Introduction

Psychotherapy has been shown to be effective in relieving depressed mood (Elkin et al., 1985) and is more effective than other treatments in panic disorder (Clum, Clum & Surls, 1993). It enables a person to change habitual ways of behaving (Szapocznik et al., 1990) and thinking (Hollon & Beck, 1994), and to improve social relationships (Winston et al., 1994). It may also be pursued as a form of self-knowledge, to improve job or marital prospects, or in the course of training. It may be provided on a one-to-one basis, to couples, in groups of strangers, or in families. People may seek out psychotherapy for themselves, or they may be pressured to have it. Similarities with counselling, with being a friend, with team-building and other motivational activities, with being a good parent and with good medical care have been claimed by many. Psychotherapy also has techniques in common with self-help, and with self-treatment guided by a book, computer or personal organizer (Newman, Consoli & Taylor, 1999). Some would claim that is just common sense, others that it is nonsense, yet others that it is the religion of our age. None of these is a position that I hold. About the only thing that everyone does agree on is that it is different from physical treatment.

This book will not address all these extensions of psychotherapy. The concentration will be on psychological therapy provided by a therapist to a person voluntarily seeking treatment for a psychological problem.

Often this problem will be diagnosable as a mental disorder, such as depression, anxiety, substance abuse or a personality disorder. However, concentrating solely on the symptoms that the client is experiencing may prevent the therapist from appreciating that the client may also be overwhelmed by an upheaval in personal relationships and a re-appraisal of deeply held spiritual beliefs. Jerome Frank, recognizing this wider context, wrote of states of demoralization rather than states of distress, and emphasized the remoralizing effects of psychotherapy.

Demoralization may be the prelude to clients losing their hold on their place in the world, and to suicide. But a demoralized person may also be in the process of *reculer pour mieux sauter* – falling back to take a better run up to a big jump. Existential psychotherapists emphasize that a crisis of personal values is both a danger and an opportunity (Deurzen, 1998). The

psychotherapist needs to be sensitive to these dimensions, and to adopt a psychotherapeutic method which not only treats dis-ease, but promotes healing.

Docherty et al. (1977) contrast 'relating to the client as a diseased organ or object of study and as a disturbed person'. They conclude that both perspectives need to be maintained in a collaboration between client and mental health worker. These authors were writing in the context of their involvement in schizophrenia research, and in schizophrenia it is appropriate to consider that the client has a 'diseased organ'. The same may be said to be true of people with some other psychological disorders, for example developmental disorders or affective psychoses.

However, I strongly believe that the metaphor of a diseased organ is wrongly applied to personality. Indeed I am doubtful about the value of the term at all, except as an actuarial predictor of common variance in large groups of people. People do think of themselves as suffering from a brain disease called schizophrenia or of sometimes being, more simply, 'out of their heads'. They do not usually think of themselves as the victims of their personality, but as active agents seeking to overcome obstacles and to achieve goals.

There will be little mention in this book of personality, or personality disorder therefore. This is not to say that there will be no recognition that some problems – or concerns, as I termed them in the Preface – are more deeply seated than others. Mental depth is an everyday metaphor which makes no presumption that the mind is an organ. Glover (1988) suggests that deeper beliefs are more central ones, and that the more central a belief is, the greater the number of other beliefs that would be affected by a change in it. A longer period of persuasion and reflection is required to change deeper beliefs, and longer therapy is required to change deeper problems (Kopta et al., 1994).

However, it is not always easy to know how deep a problem is for another person. Kopta and Howard (Kopta et al., 1994) found that chronic distress was not a deep problem very often. But there is often a temptation to assume in assessing clients for psychotherapy that the longer a problem has continued, the more therapy will be required to treat it.

In fact, the reader will find little in this book about the assessment of the suitability of clients for brief psychotherapy. This is partly because the current state of the literature does not provide an evidence basis for the assessment methods currently in use (Tantam, 1995b). It is also because I think that the function of assessment is not to select which clients are suitable for the psychotherapy on offer, but which treatment is suitable for the client. Sometimes this will be treatment that the therapist is competent to give, and sometimes not. Sometimes the therapist may be competent to give the treatment, but it will be perceived – by the client, or by a third party who is

paying for the treatment – to be too expensive, in time or money, for the benefit received. Rarely, the therapist may advise the client that the risks of treatment making them worse outweigh the possible benefits.

The task in the first interview is therefore to establish what are the client's preoccupying concerns, and what might be done about them. This will be the subject of Chapter 1.

Being depressed, becoming disabled by obsessive–compulsive disorder, or indeed having any other psychological problem, is not like having bad headaches or a wonky knee. The experience of depression includes hopelessness and a sense of personal failure. Values that have previously gone unchallenged become problematic. A person might ask him- or her-self, 'Is depression a kind of weakness?' or 'Why can't I just pull my socks up?'. Developing a psychological disorder is often experienced as a crisis, like a long-term relationship breaking up or losing one's job, which requires a reassessment of personal values. Even if the preoccupying concern of the client is, 'Help me to get better', this will be in the context of a crisis of personal values. Psychotherapists cannot ignore either request. They must be able to provide technical help in relieving symptoms where that is required, but also be able to acknowledge the spiritual crisis.

The values of the therapist, and the values inherent in the treatment, must be values which enhance the value of the client. When this occurs, when there is congruence between a therapist's and a client's values, outcome is enhanced (Kelly & Strupp, 1992). Another task in the first interview is to identify the client's own values, and in what way they have been called into question by the client's crisis. How to do this, and how to plan a treatment which will address the client's need to re-establish a stable set of values, is considered in Chapter 2.

Assessment is often taken to be a means of ensuring that clients do not drop out of treatment. It is true that non-compliance is a major reason for treatment failure. It is easy to neglect it by assuming that people drop out because they are improved, or because they were not suitable for the treatment. In fact, there are many institutional practices which make people lose confidence in the treatment that they are being given, and consequently drop out (Tantam & Klerman, 1979).

Dropping out should be taken seriously, but not by excluding clients who might drop out. Rather, treatment should be designed to give the client the hope and satisfaction in the treatment that will make drop-out unlikely. The characteristics of treatment that might influence client compliance with psychotherapy have received little attention. Klerman and I (Tantam & Klerman, 1979) found, in a study of a community mental health centre, that the client's first impressions of the centre were one of the strongest influences on whether they would drop out later. The analogy with food is obvious. If I don't like the flavour of something, I may swallow what I have in my mouth,

but eat no more. If I'm really offended, I spit it out. Usually this is a judgement that is made as soon as a new food is tasted, but it can also happen if the flavour becomes unpalatable, for example if I chew a food for too long. The analogy holds true for this, too. In the mental health centre study, most people who were going to drop out did so shortly after their first contact. Others dropped out later, but usually after a first contact with a new clinician.

Since that study, I have been more and more persuaded that these immediate emotional reactions are important in affecting compliance with many aspects of treatment and that they consequently affect outcome. I have also come to think that the immediate emotional reaction aroused by a new experience has the same origins as the emotional reaction to a new food. I therefore think that it is legitimate to apply the same term – flavour – to both.

Choosing which treatment to recommend to the client is partly a matter of choosing which flavour of treatment is most palatable, and is discussed in Chapter 3 when the range of different treatments is considered.

The reader might by now be aware that practical psychotherapy is not a new school of psychotherapy but a framework of good clinical practice, into which different psychotherapeutic techniques can be incorporated. Indeed it may have wider generality, as a framework for mental health interventions generally.

What makes me think that there is a framework? The best evidence is that relationships, stories and musical compositions all seem to share some developmental sequences in common. The ur sequence is pre-verbal: taking in (eating, listening, data gathering), playing (digestion, thinking, transformation) and giving out (excreting, acting out, responding). Managing a long-term relationship requires that these sequences are respected. In the case of therapy, they must be applied to the exchange, to the session and to the whole of the long, punctuated conversation between the therapist and the client. The topic of the conversation must be of concern to both client and therapist. The metaphors and imagery used must have a flavour which is palatable to the client. And the values which the two speakers hold must be congruent. This is also true of the values about the conversation itself. There will need to be a mutual acceptance of the values of openness and honesty, for example. Another value which is important to brief therapy is empowerment. The client needs to know the ground rules of the conversation and to feel confident that they know what is expected of them. He or she needs to know what kind of conversation it is.

It is an excessive burden, for both client and therapist, to think that the therapist is there to help the client. People are far more inclined to work to improve themselves and their situation than many mental health workers believe. Conversely, specific interventions of the psychotherapist are less helpful than the moments of self-discovery or empowerment that occur in successful psychotherapy. The conversation is not, therefore, one in which

advice or guidance is given. Rather the therapist works to talk ever more honestly with the client, touching, with greater and greater emotional intensity, on the client's concerns.

The conversation that is most similar to this is not the helping or advice-giving one, but the negotiation. Both sides want to reach the same goal. Both are unclear at the beginning what they can concede. For it to succeed, both sides need to respect each other, and particularly to respect the real difficulties with which each has to contend. Both sides need to expect that they will sometimes get exasperated with each other, but to be committed to work through that.

It is useful in a negotiation to keep regular minutes, particularly of decisions that have been reached, and to open each session of the negotiation with a statement of these decisions. I think that this also applies to therapy – at least to therapy that is being conducted along these lines. Good note-keeping is therefore necessary. Records should always be made of new findings, of commitments by the therapist or the client, and of summaries of what has been said and what has been achieved. The summaries constitute the narrative of the therapy for both therapist and client. The more they contain what the therapist and the client 'really' think, the better the outcome of therapy will have been.

The process of narrating the therapy is discussed in Chapter 4. It is considered in relation to the first assessment interview and the subsequent formulation, in relation to period reviews during the course of treatment, and to the final summary. These reviews may also correspond to the need to write letters to referrers, after the first assessment and after discharge.

The first four chapters of the book cover what is needed for the first assessment interview. They should therefore be read before this assessment takes place. It might be thought that this is a disproportionate amount of emphasis on a one or one-and-a-half hour session. There are good reasons for this. I believe that once psychotherapist and client have agreed what it is important to talk about and how to talk about it, it may require little expertise from the psychotherapist to make sure that the subsequent conversation is therapeutic. Or, in other words, the client will ensure that he or she uses the time effectively once he or she identifies what his or her preoccupying concerns are, and what approach might be taken to them. The concerns and the approach are usually identified in the assessment interview.

Psychotherapy is rarely quite as simple as this. A person's concerns may change or become more radical. The approach that seemed right at the assessment may no longer seem right later on.

Therapies are like conversations. With the possible exception of the very briefest, they often consist of repeated cycles. Each of these is initiated by a new, perhaps deeper, preoccupying concern being negotiated. Each may result in the exploration of different, sometimes more fundamental, values.

Each has a different flavour. The story of what happens in each is also different. These four elements – concern, value, flavour and narrative – therefore continue to need careful attention and re-discussion throughout the treatment.

Chapter 5 introduces the narrative approach to psychotherapy. Narratives become of particular importance in psychotherapy when they fail. It is then that psycho-dynamic or psycho-analytic approaches, which emphasize the relationship between the client and the therapist, become particularly relevant. Relationship-orientated approaches are dealt with in later chapters of this book, and readers may find that they are more understandable after reading Chapter 5.

Chapters 6 to 10 are each devoted to a different preoccupying concern. The sequence in which the concerns are presented is the most common sequence in which they emerge in psychotherapy. The final chapter addresses some of the problems that might arise when matters do not follow this orderly structure. What might be preventing the therapy from progressing and how the therapist can monitor their own work to ensure that they are not contributing to this non-progression are both discussed in Chapter 11. Some general principles of dealing with crises are then applied to some of the other challenges that may arise during therapy, such as a client expressing strong personal feelings for the therapist, or the emergence of a serious health problem. Chapter 11 is about saying goodbye . . .

Emphasizing the importance of discovering the client's real concern and de-emphasizing the conduct of the therapy sessions is not to belittle the skill of the psychotherapist. Combining emotional intuition and intellectual judgement to sift out what is 'real', and to know when the therapeutic conversation is going towards or away from it, is very skilful indeed. This is particularly true when the client is not participating fully or wholeheartedly in the conversation.

What might prevent someone from participating fully? Answering this question adequately means suspending a natural tendency among health professionals to blame clients for treatment failure. It might be easier to do this by considering therapy as a negotiation. Why do negotiators fail? Why do people sometimes negotiate dishonestly? One reason is that the negotiations are a sham, to satisfy some third party who wants an agreed solution or to make it possible to claim at a later stage that negotiations have been tried, but failed. Another reason is that what one of the parties really wants is too shameful or embarrassing to disclose, and so it is concealed behind another demand. Negotiators may realize that the process of the negotiation will draw in other elements that they would rather not have examined. Finally, the negotiator may doubt the trustworthiness of the other side, and fear exploitation. This may be a realistic, or an unrealistic, fear.

What, then, about resistance? What about the refractory client?

It is clear to any experienced practitioner that a significant proportion of clients do not do well in their therapy. Many of these clients drop out of treatment prematurely. The emphasis of the analytic therapies on the client's negative feelings for the treatment or for the therapist does not seem misplaced. And conversely, the forced optimism of therapies which deny these negative feelings seems naïve. The analytic approach seems to me to be in error in attributing these negative factors to the client's psychology. This has been a prolific source of theorizing, but at the expense of moving theory into the subjectivity of the inner world, and away from objective realities like the power, income or status differentials which separate therapist and client. Even more importantly, attributing negative factors to the client prevents a consideration of whether they are due to a failure of the therapist's understanding or formulation of the problem.

Throughout this book, I shall assume that our clients are putting as much energy as they can into overcoming the difficulties about which they consult us. This value seems to me to be an essential one to practical psychotherapy, and gives a flavour to this approach that, I hope, fosters a collaboration between client and therapist which is to the benefit of both.

1

Establishing the concerns

Why start with the consideration of concerns?

Starting a book about psychotherapy with a discussion of concerns is appropriate because it is a concern about something that takes people to a therapist in the first place. People seeking psychotherapy may be concerned about the symptoms of a psychological disorder. More usually, even if they have a psychological disorder, their concern is about a crisis in relationships or in everyday life – an existential crisis (Coursey, Keller & Farrell, 1995).

What is a concern?

Concerns are '. . . the more or less enduring disposition to prefer particular states of the world. A concern is what gives a particular event its emotional meaning' and emotions 'arise from the interaction of situational meanings and concerns' (Frijda, 1988). Concern is therefore 'a motivation construct. It refers to the dispositions that motivate a subject, that prompt him to go in search of a given satisfaction or to avoid given confrontations' (Frijda, 1986, p. 334).

An example of a concern

Alan suffered brain damage at birth. Despite this and the developmental problems consequent on it, he had been able to get to university, but found that he was unable to make friends or be taken seriously by his peers. His awareness of that diminished when he was with his family, with whom he had a close relationship, and, unless he thought or talked about the university, he had no particular distress about his social isolation when he was at home. When he returned to university, many incidents during the day reminded him of his social difficulties and made him angry and resentful. His resentment was associated with the feeling that other people should treat him better, and he often sat alone in the university bar watching other people together, and nursing his own distress.

Alan's resentment is a kind of concern. He was on the look-out for people

who dismissed him because of his disability, and who did not respect his ideas or his personality. He believed that he was as good as the next person, but that other people did not recognize this. These beliefs were such that when Alan was put in mind of them, he would feel angry rejection or, if he was also lacking in self-confidence, miserable self-pity. Other people sympathetic to him would also feel anger or sadness on his behalf. However, less friendly people would feel more hostile and rejecting because they would find the flavour of Alan's concern unpalatable. He had a chip on his shoulder, they would say.

Concerns reflect what is important to a person and, as Frijda points out, may give rise to many different emotions. Frijda (1988) writes, 'One suffers when a cherished person is gravely ill; one feels joy at his or her fortune or recovery . . .' Disability is a very important issue for Alan, and is therefore one of his major concerns. Overwhelming concerns may lead a person to seek relief from a doctor, a priest, a counsellor or a psychotherapist.

Mrs Wright was on her way to London for one of the regular monthly meetings of the charity for which she worked. As usual on these trips, she had brought some work with her but, as usual, she was lost in not unpleasant reverie. The journey seemed no different from many others until the train braked so hard that she was nearly thrown from her seat, and an elderly lady across from her did actually fall to the floor. Mrs Wright felt her heart take a sudden bound, and her mouth went dry. It was some moments before the thought formed in her mind that: 'We are going to crash'. Almost immediately there was a bang followed by repeated sounds of metal tearing. Mrs Wright hardly noticed. She had been thrown forwards almost over the seat in front of her and shortly after thrown sideways as the carriage in which she was travelling twisted onto its side. She fell onto the window, which had shattered. She was lucky not to have been cut by the glass. A man that she had noticed before was not so lucky. He was thrown with great force from one side of the train to the other, and glass penetrated his face, causing copious bleeding. Mrs Wright felt overwhelmed with horror as his blood splattered her. She was shocked to find herself thinking not of this man's injuries, but of the possibility that he might be infected with HIV and that the virus might be transmitted to her.

This is an extreme example of an overwhelming concern about personal safety. Mrs Wright wanted relief from the flood of unpleasant emotion that the situation, and her concern about it, had released. One component of psychotherapy, and of medical or psychological practice, is to provide the sort of relief that Mrs Wright was seeking. Some of the techniques that can be used are discussed in Chapter 6.

Concerns and psychotherapy

Concerns orientate us in our environment. They enable us to prioritize occurrences and to ensure that happenings that activate our deepest concerns get, *ceteris paribus*, most of our attention (Oatley, Jenkins & Stein, 1998). This process most often occurs outside awareness. In fact, when the concern leads imperceptibly to an action that takes care of the concern, we may have no awareness of there being a concern at all. Others, such as psychotherapists, might be able to infer the concern from observing a pattern in our actions, however. If no immediate action suggests itself, we may become aware of the concern because we become aware of feelings and thoughts associated with it. We might experience ourselves concentrating on a problem, or finding ways round a difficulty. We might experience ourselves on the defensive, or using our winning ways. We might, in other words, have to self-consciously recruit learnt means of resolving the concern. Very often this will be successful. But sometimes, it will not. It is these situations, of unassuaged concern, with which psychotherapists are concerned.

Concerns are normal. They engage us with the world. A lack of concern, perhaps associated with indifference, apathy or boredom, may also lead a person to consult a psychotherapist or, more often, to lead someone else to recommend psychotherapy. I do not think that psychotherapy is going to be practical for someone who has no concerns. But it may be enough for a person to feel concerned about their lack of concern. In fact, as we shall see in Chapter 10, concerns that are hidden are often the ones that most destroy happiness.

The three elements of a concern

Frijda's use of the word concern is subtle and ambiguous, befitting a term that is to be useful in psychotherapy where both subtlety and ambiguity are highly prized. Concern can be used as a feeling, as in, 'Jane's back late. I'm feeling quite concerned'. It can be used as an indication of thought, as in, 'Our first concern should be to find out whether she has already left the party'. Or, it can be applied as Frijda probably intended it, to values, as in, 'You're always so concerned when Jane's away. I think that you care more about her than you do about me'.

Of the very many ways in which human action can be classified, a three-fold classification has emerged as the most influential in psychotherapy. It has been argued that a preference of three-fold models reflects familiarity with three spatial dimensions. Harre has also suggested that models of the mind do not reflect reality, but create – and therefore restrict – it (Harre, 1979). We should, therefore, treat any model of the mind with some scepticism. However, this does not apply solely to the models used by