1 Theoretical Bridges and the Psychotherapy Process

Chapter Summary

This chapter presents the place of techniques within the complex process of psychotherapy. Each of the techniques was originally designed for a specific task such as developing new behaviors, uncovering encoded experiences, resolving internal conflicts, and promoting movement through the phases of the psychotherapy process. Techniques are simply techniques or, as Freud says, they are the scaffolds and not the building. Techniques become meaningful when they bridge the conceptualization of a client's problem with the therapeutic goal to be achieved.

For each of the techniques presented in this book, the theory from which it emerged, the procedures for its implementation, and a demonstration of its use are presented (All of the demonstrations were conducted by the first author, A.M.). Theory is believed to be a therapist's greatest tool as it provides the therapist with the conceptual skills to be innovative, creative, and flexible in applying a technique in achieving the therapeutic goal. The theoretical orientation for each of the techniques is presented according to the terms specific to it and in the "voice" of the theorist.

Introduction

This book presents a set of techniques used by therapists of varying orientations. Techniques form one part of the very complex psychotherapy process that includes theory, conceptualization, treatment plans, and their implementation. Therapy practice includes, as well, cultural and gender issues, professional and ethical guidelines, and the therapist–client relationship. Techniques become meaningful primarily when they are used within the context of theory and the goal of therapy and together they determine the techniques that are selected and how they are to be applied to bring about the desired changes.

Theory is fundamental to the practice of psychotherapy. Theory provides the bridge – the understanding – of that which takes place, for example, between a precipitating factor (e.g., loss of a loved one) and an emotional response (e.g., depression) and between a therapeutic intervention (e.g., task-direct imagery) and the therapeutic outcome (e.g., become assertive). Theory influences all of the components that become part of a therapeutic approach including its underlying philosophy, focus of therapy content (e.g., emotions), encoding of experiences, formation of psychic organization (e.g., schemas), target of change (e.g., behaviors), phases of

the change process, and therapist–client relationship. Theories differ on the position that they take towards these topics and thereby determine the goal of therapy and the means taken to achieve it.

To make the text of this book more reader friendly, the male form of third-person noun and pronoun are used in the odd numbered chapters and the female form of third-person noun and pronoun are used in the even-numbered chapters.

These topics together with the discriminate and ethical use of the techniques are presented with reference to different therapeutic approaches.

Epistemological Foundations

Epistemological assumptions lie at the heart of virtually all psychotherapy theories and indirectly influence technical approaches to treatment. Epistemology poses the question, "What is knowledge?" or "How do we know what we know?" When epistemology is applied to psychotherapy the questions that arise are: Is a therapist able to understand the client's subjective world? Does the therapist have the knowledge to guide the treatment process? If yes, how is the therapist able to arrive at this knowledge? If no, what keeps the therapist from gaining such an understanding?

The two dominant epistemologies that influence psychotherapy orientations are modernism and postmodernism, and prior to that there was premodernism. The three represent different world views or "metanarratives" (Butler, 2002, p. 13).This section will describe and critique these three world views with reference to the practice of psychotherapy.

Premodernism

In the premodern era there was a strong sense of unity and coherence. Human persons were viewed as unified beings that discovered their meaning, purpose, and identity primarily in relationship and in the recognition of their proper place in a clearly ordered world of social arrangements (Downey, 1994). Relationality and interdependence were its hallmarks. Personal tragedies and sufferings were comprehended in view of a larger picture according to which everything had its place and everyone a purpose. A theocentric view (God-centered) of one's purpose in life, human relationships, suffering and healing prevailed in this era (Kearney, 2001). Persons who healed others were perceived to function, not according to their proper authority (competency), but in virtue of a Higher Power (e.g., God).

Modernism

Modernism accepts premodernity's belief in order, unity, coherence, and history as inevitably progressive according to some plan, but situated this in the human and in human reason. The theocentric paradigm and a Higher Power were replaced by the anthropocentric paradigm that considered that the person to be the center of reality and the human person as artist, scientist, inventor, explorer, and engineer (Kearney, 2001). The hallmarks of modernism are individuality, self-subsistent autonomy, superiority of reason, transcendence and the superiority

of spirit over matter and body. Modernism believes that there is a "givenness" in the world that humans can come to know although partially and in a limited way (Downey, 1994). It believes that the mind is capable of knowing some external reality (Held, 1995) particularly through experimentation or the empirical method by which the principles and laws of the natural order are uncovered. In the same token, it is believed that therapists are able to arrive at principles and methods through research that can improve a client's reality contact and foster the actualization of a person's true self. In brief, modernism is a trend of thought that rejects previous traditions and affirms that human beings with the help of scientific knowledge, empirical methods, and technology are able to improve and reshape their environment.

Postmodernism

Postmodernism rejects the idea that there is a "givenness" in the world to be known (Butler, 2002) and that there are principles, dynamics, and forces underlying the "givenness" (e.g., depression) that can be uncovered. Postmodernism holds that knowing is a subjective phenomenon and that the mind is not capable of knowing anything outside of itself, that is, it is not capable of knowing objective truth (Held, 1995). The hallmarks of postmodernism are relationality, interdependence, community, and traditions. In place of a theocentric and an anthropocentric world view, postmodernism subscribes to an "ex-centric" view, meaning that a person does not "function as a controlling origin of self-expression" (Kearney, 2001, p. 11). Postmodernists believe that the theories and models that we have of any human phenomena are simply constructions of the mind and do not correspond to reality, thus, there is no possibility of arriving at the truth of anything. They believe that reality is co-constructed and changes from moment to moment. Postmodernism replaces the idea of a single reality, including the self, with multiple realities conditioned by individual, social, and temporal factors. In brief, postmodernism rejects the assumed certainty of the scientific endeavours to understand and explain reality and asserts that reality is not simply reflected in human understanding of it but is constructed as the mind tries to understand its own personal reality.

Critique

When applied to human conditions, it is not a question of modernism or postmodernism, rather, the question is: How do the two views contribute to our understanding of a human condition and its treatment? It can be seen that psychotherapy, for instance, incorporates aspects from both modernism and postmodernism. Take for instance, modernism's concept of "givenness" and postmodernism's concept of "social construction." An example is a child's movement away from the significant parent in order to achieve separation and individuation, a phenomenon observed in children across cultures. This "force" to move away is innate, it is the "givenness," it is not socially constructed. However the unique manner in which this "givenness" is realized in a child's life represents a social construction on part of the child and environmental conditions in which it finds itself. Not everything can be reduced to social construction. If everything is socially constructed, if there is no givenness, then the statement itself is socially constructed and not "an accurate reflection of how things really are" (Detmer, 2003, p. 38).

Psychotherapeutic Content – Client Experiences

Current psychological theories tend to be built around a model of feelings, thoughts, and behavior interacting with the environment as instrumental to change. When applied to psychotherapy, the major models focus on and address one or more of the client's inner experiences when discussing the change process. Cognitive therapists, for example, focus on thoughts and pay attention to emotion only in the sense that it leads them to the automatic thoughts and irrational beliefs (e.g., schemas) (Beck, 1976). Experientially oriented therapists focus on the client's emotions and link unexpressed emotions (affect) to the development of emotional problems and the releasing of emotions to healthy responses (Rogers, 1961; Gendlin, 1996).

Current models, however, fail to take into account other important dimensions of the human experience, such as needs, wants, longings, and desires. One exception is Caplan's (2008) Needs ABC model that places emphasis on the relational needs underlying maladaptive behaviors rather than on the behaviors themselves. Few empirical studies have investigated the role of needs in the change process.

Theorists during the past four decades have pointed out the importance of considering needs and wants in theory building and in clinical practice. Freud (1938) gave needs and impulses a central place in his psychoanalytic theory. Murray (1938) postulated a central role for needs in normal development and presented a taxonomy of needs. Maslow (1954) gave a place for needs and wants in normal development and offered a hierarchy of needs beginning with physiological needs (e.g. food) and extending to the need for self-actualization. For Gestalt therapists, needs are primary, for without them there would be no human motivation and people would have no future (Perls, 1969). Yalom (1989) observed that people regardless of their emotional state are driven (pulled) by their need (want) to matter, to be important, to be remembered, and to be loved. Blanck and Blanck (1979) differentiated between affect and drive and held that each must go its separate way so that a more unified theory can be constructed. Stumpf suggests that the mind does not just consist of intellectual representations (cognitions) and raw feelings, but also desires and wishes of all kinds (Reisenzein & Schnpflug, 1992).

It seems apparent then that the model of cognition, emotion, and behavior is inadequate to fully explain the development of both adaptive and maladaptive human behavior. By expanding this model to include needs/wants one could conceive of a triad comprised of cognitions, emotions, and needs/wants which influence the acquisition and modification of behavior (Meier & Boivin, 1983). In this context, cognitions, emotions, and needs/wants form three parallel but independent systems which interact in the acquisition and modification of behavior (Stumpf in Reisenzein Schnpflug, 1992). The independent systems comprising emotion and cognition (Zajonc, 1980; Benesh & Weiner, 1982; Lazarus, 1984) would thereby be expanded to include needs/wants.

Within this triad, needs/wants are conceived to be prime directional motivators of behaviors, emotions are perceived to be responses to either the satisfaction or the frustration of needs/wants, and thoughts pertain to the stylistic ways of construing reality, to solving problems, to managing reality, and to evaluating experiences (Meier & Boivin, 1983). The emotional response to need deprivation (e.g., the need for a sense of belonging, the need to feel worthwhile) is also referred to as emotional intelligence that can help to identify the deprived needs and serve as a guide to new thinking and behavior (Mayer, Salovey, & Caruso (2008). The triad of emotions, cognitions, and needs/wants do not operate in isolation, but within the context of the person's social and physical milieu (Meier & Boivin, 1993) (see Figure 1.1). The triad

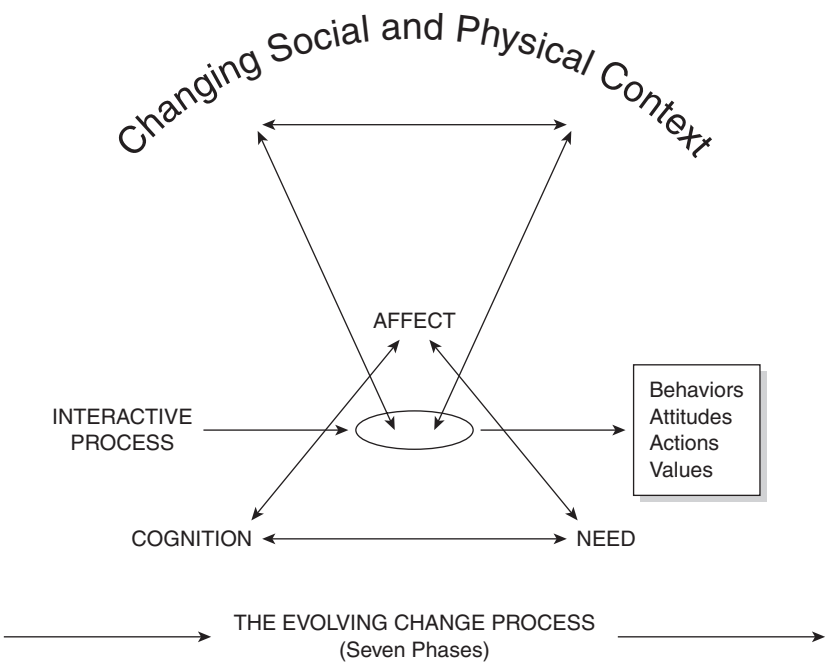

Figure 1.1 The interactive process of affect, cognition and need wants in the development of actions, behaviors, attitudes, and values within a social and physical context

continuously interacts with the social and physical context in the development of behaviors, actions, attitudes, values, and so on. This interactive process evolves according to a pattern marked by phases or stages that are summarized below.

Encoding Experiences

For psychotherapists who believe that a person's style of relating and behavior is influenced by subjective experience and that to bring about change it is necessary to access and retrieve the subjective experience, the manner in which a person stored the experiences is important as this determines the techniques to be used. Such therapists believe that a person begins to psychologically store experiences, in some fashion, beginning in intrauterine existence and extending into childhood, adolescence, and adulthood, for potential retrieval. One can think of the manner of storage and the storage "location" in classical terms such as the Unconscious, Preconscious, and Conscious (Freud, 1938). These represent three different mechanisms of storage and three levels of awareness at which they are stored. One can also conceive of storing experiences with reference to the level of intelligence development. The manner in which the human mind encodes experiences, therefore, is dependent upon the level of intelligence development. At the initial level of intelligence, the human mind encodes experiences at the sensorial or physical

level. With the development of perceptual skills, the human mind encodes experiences at the perceptual and conceptual levels. Lastly, with the ability to abstract and form and manipulate concepts, the human mind encodes experiences at the symbolic level. Thus the level of encoding is dependent upon the human mind's ability to form abstractions from the lived experiences.

The human mind encodes and represents experiences in three different ways with each having a different function (Tompkins & Lawley, 1996). The three ways of encoding experiences (sensorial, conceptual, symbolic) use different processes, have their own syntax and logic, and require a specific model of communication to access the information.

Sensory Encoding

Sensory encoding implies that the person stores experiences at the level of the senses, the physical. This is at times referred to as bodily memory. Thus a person in remembering a traumatic experience may indeed experience the same physical pain, smell, sounds, etc., as he experienced at the time of the trauma. The experience of the event is encoded bodily. The encoded sensorial information may trigger the memory of a past event.

Conceptual Encoding

Conceptual encoding refers to using perceptual and conceptual skills to encode experiences. Conceptual level encoding may be at the primitive level which is at the level of perception or at the higher level which is abstract and at the level of concepts. For example, Gendlin's (1996) experiential focusing technique addresses a client's problem at the preverbal level, that is, at the level of perception. Milton Erickson's hypnotherapy is also designed to access this layer of encoded experience (Tompkins & Lawley, 1996).

Symbolic Encoding

Symbolic encoding refers to storing experiences at the level of symbols, images, metaphors, scripts, narratives, etc. The symbols and images embody a wealth of affective, cognitive, motivational, value-related, etc., information. Not only do symbols and images contain experiences of the past but they also give direction for future growth and development.

These different levels of encoding require different techniques to bring to light their content. For example, experiential focusing (Gendlin, 1996) is able to access sensory encoded memories by getting in touch with bodily felt feelings. Empathic responding (Rogers, 1961) and experiential focusing are able to access perceptually encoded memories. Metaphor therapy (Kopp, 1995) is a linguistic method designed to access experiences encoded symbolically.

Psychic Organizations and Processes

Beginning in intrauterine life (Verny, 1981; Verny & Weintraub, 2002) and extending into infancy, childhood, adolescence, and adulthood, a person encodes psychological and physiological experiences to form "organized cognitive–affective–motivational systems" (OCAMS).

These OCAMS have elsewhere been referred to as ego states (Watkins & Watkins, 1997; Fairbairn, 1944), schemas (Young, 2005) internal representations (Klein, 1961) and psychic structures (Freud, 1923). The OCAMS, henceforth referred to as ego states, comprise sensory, memory, affective, cognitive, behavioral, and motivational aspects that influence the processing of information and give direction to the person's behaviors, actions, attitudes, values and so on. The ego states represent primitive and enduring, but changeable organizations that can serve the person well in daily living or can interfere with it. The ego states may interfere with daily living when they are formed, for example, from childhood experiences of tragedies, abuse, and parental neglect. The associated feelings of anger, fear, rage, and hate might dominate such ego states that are instrumental in bringing about attitudes, beliefs, behaviors, and actions harmful to the person and to others.

Psychodynamic and cognitive-behavioral oriented therapists assume that ego states or schemas underlie covert and overt behaviors. To illustrate, one can use as an analogy that of a tree with its branches/trunk/roots and foliage. One could say that as the branches/trunk/roots are to the foliage and give life to it, so too the ego states are to behavior and trigger it. By extension, then, it is assumed that hidden ego states are the source of emotional challenges such as depression and anxiety.

According to this perspective, treatment entails uncovering these ego states and reworking them, or the relationship between them, so as to be able to bring about new behaviors. To accomplish this task, ego state therapy (Watkins & Watkins, 1993), for example, have devised techniques to uncover the hidden and maladaptive ego states and to heal and transform them into more adaptive ego states. For example, a 35-year-old male was troubled, as an adult, by feelings of abandonment. Therapeutic work uncovered his first experience of abandonment as a child – called an abandonment ego state (Young, 2005) – at the age of two. Ego-state therapy offers a technique to heal the "abandonment schema" and then use the "healed schema" to work through current experiences of abandonment.

Target of Change: Behavior or Reworking and Rebuilding Psychic Organizations

With regards to the goal of therapy, therapist are divided into two camps with one camp arguing that change takes place at the level of behavior and the second camp arguing that change takes place at the level of reworking and rebuilding psychic organizations (e.g., ego states, schemas, structures). That is, the one camp holds that one changes that which is observed (e.g., felt, heard, seen) and is objective. The second camp holds that one changes that which is hidden and subjective (e.g., schemas, ego states). This divergent thinking between the objective versus the subjective can be traced back to Freud (1938) who at first thought that when symptoms were ameliorated, treatment was complete, only to realize later, that the mere removal of symptoms did not constitute lasting change. Change took place at the level of reworking structure. The moderate view is that there is no behavior change without at least some structural change and there is no structural change without some accompanying behavior change.

The issue is not that black and white. There are clear instances when changing the behavior is the primary target of the therapeutic work and there are clear situations when reworking the structure is the primary target of therapeutic work. For example, in the cases of acting

out anger or aggression, as in road rage, or trying to come to terms with phobias, the initial therapeutic work addresses the behavior with the goal of diminishing it. Once the behaviors have been diminished, one can then address underlying dynamics and structural issues such as low self-esteem and impoverished inner resources. In the case of recovery from childhood abuse, for example, with the associated memories, flashbacks, and interpersonal and intimacy problems, effective therapy needs to address and rework the underlying structures that initiate and maintain these symptoms.

In bringing about behavioral or structural changes, the therapist will use techniques that are designed for such tasks. For example, to help a person become more assertive, one might use imagery, a technique that helps not only to bring about change, but also to empower the person. To help a survivor of childhood trauma and abuse to behave and relate in a new way, the therapist might use ego-state therapy to bring to light the hidden dynamics or forces that are creating anxieties and conflicts regarding interpersonal relationships, sexuality, and intimacy.

Phases of the Change Process and Techniques

Insight-oriented psychotherapists hold that psychotherapeutic change takes place across time and space which is described in terms of phases or stages. For example, psychoanalysis postulates four treatment phases: opening phase, development of transference, working through, and resolution of transference (Arlow, 1989). Rogers (1961) proposed seven successive stages in changing from fixity to flowingness, and from the rigid end of the continuum to a point nearer the "in-motion" end of the continuum. Tosi (1974) outlined five phases: awareness, exploration, commitment, skill development, and redirection–change. These professionals hold that change is not an all-or-none phenomenon but a gradual forward movement through specific stages or phases.

Although psychotherapy phases or stages have been identified and described in the literature, these have only recently been operationalized and empirically investigated. Among these models are the *The Seven-Phase Model of the Change Process* (SPMCP) (Meier & Boivin, 1983, 1998, 2000; Meier, Boivin & Meier, 2006, 2008), *The Assimilation Model* (Stiles et al., 1990), and the *Transtheoretical Model* (Prochaska, 2003).

For the purpose of this chapter, the SPMCP will serve as a model of the change process. The SPMCP emerged from a therapy approach, the goal of which was to facilitate the awareness, emergence, and expression of the authentic/real self (Masterson, 1993) and to enact these in new behaviors and actions. The therapeutic approach combines exploration (of client problem) gaining insight and action.

The seven phases of the SPMCP are briefly present in Table 1.1. In an ideal therapy session, the client begins the session by presenting the problem followed by exploring the underlying feelings, thoughts, desires, values, and so on. The exploration typically leads to greater awareness or to an insight. This new awareness brings about a commitment to change and to trying out different ways of relating and being. From the trying out, the client retains those ways of being and relating that are consistent with the experience of himself. With repetition, the new experiences become consolidated. If at this point the client has achieved his goal, therapy is terminated.

Hypothetically, the client requires technical help to move through the seven cyclical phases. For example, to work through the Exploration Phase, Empathic Responding and Experiential

Table 1.1 The seven-phase model of the change process

Phase 1: Problem Definition: The client presents and discloses personal and/or interpersonal difficulties, concerns, feelings, etc. The therapist helps the client to identify and articulate the parameters of the problem in terms of its nature, intensity, duration, and extent. Psychotherapy goals are established.

Phase 2: Exploration: The client, with the help of the therapist, uncovers the dynamics of the problem in terms of its etiology and maintenance with reference to affective, cognitive, motivational, and behavioral constituents. The style of relating to others is examined. This phase represents a shift from complaining and emoting to that of wanting to better understand the presenting problems and concerns and to bring about change.

Phase 3: Awareness/Insight: The client has a better understanding of how unexpressed feelings, inappropriate cognitions, unfulfilled needs and wants, and lost meanings are related to the present problem. This new perspective (e.g. insight, awareness) provides a handle for taking responsibility for self and provides a direction for change. The uncovering process leads to a new perspective on the etiology, maintenance, meaning, and significance of the problem.

Phase 4: Commitment/Decision: The client implicitly or explicitly expresses a determination to change behaviors, manner of relating, and perspectives, and assumes responsibility for the direction of life.

Phase 5: Experimentation/Action: The client responds, relates, feels, behaves, and thinks in new and different ways and in accordance with the new perspective. He tries out (experiments with) the new awareness in everyday life situations. The experimentation takes place between therapy session and/or is rehearsed within therapy sessions.

Phase 6: Integration/Consolidation: The client makes his own and solidifies those new actions, feelings, perceptions, etc., which are consistent with his sense of self.

Phase 7: Termination: The client, having achieved the counseling goals, prepares to live without the support of the therapy sessions. The client's feelings regarding termination are addressed and worked through.

Source: Meier & Boivin, 2000; © 2000 by the Society for Psychotherapy Research. Reprinted with permission.

Focusing can be particularly helpful. To move towards the Insight phase, Empathic Responding, Experiential Focusing and the Gestalt techniques can be effective. Task-Directed Imagery, Metaphor Therapy, Ego-State Therapy, Solution-Focused Therapy, Cognitive-Behavioral Therapy, and Narrative Therapy can help a client at the Experimentation/Action phases to acquire new skills and competencies to relate in new ways. The movement from one phase to the next phase, therefore, requires specific interventions; however, certain techniques are better suited than others in facilitating this process.

Techniques and the Therapeutic Relationship

Techniques have always been considered an essential aspect of psychotherapy. They act like bridges that carry a person from "troubled" waters to land securely on the "ground," that

is, from unwanted situations (e.g., abuse) or experiences (e.g., depression) to those that are wanted. Techniques do not work magically; they receive their potency from an accurate conceptualization of the task to be achieved, and their timely application in the clinical work, and from a therapeutic relationship in which the therapist knows when to nurture and when to challenge and nudge the client towards continued growth.

Psychotherapy techniques are not like medications that operate on the person to deal with feelings of depression, anxiety, anger, and so on. Rather, the client operates on the techniques and takes from them what is needed at the moment (Meier, 2010). An analogy is that of a hungry person to whom a plate of food is brought. The person will take from the plate that which satisfies his hunger. Obviously, the better we understand the person's needs, the better we will be able to provide the appropriate food. Similarly, in therapy, the more we understand the needs of the client and what he is able to receive, the better we will be able to offer what she needs in terms of the therapeutic relationship and technical help. Given all of this, the client, not the therapist, determines what he will take from therapy.

Research has demonstrated time and time again that it is not the theoretical orientation nor the technique that is fundamental in psychotherapy research outcome; rather, the determining factor is the therapeutic relationship. Assay and Lambert (1999) identified the common factors in successful helping relationships. According to their study 15% of the variance is attributable to the technique, 30% to relationship factors, 15% to hope and expectancy, and 40% to extra therapeutic factors.

Although techniques account for a small percentage of effect in bringing about change, this should not cause one to devalue their purpose and importance. Techniques are tools for the therapist and aids for the client to help the latter move forward. It is important for the therapist to become skillful in using techniques, to time their use according to the needs of the client, and to make techniques a natural and integrated extension of his thinking and therapeutic approach in working with clients.

Therapist–Client Collaboration

The psychotherapeutic process has, from the very beginning, been considered to be a collaborative endeavor between therapist and client. Freud (1938) requested that the patient be open, honest, and forthcoming of all that he experiences during the analytic hour and that he, as psychoanalyst, would bring to the session all of his understanding and discretion in helping the patient. Today, the shape that the therapist–client collaboration takes varies according to theoretical approaches with some, such as cognitive-behavioral therapy (Beck, 1976) requiring a formal expression of the work to be done, while others, such as experiential therapy (Gendlin, 1996), require merely an informal expression. The collaborative work also varies according to whether the therapist and client take on active or passive, directive or nondirective roles.

Effective therapy integrates both client-directed and therapist-directed interventions. In the majority of cases it is the client who presents the material that becomes part of the therapeutic process and the therapist agrees to collaborate with the client to deal with it. In such cases, the client works on the concern without much help from the therapist, who assumes a more or less passive role. There are times, however, when the client is stuck or goes around in a circle, and the therapist must intervene more actively and directly by suggesting an exercise

or posing a question that will help the client to become less stuck. The rule of the thumb is that if the client is able to manage on his own, the therapist takes more of a passive role and lets the client direct the process.

The willingness to collaborate and the nature of this collaboration are continuously reworked throughout the therapy sessions. For example, a client working on issues of intimacy might become aware that these issues are related to childhood abandonment experiences, but the client might not know how to get at them. The therapist might suggest the use of a technique such as Experiential Focusing (Gendlin, 1996) and seek the client's collaboration to engage in the exercise. As therapy progresses there might be numerous occasions for the therapist to seek collaboration from the client to introduce a technique to work on a new issue that arose. It is imperative that the therapist seek the client's collaboration each time a new technique is introduced.

The counselling and therapy techniques discussed in this book are briefly presented in Table 1.2. The techniques are compared on five dimensions, namely, psychological content of

Table 1.2 Techniques compared on five dimensions

Approaches	*Content of therapy work*	*Goal to achieve*	*Therapy Process Phase*	*Nature of encoded material*	*Therapeutic relationship*
Empathy	Feelings	Express feelings	Exploration	Perceptual	Rogers's core conditions
Focusing	Bodily felt feelings	Gain awareness	Exploration	Sensorial, perceptual	Rogers's core conditions
Gestalt Empty-Chair	Feelings	Express feelings	Exploration	Sensorial, perceptual	Interactional
Gestalt Two-Chair	Internal conflicts	Resolve conflicts	Awareness	Perceptual	Interactional
Metaphor	Symbols, images	Change perspective	Awareness	Symbolic	Interactional
Imagery	Desired relational behavior	Empower person	Action	Perceptual, symbolic	Interactional
Ego state therapy	Hidden ego state	Empower person	Awareness	Perceptual	Interactional
Solution focused	Behavior that works	Change behavior	Action	Perceptual	Collaborative
Cognitive therapy	Automatic thoughts and irrational beliefs	Change thinking	Action	Perceptual	Collaborative
Narrative	Dominant life story	Build preferred story	Action	Perceptual	Collaborative
Self-in-relationship psychotherapy	Relational and self needs	Reorient way of life anchored in primary needs	Exploration, awareness, action	Perceptual	Self and relationally immersed with boundaries

therapeutic work, goal to achieve, therapy process phase for which they are suited, type of encoded experience addressed, and the nature of the therapeutic relationship. It will be noticed that the first seven entries (empathy to ego-state therapy) under the column "Approaches" refer directly to techniques. The remainder of the entries refer more broadly to a therapeutic approach that includes more than one technique.

Discriminate Use of a Technique

Techniques are potentially powerful therapeutic interventions that are able to bring to consciousness forgotten, hidden, traumatic, and early childhood experiences that might deeply affect the client and the therapeutic process and progress. For this reason, the therapist, when inviting a client to engage in a technique, needs to exercise "sound clinical judgment based on solid understanding of psychodynamics and psychopathology" (Kopp, 1995, p. 5). A technique should be seen for what it is, an instrument to further the therapy process; in the words of Freud (1900), one "should not mistake the scaffolding for the building" (p. 536).

Timing of Intervention

The timing for the inclusion of a technique in the therapy session must be right. One introduces a technique only when there is a high probability that it will be effective and help the client with the task at hand. One could say that there is a high probability that it will be effective when it appears that the client is ready to engage in the activity for which the technique is designed to be helpful. For example, if a client is carrying on an internal dialogue, it is highly probable that the client is ready to externalize the dialogue using a technique such as the Gestalt Two-Chair technique (Perls, 1969). This is consistent with Freud's (1938) recommendation that one makes an interpretation when the patient has already arrived at the insight himself (p. 43).

Provide Rationale for Use of Technique

It is important for the therapist to provide a rationale for its use and link the technique to the achievement of the therapeutic goal. It is also important for the therapist to discuss with the client the technique will be used in the session, give clear instructions regarding its use, allow the client the freedom to terminate the use of the technique, and, if completed, give the client time to describe the experience following the session.

Informal Use of Techniques

In the hands of an experienced therapist, techniques can be modified and informally used in the therapy sessions. For example, one might introduce Experiential Focusing (Gendlin, 1996)

in an informal way by asking the client who is distraught – angry, depressed, anxious – to get in touch with what he is experiencing bodily. This modified form might be used to help the client get a grip on his distraught feeling without going to the other steps that are part of the formal use of Experiential Focusing (see Chapter 3).

Ethical Considerations and the Use of Techniques

The techniques described in this book are potentially powerful therapeutic tools and interventions. Therapists should use them only if they have adequate training. It is assumed that therapists who have a graduate-level training in the helping profession will be able to teach themselves how to use the techniques. For this, it is best to form a small group and practice the technique using each other as therapists and clients. For a beginning or inexperienced therapist, the techniques should only be used under the supervision of a supervisor who is, himself, competent to use the techniques.

In using the techniques, one must be careful not to impose one's ideas or preferences on the client or to manipulate the client into a certain way of thinking or behaving. As mentioned earlier, one uses a technique to support that which the client has already started, such as resolving an internal conflict by dialoguing or engaging in new behaviors such as assertiveness.

It is important to pay attention to cultural and gender issues when one engages a client in a technique. For example, some cultures value relationships and family whereas other cultures value competence and independence. One uses a technique in keeping with the client's cultural, family and personal values and helps a client to sort these out and to live according to their values.

Lastly, clients need to be informed that they are free to discontinue with a technique when they wish to do so. They also need to be informed as clearly as possible how they will participate in the technique and the risks of their engagement.

Something to Think About

1. What is meant by postmodernism?
2. Does adding needs/wants to a psychotherapeutic model make a difference?
3. In what way does psychotherapeutic change take place at the level of both behavior and internal states such as schemas?
4. Which techniques are helpful to transform ego states?
5. What are some cautions that one must exercise when using techniques?

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