CORE SKILLS FOR PSYCHOTHERAPY

by Ian Rory Owen[1]

It is easy to define what therapy is not. It is not lecturing, nor moralizing, patronizing nor befriending. It is not the use of counselling skills by non-mental health professionals in interviewing or management. Some clinical psychologists describe their work as making "clinical psychology interventions", rather than counselling or psychotherapy. Here I am taking the word counselling to mean what the non-psychologist members of the British Association for Counselling practice. I assume that counselling psychology is deeper and wider than BAC counselling as it takes in both the rationality and inherent criticisms of psychology and the caring of counselling. I am using the word psychotherapy to describe what counselling psychologists do, as I am certain that the work of counselling psychologists requires a commitment to making a high quality relationship with frequently intelligent, sensitive, awkward and critical clients.

For ease of presentation I number what I think are the core skills and ground rules of psychotherapy, including the interpersonal qualities of the work. In practice these skills are not separate, but joined together in a seamless fabric. I claim that these core skills are the same for different theoretical approaches and for different client groups. Part of my inspiration for this paper comes from my own reflections on my work experience, plus what I see as the practicalities and inevitabilities of providing care to distressed people who can frequently be challenging and confrontative. My inspiration for this paper is the work of James Guy who rounded up many papers on the stresses and joys of providing psychotherapy (Guy 1987). I am also interested in stress management and learning from experience for therapists. I feel there are several myths around therapy which need questioning. For instance, the myth of the wounded healer, which seems to apply to so many of us (myself included). The answer to this myth is *physician heal thyself*.

1 The role itself

The role is perhaps best defined not by a rigid set of rules, but rather by principles which possibly apply in certain situations, but may be changed given certain conditions. These principles could be called "how" principles. They are the general characteristics of the work and any prerequisites for it. They are *how* to attend to clients. Perhaps the first principle is one of being self-denying: by which I mean that the purpose of the meetings are to give clients the space in which to unfold their problems in a professionals' presence. Therapists must put aside their cares and needs and be "introverted", that is, to let clients speak and use the time as they wish. Within certain bounds of course.

Next, therapists provide caring in a liberal manner. I hesitate at using the phrases "liberal parent" or "liberal friend" because professionals are neither friends nor parents of clients. But the relationship may be more intimate than these relationships, as information is given that clients would not to give their closest friends. Also, the relationship may be something like being a parent in so much that therapists can witness a rebirth and "childhood", in which clients break new ground. The image I am trying to evoke in using the word liberal is that of therapists not being punitive, attacking or invasive with the people they see. I am sure that our work brings us into intimate contact with many unusual people who do not fit into mainstream society. Another prerequisite for us is an ability to tolerate difference in others, and this is also part of what I call being liberal.

Neither is it part of the role to be without personal boundaries and to encourage clients to show up when they want, or do entirely as they please. If someone has waited a year on a waiting list and shows up for the first appointment, I am sure they are well committed to therapy. In keeping with this concept of being liberal it is not proper to make demands on clients, to bully or berate them, or attempt to convert them to one's own way of thinking. It is acceptable to put forward one's own views, or to make suggestions which you think may be of help to them.

It also seems to me that part of the role is to offer stability and permanence to clients, so that in a way, the sessions are potentially "always the same", but in fact, they are never the same. Therapists have put on the mantle of mystique and power, and loose their usual self. They become restrained, in the manner in which I am trying to describe, but of course their reactions and personality, as they are outside of sessions, do not disappear entirely. The balancing act is to

maintain the need to allow clients to enter into the therapeutic process and make good use of sessions, and for therapists to be themselves whilst offering a human face to the professional task.

2 Creative silence

In line with the remarks made above, Curtis has researched the use of self-disclosure and found that it can be ineffective as a technique (Curtis 1981). But creative silence can also be both destructive or helpful in different situations with the same client. Creative silence is used to make an ambience of a safe welcoming space where clients can be themselves and take full advantage of the 50 minutes. This is the acceptance and valuing of clients by "neutrality". In a silence clients are in touch with their own thoughts and feelings in an intense manner as they may fear rejection and are frightened of speaking their secrets aloud. It is often the case that silence is felt in all manner of different ways as it is also an ambiguous and minimalistic way of accepting someone.

Inappropriate comments and unnecessary self-disclosure are ruinous to enabling clients to enter the therapeutic process and creating an appropriate distance. The psychological distance can be lessened by warm, concerned and intimate self-disclosing responses by practitioners. The distance may need to be kept for the purposes of making clients structure the relationship, and so be assertive and take risks in being true about themselves in the session. This may be one aspect which helps them make changes in their relationships with others.

Generally I have great respect for the person-centred approach but I am sure that the three principles of warmth, congruence and empathy are just not enough. I can even think of situations where they may be a hindrance: If a client is expressing and feeling a large amount of self-loathing, anxiety or guilt, then surely these are times when warmth will be misread by clients as being laughed at, or not understood. To be warm at times such as these is a mismatch, as it is an attempt to put a sticking plaster on a broken leg.

As a concomitant of silence, listening and understanding are major parts of therapy. Therapists bear witness to never expressed emotions and memories, and hear of injustices that may have been perpetrated many decades ago. The problem with listening and understanding is to hear what clients say, as they intend to say it. Where understanding goes wrong is that

therapists hear what a theory has told them to hear, or their own version of clients' phrases. Understanding someone as they are trying to be understood, without the addition of any other meanings, is a difficult task.

3 Relating

The degree of sophistication in interpersonal skills surely marks out therapists and mental health workers from all the other caring and helping professions. A major principle I call "helping, not harming". If therapists have destructive, spiteful and exploitative tendencies with colleagues and friends, then that is one thing. The same destructiveness cannot be enacted in the sessions.

I strongly believe that the relationship that therapists offer is not an ordinary social one. There are various rules which both parties should obey for each other's safe passage. For instance, we have to choose whether we answer direct questions. Sometimes these questions are about our sexual orientation and whether we are currently living with a partner. Is it best to announce at the first session that clients have not entered into a reciprocal relationship, and that personal questions will not be answered? Or is your policy such that intimacy and honesty become two way, instead of just one? Again, both therapists and clients are there for the clients' benefit. Sessions are conducted on therapists' turf and rules, but these exist to encourage the self-healing forces of clients.

I feel that this is the place to mention what is frequently called the transference-countertransference relationship. I see this as a way of disowning the real and conscious aspects of any relationship. In Freud's original conception both transference and countertransference are based on unconscious wishes which can only be deduced by a psychoanalytically trained other. I have no evidence for my next remark, except that after careful consideration, I feel the terms are both allusions to a metaphor which seeks to explain how people can misperceive and treat one another, and act in an immature inflexible way, similar to that of a child or teenager. The metaphorical image that is alluded to, I feel, is one of the radical inventions of the 1890s: cinematographic projection.

In transference (originally *ubertragung*, carrying over) something is said to be displaced, projected or transferred on to another from one's past "prototypes" (Laplanche & Pontalis, 1985, p 455). It includes treating another, particularly the therapist, as one's mother or father, brother or

sister. I do not deny that people live on old habits of perception, interpretation, cognitions and relating. But I think that the conscious feelings, thoughts and modes of relating must be the starting point for any discussion of motivations, and ultimately be for clients themselves to correct. Old habits die hard, but they do die away, and change does occur, sometimes very slowly, sometimes very rapidly. Our task is to find out how change may be promoted. But no one can be forced to change. Clients make changes in their own time.

After the above refutation of the concept of transference the behaviours and misperceptions to which the word refers still exist and have to be worked with. You deal with clients misperceptions of you by not playing a complementary role to them. An asocial silent response can be given but this has the possible effect of demeaning or ignoring them. The aim is to help inappropriate modes of relating become extinguished. But this assumes that you can distinguish appropriate from inappropriate ways of relating to yourself. The concept of transference falls down because it assumes it is possible to tell inappropriate emotion or action from appropriate ones, as the psychoanalyst Chertok points out (Chertok, 1968, p 575). To precis Chertok's conclusion he says that transference is a relevant principle, but that there is currently no way of distinguishing it. Anything which takes its place must be able to achieve this. Any method of dealing with misperceptions requires this distinction to be made. For instance, when clients express anger at you, is that a true anger at your real misdeeds? Or, a displaced anger because something has happened to them outside of the session? If you feel misconstrued this could be the point at which an intervention can be made which points out the difference between what you actually said and intended - and what clients heard or interpreted your intention to be.

Therefore it follows that negative transference is a real feeling of dislike that you may or may not have earned. Some people do take out their anger on innocent bystanders. Positive transference is, likewise, real positive feelings which may be due to your personal qualities, your interventions, or the effect of your non-judgemental approach.

Instead of countertransference (*gegenubertragung*, towards or counter carrying over) I see a different conscious and reality-based skill. Countertransference is any disruption of the therapist's constant attentive attitude. I believe that the emotions that are usually referred to as countertransference are not unconscious wishes, as Freud's definition maintained: "The whole of the analysis, unconscious reactions to the individual analysand especially to the analysand's own transference", (Laplanche & Pontalis, 1985, p 92). What is usually termed countertransference

are conscious reactions to clients which are often strong anxiety, guilt, anger, and other emotions.

Perhaps in the place of countertransference is another major interpersonal skill is that of recognizing the quality of the relationship as it takes place. It is easy to have excellent hindsight as to what has happened, but difficult to have good quality insight as something happens. Part of this may involve sensing how we are being seen by clients, and sending therapeutic messages which let them know how we are seeing them.

Finally, a word about the nature of the confidentiality being offered which might be another item to be explained at a first session. If you are permanently in supervision, do you tell them this or omit it? In all honesty you will be talking about them to others, but you will be claiming that you will not be telling others. A paper by Bromley discusses several models of confidentiality for psychologists which may be used in different circumstances (Bromley 1981).

4 Learning from experience

Here I bring together a number of items which take place in supervision and resolving countertransference reactions. I am sure that psychotherapy is one of the most difficult and stressful occupations. One of the reasons for this may be the inevitability of sometimes feeling "naked" and exposed, "in front of" clients, when there is a popular myth that therapists are always unruffled, in a perpetual state of unshockable enlightenment, and have no weaknesses of their own. The aspiration to be an invincible therapist is wish for perfection which can never be granted. I think the more usual state is due to working in the highly charged emotional setting of therapy can induce considerable anxiety in therapists. Also, when certain taboo subjects are raised, therapists may respond non-verbally and emotionally to the subject at hand. However, within the confines of the role, this reaction may or may not be expressed. Therapists have a need for safety and self preservation. Any long-term emotional reactions to high stress work need to be dealt with in some positive coping manner. The refusal to acknowledge this leads inevitably to negative coping mechanisms, hurting clients, personal depletion, ill health, exhaustion, general anxiety, burnout, cynicism, depression, leaving the profession, and worse.

The ephemerality and uncertainty of seeing clients come and go, cancel sessions and promise to come again, come an hour late, or on the wrong day, are all stressors. Because the

work is so personal with much personal prestige being tied up in the role and the quality of relationship one makes with clients, it is difficult to blame it all on what has previously been termed "transference" in order to stay and blameless for one's actions. The transitory nature of the work must take its toll because we see a steady stream of people who have suffered for many years and may have inflicted suffering on others. In some cases our exposure to bad news, hearing at first hand how others have "gone wrong" may not help us "go right". There are therapists who end up very ambivalent and disillusioned. For them, the safe area of the world gets smaller and smaller.

I have come to realize the place of uncertainty within all aspects of life. I maintain that there are a mass of possible influences which contribute to physical disease, psychological disturbance and individual character. I feel strongly that uncertainty, and lack of specific knowledge about the causes of feelings and personality, must be acknowledged. I believe human nature is such that we are unable to know fully our own and others' motivations. I do not know how I have come to be like I am. I may imagine that I could be different, but I may not want to change because I enjoy the current safety I have in knowing what I know now, and being like I am.

The way into positive coping mechanisms is to monitor one's own mental state by use of some means of reality testing or calibration. This could be regular or occasional personal therapy in addition to supervision. It is the deployment of one's own stress management programme in which we look after ourselves, friends and families. I am reminded of an old joke about two therapists who meet on the street one day. One says to the other "Hi Sue, you look great... *How am I?* "

5 Speaking

When two people make sense of each other, only an aspect of this process is due to the actual words which are exchanged. It is the way that you say something that provides the context in which the explicit semantic content of what you say is understood. While clients are with you, they will be reading your non-verbal reactions to them, either correctly or incorrectly. They will be working out how good a therapist they think you are. If they question your competence how do you respond? Do you tell them they are categorically wrong? Or perhaps they have a wrong

interpretation? Or perhaps they have a point - that they feel badly done by for some other reason. Or are you silent?

Without you having to say a word, clients are making sense of you by your looks, clothes and manners. But, when do you choose to speak? And how frequently is this in a session? Speaking provides a more distinct message than listening, but your words may be misconstrued. The ideas mentioned below are contained in another paper of mine (Owen 1992). Here I re-present them in brief.

Reframing is the name I give to the effect by which an interpretation of something or someone changes. It is equivalent to the term gestalt, which used in the sense of gestalt formation and destruction, means a continuing process of resolving and reforming figure-ground relationships. We are probably all familiar with Rubin's vase, the ambiguous picture of either a vase or cup, or two faces seen in profile. For many years this picture seemed utterly pointless to me. Then I had a sudden realization. I realised that the principle at play is the same in making an opinion of another or of oneself. Reframing, the creation and destruction of gestalts, happens continuously throughout life. In therapy the heightened emotional atmosphere, and the focusing on unexpressed and avoided aspects of existence, all help to create cognitive and emotional change. Below the ways of speaking by therapists are reframes of different sorts.

Psychoanalytic interpretation is the voicing of a specific hypothesis about the probable cause of a current emotion of clients, or about the current perception of therapists by clients. Interpretations are only sparingly given in analytical therapy, and in some sessions the therapist may not speak at all and only listen. This abstinence in interpreting provides them with much emphasis when they are delivered. The remarks made are not open to a two way discussion. Classical Freudian technique is probably most succinctly presented by Ralph Greenson (Greenson 1967).

Reflecting back is the creation of Carl Rogers who sought to avoid the implications that are connoted by the implied authority and all knowing quality of analytical interpretations. Reflecting back comes in differing forms but its main intention is to select some current aspect of clients' thoughts, feelings or behaviour, and to bring them to the attention of clients as a method of letting clients know how they are being seen and so validating them. This is a subtle of provision of new material to change the figure-ground relation, and so, the meanings that clients' create. The meaning that therapists select, and how they are spoken, emphasize some aspect of

clients' experiences, as they can never be precisely as clients first said them.

6 Frame management

The psychoanalyst Robert Langs has coined the term frame to mean the setting of boundaries (AKA holding or containment), the contextual and contractual aspects of therapy (Langs 1988). For instance, agreeing payment, if any; the times and frequency of meeting; the rules contacting each other outside of the sessions in the case of emergency or for cancelation; a definition of the therapeutic process. It also includes such aspects of therapy as the decoration of the office and the seating arrangements, and the rules for the behaviour of each party. A secure frame holds both clients and therapists in safety so each knows how he or she stands with respect to the other. The ground rules are in place to make a secure on-going ritual of the meetings. Saving the frame is the term for any spoken action which reminds clients of the basic rules of the sessions you provide.

Langs' research has shown that these most basic aspects of therapy are important to clients. For therapy to be effective a sense of safety has to be generated by providing regular sessions at regular times, with therapists working in a regular manner. Langs has many points to make about this. But basically he contends that his research has shown that clients find any deviation from the original agreement to be disruptive, unsettling and possibly abusive. For instance, if therapists suddenly cancel, double book, run late, go over time or finish early, or change appointment times, these actions are seen as being obstructive. The communicative approach of Langs also believes that clients remarks are disguised running commentaries on the personality, competence and implications of their therapist's behaviour (Langs 1982).

7 Introducing techniques

The use of techniques can also have positive and negative effects. Positively, they can help clients create new thoughts and feelings or become aware of current ones and so produce new material in the session. Drawing one's family shield, two chair work, free association, relaxation exercises, guided imagery, psychological testing, drawing graphs of improvement, rating anxiety, doing home work, so on and so forth all have a place. The BPS Code of Ethics states

that therapists have the responsibility to explain the procedure beforehand and obtain clients' consent for interventions while respecting their right to refuse (BPS, 1991, p 2). But if techniques are used, they may distract from the difficulty and anxiety of relating to another. For therapists they may be a nice time filler as the moves for clients are planned in advance and provide an opportunity for clients who cannot handle 50 minutes of relating to someone to be distracted for a while.

I can see pros and cons about whether to explain to clients how you are going to work with them in the first session. The reasons for explaining about your silences may be something like "I will usually be silent unless I have something to say which I think will help you". Or you could prepare them by stating that you might suggest they could take part in an exercise, if you think it would help them. If so, you would explain the exercise in advance and let them decide if they wanted to take part. The alternative at a first session is to sit in silence for the first 20 minutes and let them structure the meeting. Then you could say if you feel you could work with them, and describe the nature of the relationship into which they are entering.

Challenging or confronting clients may be a part of therapy and may need to be done when the circumstances dictate. It must always be done with care so that clients know they are being cared for, even though they are being asked to explain some lie or self deceit. Also, occasionally, under the heading of speaking, go some items which are usually banned from therapy. However, from time to time they might be necessary. Advice and information giving are sometimes appropriate interventions, and should not be entirely ruled out. Asking the question why also provides information on a person's reasoning and motivations, and is not just an intrusive or judgemental move. Also, on-going assessment for therapy occurs, and the applicability of the relationship you are providing requires constant evaluation. It should be born in mind whether the meetings should continue or stop. Appropriate referrals to another specialist therapist, for psychiatric assessment, legal help, or social work input may also be required from time to time. Finally, there are matters that therapists are involved with out of the sessions. These include on-going management, monitoring of one's performance and stress, and learning by supervision. These also are a major part of the job of therapy.

In conclusion, this paper is a collection of thoughts on the possible prerequisite and core skills for psychotherapy. I aimed to emphasize the realities of the job and the full range of events that occur in practice. This is a job like no other: Therapists are deeply touched and changed by

their work. To be well intentioned, genuine, warm and caring is not enough. Therapists have to resolve the contradiction of taking on a variable professional mask while being true to themselves. An ability to learn from both positive and negative experiences is required. The ability to acknowledge one's own limitations is a must, as is the ability to deal with our own disappointment with poor outcomes, despite having done your best. I contend that to help another transcend their problems you must have gained a new perspective on your own.

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