Something Happens: Elements of Therapeutic Change

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ABSTRACT

To make a difference therapists need a theory with which to understand the patient.[1] They choose theories that suit them, and need technique to maintain the therapeutic setting. Psychotherapy developed from healing and medicine, and from our ethological heritage of care for dependants. It happens in a special setting which makes new experiences possible. In this article I list a number of ingredients that are necessary in any effective psychotherapy.

KEYWORDS

drama, healers, neutrality, primary task, theory of change

A desire for change

TO BEGIN WITH there is a need for help. People who have got to the point of asking are often ready for change. Malan, Bacal, Heath, and Balfour (1968) noted that many patients who had been in grave difficulties for many years improved quite dramatically after the first consultation interview, before they could be allocated to the treatment or the control group. Change had been taking place under the surface but the subject needed the moment and the presence of a skilled person to notice it. There is a long history of attending carefully to the preconceptions that people bring with them to therapy (Reder & Fredman, 1996).[2] These are not always hopeful. Previous disappointing or abusive experiences will colour their expectations. Because precarious change is already taking place, a request for therapeutic help needs to be explored carefully.

For the clinician evidence of change is the single most important information to collect in the consultation. Over the years I have noticed how, within a few moments of meeting

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a patient or family, I have a sense of whether things are better or worse (it is not always helpful to ask). News of improvement is most welcome of all in a first consultation, since it means that the problem is perceived to be on the mend before one has done anything. Throughout history healers have had to rely on nature to do their work. The desire for change gives momentum to healing, and effective therapy harnesses developmental strengths and resilience.

The placebo effect is a particular case of this and is mightily powerful medicine. This is why it has to be controlled for in trials. And like so called active drugs it produces brain changes in the patient, though oddly not always in the same places as the drugs being tested (Mayberg et al., 2002). Placebo analgesics can produce endorphins in the brain, but are at the same time the result of thoughts or fantasies about the intervention, about what it means (Moerman & Jonas, 2002). Psychological change is a perceptual shift but also an event in the body.[3]

Change is never wholly desired. Fear of change is not surprising but a patient who actively clings on to the problem is more of a challenge to the clinician. In the 1890s the young Freud (1955a) noted that his patient (Elisabeth von R) resisted interpretations, because they provoked thoughts she would rather not have. He wrote, 'the patient's "not knowing" was in fact a "not wanting to know"' (p. 270). 'During this first period of her treatment she never failed to repeat that she was still feeling ill and that her pains were as bad as ever; and . . . *she looked at me as she said this with a sly look of satisfaction at my discomfiture*' (pp. 144–145, emphasis added). Whether or not they recognize the term, all therapists need strategies for dealing with resistance, and its satisfactions.

A primary task

The engagement of a helper creates a temporary relationship, a small organization with a primary task (Rice, 1963). This produces a boundary around itself defining what is, and what is not, relevant. The minimum condition for therapy is one person asking another, who is perceived to have the relevant skills, for help. The helper responds: 'What can I do for you?'.[4] In western culture a familiar image of this set-up is the Peanuts (Schultz) strip cartoon character Lucy van Pelt sitting at her stall offering psychiatric help for 5 cents. A service is available, the customer/patient describes a problem, and the helper asks questions about it. The outcome is an opinion, with or without an instruction. This is an ethical engagement. The patient gives authority to the clinician to try to help but can withdraw it at any time. The therapist also has the right to terminate, or not to take on the case at all. Authority is in this sense a technical term, meaning that the patient's agreement to be helped entitles the helper to ask and do things that would otherwise be impertinent. For a doctor to examine a patient physically without this permission is assault.

The capacity to keep the task in mind is closely connected to the therapeutic alliance, which gives the participants flexibility to review goals as they go along. The presenting problem may disappear only to be replaced by another. The literature on psychotherapy process (Carr, 2005; Orlinsky, Rønnestad, & Willutzki, 2004) consistently shows that collaboration is crucial. This makes it easier to deal with inevitable conflicts, misunderstandings and resistance. A simple test of whether the task is being met is this thought experiment for the clinician: Imagine being asked, at any moment, 'why are you doing this now?'. The answer has to link the therapist's current activity with the agreed primary task: 'I am making a family tree with you because I want to show the connection between the problem your child has now and relationships between you and your parents a generation ago'. The obligation to account for your intervention is most acute if something goes badly wrong and the treatment is taken apart in a legalistic process such as an

inquest. But the point of this is not just to be prepared if challenged by your professional association or a litigious patient. It is to monitor your work and, if asked, answer the question without mystification.

A theory of mind and a method of treatment

On their own such obligations are little more than pieties. There is a boundary, but what happens inside it? Questions asked by therapists are selected to test hypotheses. They originate in wishes, anxieties, hunches – even prejudices – in the therapist's mind, but become located within a theory[5] that generates a formulation or diagnosis. The therapist is looking for evidence, not simply trying to help. Being kind, for example, is necessary but it is not sufficient for therapy. It may helpful to be listened to by a Samaritans volunteer, but this is not the same as being understood. Simply being there for the patient does not give a new meaning to the problem: 'Empathic moments are not enough' (McCluskey, 2005, p. 14).

Technique maintains a therapeutic atmosphere. Without it the meeting becomes a social one, with its own rules and pressures. When people meet they make rapid calculations about status and influence, usually without thinking about it. As well as genuine attentiveness and affection, seduction and bullying are also possible in any conversation, however well concealed by therapist or patient. Therapists need a method to manage these powerful effects. While outcomes may be more accurately measured (Fonagy, 2004) the principles of psychotherapy have changed little.

Meanwhile the patient has his or her own theories, in particular about the sources of the problem and the ability of the therapist to help with it. Therapy is a 'theory exchange', and proceeds by trial and error. Postmodern and social constructivist therapists have highlighted the cultural context of this conversation (Hoffman, 1993) in which patient and therapist compare their differing views, not always comfortably. Modern therapists are inclined to think that earlier ones just told the patients what was wrong with them ('pathologizing') in a one-way conversation. Because of prevailing views of authority and gender, psychological treatment was more patriarchal in the past (Kraemer, 2002) but nothing truly therapeutic is achieved without change in both participants (de Shazer, 1982).

A common finding of psychotherapy research is that most effects are nonspecific (Drisko, 2004). Change happens in spite of, rather than because of, the particular model or theory being applied. Yet therapists in controlled trials who are not particularly keen on the method being tested get less good results compared to enthusiasts (Elliott, Greenberg, & Lietaer, 2004, p. 509). This is hardly surprising. Enthusiasm about one's method is one of the nonspecifics of treatment. It enhances the placebo effect. This is facilitated by the atmosphere and quality of the setting. The therapist is specially qualified or authorized, and the place of treatment is apart from the ordinary.[6] 'Theories held by therapists are more or less myths to give them confidence, and to guide them in the dark' (Frank, 1971). This sounds rather cynical, as if any theory would do, but the theory has to be one with which the clinician identifies: 'the purpose of specific ingredients is to construct a coherent treatment that therapists believe in' (Messer & Wampold, 2002). Campbell (2004) writes of a near-Damascene moment when he realized that somebody seen as 'sad' may not actually have this quality inside them. A theory is espoused (like a spouse) for passionate reasons, usually after some searching. It equips the clinician with a perspective that suits him or her, to be practised until it is intuitive.

What is common to almost all psychotherapy theories is a belief in mental life for its own sake; that you are free to have any thoughts you like, and if you don't like them you

can get help to change them. An anxiety may be perplexing, a thought evil in intent, or a desire shameful, but these do not necessarily cause harm to anyone else. Such an idea was heretical in Europe until the philosophers of the enlightenment challenged prevailing religious orthodoxies. Yet many people still believe that bad thoughts are just as wrong as bad actions, and should be confessed and given up, even punished or exorcized. This is to suppress mental activity through will power or obedience rather than reflect on it freely. As western clinicians meet more clients from nonwestern cultures such moral views, and familiarity with traditional healers (e.g., Kua & Tan, 2005), may become more common.

Courage and honesty

Wanting to change is not enough to make it happen. The pain must be intolerable at some level.[7] Despair is not essential but some kind of courage is needed to take the step to getting help, to own up to having a problem, and to describe it in detail. Shame (Loader, 1998) is a powerful source of resistance, and honesty a primary condition for change. Even patients who are hard to like can be admired for their courage, and the feeling may be mutual. Over 70 years ago Strachey (1934), citing Melanie Klein, wrote of the analyst's agonizing resistance to making a mutative interpretation (one which leads to change): 'There must be some quite special internal difficulty to be overcome by the analyst in giving interpretations . . . there seems to be a constant temptation for the analyst to do something else instead . . . giving a mutative interpretation is a crucial act for the analyst as well as for the patient, and he is exposing himself to some great danger in doing so'.[8] All therapists know the feeling of having something to say, perhaps with a beating heart, but not daring to voice it.

A specific narrative

Some patients, especially adolescents, can be terribly vague. A teenager told me that her problem was 'people'. Naturally I asked for more details. I needed to know about which people, what happened, and when. It is in the telling that the narrator begins to make fresh connections through remembering, or free association. The story is not fully known until it has been worked out using the therapist as 'an assistant autobiographer' (Holmes, 1998, p. 182) or 'an enlightened witness' (Miller, 2001). What emerges is therefore personal, intimate and raw. This is like midwifery, entailing struggle and sometimes firm action.

In the presence of her children, one of whom had been referred to me, a woman tells me through an interpreter that her husband died several years before. Since then she and her family had to leave their home country and she became a psychiatric patient here. I had to know exactly how the father met his death, where, when and how. I put pressure on the interpreter and the mother to be brief and clear. The children's father had been murdered by the secret service. While I felt like an impatient police officer the family seemed relieved to be hearing this tragedy described in dispassionate detail.

The curiosity of therapists is not always gentle but is tempered by the overriding need to be neutral.

Neutrality and reflectiveness

Therapists are engaged when ordinary advice has failed. They work hard at neutrality, at being 'nonjudgemental'. This is not the absence of judgement, but the absence of blaming. At its simplest it is the acceptance of the patient as he or she is, before trying to effect any change. Even saying 'ok' when hearing about the problem, rather than

remaining silent or looking quizzical, can be quite containing. People asking for mental health help often feel guilty or ashamed and expect to be criticized, so it is surprising to them when they are not. This is therapeutic in itself.

But the therapist also has him- or herself to deal with. Then neutrality is a more demanding discipline, in which you become aware of your prejudices and fantasies when with the patient: 'How did I come to be thinking or feeling like this?'. Neutrality may be the most misunderstood concept in psychotherapy. Beginners feel that their opinions and reactions have to be stifled and that they must slavishly follow the method. But a therapist who has no personal view is no use at all. People ask for our help because, while wanting their own point of view to be registered and respected, they hope we will have another one that will make a difference. Postmodern therapists, indirect descendants of the antipsychiatric revolt started by Ronald Laing in 1960, are preoccupied by the constant danger of perpetuating social injustices in the power structures of the clinic. They have revealed its social context and shown how therapy is itself inevitably a political activity (White, 1995). Even with the best intentions it is not difficult to privilege one's own views over those of the patient. Yet, though not always couched in cultural terms, the patient's experience has from the early days been seen as the most central, and most fragile, element of psychotherapy.

In remarkably modern terms Freud wrote in 1912 of the analyst's obligation to 'turn his own unconscious like a receptive organ towards the transmitting unconscious of the patient. He must adjust himself to the patient just as a telephone receiver is adjusted to the transmitting telephone' (Freud, 1955b). Psychoanalysts and systems therapists struggle to describe this active yet noninstrumental state of mind, which shares some of the qualities of traditional eastern religious or meditative disciplines. Wilfred Bion (1970) spoke of the need to abandon memory and desire when with the psychoanalytic patient.[9] Later Cecchin (1987), one of the original Milan group of family therapists, said one must be trained to achieve neutrality 'to see the system, to be interested in it, to appreciate this kind of system without wanting to change it'. From this position problems seem different already; they move from a fixed location to where they may be more easily observed by both players.[10] A central goal of all psychodynamic therapy trainings is to learn that neutrality is not a passive state of accepting what is on the surface, but a restless,[11] anxious and imaginative search for a fuller picture. Injunctions to take up a position of 'not knowing' are designed to move our cherished notions aside to make room for the patient's, not to empty our minds entirely. Similarly the rule that therapists never give advice is a reminder that ordinary opinions are unlikely to make a difference, not that we are never to be openly helpful. In any case advice is often taken even when it has not been given. Many therapists tell of patients who report that 'I did what you said', when they have no recollection of issuing any instruction at all. Any observation by a therapist can be taken as an implied command by an attentive patient (Watzlawick, Beavin, & Jackson, 1967).

When change is occurring, for whatever reason, Haley (1976) advised therapists not to take the credit for improvement but rather to be pleasantly mystified by it. This is to avoid provoking resistance in the patient. In any case symptoms may improve without our knowing precisely why.[12] Bion made the striking but obvious point that the therapist might have no idea what the patient is thinking. In contrast the patient may not notice what has changed, and that the original problem has waned or even gone away. This need not be routinely commented on. Given the potential for humiliation of patients, saving face is a high priority. Neutrality is to be approached but can never be achieved. Therapists cannot completely hide their pleasure or disappointment, nor should they. And knowing when to laugh with the patient is a valuable skill.

A tradition

Theories always build on earlier ones. I have noted how Freud described some of the elements of therapy for the first time, but he followed others, including 18th- and 19th-century poets, philosophers and scientists, and also an irregular line of doctors and healers from ancient times. The craft of healing is one of the many cultural activities that distinguish humans from other primates. In most traditional societies there are healers (such as shamans) whose effectiveness depends on the induction of altered states through ritual, symbols and rhythm. A special event is necessary. The subject journeys through the cosmos, meeting creatures and spirits, and then comes back to earth (Drury, 1989). This is exciting and quite possibly dangerous but it is held together by the authority and experience of the healer. The firmer the boundary the more risks it is possible to take. This is one of the anthropological antecedents of medicine and of therapy (Frank & Frank, 1991).[13] Another is the care we give to our own dependants, young and old as well as ill, which is far greater than in any other species. The newborn human infant is the most immature of all mammals and needs longer and more intensive care. The elderly, in traditional societies at least, are revered even when they have no useful economic function. These tasks, which give life to the term 'duty of care', require imagination on the part of the caregiver: 'This was how I used to be' or 'this is how I may become'.

Therapeutic methods without ancestry may be suspect. Revolutions that obliterate previous authorities, rather than revising them, are unstable. For a time family therapy existed in this state but there is now more recognition that new ideas come from old ones (Dallos & Urry, 1999; Flaskas, 1996; Kraemer, 2002). Because there is no right way of doing therapy, therapists have to belong to professional associations which regulate the membership and help them to learn from one another in developing their craft, the coherence of its theory and its evidence base.

Something happens

In modern treatments trance is not required but an altered state is, almost by definition, necessary for change. The capacity to be moved and transformed by laughter, crying, music and metaphor is acquired in early life, and is just as important for all of us in modern cultures as it ever was. These use the preverbal right side of the brain, which is far more active in infancy than the left. Not being in your ordinary, left brain, workaday state of mind is a common condition for change (Schore, 2003), while narrative puts both sides of the brain to work. It is a fundamental property of mind and culture to give meaning to experience (Geertz, 1973).[14]

The helping relationship is not symmetrical. Lucy van Pelt and Charlie Brown are on opposite sides of the counter and therefore in different roles. Even though they are at other times peers and friends the rules of ordinary conversation – of (selective) mutual self-disclosure and gossip (Dunbar, 1996) – are suspended.[15] The therapist is not asking for help and is not offering much of his own story, but is setting himself up to be challenged.

I was introduced to a girl, with her parents, by a paediatric colleague who described me as a child psychiatrist. Her father looked suspicious and the girl immediately said, 'are you a wacky doctor, then?' I asked her which of us she thought would be most insulted if this were the case. She laughed and her father, who later told me of his violent tendencies, relaxed a little.

At moments like these the therapeutic relationship comes into focus. It is more alive when the participants can push at the boundary, like boxers on the ropes. There may be

eye contact, not necessarily friendly. A sense that this relationship can stand a bit of stress – that it has resilience – is established. Creating, challenging and repairing a therapeutic alliance have powerful effects (Safran, Crocker, McMain, & Murray, 1990). The relief and surprise when contact is made is sometimes accompanied by tears or laughter or may barely be noted; 'something that may be imperceptible to either patient or analyst except, perhaps, for a sense of increased well-being when in each other's company' (Fonagy, 1998). Being attuned, then losing it and recovering it again replicates the 'good-enough' relationship of infant and caregiver.[16] In cognitive-behavioural therapy (CBT), too, the 'here and now' is important. In a major study of CBT for chronic depression 'the single best predictor of psychotherapy outcome . . . was the overall degree of emphasis therapists placed on discussing the patient–therapist relationship' (Vocisano et al., 2004). In general, reflecting on the relationship could be anything from saying 'am I asking the right questions?' to a psychoanalytical transference interpretation. It is gossip about ourselves. This bring the experiences of the participants firmly into the present.

Like drama, therapy is live. Though speech is the 'official' language of both theatre and therapy the occasions that make a difference, particularly in family therapy, can be moments of seeing, feeling or touching. 'Just look at that expression on his face. Do you think he believes a word you are saying?', 'You two seem pretty cosy there; there's not much room for anyone else'. Here the therapist is like a stage director. The playwright Arthur Miller (1957) wrote, 'drama is the art of present tense *par excellence*' (p. 11). 'Learning from experience' means being affected here and now. And, as in the theatre, where the actors bow at the end to show that the event is over, we can mark therapy's boundaries in a formal way. I always shake hands with everyone in the family who is old enough, which also highlights a hierarchy of social skills.

Conclusion

Therapy is a special case of looking after. Efforts to make it less hierarchical and more collaborative are welcome, but they do not remove the powerful expectations invested in healers by their patients, nor could they. This hopeful, or fearful, opportunity is not confined to formal psychotherapies. Any kind of contact between someone seeking help and someone offering it can be therapeutic, or not. How people look after one another is the prototype of therapeutic help, and we know much more about that than Freud did a century ago (Cassidy & Shaver, 1999; Tronick & Weinberg, 1997).

Therapy needs a secure boundary of theory and disciplined technique to allow the participants to take risks. At the time this can feel just the opposite – meaningless and undisciplined. Though words are the currency of psychotherapies, change can occur outside language and sometimes beyond awareness. The object of the exercise is not new knowledge but a different frame of mind. Even in behaviour therapy carrying out the apparently simple task of keeping a symptom diary[17] makes things happen. In the context of a therapeutic relationship observation of oneself leads to change.

Notes

1. Since some of this is historical I use 'patient' to describe the person asking for clinical help. Readers can replace the word with 'client' if they wish. In work with families and groups there are of course several people to engage with but the principles are the same, with the added effect of clients influencing one another. A detailed discussion of the particular elements of change in couple, family and group therapies is beyond the scope of this article. In that the parents are usually the ones requesting help, child psychotherapy is in this context a form of family therapy, though once the child is engaged it has a life of its own.

2. Psychoanalyst and psychiatrist Dr. Henri Rey would ask a patient, 'what were you thinking about while you were sitting waiting to see me?'.
3. Corrigan (2004) suggests that spindle cells in the anterior cingulate cortex, present only in great apes and humans, may be a key location for connecting thought and feeling at times of therapeutic transformation.
4. A question that immediately proposes a conversation between two individuals. Its impact is quite different from 'what seems to be the problem?' or 'how can we help?'.
5. Though the theory of acupuncture is not generally accepted in western medicine it provides a coherent view of the human body and its ailments, and has proven results (e.g., Joosa et al., 2004).
6. Psychoanalysts are probably the most acutely aware of this. The consistency and appropriateness of the setting are essential elements of the treatment. The effects of any treatment where drugs are not given are beginning to be seen as context dependent. 'Many of the elements of the healthcare encounter that are categorised as incidental in the context of drug trails are integral to complex non-pharmaceutical interventions' (Paterson & Dieppe, 2005, p. 1204).
7. Nobody goes to a therapist for a trivial reason. A slight toothache does not take you straight to the dentist.
8. Decades later Bion (1990) wrote in the same vein: 'In every consulting room there ought to be two rather frightened people: the patient and the psycho-analyst. If they are not one wonders why they are bothering to find out what everyone knows' (p. 5).
9. 'The capacity to forget, the ability to eschew desire and understanding, must be regarded as essential discipline for the psycho-analyst' (Bion, 1970).
10. The use of positive connotation (Palazzoli, Boscolo, Cecchin, & Prata, 1978), the reflecting team (Anderson, 1987) and externalizing the problem (White, 1995) also serve to free both therapist and patient from familiar and predictable perceptions.
11. 'Float like a butterfly sting like a bee' (M. Ali).
12. Justin Schlicht reports a case where he felt he had got everything wrong yet the patient recovered dramatically (Schlicht & Kraemer, 2005).
13. It may be that psychoanalysis is so often regarded with suspicion because its theory includes similar notions of change; that one makes unusual connections between different parts of the mind, and a reliance on dreams is central.
14. 'As our central nervous system – and most particularly its crowning curse and glory, the neocortex – grew up in great part in interaction with culture, it is incapable of directing our behavior or organizing our experience without the guidance provided by systems of significant symbols' (Geertz, 1973, p. 49).
15. 'Presenting work with a couple who are in a violent relationship [Gianfranco Cecchin] asks them, "why do you do this to each other?". This seems to be just the sort of question that anyone might ask. How is this different from the similar-sounding comments made by the couple's friends and relatives? One important difference is that the therapist is actually struggling to be more interested in finding an answer than in stopping the offending behaviour. The usual reason for asking such a question is less out of curiosity and more a way of saying, "why do I have to put up with this?", which is not the same question at all' (Kraemer, 2002, p. 207).
16. 'The miscoordinated state is . . . a normal interactive communicative error' (Tronick & Weinberg, 1997, p. 63) 'successful reparations . . . are associated with positive affective states . . . In normal dyads, interactive errors are quickly repaired . . . Normal interaction is a process of reparation' (p. 64).
17. Whether intended or not, such an instruction is in effect a paradoxical intervention. The patient is asked to carry on with the symptom in order to provide a baseline for the psychologist. It is very hard not to change under these conditions.

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