

Introduction

Psychotherapy offers one of the many ways people can help themselves to change. Through a trusting, confiding, professional relationship patients widen their range of options and increase their ability to implement these options. Therapists focus on the patient's range of responsibility and the possibilities for change within that range of responsibility. The intentions, spoken words and non-verbal communications of the therapist are the instruments of change. As an agent of change, therapists are often affected by their attempts to help patients transform themselves. These changes may be used both personally and professionally to enhance the therapist's functioning.

We live in an ever-changing space-time continuum in which the only constant is change. The psychotherapeutic relationship evolves over time through a series of stages: engagement, pattern search, change and termination. By grasping the movement of the psychotherapeutic relationship by stages through time, therapists learn to predict and influence outcomes. The key to expanding effectiveness lies in our ability to "step back" from experience, to observe what we are experiencing and utilize new awareness to sharpen our maps for psychotherapeutic sequence. Training requires the on-going assimilation of new observations about the minds of others and the self during the many variations through the stages of psychotherapy. We will use the term Observing Self to refer to this universal human capability to monitor the mind's contents.

Each of the modules calls upon trainees to activate their Observing Selves to focus on specific aspects of their own minds relevant to the role of psychotherapist. And to what end? What are therapists trying to help their patients do? Patients come for help. They want to leave the therapist's office with something. That something involves thinking, doing, feeling different from the way they were before entering the therapist's office. Therefore therapists help patients develop a different, more effective view of their future. The past and present help to inform the creation of a better future. **Therapists encourage the activation of the observing selves of their patients to help them reconstruct their views of the future.** The modules provide a collection of key psychotherapeutic abilities that facilitate the accomplishment of this intention.

Module 1: Basic Listening Skills. Each of us listens to others in distress in certain specific ways. How do you listen? How much emphasis do you place on words, non-verbal communications, underlying meanings? How empathic are you? How well do you register the experiences of others? To answer these questions, your Observing Self scans those parts of your mind that exercise these functions.

Module 2: Verbal Response Modes and Intentions. Speech forms can be categorized. Modes of psychotherapeutic speech are directly related to ordinary speech. We nod our heads and murmur "hmm" to encourage a speaker to continue speaking. We ask questions, we ask for clarification. By attaching these psychotherapeutic modes to what you already do, you specify your verbal instruments of psychological change. To what end? What are you intending as you use these verbal instruments? Activate your observing self. Ask what response you are intending to evoke in the listener, the patient. Most of our communicating lives is spent not paying attention to what we are seeking from another as we speak. As a novice psychotherapist, you have a chance to wonder: what am I trying to make happen in the mind of this other person?

Module 3: Working Alliance: Psychotherapy requires trust by the patient in the therapist.

This module encourages you to examine the ways in which you establish and maintain helping relationships. How do you engage others? How do you demonstrate competency, knowledge, trustworthiness, the willingness to help? Watch how you start a professional helping relationship.

Do you lead with empathy and basic listening as does Carl Rogers whose tape you may see? Do you jump right in with advice as do many psychiatric residents? Do you find yourself overly concerned with your own performance so that you ignore your patient's needs? This module teaches you the value of research—that standardized instruments might be able to tell you something important about your relationship with patients. The working alliance inventory (WAI) has provided support for the idea that the strength of the working alliance correlates well with psychotherapeutic outcome (Greenberg, ???). Research data offers a dispassionate view of your helping relationships.

Module 4: Inductive Reasoning to Determine Patterns. Looking for dysfunctional patterns requires the gathering of real information from the patient's life. Therapists sift through bits and pieces to find key facts that provide a connection to enduring patterns. The causes of human psychological distress are not infinite. Each of the psychotherapy schools stands upon some fundamental concept of human distress. Gathered together these fundamental human problems, like fear of being abandoned and fear of being dominated, provide possible basic patterns into which the data from each patient can be fit. Patients are enormously supported when they discover meaningful coherence in their mental confusion. Beginning therapists are confused by the proliferation of possible basic patterns. Try to find your favorite ones: lack of assertiveness, past-present, negative self-talk, fear of emotions. Fill in the blanks of your favorites and learn others. Then practice going back and forth between data points and basic patterns. In doing so you will be observing another basic psychotherapeutic function—inductive reasoning. Inductive reasoning takes you from the single event to the general pattern. Deductive reasoning then tries to fit the general pattern onto the specific.

Module 5: Strategies for Change. The widest variations among the psychotherapy schools comes in the strategies and techniques for promoting change. However, you cannot force patients to change. Unlike surgery, therapists rarely do it to their patients. You can only encourage, facilitate, advocate for change. If your patient does not want to change, you are almost irrelevant. How do you change? Resiliency is that human quality that allows us to recognize that “the terrible thing that just happened can be modified by the way I think about it in the future. It happened but how I represent it in my mind-brain is under my control.” How resilient are you? What part does your Observing Self play in your response? How do you help your patient co-imagine and then carry out a new future? Study the techniques that most fit your experience. If you learned to be assertive, learn the details of how to help others become more assertive. If you like to change thought patterns, study the way in which cognitive therapy as well as other approaches help people change the ways they think about themselves and others. If you are a student of relationships, examine the ways in which relationships can be changed.

Module 6: Resistance. Patients often do not match their therapists' expectations. In life outside the office, you might easily get mad and stomp off when someone does not live up to what you are expecting. Therapists can easily become angry at patients because patients often do not live up to expectations. And here is a valuable lesson both in therapy and out of therapy.

Instead of getting angry, activate your observing self. Allow your first thought to be: “I wonder what is going on here.” The next thought to entertain: “I wonder what makes it difficult for this person to carry out this simple expectation.” Your first assumption should be: “The patient is fully intending to improve, to change, so something is getting in the way.” Too often therapists take the failure to meet expectations as a personal rebuke. Sometimes it may be. But stepping back to take the extra breath both in therapy and in life can be beneficial to all concerned. Instead of a reflex nasty response, you can provide a helpful response.

Module 7: Transference and Countertransference: Freud observed that patients distort the person of therapists by seeing them through the lenses of earlier relationships. Therapists also distort the person of patients in the same way. WE CAN'T HELP IT! We know the present by comparison with past experiences—what is similar and what is different. Therapists offer a unique similarity to parental and other intimates by their supportive, altruistic interest in the patient's welfare. Few others than parents offer this kind of caring. Patients, then, can add extra wishes to previous experiences creating a distorted view of the therapist. Here, the ability of both participants to step-back, to activate their observing selves, can be very useful. Why? Because the distortion of the therapist by the patient is very likely to resemble current and future distortions of other intimates. The therapist metaphorically peels off the distortion from his/her sense of self, places it “over there” as some specimen to be examined by both of them. Then the therapist invites the patient to examine the distortion together. The invitation requires that patients activate their Observing Selves to dispassionately examine their contributions to the possible distortion.

Countertransference originated as a response to the patient's transference: a counter-to-the-transference. We have since learned that therapists, like patients, bring their own personal distortions to the therapeutic encounter that have little to do with the patients themselves. Perhaps the most toxic countertransference reaction is sexual attraction. Sexual attraction seems so easy to act out, so alluring, so romantic and so professionally devastating to therapists and personally devastating to patients. Unfortunately trainees become so frightened by having any emotional response to patients that they numb themselves. In so doing they miss potentially wonderful information about themselves and about their patients. So be open to your responses. Let your observing self take your dreams about patients, your thoughts and emotions about patients into consideration. Examination and discussion with supervisors and possibly peers will allow you to learn more about yourself as well as more about your patient. Be willing to observe yourself and study yourself! After all, being a therapist is the only way to be in psychotherapy without having to be the patient.

Module 8: Termination. How do you say goodbye? Parents have more trouble letting go of growing up children than do the children letting go of their parents. Therapists may have more trouble saying goodbye to patients than do the patients. There is a subset of patients for whom saying goodbye feels like being abandoned and so termination can be difficult for them. Termination then can be a valuable focus of therapy. For those trainees seeing patients for “medication management” this module serves as a warning: these patients become much more attached to you than you might imagine. A study of patients whose resident physicians were leaving the outpatient clinic at the end of a year's rotation clearly demonstrated the difficulty: after being told that their resident was leaving 20% of patients worsened, 32% required

medication changes and 10% decided to stop their medications. (Mischoulon, Rosenbaum & Messner, 2000). Some patients will become very attached to you. Be prepared to discuss this attachment and the difficulty in giving it up.

Experimental Module: Future-oriented Formulation. The appendix contains an “experimental module” so named because it has not been fully used by sufficient numbers of residents to be included as one of the basic modules. We are requesting that your training program try it out and let us know what you think of it and how to improve it.

This module introduces two very different but related concepts: formulation and the future. We suggest that the therapist is a co-imaginer of the patient’s future. If so, then the therapist imagines in as much detail as possible what the patient is seeking and how likely it is that the patient will be able to realize this future. Formulation involves both *assessment* of the patient’s current state and *treatment planning*.

Future-oriented assessment includes not only the patient’s current complaints and problems but what the patient is seeking and how they think the goals can be accomplished. In addition future-oriented assessment attempts to view problems as difficulties with the future; the module describes the implicit future in many of the pathological formulations of the psychotherapy schools as well as problems with the future in many diagnostic categories.

Future-oriented treatment planning focuses on various ways to help people change the ways in which they conceptualize the future and the common impediments to actually creating images of a better future.

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We are not attempting to introduce a new school of psychotherapy. There are already too many schools, each emphasizing key aspects of human psychological functioning: emotions (Emotion focused), thinking (Cognitive), behavior (Behavioral), interpersonal (Interpersonal), systems (family). Psychoanalysis has special as well as broad applications in each of these realms. Many unique schools have come and gone like Primal Scream. Others survive with passionate supporters on the fringes (Reichian). Many forms of brief therapy come and go while the magician from Arizona Milton Erickson continues to fascinate many after his death with his remarkable intuitions about human change.

Instead we are trying to encourage you to think for yourself within this rich tradition. We hope to help you to define what fits for you with your patients, in your settings, using your ability to be self-aware, during the stages of psychotherapy, while aiming to help your patients develop more effective personal futures.

We instead advocate a shift away from developing new schools of psychotherapy and instead, developing a neurobiology of psychotherapy.

Psychotherapy helps to change brain function. Pharmacotherapy helps to change brain function. Each of these modalities provides a means to help patients free themselves up from dysfunctional brain circuits in order to create new ways of thinking, to help plan better futures. The mind-barrier should be dissolved! (Beitman, et al 2003). A clear delineation of the basic process of psychotherapy like self-awareness, empathy, and pattern recognition in both patient in therapist will help to clarify the neurobiological intentions of psychotherapy. With this knowledge we may be able to specify techniques and models to help alter brain activity.

Yet psychotherapy remains firmly entrenched in words, ideas, feelings. The

neurobiological imperative forces the creative mental gymnasts of the various psychotherapy schools to describe their favored processes in terms that can be mapped onto the brain. This discipline provides a welcome relief from off-handed theories and confusing jargon, forcing theoreticians to place their concepts within the realm of potential brain scan verification.

As you study your minds through the use of the modules, try to conceptualize how your brain supports these processes. Try to think about how you may be trying to help your anxious patients to activate parts of their prefrontal cortices to inhibit amygdala firing. Try on other circuits. You will be entering the brave new world of neurobiologically-informed psychotherapy.

THE PROCESS OF LEARNING

This training programs relies on active learning through active participation in group exercises and homework. In parallel with patient change in psychotherapy, trainees' change depends largely on your own motivation to learn. And learning means changing the way you think about yourself, your relationships and psychotherapeutic change.

The modules are designed for flexibility and innovation. Many programs use the modules as a framework within which to view video tapes, discuss relevant, current patients and most importantly to role play various situations and difficulties.

In addition the modules group provides an safe environment to learn about you and your colleagues. Three of the exercises are designed to promote self-revelation: 1) guessing your colleagues intentions in Module 1, 2) describing the personal details of your triple column in Module 4 and 3) your countertransference responses to a colleague and patient in Module 7. You learn both how similar each of you are as well as how different you are. And hopefully you enjoy the benefits of a closely knit group experience.

Do the homework! Participate in the seminar. Allow yourself to be seen and heard. And enjoy learning psychotherapy for the rest of your life.