of three general categories:

Directive therapies follow a protocol that asks the client to undertake particular tasks or to follow certain procedures designed to address target symptoms. Cognitive-behavioral therapy (CBT) is an example of the directive type (Craske, 2017).

Exploratory therapies look for the precursors and underlying sources of current behavior with the hope that exposing them to the patient's examination will effect improvements in problematic areas. An example of the exploratory type is psychodynamic psychotherapy (Cabaniss, 2016).

Experiential therapies use expressive techniques to help clients recreate, connect with and alter harmful influences from the past, using role-playing, artistic activities, music and the like to bring those influences under present control. Gestalt therapy is an example (Wheeler & Axelsson, 2017).

In practice, however, these three categories often overlap. A therapy that begins with a directive protocol may soon need an exploratory technique to deal with issues outside of the original symptoms.

A psychodynamic approach might require a role-playing exercise to overcome a specific problem. An experiential approach based on current behavior could require a cognitive-behavioral protocol to make further progress.

No one can be proficient in all 400-plus psychotherapies. Familiarity and ease with several, however, is usually worthwhile. Jane, the therapist featured in subsequent chapters, knows and uses around half a dozen. Her *eclectic* approach to psychotherapy, utilizing a variety of strategies, allows Jane to help more patients.

Common Features of All Psychotherapies

Despite their many differences and wide variety of principles and practices, all types of psychotherapy share certain essential qualities. The three most important of these elements are the *placebo effect*, the *nonspecific healing forces* and the presence of *therapeutic change agents*. These common elements may be necessary for the success of the treatment but no one alone is sufficient to ensure a favorable outcome.

The Placebo Effect

Sometimes called the placebo response, this feature refers to the beneficial effect obtained from an inert or inactive treatment.[1] In general medicine, this remedy is sometimes called a "sugar pill." Although the placebo itself has no scientific therapeutic rationale, it often effects real change. For example, a sugar pill given as an analgesic can alleviate arthritis pain for long periods (Zhang, 2019). Even surgical interventions can turn out to succeed because of the placebo effect. This surprising result was discovered when surgeons treating angina (cardiac-induced chest pain) found the same benefit resulted from a sham (placebo) surgery as from the actual internal mammary artery ligation that had been a standard treatment for this symptom (Miller, 2012).

Legitimate trials of new drugs and treatments always include an inert alternative against which to measure the medication's benefits. The results of clinical drug trials frequently show that the

placebo alone accomplished a surprising portion, sometimes as much as 40% or more, of the expected benefit. The tested drug or treatment must show it is significantly better than the placebo before it is approved for general use.

In psychotherapy, the placebo effect often shows up early in treatment as the patient's presenting symptoms improve before any real therapeutic work has been accomplished. In fact, patients on a waiting list may already begin to feel better, apparently in anticipation of treatment that has yet to begin (Endicott & Endicott, 1963). Throughout therapy, this factor may accelerate progress because of the patient's expectation of benefit.[2]

The placebo effect may work by mobilizing the intrinsic tendency toward self-healing that characterizes all living beings. In psychotherapy, it seems to originate from the hopeful possibilities stimulated by the prospect of professional help from an expert practitioner. Any elements of the psychotherapy experience are likely to enhance these effects and may lead to permanent benefits.

- The initial interview may provide such hopeful expectations because the therapist comes across as professional, competent, knowledgeable and concerned.
- Early progress, such as the elimination of unrealistic worries or an appreciation of the therapist's understanding of the identified troubles may result in the disappearance of or at least a reduction in some presenting problems.
- Even personal characteristics, as perceived by the new client, may have a placebo effect. The good reputation of the therapist, the professional surroundings of the office environment and the professional appearance of the therapist, the perceived confidence that the therapist can help, or the association of the therapist with a respected institution—all may contribute to early progress.

While the placebo effect may be more significant at the beginning of therapy, its continuing influence plus the new developments that continue to stimulate it can persist through the entire treatment period.

The placebo effect is sometimes regarded as a counterfeit benefit, one that is not based on actual change, but this notion ignores the way emotional expectancies can modify the way experiences are integrated into general behavior. Hopeful expectation can lead to real and permanent change. Optimism fuels progress.

Nonspecific Factors

We can broaden the idea of "psychotherapy" to encompass a variety of healing activities that promote the recovery from psychological impairment. These might include:

- Unconventional approaches such as faith healing, religious revivalism and the immersion in cults.
- Various magic ceremonies that incorporate the supernatural and its rites, such as calling upon spirits or casting spells.
- The mundane material provided in self-help books, some of which recycle simple ideas and obvious solutions but which nevertheless continually find a willing audience. For example, *How to Stop Worrying and Start Living* by Dale Carnegie, published 75 years ago, is still in print and selling today (Carnegie, 1948).
- And, of course, all the different systems of psychotherapy.

The common elements linking these seemingly disparate areas comprise a nonspecific set of forces first noted by Jerome Frank.

In *Persuasion and Healing*, Frank identified four shared characteristics that were common to all of these different modalities (Frank & Frank, 1991):

- The first characteristic was a *relationship* with another person who was perceived to have the ability to bring healing forces to bear. The bond with the healer must be one that encourages open, revealing speech and the expression of emotion. The healer might as easily be an evangelical preacher, a tribal shaman or a self-help author as a widely published psychotherapist.[3]

- The healing activity had to occur in a special safe *environment* that validated the healer's prestige and competence. The setting could be an isolated commune or an outdoor revival meeting under a tent or a magic circle made from a ring of stones or an office in a professional building: all of them convey the safety of a protected sanctuary.
- The activity must occur in the context of an explanation that made sense of the sufferer's ordeal. Frank called the explanation the *myth*, perhaps to include the wide variety of logical and irrational features each typically contains.[4] The "myth" could be the potency of a sacred amulet or the soul-saving act of confession or the power of unconscious mental forces.
- Finally, all of the varied efforts had to include a procedure, an articulated system, that could be employed to guide the sufferer through the recovery into health. Frank called this feature the *ritual*. Equivalent processes might be a ceremonial baptism or handling venomous snakes while speaking in tongues or the acceptance of the psychoanalytic couch.

Relationship, environment, myth and ritual do not evoke the practical realities of 21st century life. The comparisons between psychotherapy and such religious, magical or self-help practices that lack an accepted scientific basis may strike the modern reader as inappropriate if not distasteful. It might help to keep in mind that the human brain has undergone little change over the last 200,000 years, a mere flicker of evolutionary time. We possess the same drive to pursue patterns and meanings and experience the same swarm of emotions as did the earliest Homo sapiens. No surprise then that we have the same responses to myth and ritual as our progenitors. Perhaps the parallels are less disconcerting if we acknowledge that emotional forces and the effect of various traumas on our psyches are as potent now as they were when humans were hunter-gatherers living in tribes whose daily existence was always under threat. Today, we can be grateful that, with a willing, patient and a skillful therapist, these ancient dynamics can be mobilized to help improve the lives of modern sufferers.

In any case, the parallels between Frank's identified nonspecific factors and modern psychotherapy are clear:

- We take on the mantle of healer when we present ourselves as competent, recognized therapists. Our social standing is bolstered by the assumption that we have the special training of our profession and is further supported by the certification of a professional accreditation and by a license issued through a controlling government agency. These external attributes justify and sanction the *relationship* we offer to our patients and clients.
- Our activities typically take place in a closed, pleasant space, usually our office, that can be soundproofed and protected from intrusion for the duration of the meeting with our sufferer. We provide privacy and, within certain legal limits, confidentiality. Thus, we fulfill the requirements for a special safe *environment*.[5]
- We typically provide a description or a diagnosis of sorts for the identified psychological issues we propose to treat. While our particular account may differ from what might be offered by a therapist with a different theoretical stance, our explanation will be internally consistent and, hopefully, persuasive. In other words, our sufferer is invited to accept our *myth*.
- The sufferer learns, either through our direct educational efforts or from experiencing the conduct of the therapy, that we have a set of procedures, a coherent methodology, that will be followed to achieve the desired healing. The range of procedures in psychotherapy is wide, encompassing free association, meeting with a group of fellow sufferers, painting one's feelings on canvas or role-playing a past trauma. This process constitutes our *ritual*.

So, rather than begrudge the comparison between our own professional activities and the somewhat fringe or suspect status of the other varieties of persuasive healing, perhaps we should be more confident in our own approaches, knowing that they occur against

a background of historical success over millennia of interpersonal healing.

Therapeutic Change Agents

The last of the common elements found in all psychotherapies were clearly identified by T. Byram Karasu and comprise three necessary healing forces (Karasu, 1986):

- The first nonspecific healing force Karasu called *affective experiencing*. Behavioral problems contain emotional content. For example, a simple phobia, say, fear of spiders, means that the expectation of meeting a spider or seeing one in proximity to oneself elicits anxiety, dread, disgust. These strong feelings must be disarmed in the course of treating the phobia.

  The more subtle or widespread problems that might bring someone to a therapist come with their own set of affects and require the same attention and eventual resolution for the treatment to succeed. These emotions may emerge as a sudden strong release (catharsis or abreaction) or they may simmer along within the regular therapy work. Attention to the affective experiences of the patient is needed to remove barriers to change and to enhance new, more adaptive behaviors.
- *Cognitive mastery* is the second prerequisite for treatment success. Here Karasu recognizes the same requirement as in Frank's theoretical system or *the myth*. In both classifications, the methodology provides an intellectual framework that creates a rational understanding for the origin and impact of the target behaviors. A psychodynamic approach may identify early childhood traumas that manifest as current difficulties. A cognitive-behavioral analysis might focus on antecedent forces that lead to cognitive distortion. An existential therapy may emphasize the need to accept the realities of human survival. In all cases, the rational basis provided by the therapy system is used to guide the treatment toward a favorable result. The

ability of the sufferer to understand the problematic behavior, not as a mysterious, uncontrollable set of forces, but rather as an identifiable, rational, explainable set of circumstances provides the sense of control (of "mastery") that promotes the desired recovery and healing.

- Karasu identified the third requirement as *behavioral regulation*. Here he recognized that actual, persistent positive change in behavior is the unique measure of treatment success. As mentioned in the definition given earlier, effective psychotherapy, regardless of its many systems and methods, requires a helpful and stable change from maladaptive to successful behaviors.

  More specifically, this principle of behavioral regulation rejects the significance of the common, highly valued features of a particular psychotherapy system. Examples might include insight produced by a psychodynamic therapy or the recognition of overgeneralized thoughts in a CBT protocol or the acceptance of the inevitability that life ends developed within an existential therapy. These are real achievements, but they are only provisional steps toward the hoped-for emergence of stable new behaviors that constitute the treatment goals.

  In too many cases, however, the patient remains in treatment for long periods, steeped in the experience of a particular therapy method, perhaps achieving many of these provisional steps, but absent real behavioral change—with little to no improvement in the problematic behaviors that brought them to the therapist. Lacking the required "behavioral regulation" the therapy fails to achieve its desired aim.

The presence of all three healing forces provides the best opportunity for the desired outcome. If one or more is missing, success becomes more elusive. For example, consider a highly emotional client who never achieves cognitive mastery. Think of an intellectually sophisticated patient who understands the structure and meaning of his problem but fails to generate the appropriate emotional response. Neither is likely to achieve the behavioral changes that would alleviate their troubles.

The Psychotherapy Relationship

The preceding discussion of the elements of psychotherapy all manifest themselves through the *relationship* between the therapist and the person, family or group who require the therapist's services. In fact, two types are present throughout the therapy: the real relationship and the therapeutic alliance.

The Real Relationship

The real relationship arises from the administrative and structural demands behind the work of the therapy itself: the non-therapeutic transactions between the two parties. It includes the agreement on a schedule of sessions or even how many sessions will be allowed. It can involve the financial arrangements, including whether they require third-party payments or self-funding, as well as the expectations of when the bills will be due and payable.[6]

Beyond these practical decisions, the real relationship incorporates certain concrete, non-therapeutic expectations. Examples are the recognition that the therapist is paid for services rendered, that therapists have other clients, that they go home at the end of the day, enjoying a separate life outside of the office. Other expectations include: all appointments will be kept. The session will start and end on time. Bills will be paid in a timely fashion. The office environment will be respected.

From time to time, certain aspects of the real relationship will contaminate the therapeutic effort. For example: The client may fail to keep an appointment. The patient may arrive chronically late. The client may not pay the bill. The breakdown in these administrative matters usually means the therapeutic alliance has weakened. It can also indicate that the therapy has failed to address some important aspect of the treatment plan and effort must be diverted from other therapy efforts to address and correct the omission.

The Therapeutic Alliance

The professional relationship between the participants in psychotherapy is termed the therapeutic alliance.[7] It refers to the

commitment between them that together they will overcome the behavioral difficulties that are the agreed focus of the treatment. Disruption of the therapeutic alliance often results in treatment failure and in clients leaving therapy prematurely (Homan, 2019).

The therapeutic alliance is the result of contributions from both the therapist and the client. The therapist brings such personal assets as warmth, sincerity, flexibility, tolerance, openness, empathy, integrity and concern for the client. The client provides, among other things, emotional intelligence, motivation, trust and a willingness to cooperate. The safe environment, such as the office, contributes to the confidence between them that the work can succeed.

This alliance alone will usually account for some of the progress the patient makes regardless of the psychotherapy procedure itself. How much it contributes is a matter of speculation and percentages vary. My own estimate is that it accounts for around 50% of the success of the therapy. Assuming that to be true, it suggests that even the most poorly run course of treatment—poorly run from a technical perspective, that is—will still accomplish half the job, *provided the therapeutic alliance is strong*. The other 50% depends on the accuracy of the formulation, the precision of the treatment plan and the skill of the therapist. While it may be a comfort that half the job is already assured by the therapeutic alliance, professional satisfaction can only result from the sense that everything possible has been accomplished.

Beginning Treatment

Every course of treatment begins when the therapist first encounters the person who is seeking help. This encounter should comprehend four steps that will help ensure a successful outcome:[8]

- First, an *initial evaluation* that allows the therapist to assess the prospect's motivation and suitability for treatment and to identify the problems on which the therapy should focus.
- Second, a *formulation* or analysis of those problems within whatever intellectual framework the therapist relies on for understanding.

- Third, the construction of a *treatment plan* that encompasses the therapy's goals and hoped-for outcomes.
- Fourth, an *agreement* with the client on how they will accomplish its goals.

This section briefly examines each of the four steps.

The Initial Evaluation

In this short summary, it is difficult to cover the many tasks and complex decision-making included in the initial interview. The reader may want to consult the many other sources of information on this topic.[9]

The first meeting between the two participants is often a semi-structured interview that permits the patient to lay out the background of the presenting problems while it also allows the therapist to gain the required facts of the case through direct questions. Additional information might include the referral materials and the records of prior treatment.

An important datum is to determine what it is that the client *wants* from therapy. This question is usually neither simple nor obvious, and what is wanted may not be the therapeutic benefit the therapist hopes to offer. One study (Frank et al., 1978) compiled a list of over a dozen different requests, including such things as:

- Clarification. A client, referred by someone else, may seek a better understanding of their supposed problem, perhaps hoping to be told there is none.
- Ventilation. The patient may want a sympathetic auditor, possibly someone who will agree the fault lies with others.
- Control. The client could perceive the therapy relationship as a power struggle and be determined to win it.
- Confession. The patient may hope for relief merely by revealing things in confidence that cannot be said elsewhere, with no motivation for behavioral change.
- Nothing. The client was coerced into treatment by someone else, a spouse or even a court, and has no intention of cooperating.[10]

It may take considerable effort to elicit a covert agenda but the additional work is a critical element of the initial assessment. For therapy to reach a successful outcome therapist and client must agree that what the client wants is something the therapist can and will provide.

The initial interview should culminate in a coherent history leading to an initial understanding of what the patient needs. It should include a mental status evaluation, especially with an assessment of risk as to suicidal or other potentially harmful behavior, although many of the mental status data points can be assessed without formal questions. The sum of all the information-gathering should result in a clear idea of what needs to be accomplished.

Formulation

An important but often overlooked feature of the initial interview is the formulation. Using the information gathered, and with a background of psychological knowledge, the therapist can identify what caused the problems that the therapy is expected to resolve. The intellectual framework for this understanding can be any of the psychological models that underlie the different therapeutic modalities. In other words, it could be psychodynamics, or cognitive-behavioral theory or any of the humanistic systems. So long as the result is a coherent explanation, based on cause and effect, the formulation will be useful in deciding how to proceed with treatment.

In medical practice, a standard part of the evaluation is a *differential diagnosis*, a rank ordering of all the diagnostic possibilities suggested by the patient's signs and symptoms. This listing leads to a series of tests and other procedures that will rule in or rule out diagnostic possibilities until, hopefully, only one—the most likely of the lot—becomes the correct diagnosis. The validity of these tests relies on the scientific understanding of the underlying pathology that presents as a medical disease.

Tests and procedures for psychological assessment are far less useful. They comprise a variety of instruments, often in the form of questionnaires, to help screen, diagnose and monitor various conditions. In

an evaluation for psychotherapy, however, these written instruments may not be practical or dispositive. Like the taxonomy of diagnostic categories, they rely on descriptions of patient symptoms. Lacking the body of scientific data that underlies medical testing, however, they can only confirm a descriptive category or bolster the therapist's judgment about symptom severity. When administered, they take time away from the face-to-face interaction so important to establishing a therapeutic alliance. Perhaps their main value is to provide research data or a concrete basis for insurance claims or for medicolegal purposes. In real-world terms, the practicing therapist will usually rely on making a best judgment based on the history and mental status alone.

Formulation is a challenge because it requires inductive reasoning. Unlike the more familiar deductive process, *the more information presented the harder the inductive task*. In deductive reasoning, the kind needed to arrive at a diagnosis, for instance, the more facts available the easier it is to reach a conclusion. A diagnosis is based on identification of the individual elements that define it. If the only symptom is "anorexia," for example, the number of possible diagnostic categories is large (dieting, bulimia, chemotherapy, depression, delusional disorder and more), but add hopelessness, early morning awakening, anhedonia and suicidal ideation and the diagnosis of major depression begins to emerge.

Inductive reasoning, however, requires building a single abstract concept out of a collection of data. The more items available the harder it is to find the specific group into which they all fit. For example, consider the pair: a banana and an orange. The obvious category is "fruit." Now add oatmeal and coffee. The four items may be grouped as "breakfast food" but they might also be "things I need from the supermarket" or even "foods I don't like to eat." The answer, at least, is less obvious than for only the two items. Add further: Grandma's cookie recipe and a crock pot. Perhaps the category for all six items is now "things found in the kitchen," certainly a more vague and tentative conclusion than before. An initial interview may reveal a list of 10 or 20 disparate items of history and current symptoms, making the effort to contain them in a single useful set a challenging task.

A shortcut to this process is a list of categories that covers most of the psychotherapy topics into which the available facts may be incorporated. In effect, this exercise turns the difficult process of induction into the easier mode of deduction. Here are some categories with descriptions:

Biological	Disorders with a known or likely organic basis.
Developmental	Troubled transition between phases of adult maturation.
Dissociative	Complications from abuse, neglect or other trauma.
Situational	Stress-related symptoms with inadequate coping skills.
Transactional	Social difficulties arising from interpersonal dysfunction.
Existential	Responses to isolation and death.
Psychodynamic	Irrational behavior reflecting intrapsychic problems.

Using these seven likely areas of difficulty, most patient histories can be categorized in a way that leads to an inductive conclusion about what needs to be done in the recommended therapy.

Treatment Plans

Using the history and the formulation, therapists should be able to identify the areas of behavioral dysfunction that will be the focus of treatment. These ideas can then be developed into a concrete plan of treatment.

The plan begins with a decision about what should be the overall desired outcome (the AIM) of the treatment. As noted above and as the examples suggest, the therapist may determine that what the client *wants* is something inappropriate or unattainable. For example, a client, considering divorce, may want the therapist's agreement that the spouse is responsible for a bad marriage, while the therapist may have recognized distortions in the client's perceptions and the ways the client has created unnecessary problems in the relationship. These observations

could form the basis of a workable treatment plan. They must then discuss and negotiate until what the client wants and what the therapist is willing to accept are congruent, if not exactly the same.[11]

Next, the therapist must decide what has to be accomplished (the GOALS) in order to reach this outcome and which of the available therapeutic approaches (the STRATEGIES) might best reach them. The final step is to select the specific techniques (the TACTICS) needed to carry out a strategy.[12]

In outline form, a treatment plan might look like that in Figure 2.1.

In this example three distinct goals are required to reach a successful outcome. Each goal needs its strategy and tactics, although goals 2 and 3 both need strategy 3.

Suppose, for example, that the *aim* for a depressed patient with a poor employment history was to help overcome the mood disorder.

Figure 2.1 Complex treatment planning diagram Source: From *Treatment Planning for Psychotherapists*, 3rd edition, by Richard B. Makover, © 2016. Used by permission of American Psychiatric Association Publishing.

It might require a course of antidepressant medication to reach *goal 1* (a normalized mood), a clinical case management (directive) approach to deal with the employment problem (*goal 2*), and a cognitive-behavioral examination of the depressive ruminations that accompany the illness (*goal 3*). CBT is a *strategy* needed for the ruminations but also for the employment issues. When and how to use these three *strategies* would depend on the flow of each session. Finally, the effective use of any *strategy* requires knowledge of and familiarity with the particular tools of each. For CBT, for example, the *tactic* of exposure and response prevention might be needed.

The Treatment Contract

The final step in treatment planning is the presentation of the plan to the patient in order to reach an agreement on how therapy will proceed: the *treatment contract*. The contract is usually verbal. Some negotiation may be needed if the patient has different ideas about what should happen. What the patient wants and what the therapist can offer must, in the end, be congruent. The validity and usefulness of the contract depend on the patient's sincerity, openness and honesty. A patient with strong sociopathic traits, for instance, may lack these qualities and the result will be a false contract that will ultimately fail.

It is tempting to skip this step and just move ahead with the planned therapy, but failure to agree on a treatment contract will often result in a poor outcome. If the therapist assumes that an agreement has been reached without overtly confirming what it comprises, the disconnect will often lead to a breakdown of the progress of therapy that becomes a structural impasse. Unless resolved, treatment—at least, effective treatment—will end.

Modification of Plans

Treatment plans for behavioral health therapies cannot rely on a formal diagnosis. As noted before, the official list of disorders (American Psychiatric Association, 2022) is essentially a collection

of descriptions, a taxonomy based on observed characteristics lumped together under separate headings. Human beings are full of contradictions and variations, however, and patients often present with an assortment of symptoms that do not fully match any single diagnostic category or that span several different categories. Instead, accurate assessment of what problems need treatment is better addressed through the formulation, the detailed assessment of what troubles that singular client.

Although the formulation is unique to a particular client, it rests on a more general understanding of human behavior and especially on the deviations from successful behaviors that qualify as symptoms. The specificity of the formulation leads to a treatment plan that recognizes what is the client's maladaptive behavior and that proposes to correct it.

One aspect of human behavior, however, that undermines the integrity of the formulation is that human beings, to be blunt, tend to lie. Mostly, they are lies of omission, as the interviewee leaves out important facts from the history, but lies of commission are also a problem. Lying is organic to the human species: people lie to protect themselves or to maintain or gain social status. They lie in business transactions as well as in intimate relationships. So it should be no surprise that they lie to their therapists. Incorrect and missing data introduces flaws into the formulation that will sometimes seriously encumber treatment plans.

The original formulation relies on the initial history. When additional history or corrections emerge over the course of treatment, the formulation must also evolve and the treatment plan that rests upon it must be modified to reflect that evolution. One hopes that the subsequent formulations represent *successive approximations of the truth* and that therapy becomes more accurate and effective as a result.

Summary

Psychotherapy, like most of health care, requires not only a scientific knowledge base but also the flexibility and creativity of an

experienced practitioner. As with many healing efforts it can be more an art than a science. The therapist who is aware of, and practices within, the historical framework from which it developed may be more successful at helping troubled people find better solutions to their problems.

Notes

1 The placebo effect can also be harmful, especially when it is appears to support commercial activities that seek to take advantage of the public's naivety. Countless patent medicines and worthless remedies are advertised and sold based on the expectation that the placebo effect will promote some claimed benefit for which there is no scientific basis. People are asked to believe that product X will restore lost memory function, promote lasting weight loss, control pain or overcome sexual dysfunction, to name a few examples. Thanks to the placebo effect some of those claimed benefits can actually occur, but often only temporarily and usually far less than is needed.
2 The recent proliferation of online psychotherapy services, lacking some of the requirements of in-person treatment, may owe their initial success to the placebo effect.
3 An open question is whether computers can fully replace human therapists. At present, they can help implement certain rigid protocols under human supervision. Whether they can ever develop the empathy, flexibility and creativity of a human therapist seems doubtful.
4 He also used the term "demoralization" to characterize the emotional distress and confusion that accompanied the suffering.
5 Remote delivery of psychotherapy ("Tele-Mental Health") surged during the 2020 viral epidemic and may persist because of convenience and increased access. Will those seeking help from a remote location, such as their home, experience it as a safe environment? Will their data be secure? If not, will their therapy be less successful?
6 The real relationship in fee-for-service arrangements also includes the unfortunate temptation to keep clients in treatment beyond the time legitimately required, either because therapy goals have been met or because progress has slowed or stopped or because of a comfortable relationship between the parties that becomes mislabeled as "support." The only remedy to this distortion of ethical principle depends on the practitioner's moral compass.
7 Other terms in use are the working alliance and the psychotherapy relationship.
8 Any experienced supervisor will have noted how often a therapist has missed one or more of these necessary steps when they confront the breakdown or failure of the therapy.
9 For example, Makover (2017).
10 The list of "wants" also included: administrative help; advice; psychodynamic insight; psychological expertise; reality contact; non-psychiatric medical treatment; succor.
11 The agreement also constitutes "informed consent," an important medicolegal element of any treatment.
12 See also Makover (2016).

References

American Psychiatric Association. (2022). *Diagnostic and Statistical Manual of Mental Disorders*, *Fifth Edition, Text Revision (DSM-5-TR)*. American Psychiatric Publishing.

Bergin, A. E., & Garfield, S. L. (Eds.). (1994). *Handbook of psychotherapy and behavior change*. Wiley.

Cabaniss, D. L., et al. (2016). *Psychodynamic psychotherapy: A clinical manual* (2nd ed.). Wiley.

Carnegie, D. (1948). *How to stop worrying and start living*. The Chaucer Press.

Craske, M. G. (2017). *Cognitive-behavioral therapy* (Revised Ed.). American Psychological Association.

Dimeff, L., & Linehan, M. M. (2001). Dialectical behavior therapy in a nutshell. *The California Psychologist*, 34, 10–13.

Endicott, N. A., & Endicott, J. (1963). “Improvement” in untreated psychiatric patients. *Archives of General Psychiatry*, 9, 575–585.

Frank, A. W., Eisenthal, S., & Lazare, A. (1978). Are there social class differences in patients' treatment conceptions? *Archives of General Psychiatry*, 35(1), 611–619.

Frank, J. D., & Frank, J. B. (1991). *Persuasion and healing: A comparative study of psychotherapy* (3rd ed.). Johns Hopkins University Press.

Homan, J. B. (2019). *Attrition and psychotherapy*. Portland State University Dissertations and Theses.

Karasu, T. B. (1986). The specificity versus nonspecificity dilemma: Toward identifying therapeutic change agents. *American Journal of Psychiatry*, 143, 687–695.

Makover, R. B. (2016). *Treatment planning for psychotherapists: A practical guide to better outcomes* (3rd ed.). American Psychiatric Association Publishing.

Makover, R. B. (2017). *Basics of psychotherapy: A practical guide to improving clinical success*. American Psychiatric Association Publishing.

Marcus, E. R. (2002). Psychoanalytic psychotherapy. In Herren, M., & Sledge, W. (Eds.), *Encyclopedia of psychotherapy* (pp. 275–296). Academic Press.

Miller, F. G. (2012). The enduring legacy of sham-controlled trials of internal mammary artery ligation. *Progress in Cardiovascular Diseases*, 55(3), 246–250.

Wheeler, G., & Axelsson, L. (2017). *Gestalt therapy* (2nd ed.). American Psychological Association.

Zhang, W. (2019). The powerful placebo effect in osteoarthritis. *Clinical and Experimental Rheumatology*, 37(Suppl. 120), 118–123.

Therapeutic Communication

Communication between therapist and patient is at the heart of every therapeutic methodology. It is the means to support the therapeutic alliance, to identify and illuminate areas and topics of significance, to mobilize emotion, to overcome resistance, to facilitate behavioral change. The various types of communication are, in effect, the therapist's tools of the trade.

When they employ these tools, therapists themselves become therapeutic instruments. Just as it is not the scalpel that treats a physical problem, it is the surgeon who wields it, so in psychotherapy it is not the theory that helps the patient heal—not the strategies and tactics that make up the treatment process—it is the therapist who chooses how and when to "wield" these tools: which ones to use, the timing of each intervention, and the evaluation of which interventions are effective and which are counterproductive. Just as the surgeon develops the skills to use the scalpel, so must the therapist learn to use the psychotherapy tools available. Among the therapist's tools are words, phrases, questions, statements; in other words, cognitive decisions made in response to the patient's verbal and non-verbal production, within the historical context of that person's unique history.

Ideally, every communication from the therapist should have a therapeutic purpose. To accomplish this difficult goal, the therapist must utilize the cognitive function sometimes called the "observing ego" to monitor the progress of a session and make immediate judgments about what to communicate in response to what the patient says and does. The observing ego, or self-observation,

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