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PSYCHOTHERAPY AND THE PROCESS OF CHANGE:
TOWARD AN INTERACTIVE-COGNITIVE MODEL
OF THERAPEUTIC INFLUENCE

A Thesis Presented

by

JEFFREY B. MAR

Submitted to the Graduate School of the
University of Massachusetts in partial fulfillment
of the requirements for the degree of

MASTER OF ART

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Psychology

PSYCHOTHERAPY AND THE PROCESS OF CHANGE:
TOWARD AN INTERACTIVE-COGNITIVE MODEL
OF THERAPEUTIC INFLUENCE

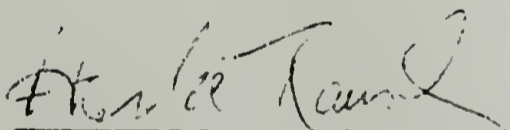
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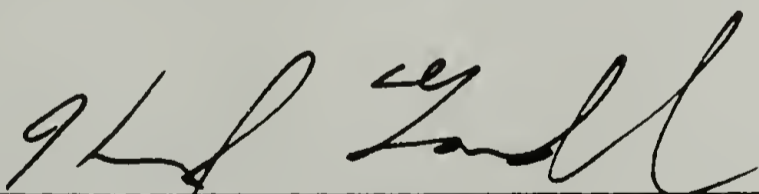
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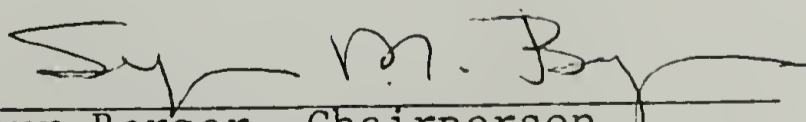

Seymour Berger, Chairperson
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ABSTRACT

This Master's thesis attempts to construct a theoretical model of the process of individual insight-oriented psychotherapy. Its goal is to offer a framework for organizing the experience of the clinical interaction in a way that illuminates the nature of clinical influence and the process of change.

The theoretical model developed in this thesis attempts to address three basic questions. First, what exactly are we referring to when we talk about change? Second, how should we make sense of the moment to moment interaction between patient and therapist? Third, what is the link between the moment to moment interaction in the therapeutic situation and meaningful psychological change?

The conceptual framework developed to address these questions is based on a synthesis of ideas drawn from a number of theoretical traditions; including communication/systems theory, psycho-analytic theory, cognitive/self theory and information processing theory.

The thesis' theoretical argument begins by presenting a general view of human functioning, based on the notion that people operate in the world on the basis of emotional/cognitive "schemata". It extends this thinking

to the clinical process, suggesting that perhaps the most important kind of change involves the patient's self-schemata; i.e., self-concept. Having posited what exactly is being changed in the clinical process, the thesis proceeds to identify three ways through which the therapeutic interaction can foster this kind of change.

The first channel of influence involves the therapist's direct verbal interventions. In this case the patient establishes a new sense of self based on the novel way the therapist articulates an understanding of the patient. The second channel of influence highlights the therapist's indirect analogic communication. Here the emphasis is on meanings that get attached to the therapist's interactional stance. These meanings can form the basis for influencing the patient's self-concept. The third channel of influence stresses the patient's self-observation of the therapeutic relationship. The key here is how the patient sees him or herself interacting with the therapist. This image of "self in the therapeutic relationship" can, under certain conditions, bring about important changes in the patient's enduring sense of self.

This is followed by an extended discussion of the therapeutic interaction. The purpose of this discussion is to detail the various influences, primarily cognitive in nature, that can shape the direction of the clinical

exchange. The point here is to lay the groundwork for understanding the "logic" behind the way therapist and patient respond to each other. The thesis then proceeds to offer a case illustration. The focus here is to demonstrate one key element of the entire framework: How the nature of the interaction can challenge the patient's enduring sense of self (channel of influence #3). The thesis concludes by offering some ideas about how one might go about evaluating and empirically validating the model.

INTRODUCTION

There are a number of personal motivations which have shaped this Master's thesis. Most importantly, this project reflects a growing dissatisfaction with the conceptual models available to explain the process of individual psychotherapy and the nature of therapeutic change. As I have become more involved in the field, I have become increasingly struck by the gap between the experience of doing psychotherapy and the formal theories attempting to account for that experience.

To be sure, the library is filled with theories attempting to explain the clinical process. While many of these efforts have indeed supplied meaningful insights into the experience of doing psychotherapy, I have yet to come upon a conceptual system that comfortably works for me. Part of the difficulty is that, over time, I have informally developed a personal vision of the clinical process--a vision that has drawn loosely from a number of diverse theoretical sources. This idiosyncratic working image of the therapy experience does not readily fit into any one of the existing theoretical models. As a result, I have felt compelled to generate my own conceptual synthesis. In a sense, I have taken on the task of

confronting the fundamental question, "How does psychotherapy work?", in a manner that has as its most important guideline that it be personally convincing.

This thesis has also been guided by the belief that the relationship between therapist and patient lies at the heart of the therapeutic process. Patients get better or worse largely because of the kind of relationship they are able to develop with their therapist. Personal experience, both as a therapist and as a patient, leaves me convinced that the way in which patient and therapist fit together is central to the course of treatment. Thus, the answer to the question "How does therapy work?" must ultimately be based on a detailed examination of the nature of the therapeutic relationship.

Unfortunately, the tendency among many clinical theorists is to only give lip service to the importance of the therapeutic relationship and to quickly pass over it in order to address more theoretically "sophisticated" aspects of the treatment. The implicit message is that a careful consideration of the therapist-patient relationship is an exercise in the obvious, and that every seasoned therapist should already have a good sense of the basic features of a facilitative relationship. This thesis challenges this tendency. One might view this as an effort to make theoretically respectable a personal

intuition about the centrality of the therapist-patient relationship.

The goal of this Master's thesis is ambitious. I will attempt to construct a theoretical model of the process of individual insight-oriented psychotherapy.¹ The hope is to fashion a method for organizing the experience of psychotherapy in a way that illuminates the nature of clinical influence and change. Perhaps the following list of questions will help to further clarify the nature of my conceptual task. These questions crystalize the issues that my model will attempt to address.

1. What exactly are we referring to when we talk about change? What is being changed?
2. How should we make sense of the moment to moment interaction between patient and therapist? How can we organize clinical process?
3. What is the link between the moment to moment interaction in the therapeutic situation and meaningful psychological change? In other

¹The term individual insight-oriented psychotherapy is meant to designate all but the most symptom oriented behavioral approaches. This includes any therapy where understanding and the making of meaning are acknowledged as being an important part of the therapeutic process.

words, what exactly transpires between client and therapist that fosters change?

The answer to these questions will be based on a synthesis of a number of ideas prominent in the field today. In particular, I will be drawing on the ideas of the communication and systems theorists, the ideas of psychodynamic theorists, the thinking of the cognitive-self theorists and, finally, notions from information processing theory.

The emphasis on theory is based on the belief that the first step toward a rigorous examination of the psychotherapeutic experience is to devise a set of appropriate conceptual tools. We need a framework--in the form of sensitizing concepts--to guide our observation. Without firm theoretical grounding, psychotherapy research is prone to become, in spite of the most sophisticated empirical and analytical techniques, an irrelevant exercise in counting for its own sake. The following passage forcefully makes this point.

One of the most serious criticisms that can be made of the research employing content analysis is that the "findings" have no clear significance for either theory or practice. In reviewing the work in this field, one is struck by the number of studies which apparently have been guided by a sheer fascination with counting. Unfortunately, it is possible for content analysis to meet all the requirements of objectivity and quantification...without making

any appreciable contribution to theory or practice. It is all too common an error to equate "scientific" with "reliable and quantitative". Unless the findings of a content analysis have implications for some theory, however vaguely formulated, the study can merit serious attention only on the highly tenuous claim that some day the significance of the findings will become apparent. It should be apparent that the value of a content analysis will depend upon the quality of the a priori conceptualization.

(Cartwright, 1966, p. 447-448)

Taking Cartwright's cue, my primary task will be to work out such an "a priori conceptualization." Carl Rogers (1961), taking a slightly different perspective, offers another reason why, in studying certain types of phenomena, theory is so absolutely crucial.

Objective research slices through the frozen moment to provide us with an exact picture of the interrelationships which exist at that moment. But our understanding of the ongoing moment--whether it be the process of fermentation, or the circulation of the blood, or the process of atomic fission--is generally by a theoretical formulation. . . . (1961, p. 127).

Thus, when it comes to making sense out of process phenomena, like psychotherapy, the central task is to develop narrative explanations that link events over time. Perhaps the most appropriate method to initially generate these narrative explanations is through an act of participant-conceptualization and not by the collection and manipulation of static measurements. This effort is guided by this fundamental epistemological orientation.

The thesis is divided into two main sections. In Part One, I discuss the theoretical foundations which have guided my conceptual effort. This includes an examination of the initial assumptions which have influenced my thinking. It also includes a review of the work of three prominent clinical theorists upon whose work I have drawn most directly. This first section concludes with the presentation of an overall framework for understanding how humans function in the world. This metapsychology provides a general theoretical context for the ideas which are to follow.

In Part Two, I develop a set of ideas devoted to explaining the process of therapeutic influence. This theoretical model is discussed in terms of three "channels" of influence. The third channel of influence, which stresses the importance of the therapist-patient interaction, provokes a detailed discussion of the pragmatics of the therapeutic interaction. This is followed by a chapter that identifies some of the conditions which facilitate the process of change. In the next chapter I attempt to demonstrate part of the theoretical model (channel of influence #3) with a case illustration. In the final section, I confront the question of how one might go about evaluating the model and share some personal reflections on this project.

PART ONE
THEORETICAL FOUNDATIONS

C H A P T E R I
INITIAL ASSUMPTIONS

This chapter begins with a list of the basic working assumptions that have guided my thinking about the psychotherapy process. This rather loose collection of assertions provides a backdrop to the theoretical model which will be presented. These working assumptions have evolved over a period of time-based partly on personal experience, partly on discussions with other therapists, and partly on a selective reading of the clinical literature. Although I am claiming this to be my personal list, it is clear that these assumptions are part of important currents in contemporary clinical thought. To acknowledge this larger context, I have made it a point to include the words and thinking of others in the field.

The Centrality of the Therapeutic
Relationship

As has already been stressed in the introduction, psychotherapy and the process of change can best be understood in terms of the therapist--patient relationship. Rather than being merely a pre-condition to the influence process--as only "setting the stage"--the thera-

peutic relationship is the very medium through which change gets transacted. Bordin (1959) make the point thus:

The key to the influence of psychotherapy, on the patient is in his relationship with the therapist. Wherever psychotherapy is accepted as a significant enterprise, this statement is so widely subscribed to as to become trite. Virtually all efforts to theorizes about psychotherapy are intended to describe and explain what attributes of the interactions between the therapist and the patient will account for whatever behavior changes results (p. 235).

Starting with Ferenczi's (1950) initial break with Freud, the debate as to whether relational factors, as opposed to technical factors, lie at the heart of the corrective process has been a prominent feature in discussions of clinical theory. Fairbairn's (1958) object relations view of the analytic situation; Winnocott's (1965) concept of the "holding environment"; the nurturant-reconstructive approaches taken by From-Reichman (1954), Little (1951), Guntrip (1961), and Kohut (1971); Alexander's (1946) notion of the "corrective emotional experience"; Greenson's (1981) ideas about the "real relationship"; Rogers' (1961) "facilitative conditions"; Frank's (1961) "non-specific" healing factors; and, more recently Lang's (1976) use of the notion "bi-personal field," all represent attempts to expand the argument that psychotherapy can best be understood in terms of relational factors.

Moreover, an accumulating amount of empirical evidence has pointed in this direction (see Garfield & Bergin, 1978, for a comprehensive review of this literature). Specifically, it has been shown that effective clinical relationships tend to have certain characteristics. These characteristics are determined, in part, by the personal characteristics brought to the relationship by both the patient and therapist. Moreover, it has been shown that the interaction of patient and therapist characteristics, i.e., the nature of their relationship, is as important in determining outcome as the characteristics of the members of either group considered separately (Cartwright and Lerner, 1963; Rogers, et al., 1967).

Perhaps another way of stating this view is that the real relationship that exists between patient and therapist plays a crucial role in the therapeutic process. In a classic paper, Greenson (1982) summarizes this position from a psychoanalytic perspective:

. . . a survey of the recent psychoanalytic literature reveals that a significant number of psychoanalysts, a group too heterogeneous to be classified, do not deny the special value of transference phenomena and transference interpretations, but maintain that the total relationship between the patient and the analyst must be taken into account in order to fully understand and handle the vicissitudes of the psychoanalytic situation. They believe that a wide assortment of object relations, other than

transference, takes place in the course of an analysis in both patient and the therapist. It is their contention that the proper handling of these "nontransference," "extra transference," or "real" interactions are an indispensable ingredient for successful psychoanalytic treatment (p. 87-88).

What are the implications of this assumption, especially in terms of our efforts to construct a theoretical model of the psychotherapy process? Perhaps, most importantly, we are forced to move beyond describing what is happening only to the patient and, instead, expand our focus to include the therapist-patient dyad. This requires a set of conceptual tools that can link the dynamics of the therapeutic interaction to changes within the patient.

The Importance of Looking at Interpersonal Process

Patterns of moment to moment interaction are what ultimately characterize any human relationship, including the therapist-patient relationship. Thus, the therapeutic relationship is more than just an amorphous, subjective entity (i.e., warm, empathetic, hostile, etc.) but, instead, is an ongoing process of transactions that tend to settle into discernable patterns. Through careful observation, these patterns and the transactions that go into making them, can eventually be characterized.

Strupp (1973) articulates this as follows:

Freud conceived of psychotherapy (subsuming psychoanalysis), particularly in his early work, as a set of treatment techniques analogous to a surgical procedure performed by a physician on a patient. Psychotherapists following Freud gradually became convinced that psychotherapy must be understood in terms of the interactions or transactions between patient and therapist. This conceptual change had far-reaching implications, leading eventually to the view that the communication between the two participants is critical. Stated in another way, if one is interested in understanding the process of psychotherapeutic change, one must look at the psychotherapeutic process. The crucial information is somehow embedded in the verbal and non-verbal communications, and it is the job of the researcher to impose order on the process in a way that meaningful answers emerge (p. XIII).

The work of the communication theorists is especially relevant here. Bateson (1972), Jackson (1968), Haley (1963), and Watzlavick (1967) have all contributed to this important way of viewing human relationships. Much like two dancers, therapist and patient are continuously moving in coordination with each other through their common interactional space. It is the task of the careful observer to get beyond the general "feel" conveyed by these moves and, instead, characterize the particular moves, or combinations of interpersonal moves, that give each therapy its distinctive flavor. It is in the patterning of these interpersonal moves and counter moves that we will eventually be able to understand the process of therapeutic change.

The Importance of Inner Experience

Relationships involve much more than the exchange of overt interpersonal behaviors. Each participant is also involved in a host of ongoing cognitive-affective activities that directly mediate the course of the overt interaction. Anchin (1982) makes this similar point:

. . . any interaction entails far more than overt behavioral exchange. Indeed, the very meaning and impact of an interaction stems from the fact that, simultaneous with the flow of overt events, each interactant continuously engages in a rapidly firing, complex, yet organized set of covert affective and cognitive processes. These processes influence the perception and interpretation of the overt acts, their nature and course, and the personal and relational meanings that are derived from them. (p. 101).

This view has been addressed by a number of perspectives in psychology. For example, person-perception research (Laing & Esterson, 1964), the analysis of behavior from a social learning perspective (Bandura, 1977), the writings of the cognitive-behavioral theorists (Mahoney, 1977) and even the formulations of analytically-oriented thinkers (Leowald, 1960) all highlight the affective and cognitive components of interpersonal behavior. Notions like "interpersonal construal," "trait attribution," "generalized assumptions about self and other," all point to ways in which internal processes mediate our interactions with others. It follows, then,

that a truly complete model of psychotherapy must pay close attention to both the therapist's and patient's internal experience of the unfolding relationship. While this unavoidably makes the task of understanding the therapeutic transaction more inferential, such inferential data is indispensable in constructing a meaningful picture of what is really transpiring.

The Appropriateness of a Cybernetic Epistemology

Interpersonal behavior is embedded in a feedback network where the concept of linear causality is no longer appropriate. The study of such processes should, instead, be grounded in an epistemology stressing mutual influence and circular causality. Danziger (1976) notes, in contrasting linear and circular conceptions of causality, that the feedback inherent in any human transaction implies that "two individuals in interaction are simultaneously the causes and the effects of each other's behavior" (p. 84).

This view of human interaction has certainly left an important mark on the shape of clinical theory. In addition to the more drastic revisions offered by the systems theorists (Jackson, 1968; Levenson, 1972; Haley, 1963), there is also an increasing tendency among

psychoanalysts to acknowledge the reciprocal nature of the therapeutic situation. This is especially apparent in more recent discussions of the concept of countertransference (Racker, 1968; Searles, 1979; Langs, 1982).

This circular view of causality makes the task of articulating a model of psychotherapy much more challenging. One difficulty is that our language is steeped in the tradition of linear thinking. The very medium which we have to communicate such a model can actually undermine the effort. In addition, the task of portraying all of the communicational loops can be overwhelming, if not impossible. There always exists one more feedback link or one more level of context to take into consideration. We are, thus, forced to more openly acknowledge the limitations of any model building effort and realize that it is only through a compromise; i.e., by restricting the scope and complexity with which we attempt to depict "reality," that we are able to keep things manageable.

The Importance of the Notion of Fit

The manner in which therapist and patient come together and blend their respective styles--the way they "fit"--determines, to a great extent, the course and outcome of their relationship. The choice of the spatial

metaphor here; i.e., two people "fitting" together, is especially appropriate because it re-emphasizes the alternative epistemology suggested in assumption #4. In other words, the therapist does not "do" something to the patient that "causes" the patient to change. Instead, employing this notion of fit, both participants go through a process of mutual accommodation as they negotiate (usually at a level out of awareness) how they are going to share their common interactional space. Change, if it should occur, is largely a product of that meshing process.

Dell (1982), drawing on the thinking of Bateson (1972) and Maruyama (1963) employs the term "fit" to draw what he views to be a revolutionary distinction about the way we can understand human behavior. His point is that we should not try to understand people in terms of causal antecedents (linear or circular) but, rather, by examining the way we interface with our social environments. From his perspective, concepts like complementarity, evolution, structural determinism, as well as "fitness" offer more explanatory power than the concept of causality.

Leary (1957) provides perhaps the most elegant attempt to operationalize this concept of "fit" through the use of a two-factor (dominance vs. submission and hate vs. love) circumplex having behaviorally defined segments.

His circle is essentially a device for breaking down interpersonal behavior into a functional system of classes or categories. In a sense, he has devised a taxonomy of interpersonal behavior. What makes his work especially relevant to this discussion is that it suggests that every interpersonal style pulls for a particular well defined complementary response and that such interpersonal pulls gain their force from the fact that certain styles naturally fit together.

A growing number of theorists have made this concept central in their thinking about the clinical process. Beir (1966), Carson (1968), Wachtel (1976), and Levenson (1972) all suggest, in one form or another, that the way in which a therapist and client fit together (and especially the way the fit is altered through the course of therapy) lies at the core of the healing process. Perhaps Levenson (1972), in attempting to explain how a particular type of non-fit is crucial to the process of therapeutic change, makes this point most poetically:

The function of the therapist is through awareness to resist transformation. Like a continuous discordant note, he shifts the melody. What emerges is still the patient's private myth . . . but a myth shifted to account for new data. . . . The therapist . . . acts from within the structure of the patient's transactional field--as it were, by being unassimilated. The patient can reject the therapy (as of course does happen) or he can encapsulate it (as in those interminable twenty-year "pearls of

treatment") or he can meet the new experience by changing (p. 214-215).

Finally, Guntrip (1975) offers a nice bridge to the next assumption (assumption #6) by suggesting that a productive therapeutic fit may be largely unrelated to the theoretical or technical prowess of the therapist, but may instead, occur naturally:

. . . psychoanalytic therapy is not a purely theoretical but a truly understanding personal relationship. . . . But the capacity for forming a relationship does not depend solely on our theory. Not everyone has the same facility for forming personal relationships, and we can all form a relationship more easily with some people than with others. The unpredictable factor of "natural fit" enters in. (p. 146).

The Importance of the Therapist's Personality

Who the therapist is as a real person has an enormous influence on the course of any psychotherapy. For better or worse, the therapist's individual qualities--personality, attitudes, beliefs, interests, values, and style--play a central role in shaping the therapeutic interaction. No matter how rigorous one's training and grounding in proper technique, the idiosyncracies introduced into the treatment by the therapist's personality cannot be wholly submerged. Instead, these personal characteristics should be understood as laying at the core of the therapeutic process. In what was later to be a

common theme among the humanists and existentialists, Jung (1934) wrote:

It is in fact largely immaterial what sort of techniques he uses, for the point is not technique . . . the personality and attitude of the doctor are at supreme importance--whether he appreciates this fact or not. . . . (1964, p. 159-160).

Fairbairn (1958) echoes this view, from a slightly different object-relations perspective:

The relationship existing between patient and analyst is more important than details of technique; and it would seem to follow that the role of the analyst is not merely to fulfill the dual functions of (1) a screen upon which the patient projects his fantasies, and (2) a colourless instrument of interpretive technique, but that his personality and his motives make a significant contribution to the therapeutic process (p. 59).

Over the years, this position has evolved into a detailed examination of exactly how the therapist's personality can affect the therapeutic process. Thus, Truax & Mitchell (1971), from a client-centered perspective; Fromm-Reichman (1954) and Sullivan (1953) from an interpersonal framework; Racker (1968), Little (1951), Winnocott (1965), and Langs (1976, 1978) from a psychoanalytic point of view, and Carson (1968) from an interactional perspective, have all attempted to refine our understanding of how the therapist's personality can contribute or detract from the clinical effort. To supplement this clinical literature is a well established

body of more formal empirical research that clearly demonstrates that certain personal qualities of the therapist can positively affect the outcome of psychotherapy. For an extensive review of this literature see Parloff et al., (1979).

Perhaps the strongest testimony supporting this position comes from the very structure of the psychoanalytic profession --a structure that requires all of its candidates to undergo an extensive training analysis. Carson (1968), using the interactional framework developed from Leary's (1957) earlier work, makes this point in a more specific manner:

If the effectiveness of the therapist is dependent in part on his ability to move the client at will through various portions of the interaction matrix, it follows that the success of therapy will in turn depend in part on the therapist's capacity to adopt stances complementary to those with which the client needs to experience. The most generally effective therapist should be one who can move comfortably to virtually any position in the matrix, a characteristic that is tantamount to maximum personal adjustment (p. 288).

It follows, then, that any model of psychotherapy attempting to incorporate this assumption must make explicit this link between the personal qualities of the therapist and the course of the therapeutic interaction.

The Similarity Between the Psychotherapy
Relationship and Other Relationships
in Facilitating Change

The manner in which patients are influenced and change in psychotherapy has much in common with the way people change outside the clinical setting. The "good" therapy relationship mirrors, in many ways, those rare, naturally occurring relationships that result in meaningful change. Kiesler (1982) makes this point forcefully.

The rock bottom assumption of interpersonal therapy is that the client--therapist interaction, despite its unique characteristics, is similar in major ways to any other human transaction (p. 14).

This assumption serves to widen the scope of our theoretical effort. Instead of relying exclusively on our observations of the clinical situation, we can expand our field of vision and look elsewhere for additional leads about how relationships change people. It follows, then, that any theory of psychotherapy should be informed by our understanding of human interaction and change, in general. In this light, the views of many non-clinical theorists become relevant to our effort, including the work of the communication theorists (Bateson, 1972; Haley, 1963; Watzlavick et al., 1967), the social psychologists (Mead, 1934; Thibaut and Kelley, 1959; Goffman, 1959; Strong and Claiborn, 1982, for a recent synthesis), and the interper-

sonal personality theorists (Sullivan, 1953; Leary, 1957; Anchin and Kiesler, 1982; and Magnusson, 1977). In addition, the insights gained from developmental psychology may be helpful. Thus, we might also be able to refine our thinking about the therapist-patient relationship by looking closely at the facilitative dimensions of the healthy parent-child interaction (Winnocott, 1965; Leowald, 1960).

The Importance of Self/Other Representations

Psychotherapy, in its most meaningful form, provides patients with the opportunity to alter inner models of self and relationships. It is an attempt to change core assumptions about oneself and one's social world. Jerome Frank (1963) makes this point very directly:

The aim of psychotherapy is to help a person to feel and function better by enabling him to make appropriate modifications in his assumptive world (p. 37 and 38).

According to Frank, the term "assumptive world" can ultimately be defined in terms of internal representations of self and other:

(The term "assumptive world") is a short hand expression for a highly structured complex, interacting set of values, expectations, and images of oneself and others, which guide and in turn are guided by a person's perceptions and behavior and which are closely related to his emotional states and his feelings of well being (p. 27).

This assumption is echoed over and over again in a variety of forms throughout the clinical literature. Strachey's (1934) classic description of the treatment process, Roger's (1954) pioneering psychotherapy outcome research, Kelley's (1955) innovative clinical technique, Kohut's (1971) reformulation of psychoanalytic metapsychology and even Eric Berne's (1961) transactional analysis all draw upon the common fundamental notion that therapeutic change involves shifts in the patient's inner representations of self and others.

One implication of this view is that it is not enough to describe change in psychotherapy simply in terms of changes in overt behavioral tendencies or observable relational patterns. Our explanation most ultimately be grounded in an appreciation of how internal processes, especially the ways in which we perceive and attach meaning to our social experience, shape our patterns of behaving in the world. The patient's meaning structure and the cognitive patterns which generate these structures must be at the center of any model of psychotherapy process and change.

The obvious conceptual task, then, is to make explicit the link between the therapeutic interaction and these inner models of apprehending reality. The thinking of the self-theorists (Cooley, 1902; Goffman, 1959;

Cottral, 1969; and Epstein, 1980) and the symbolic interactionists (Mead, 1934; Blumer, 1968) are especially relevant here. What ultimately must be explained, and eventually empirically demonstrated, is the connection between specific therapist-patient transactions (or patterns of transaction) and changes in the way in which a patient goes about viewing himself and his social world.

There are undoubtedly additional predilections which have influenced the thinking behind this thesis. However, these eight assumptions describe the most important elements of the world view which lies behind this work. Another way of viewing these assumptions is that they represent one set of criteria for evaluating what is to follow. Thus, the merit of the theoretical model that is to be described will partly depend on how well it works within this set of theoretical parameters.

C H A P T E R I I
THREE MODELS OF PSYCHOTHERAPY

What follows is a discussion of three efforts to develop a conceptual model of the psychotherapeutic process. These particular models have been chosen because they offer, each from a slightly different vantage point, a compelling synthesis of many of my own ideas. They represent, in a sense, the state of the art in terms of the conceptual work that has been done towards understanding psychotherapy from an interaction-process point of view. Because of the complexity and richness of each of these models, my discussion must necessarily be limited. After briefly summarizing their major theoretical points, I consider each model's specific strengths. The discussion ends with a look at the limitations of each model.

Robert Carson

Perhaps the strongest effort to integrate the interactional point of view can be found in Robert Carson's pioneering book, Interaction Concepts of Personality (1968). This stimulating work is one of the earliest attempts to synthesize a model of psychotherapy

based on the interpersonal psychiatry of Sullivan (1953), the social exchange notions of Thibaut and Kelley (1959), and the interpersonal psychology of Leary (1957).

His starting point is that we behave the way we do based on an inner set of socially generated images of our place in the world. These images of Self and Other are based largely on the feedback one receives from his or her social environment. This view of personality provides Carson with a powerful way of understanding why people tend to stay the same and why meaningful change is often so difficult. People persist in fixed patterns of behavior because their inner set of perceptions, expectations, and "ways of seeing" tend to be confirmed by the interpersonal consequences of their very own behavior. In other words, people remain the way they are, for better or worse, because of the consistency of the feedback which they provoke from those around them.

Based on this cognitive-interpersonal view of personality, Carson describes his view of the clinical process:

The role of the therapist is to provide his client with experiences that result in an expansion and loosening of the client's Image of Self. Success in this venture would free the client from his slavish devotion to the maintenance of a constricted Selfhood, and from his need to manufacture crucial evidence in its support. . . . The therapist must cause the client's Image to be changed, particularly that

aspect of it constituting the client's fundamental concepts of himself in relation to the world. The focus of the effort is therefore a cognitive, or at least quasi-cognitive, structure. In a sense, the client needs to be provided with a different and more adequate set of beliefs about himself and his life (1968, p. 272).

The crucial question, of course, is the exact nature of such "experiences that result in an expansion and loosening of the client's Image of Self." Carson attempts to answer this by describing the "cardinal therapeutic tactic" in the following way:

The therapist must avoid the adoption of an interpersonal position complementary to and confirmatory of the critical self-protective position to which the client will almost invariably attempt to move in the course of the therapeutic interaction. In other words, the therapist must be one person in the client's life--and he will frequently be the only one in a sustained relationship--who does not yield to the client's pressure to supply confirmatory information (analogic or digital) to the latter's crippled self (1968, p. 180).

Carson's work is important for several reasons. At the most general level, he synthesizes a number of important interpersonal principals into an integrated depiction of the clinical process. More specifically, he has clearly identified what ideally gets transformed in psychotherapy: The patient's working image of Self and Other. He has also articulated how this change comes about: The therapist disconfirms the patient's inner images of Self and Other by offering non-complementary

responses to the patient's habitual patterns of relating. What remains to be done is to flesh out this basic outline. Carson's conceptual map has to be made more specific so it can be more accurately applied to the complexities of real life clinical data.

One area of the map that remains conspicuously uncharted is the process by which a therapist arrives at a response to the patient. A truly interactional view of the therapeutic exchange must carefully consider the interactional dynamics in terms of both participants, including the therapist. Carson alludes to this only briefly, suggesting that the flexibility of the therapist's personality plays a major role in his or her ability to take on a variety of appropriate non-confirming stances.

. . . the success of therapy will in turn depend in part on the therapist's capacity to adopt stances complementary to those with which the client needs to have experience.

Carson's model falls short of specifying how the therapist manages to do this (or alternatively, is unable to do it).

What also needs to be more fully developed is the exact mechanism by which the therapist's non-confirmatory responses do (or, in some cases, do not) result in a shift in the patient. To simply say, on an abstract level, that therapists' non-complementary responses result

in patients changing is not enough.

Finally, Carson remains firmly entrenched in the epistemology of linear causation. The therapist "provides" the patient with a response which "causes" a shift in the patient's view of him or herself and the world. An important refinement to his model would be to recast this view of causality into terms that are truly interactional; so that both therapist and patient are seen as participating in a mutual dance of cause and effect.

Robert Langs

For over a decade, the psychoanalytic investigator Robert Langs has written prolifically and forcefully in favor of a communicational model of the psychoanalytic conversation. For a representative collection of his work see Langs (1978). His emphasis has been on examining and conceptualizing the analytic method from an interactional perspective which focuses on the reality of the shared activity between the two participants in the psychoanalytic dialogue. He uses the term "bipersonal field" as his primary metaphor for depicting the clinical situation. This metaphor stresses the interactional qualities of the therapeutic process and postulates that every experience and communication within the "field" receives vectors from both patient and therapist. His important message is that

such vectors do not originate exclusively from the patient (i.e., the patient's transference) but can just as likely originate from the therapist as well. The work of therapy is to use the reality of this unfolding communicational field as a basis for self-understanding.

He uses the term "adaptive context" to designate this unfolding reality and contends that the words and actions of the therapist are perhaps its most important features. Whatever the patient says about himself or his world "out there" is colored by the stimuli coming from the therapist.

Every communication from the patient and the therapist must be considered in terms of the ongoing therapeutic interaction and in terms of the adaptive qualities of each response. (p. 461).

According to Langs, it is of prime importance to "get hold" of such allusions; to acknowledge the influence of the adaptive context and to use the patient's (as well as the therapist's) reactions to the here and now as a tool for gaining access and insight into the hidden mental life of the patient. One consequence of this view is that the "interactional realm takes precedence, and must be understood first . . . before interpreting unconscious content, fantasy, memories." (1976, p. 419).

While Langs pays strict allegiance to the classical psychoanalytic tenet stressing the primacy of insight

(and, by extension, the centrality of the therapist's interpretive work), what makes his thinking particularly innovative is his willingness to appreciate purely interactional components of the curative process. Using the clinical insights first arrived at by the Kleinians, Langs pictures the clinical process as a back and forth, largely unconscious, exchange of "introjects." What allows this process to be curative is the therapist's ability to absorb and process the patient's pathological introjects and, in turn, give them back to the patient in a form that can be more adaptively used. Langs uses R. Fleiss' (1953) phrase "the metabolizing of projective identifications" to describe this process.

There are a number of ideas in Langs' thinking that have been particularly useful in my own theoretical effort. His use of the "bi-personal field" metaphor, his emphasis of the "adaptive context," and his stress on the importance of countertransference are all ideas that I have incorporated into my own interactional perspective. In addition, Langs employs a number of concepts that creatively blend interactive with intrapsychic phenomenon. Processes which Langs identifies as "metabolizing," "trial identification," and "detoxification" are clearly intrapsychic events, yet they are discussed as being embedded in the context of a larger interactional sequence.

Similarly, processes such as projective identification, introjective identification, and projective counteridentification --all important mechanisms in Langs' conception of the therapeutic interaction--combine external communicational dimensions with internal affective-cognitive dimensions.

Finally, Langs offers us an attractive research methodology. He suggests that we perform case-specific and session-specific micro-analyses of actual clinical material. He asserts that this kind of detailed retrospective examination of the therapeutic process is the only way to obtain meaningful validation of our hypotheses. In fact he provides us with a very simple formula for conducting such a validating process (and demonstrates it in several of his books):

Within the clinical situation, the following validating sequence is essential: Material from the patient, intervention by the therapist, validation from the patient--and, secondarily, from the therapist (1978, p. 386).

Langs continues with some additional guidelines on the validating process.

Clinical validation should occur in two spheres: cognitive and interactional-identificatory. In regard to the first area, true confirmation constitutes the revelation of previously repressed material which helps to reorganize the previous association, sheds unforeseen light on the material, and provides truly original insights into the patient's current anxieties, conflicts, and inner mental life. . . .

In the interactional-identification realm, derivatives of a positive introjective identification should appear in the material from the patient subsequent to a valid intervention. Such responses are based on an unconscious introjection of the therapist's valid functioning as reflected in his insightful interpretive efforts (1978, p. 386 and 387).

This methodology, particularly his second interactional approach toward confirming clinical hypotheses, seems well suited to the kind of cognitive interactional notions developed in my model of the therapeutic interaction.

Perhaps the most important area of divergence between Langs' thinking and my own is around the relative importance of insight. While Langs acknowledges that one avenue of cure is object-relational, he fails to develop the full interactional implications of this point of view. For Langs, the therapeutic object relation is achieved primarily through the therapist's ability to appropriately manage the maladaptive interactional pressures of the patient. In more psychoanalytic terms, this involves the ability to detoxify the patient's pathological projective identifications. The way the therapist does this, according to Langs, is by steadfastly sticking to the task of facilitating affectively meaningful insight. Such an interactional stance signals to the patient that what he or she is presenting to the therapist is tolerable. There

is an implicit green light to share more and go deeper, with the assurance that what might emerge will be containable. Thus, the primary curative tactic is very much equated with the ability to facilitate insight.

My view, in contrast, is that our understanding of the interactional components of the therapeutic process need not be viewed only in terms of the therapist's ability to generate insight. Therapists can respond to patients in a variety of ways that can result in meaningful and enduring change. The facilitation of self-exploration and self-understanding is only one available alternative. The task, of course, is to generate a conceptual framework that can accommodate this expanded notion of the process of change.

Mardi Horowitz

The ideas of Mardi Horowitz (1979) represent an ambitious effort to grapple with the question of how people change in psychotherapy. Drawing from a wide variety of theoretical traditions, both in and out of psychoanalysis, Horowitz presents a method, "configurational analysis," that organizes how one should observe and make sense of the clinical process. His framework revolves around three basic dimensions to track the moment to moment dynamics of the clinical process.

His "state" analysis is based on the idea that people are continuously passing through a number of "recurrent patterns of experience and behavior." These "states" are experienced as distinct phenomenological entities, each made up of a unique combination of behavioral, emotional, and relational tendencies. Words like "mood," "state of mind," and "level of consciousness" all capture a bit of the concept. Moreover, Horowitz asserts that by carefully observing changes in facial expression, intonation in speech, arousal level, focus and content of verbal reports, degree of self-reflective awareness, and other qualities in the patient's experience specific states can not only be characterized but that the transitions from one to another can be pinpointed. From this perspective, people change when they alter the way they distribute their time among their repertoire of states. Change also occurs when new states (i.e., new constellations of feeling and behaving) expand a person's repertoire of states.

The second dimension in Horowitz' configurational analysis involves what he terms "self-images and role relationships." These are the inner models which organize and influence the ways people view themselves in relation to others. In Horowitz' view, one's view of self is always embedded in the context of a relationship. The

concept of self is, thus, very much an interpersonal concept. People run into difficulties when they spend too much time operating from maladaptive and/or painful inner self/object images. Therapeutic change involves a shift in the ways the patient uses these inner models such that more adaptive and less painful "filters" come to dominate a person's way of seeing self and the world.

Horowitz suggests that everyone, no matter how integrated or mature, has a multiplicity of such images. In his view, everyone draws from a personal repertoire of such models. The task of therapy, in one sense, is to increase the likelihood that the patient will fall back on those particular images which allow him or her to function more satisfactorily.

The third feature in Horowitz' configurational analysis focuses on the patient's pattern of information processing. What concerns Horowitz here is the "software" of the patient, particularly those conflicted ideational constellations that lead the patient into difficulty. From this perspective, each "state" is characterized by a particular routine with its unique pattern of associations. In a sense, this is the most important aspect of Horowitz' model, for it is through the patient's cognitive apparatus that the clinical process exerts its influence. Change, according to Horowitz, results from

new ways of processing the information we have about ourselves and our world.

What is perhaps most exciting about Horowitz' model is that it represents a serious attempt to capture the full complexity of the clinical situation. His model acknowledges the large array of factors that play a role in the therapeutic interaction. To do this, Horowitz is forced to weave together a number of divergent strands in current clinical theory--ranging from psychoanalytic metapsychology to recent advances in cognitive theory. His book, in some places, reads more like a chemistry text and reminds us that the task of modelling the clinical situation in a way that is clinically relevant is necessarily a demanding one. However, his use of a multi-layered micro-analysis suggest that there are ways to keep such complexity manageable.

Horowitz has not only attempted to bridge the gap between clinical practice and clinical theory, he has also attempted to bridge the gap between clinical theory and empirical validation. This effort is based on two guiding principles. First, his methodology clearly reflects a commitment to linking clinical inference and explanation to concrete observables. His use of video, detailed case transcriptions, and group consensual observation are all attempts to strengthen the link between theory and clini-

cal data.

Second, Horowitz' methodology reflects the growing disenchantment among modern clinical researchers with standard statistical procedures and the realization that only a limited amount can be learned from comparison of mean differences between groups. Instead, he has devised a system of empirical validation that is based on the intensive analysis and observation of a single case. As such, his system is clearly idiographic and falls very much within the tradition of the classical clinical method of inquiry. However, Horowitz' model attempts to bring a new level of discipline and organization to the time-honored method of the case study--a method which at times can become wildly inferential and largely immune to rigorous validation.

Another outstanding feature of Horowitz' model is that it has taken on as its primary focus the very process of change. Instead of relying on well-worn phrases like "working through" or "strengthening of the ego"--phrases which only tend to make the process even more mysterious--Horowitz attempts to confront the issue directly. Using an information processing perspective, he attempts to schematize the transformation process on a level that is concrete enough to be applied to the details of the actual clinical interchange. Such specificity in

detailing the process of change is an instructive refinement to much of what passes as clinical theory.

Perhaps the most important limitation in Horowitz's model is that it fails to fully account for the interactional nature of the clinical situation. Horowitz is primarily concerned with depicting changes in the patient and devotes little attention to the therapist's half of the therapeutic transaction. While he does not rule it out, Horowitz seems resistant to fully explore what is behind the therapist's interventions. They are simply treated, linearly, as input into the patient's information processing system. A truly interactional picture, however, would carefully consider the therapist in terms of state, image of relationship, and information processing.

In summary, the work of Carson, Langs, and Horowitz all represent ambitious attempts to place some conceptual order into what goes on in the clinical situation. Carson most clearly articulates an interactional framework for understanding the nature of influence in the clinical process. His suggestion that the interactional dynamics of the therapist-patient dyad; i.e., how these two negotiate a "fit," lies at the core of my thinking.

Langs pushes us to more seriously consider the therapist's contribution to the course of the clinical

process. He also suggests that we focus more attention on the immediate communication matrix--the "adaptive context"--in attempting to understand the meanings of emerging clinical material. Both of these ideas are prominent features in my own theoretical formulations.

Finally Horowitz' method of configurational analysis systematically traces the impact of the clinical interaction through a micro-analysis of patterns of the patient's information-processing. This thoughtful attempt to link patterns of interaction to patterns of cognition is a key element in my own model of the therapeutic process. In addition, Horowitz' single case micro-analytic research methodology seems to offer the most promising method of empirical validation.

The stage is now set to present my own ideas. The parameters of the task have been clearly drawn. I have put forth several basic orienting questions and an assumptive framework with which they might be addressed. I have also examined three other attempts to model the psychotherapy process and have highlighted their most useful components. What remains is to weave these strands together into a coherent picture.

C H A P T E R I I I
A GENERAL VIEW OF HUMAN FUNCTIONING

Any attempt at a meaningful understanding of psychotherapy and the nature of change must be done within a larger framework of how people function in the world. If psychotherapy can indeed be seen as one type of human experience, then it follows that the most compelling model of clinical influence should be closely wedded to this broader view of how people adapt and change. Thus, before we get into the details of my model of psychotherapy, let us first step back and discuss this wider theoretical context.

This general view of human functioning pictures people as being in a continuous process of adapting to their environment. The manner in which people adapt to their environment is based on how they process the raw data of their experience. What is being suggested is that there are a number of crucial intervening steps between stimulus (i.e., the environment) and response (i.e., pattern of adaptation). This intervening internal processing is, under ideal conditions, used to shape an individual's perceptual, interpretive, and response tendencies into a functional stance toward the world.

Perhaps the most useful way to analyze this internal processing is to view it as being organized around a number of distinct, but interrelated schemata. These schemata are thematically focused information processing routines which are employed to apprehend and respond to the environment. We might view an individual's schemata as that person's private neural library of software packages. Any one (or combination) of them can be activated by a particular configuration of stimuli from both the inside, in the form of mental input, and the outside, in the form of environmental input. Once activated, these schemata coordinate a pre-patterned set of perceptual, interpretive, and response functions.

Our understanding of this notion can be further refined in a number of ways. One of the most confusing aspects of schemata is that they represent both a characteristic patterning of activity and also a clearly identifiable cluster of informational content. Thus, a schemata can be described not only in terms of the style in which information is handled (such as "deliberately," "obsessively," "impulsively," "logically," etc.) but also in terms of the assumptions (such as "the world is a dangerous place," or "a smiling face means that a person is likely to have friendly intentions") and input data (such as "it is cold and I am hungry," or "the person just

said hello to me). Seeing schemata as both activity and informational content can make it an elusive concept.

Schemata can be differentiated both horizontally and vertically. Horizontal differentiation involves classifying these information processing routines in terms of functionally and/or situationally specific themes. The schemata "I am shopping for groceries" can be viewed as horizontally distinct from "I am attending church." Vertical differentiation involves distinguishing schemata according to their relative level of generalizability. Lower order schemata are situationally and functionally specific: "My next task at the grocery store is to pick out some apples," or "I should now be singing the next hymn of the church service." Higher order schemata can be applied to a broader class of activities: "By grocery shopping, I am trying to be a helpful husband," or "By attending church, I am being a morally principled person." What makes it especially difficult to talk about schemata is that individuals adapt to their environment by simultaneously employing a number of them at a variety of levels.

It is important that these schemata be seen primarily in terms of their adaptative function. This means that their most important characteristic is their ability to change in response to shifts in a person's experience of the world. Another way of stating this is that sche-

mata are empirically derived and not transcendental. They are the result of an individual's interaction with others, things, body parts, mental images, and so on. Thus, not only do these schemata shape one's interpretation and response to the world, but they are shaped by one's experience to the world. The cognitive interface between people and their environment is essentially an open system of feedback loops.

C H A P T E R I V

THE SELF-CONCEPT

One class of schemata that plays a particularly important role in shaping ones interpretation and response to the environment are self-schemata. Self-schemata are those routines of information processing that determine our sense of who we are, how we are doing, and what is and should be our place in the world. Self-schemata play such a prominent role in a human being's adaptive efforts that I have chosen it to be the focus for my model of psychotherapy influence. This is not to suggest that significant change cannot involve other aspects of the person-environment interface, but simply that self-schemata appear to be the best candidates for constructing a more circumscribed model of the process of therapeutic change.

We are now in a position to more productively address the first orienting question: What exactly is changed in psychotherapy? Drawing from this wider theoretical context we can answer this question in the most general sense. What gets changed in psychotherapy is the way in which patients go about interpreting and responding to (i.e., processing) the data of their

experience. For our purposes, however, we will be focussing on one aspect of this overall picture of this cognitively based notion of adaptation. Using this more narrow focus, what is changed in therapy is the way the patient views him or herself; i.e., self schemata.

If changes in self-schemata are to be at the center of our inquiry, it is important that we look more closely at this concept. As alluded to earlier, the self-schemata is not a single entity but more usefully can be seen as a constellation of sub-schemata. The particular type of self-schemata that will be our primary concern involves the sense of self as object. In other words, the picture that people carry around of themselves--their self-image. An especially helpful approach toward analyzing the self-concept has been put forward by Hewitt (1984) from a symbolic interactionist perspective. He suggests that the self-image can be seen as self as object and, as such, can be viewed from three analytically distinguishable vantage points: Its location. in relation to other selves (e.g., "I am a father to my daughter"), its qualities and attributes as these are imagined by self (e.g., "I am a caring father") and the evaluations made of the self as object (e.g., "I value the fact that I am a caring father"). Hewitt further suggests that such descriptions of self can be "situated" (i.e., limited to a

specific situation) or "biographical" (i.e., enduring). His method of analyzing the self concept corresponds to my method of understanding schemata, in general, along horizontal and vertical dimensions. Jumping to the therapeutic situation, it is clear that Hewitt's breakdown offers us a convenient method to organize our view of clinical influence.

Having designated the self-image as our focus, we can begin to think more carefully about how people go about constructing and modifying the various components which make up the overall view of self. This is an important question because it pushes our thinking in the direction of psychotherapy and the process of change. In addressing this issue, I have again drawn heavily from the perspective of the symbolic interactionists.

People construct images of themselves based on their interaction with the environment. It is from the data of one's experience that an individual fashions a picture of self. Some experiences are explicit in the way they affect a person's self image (e.g., receiving a report card, getting praise). Most experiences, however, do not have such direct implications. These experiences exert their influence by being part of a larger pattern of experience which, in turn, can generate meanings that can alter one's self-image.

This raises a very important distinction. While it is true that one's sense of self is based on one's interactions with the environment, there is perhaps a more useful way to look at this process. It is the meanings that are assigned to one's experience of the world that are really the key to shaping one's image of self. What this suggests is that the phenomenology of one's experience of the world lies at the heart of creating a self-image. The notions of "meaning making," "perceptual set," and "interpretive activity" take on special importance in this light. If we are to understand how experience generates self-images we must first look at how an individual makes sense of that experience.

This perspective, unfortunately, introduces another source of complexity and ambiguity. This interpretive activity, like every other aspect of our cognitive apparatus, is molded by our interaction with the environment. This creates a situation where the very activity which shapes the way in which we take in our experience of the world, is simultaneously being altered by that experience. In this state of mutual flux, it becomes extremely difficult to grab onto and hold meanings, for they are continuously shifting. Thus, we can easily find ourselves caught in a series of maddening recursive loops. The only way to escape these loops is to

strategically limit one's field of vision so that one is still able to capture the flavor of the phenomena yet does not get lost in its unresolvable intricacies. Perhaps the most difficult part of exploring this topic and developing a coherent model has been to know how to set these limits.

Now that we have considered, in a general way, what goes into shaping an individual's self-concept¹, the stage is set to consider how psychotherapy, in particular, can shape an individual's sense of self. However, before we begin that task (which, incidentally, is this Master's thesis' primary purpose) we have one more preliminary issue to address. It is an important issue because it forces us to answer directly the question of why we have chosen to focus all of our attention on the self-image.

If our primary interest lies in understanding how psychotherapy can alter a patient's way of adapting to the world, then the justification for spending so much effort looking at the self-concept lies in our ability to convincingly establish the link between a person's self-concept and his or her pattern of responding to the world. What follows are various ways to try to conceptualize that link.

¹In this paper, I am using the terms self-image and self-concept interchangeably. Both are used to designate the constellation of mental images that one has of oneself.

One way in viewing the link between self-image and behavior is that self-images are an important part of the way in which individuals make sense of their world. Self-images serve as powerful filters in the effort to derive meaning from experience. It is largely on the basis of these meanings that individuals respond to their environment. For example, if a person goes into a situation with a particular self-image prominent in his mind, he will unavoidably be sensitized toward viewing the situation in ways that confirm this self-image. This reaffirmed sense of self will, in turn, affect the way he behaves in that situation.

Self-images are involved in more than just this interpretative function. They also serve to define one's role in any given situation. This role serves as a powerful guide to behavior. For example, if I see myself as a student there are certain rules of conduct which go along with being a student. The term role is used here rather loosely. It can refer to something as rigid and rule-prescribed as "the goalie on the hockey team" or to something as vague and personally idiosyncratic as "a good friend." The important point is that one's self-image provides important information about how one should act if one wishes to fulfill a designated role.

Self-images also shape our patterns of motivation.

If we assume that self-images always exist alongside idealized images of self, then the way in which these two images match up to each other can greatly influence how an individual directs his or her behavior. From this perspective, images of self (both "actual" and "idealized") play a crucial role in shaping what the symbolic interactionist have called our "plans of action." Thus, if human behavior is to be understood in terms of intentionality, the tension between the actual and idealized self-image lies at the core of such understanding. For example, if one feels destined to be, let's say, a great piano player, this image of self will have an enormous influence on shaping the person's long range behavioral goals and, by extension, shape the more immediate plans of action that are employed on a day to day or even moment to moment basis.

Our final way of understanding this link utilizes Horowitz' notion of "states." People's behavior can be understood as arising out of a limited number of recurrent states. These states are defined as organized constellations of emotional, perceptual, cognitive, and behavioral responses which form a coordinated and identifiable gestalt. We often label these states as moods. The states in which one finds oneself are determined by a number of factors, including one's physiological status

(e.g., how hungry, tired or drugged a person is), the social environment (e.g., whether one is with trusted friends vs. about to go to a job interview), environmental factors (e.g., how hot and uncomfortable it is) and cognitive-affective factors (e.g., how worried one is). It is the character of the mix of these factors which serves as the gating mechanism determining the choice of a state. One of the most important variables affecting this gating apparatus is the person's current image of self.

It is on the basis of this mix of factors that a particular state is activated. Individuals settle into particular states through a gating mechanism that selectively allows one state, out of the many possible, to be activated. What is especially significant about this gating process is that it is very sensitive to an individual's current image of self. In other words, one's self-image plays an important role in determining which state is "let through." Once a certain state is activated, one is primed to interact with the environment in a particular style. Thus, through the intervening variable of "state" we can see how self-image can influence behavior.

PART TWO
TOWARD A MODEL OF PSYCHOTHERAPY
PROCESS AND CHANGE

With this more general theoretical context as a backdrop, we can become more specific. The focus is now an identifying exactly how the therapeutic interaction influences the patient's self-concept. The discussion begins by describing three different ways of understanding the process of therapeutic influence. We should stress here that while this division imposes a certain amount of order on the phenomenon, it also conveys a false sense of compartmentalization. Therapeutic influence involves a seamless blend of these three, and probably other, processes.

It should be noted that a great deal more space is devoted to pursuing the implications of the third channel of influence. There are some important reasons for this. One of the initial goals of this project was to articulate a model of therapy process and the nature of change from an interactional perspective. The emphasis on the third channel of influence--which stresses the importance of the therapeutic interaction--reflects that bias. However, in the course of developing my ideas around the question of how psychotherapy changes patients' self-images it became clear that there were other ways to look at this process. My discussion of the first two channels of influence is a modest attempt to acknowledge this fact.

C H A P T E R V
THREE CHANNELS OF THERAPEUTIC INFLUENCE

Channel #1 - Direct Intervention

This first channel acknowledges the importance of a therapist's direct attempt to influence a patient's self-image. By verbally sharing an understanding of the patient's behavior, thoughts, feelings, current situation, and history, a therapist can offer new ways for a patient to view self. In using this channel of influence, a therapist is, in effect, asking a patient to look at things his or her own way. For example, instead of understanding a patient's failed relationship as an incapacity for intimacy, a therapist might reframe it as a necessary but painful step towards self-differentiation and maturation. Or, perhaps, instead of seeing a patient's missed session as being an indication of irresponsibility it might be instead seen as the patient's desire to protect the therapist from what is believed to be destructive anger.

In insight oriented therapy such interventions would be called "interpretations," while in the vocabulary of the family therapists, they might be labelled

"reframes". In fact, a number of schools of psychotherapy, including psychoanalysis and psychoanalytically-oriented psychotherapy, certain family and strategic therapies, and the cognitive therapies use this as their primary therapeutic tool. In effect, all of these approaches revolve around explicit efforts to influence the patient's manner of seeing the world by verbally offering new meanings. What distinguishes this channel of influence from the two which are to follow is that these meanings are communicated in a direct form. This mode of influence can be analyzed by looking at the verbal content of a therapy session.

Again using Hewitt's (1984) three dimensional analysis of the self-concept, we can break down a therapist's interpretations about the patient's self-image into the same categories. Thus, the therapist's comments can be directed, at one level, at defining the patient's role or identity. For example, the comments: "You always seem to be the caretaker," "It's hard to handle all of the pressures of an independent, young adult" are instances where the patient's self is being defined in terms of social location. Therapists comments rarely stop at this point. They usually are also directed at identifying certain qualities or traits in the individual: "There is a part of you that would really like to be taken care of" or

"It is difficult for you to assert the power you have." As these two examples suggest, the message about the qualities of the person are often only implied by the statement. While there are many instances where a therapist will directly describe a quality in the patient, the usual approach is less direct. Finally, a therapist's interpretation may also convey an evaluative or emotional dimension as well: "You talk as though you're sensitivity is a liability, I don't see it that way" or "I am impressed with how well you are making it through this difficult period." According to most models of clinical technique, therapists are discouraged to share emotional reactions or to offer value judgements. Therefore, this type of direct message about the patient's self-concept is probably the least common of the three. However, when it comes to the therapist's indirect analogic, communication about the patient (i.e. channel #2) the emotional and evaluative dimension is probably the most prominent.

Once again, the intention here is not to explore this avenue of therapeutic influence in any great depth. This channel--that is, direct efforts to change the patient's view of self--has gotten more than its fair share of attention in the thinking of clinical theorists. In fact, it is probably at the core of most clinical theories where meaning and insight play a role. The point

here is to briefly acknowledge the usefulness of this more traditional perspective while keeping our focus primarily on a more interactional perspective. But the important message should be that the data out of which a patient can refashion an image of self can come in many different forms.

Channel #2 - Analogic Self Messages

This second channel of therapeutic influence stresses the importance of the therapist's interactional posture in shaping the patient's sense of self. The concern here is on the analogic communication of the therapist--communication made up of messages that are embedded, often unconsciously, in the interactional stance of the therapist. The key to understanding this view of clinical influence is the symbolic interactionist notion that people arrive at a sense of who they are based on the responses of those around them. More precisely, individuals develop an image of themselves based on their inference of how others see them.

Both channels #1 and #2 stress the importance of the therapist's working image of the patient in influencing the patient's self-concept. However, in the first, this working image is conveyed directly in the form of therapeutic understanding and/or reframing. In the

second, this process is much less direct, involving messages that are only implied by the interactional behavior of the therapist.

Robert Langs (1982), from a psychoanalytic perspective, alludes to this distinction when he identifies two separate avenues of cure in the therapeutic process. His first avenue of cure which involves "the achievement of affectively meaningful, valid cognitive insights" (p. 128) roughly correspond to our first channel of influence. The second avenue of cure which he describes as "one that is object relational and interactional involving unconscious identificatory processes" (p. 128) mirrors, in many important ways, this second model of influence.

In discussing this second model of influence, both Langs and myself stress the power of the analogic communication embedded in the therapist's interactional stance. In addition, we both emphasize that much of this communication is done outside of the therapist's conscious intentions and control. Langs' use of the term "identificatory process," however, refers to much more than what is being described here. Langs' term refers to all of the different ways that a patient's internal world is modified by one's effort to be like (i.e., to "identify with") an external object. The emphasis here, in con-

trast, is on a specific aspect of Lang's broader conception of the identification process. We are concerned with the patient's incorporation of the therapist working image of the patient.

Perhaps the following outline of the basic units of the therapeutic exchange helps to clarify this process:

- 1) The objective behavior of the therapist
- 2) Based on this behavior (and a host of other contextual and cognitive factors), the patient develops a sense of the therapist's interactional posture.
- 3) Based on the perceived interactional stance of the therapist, the patient infers how the therapist views the patient.
- 4) The patient's sense of how the therapist views the patients can, under certain conditions, bring about meaningful changes in the patient's view of self.

The remainder of our discussion of channel #2 revolves around the following question: How can we best understand the process by which a patient makes inferences about how the therapist "sees" the patient? In terms of the above outline, our concern will be on clarifying how step #3 comes about. The issue of change, step #4 in the outline, will not be considered in this section but will be considered in greater detail in a later chapter.

The key to answering the above question is to more precisely develop an understanding of the notion "the perceived interactional posture of the therapist." This term

refers to how the patient perceives the therapist to be positioning him or herself in the therapeutic relationship. This perception of the therapist's interactional stance is rarely a single well defined cognitive entity, but is more likely to be experienced as a multifaceted flow of conscious and unconscious impressions. In the following passage, I describe how a patient might go about making sense of a therapist's interactional stance. This example is based on an actual case that I saw several years ago. This description is what I believed to be this patient's view of my interactional stance midway through the fifth session of a ten session brief therapy. It corresponds to a section of the session in which the patient has been relatively active and I have been primarily silent.

The patient sees the therapist as a supportive audience to his attempt to make sense of his problems. He interprets the therapist's silence as an invitation, and perhaps even a mild demand, to take on the role of the "good" patient--working hard to share his problematic feelings and to figure out a way to overcome them. He also sees the therapist as a potential source of wisdom who, if given enough data, may be able to offer a way to solve his problems. In a related manner, the therapist is seen as a potential source of comfort who, if shown enough pain, will offer a soothing palliative to the patient's difficulties.

Such an image of the therapist--as a potential but relatively inactive source of wisdom and comfort may provoke several other, deeper images of the therapist; a withholding, and uncaring caretaker, or, alternatively, an inade-

quate or disabled caretaker. In either case, the task of the patient is to bring out the positive but currently unavailable qualities in the therapist. Finally, the patient also views the therapist as a demanding critic, harshly evaluating his performance as a therapy patient. The regular stumbles in his speech are indicative of his effort to edit and polish his presentation.

It is clear from this above description that a patient's sense of the therapist's interactional stance is likely to be a complex constellation of intertwining and shifting mental images. Moreover, any effort to characterize this collection of impressions must necessarily utilize a great deal of inference. This leads to a certain amount of unavoidable indeterminacy when it comes to defining the patient's sense of the therapist's interactional stance. It should also be stressed that these impressions are based on patterns of experience rather than on the discreet elements that make up those patterns. Thus, it may be impossible to link any of these impressions of the therapist directly to any one piece of interactional data. As slippery as this notion is, however, it is indispensable in understanding this avenue of therapeutic influence. For it is out of this sense of the therapist that powerful messages about the patient's self emerge.

What emerges from this composite picture of the therapist's interactional stance is the therapist's

"working image" of the patient. This corresponds to step #3 in the above outline. Another way of putting this step is that patients infer how they are seen by their therapists based on how they see their therapists acting toward them. For example, consider the therapist who is seen as taking an attentive, respectful, but non-intrusive stance to a patient's attempt to struggle with an issue. One set of meanings that might accompany this interactional stance is that the therapist is seen as having an image of the patient of being well equipped to independently cope. This may set the stage for some meaningful shifts in how the patient views him or her self.

Channel #3 - The Therapeutic Relationship

Our third and final approach toward understanding the nature of therapeutic influence is based on the notion that people construct images of themselves by turning themselves into what the symbolic interactionists have termed an "object". In other words, individuals are continuously stepping outside of their actions in order to gain some sense of who they are. Applying this idea to the clinical situation, we might say that an important aspect of the transformation process in psychotherapy involves providing an experience--the therapeutic relationship--that challenges the patient's self concept.

In the course of interacting with the therapist, the patient finds himself acting in ways which disconfirm old notions of self. It follows, then, that the crucial therapeutic tactic, is for the therapist to take on a posture that forces the patient to adopt an atypical pattern of interaction. It is only after being pushed into a new way of relating that the patient has the experiential basis for seeing him or herself in a new way.

For example, consider the male patient who carries around an image of himself as dependent and incompetent. Out of this self-concept comes a pattern of behavior which invites others to offer confirmatory responses. Thus, this patient is likely to be caught in a social matrix where he typically relinquishes control and lets others take care of him. However, if this patient were to be engaged in a relationship where such an interactional style was not met with a complementary response (i.e., the patient is not automatically taken care of), the patient might be forced to shift his style of social engagement and exert more initiative. If this shift in relational style is appropriately encouraged, the patient may begin to experience himself as being more competent and self-directed. This new kind of interactional experience can be the basis for revising old assumptions about who he is and what he is capable of doing.

If people arrive at images of themselves based on the nature of their interpersonal relationships, an obvious preliminary question to ask is how do these relationships take on their particular nature in the first place. In other words, if we want to understand how relationships foster change we have to step back a bit and first understand the process by which a relationship takes on a particular direction and pattern. Developing a framework for understanding the pragmatics of the therapeutic interaction, i.e., how the therapeutic interaction takes on its particular shape, will be the focus of the following chapter.

C H A P T E R V I

THE PRAGMATICS OF THE THERAPEUTIC INTERACTION

The Interactional-Cognitive Stance

This approach to understanding the pragmatics of the clinical relationship has a cognitive emphasis. In other words, patient and therapist interactional behavior can best be seen as being guided by mental events. The real challenge at this point is to develop some conceptual tools that will enable us to characterize these mental events, and, in turn, trace the "logic" of how an interaction unfolds. The key to this effort involves what I have termed the "interactional-cognitive stance". The assumption behind this core notion is that every piece of interactional behavior can ultimately be explained as emerging from a set of cognitions. How an individual engages in a relationship is determined by the make-up of this interactional-cognitive stance.

The image that best captures this notion is that of an ever-changing three-dimensional jig-saw puzzle of interlocking information processing clusters that are constantly interacting with each other and with the environment. This communication is done via input

routines with perceptual and interpretive functions and output routines whose functions are to generate plans of action. Thus, the therapeutic relationship can be viewed in terms of how the therapist's and patient's respective interactional-cognitive stances come to generate particular behaviors and how these interactional-cognitive stances are, in turn, continuously shaped by each participant's experience of the unfolding interaction. The following diagram (Figure I) might be helpful in illustrating the back and forth nature of this process.

Thus, the therapeutic interaction can be viewed as the back and forth exchange of interactional behaviors that constantly shape the interactional-cognitive stance of each participant. Each new stance is, in turn, the basis for another exchange. This diagram fails, however, to refine our understanding of what exactly are these interactional-cognitive stances. What follows is an extensive examination of this all-important concept. The discussion is broken into seven sections, each one describing in detail a different component of the overall interactional-cognitive stance.

A word of caution is in order. There is a danger in discussing the notion of the "interactional-cognitive stance" in terms of organized and discrete components. The problem is that this constellation of cognitions does

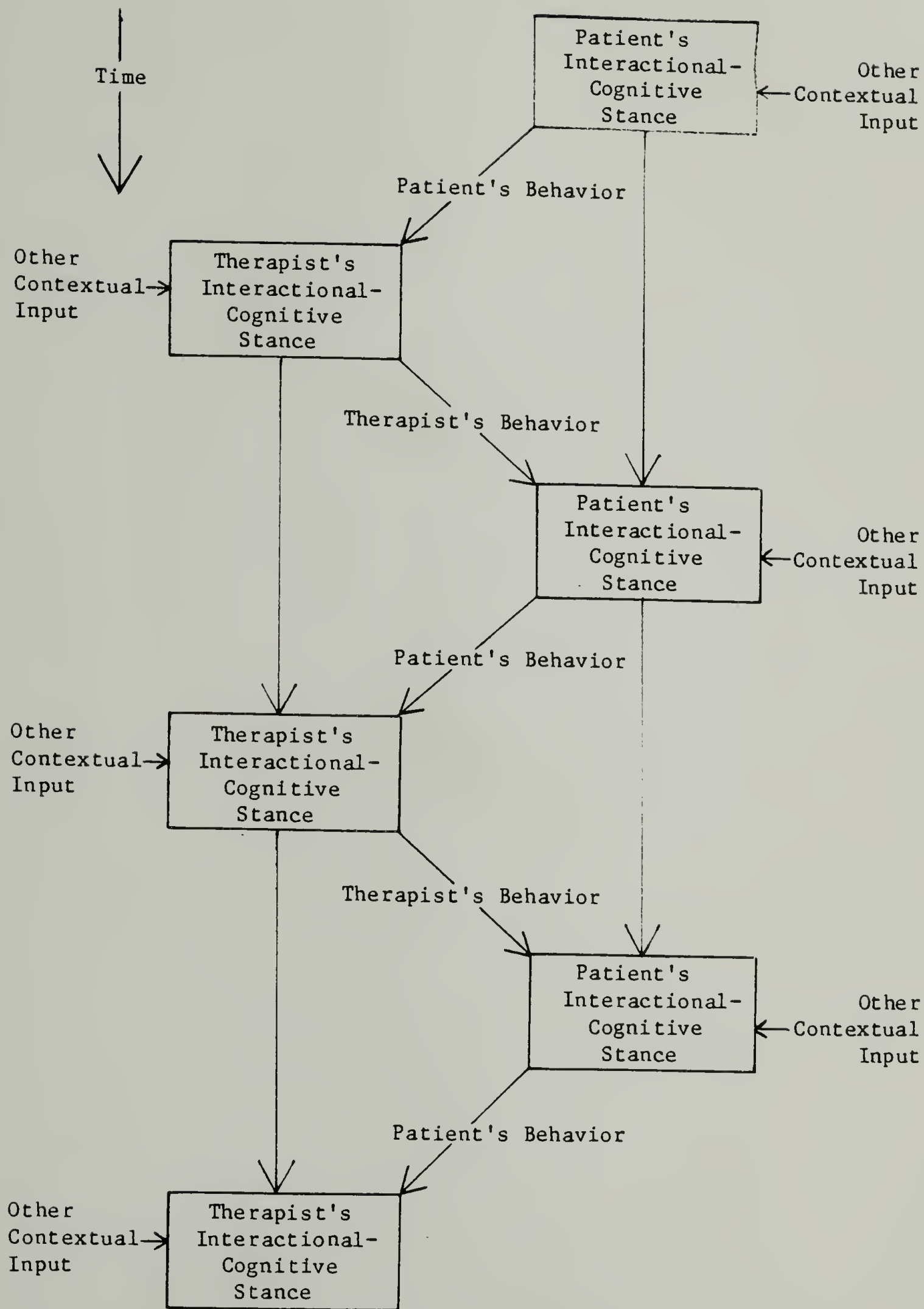


Figure 1. Model of therapeutic interaction.

not lend itself to tight compartmentalization. The term interactional-cognitive stance is used to designate an ever-changing net of meanings which actually depend on their complex intermingling in order to maintain their functional integrity and do not exist as separate entities. Therefore, the following attempt to identify and analyze the various components to this interactional-cognitive stance is admittedly artificial and is presented primarily for the sake of keeping the discussion manageable. We must remember that the organization of our discussion is not meant to mirror the way the interactional-cognitive stance exists out there.

1) Working Image of the Other

The phrase "working image of the other" refers to the collection of mental representations of the other that guide interactional behavior. How one chooses to respond to an individual is influenced, to a great extent, by how we see, both consciously and unconsciously, that individual. There are a variety of different ways in which a person "sees" an interactional partner.

In the most straightforward sense, these mental images correspond to the perceived qualities and attributes that go into one's general enduring sense of the other. If asked to describe a person, this is a set of

cognitions that one would rely upon. It is important to note that the way one goes about constructing this image of the other is loaded with bias. People invariably see those around them in terms of existing cognitive schemata. In psychoanalytic psychotherapy this process of distortion has been labelled transference or countertransference, depending on who is doing the distorting.

People also view their interactional partners in terms of transitory states (see Chapter IV for a previous discussion of this concept). For example, in addition to seeing a patient in terms of enduring qualities (i.e., obsessive, borderline, high-achiever, etc.), a therapist can also see the patient in terms of the temporary style in which he or she is processing and engaging the world (i.e., anxious, angry, pre-occupied, defensive, etc.).

People also assess others in terms of their interactional stance. By interactional stance we are referring to how an individual has positioned him or herself in the relationship. Knowing another's stance allows one to predict that person's future emotional and behavioral responses. These predictions can serve as one's guide in the relationship.

Closely related to this cluster of mental representations is an individual's sense of the interpersonal pressure of the other. What is being highlighted here is

how people are continuously interpreting the behavior of others in terms of what is being asked of them. For example, a therapist may experience a patient's repeated phrase, "Do you know what I mean?" as a demand for (among many other possibilities) undifferentiated fusion. Out of the many impressions that go into making up one's working image of the other, this kind, in particular, calls out for a particular behavioral response.

Another important feature of this composite image (which, unfortunately, is unavoidably awkward to put into sentence form) involves an individual's sense of how the other person sees him or herself. This is the inference of how one is seen through the eyes of another. In certain situations, this can be the most important piece of information about how one should act. If a person has a strong need to confirm another person's view of who he or she is, then this individual is obligated to conform to the expectations that accompany such an image. For example, if a patient senses the therapist sees him as a sensitive and caring person he will have to behave in certain ways in therapy if he wishes to conform to the perceived expectations of the therapist.

Individuals also evaluate others in terms of their potential interpersonal resources. People are always gauging, both correctly and incorrectly, what the other

person has available to offer. In psychotherapy, patients see their therapists as providers of a variety of resources including emotional support, advice, insight, and a number of other, more idiosyncratic things (like forgiveness, admiration, punishment). What the therapist is perceived as "having," will partly determine the approach that a patient will take towards the therapist.

People appraise their interactional partners in terms of relative status. This can be determined along a variety of dimensions, including age, education, economic status, sex, ethnicity, and physical attributes. This is especially important in terms of one's sense of who has the power and control in a relationship. As will be discussed in the next chapter, therapeutic leverage is often directly related to the patient's attribution of power to the therapist.

An important aspect of developing a sense of another is by getting an idea of how they are reacting to one's behavior. Toward this end, people are constantly monitoring their interactional partners ongoing reactions in order to decide where one wishes to go in the interaction. In a sense, an individual's "working image of the other" is changing from moment to moment as a result of this feedback. In psychotherapy, patients are invariably cued by therapists as to whether they should pursue their

current track. For example, the reason a patient talks at such length about, let's say, his mother, may be more a function of the reinforcing responses (including attentive nods to continue) of the therapist than of any deep need on the part of the patient.

2) Working Image of Self

Another group of cognitions that figure prominently in how a person responds to another are those that are related to the person's view of self. Out of the loosely knit network of self-images emerges a sense of what one can, should, and wishes to do. In the previous section, the emphasis was on how the view of the other shapes behavior. In this section, the focus is on how the view (or more precisely, views) of self guide one's behavior.

At the center of this constellation of self-thoughts and self-feelings is, of course, one's working image of self. The term which perhaps best captures this cluster of cognitions is "identity." This is the sense of who one is, in terms of descriptive qualities, (handsome, witty, stupid, likable, etc.), in terms of acknowledged capabilities (e.g. I'm a good caretaker, I am a poor public speaker, I am a good athlete, etc.), and in terms of how one evaluates one's qualities (e.g. I dislike being

overweight, I like my ability to work hard) or how one evaluates one's self as a whole (e.g. I am basically an incompetent person, I am a worthwhile person).

For example, the extremely depressed patient who finds it difficult to talk about him or her self in therapy, may be operating from a global, and irrationally exaggerated, negative evaluation of self. Such an image of self would make the patient feel painfully ashamed to share any bit of him or her self. While it is possible that a single rigidly constructed working image of self may dominate one's interactional-cognitive stance regardless of the situation, it is much more common (and probably healthier) that a variety of working images are potentially available to a person, depending on the stimulus properties of his or her current situation.

Thus, the emergence of any particular working image of self is in most cases, a transitory situationally-dependent phenomenon. However, it should be stressed that for any individual certain images of self tend to come to the fore with more regularity. These are the self-images that one is most likely to use in describing his or her identity.

A very important component of one's working image of self has to do with the person's appraisal of his or her interactional needs. A person looks at his or her

self and determines what still requires some attention. What we are suggesting here is that things like drives, needs, motivation, and all the rest of those things that allegedly "push" an individual to engage in certain kinds of interactions are really mediated by these cognitive self-appraisals. If we return to our original notion of how the working image of self is generated this picture becomes clearer. People are continuously monitoring themselves in order to establish some sense of who they are and how they are doing. This monitoring process keeps track of the totality of the person's experience, including one's perceptions, thoughts, feeling, states, and physical condition. A person's needs, interactional and otherwise, are included in this process. This results in a continuously updated image of self that includes, among many other things, a cognitive appraisal of one's interactional needs. This cluster of cognitions about oneself is extremely important in shaping one's subsequent interactional behavior.

Another way of thinking about how people construct images of themselves involves the notion of role taking. Roles are well defined situational identities that not only provide a way to label and view oneself, but, more importantly, offer a person an established code of conduct. By accepting a role, a person has implicitly

contracted to follow a set of guidelines about how one should be in the world. Role-taking is essentially a way of defining oneself in terms of a behavioral niche that has been sanctioned and defined by the larger social context. One has, in a sense, turned to the outside social environment--the culture--for help in defining who one is. This is in contrast to the mechanism of self-definition just previously discussed which involved a much more personalized and idiosyncratic avenue for generating a self-concept based on one's own observation and appraisals of self.

In the case of well defined and highly institutionalized roles, the guidelines are explicit, detailed, and can cover almost every conceivable situation. In the case of a less defined role, like the role of a psychotherapy patient, there is much more room for ambiguity and confusion. Thus, roles differ widely in their ability to provide specific behavior guidance across a number of interactional situations.

In psychotherapy, a very powerful but underacknowledged explanation for both patient and therapist behavior involves this phenomenon of role taking. Patient and therapist act the way they do based on their image of what they believe to be the behavioral "requirements" of their respective roles.

In spite of adopting the same role, two people may choose to act quite differently because they each have a different interpretation of how the role should be enacted. Again, these differences are likely to be much greater for roles which are less precisely defined by the larger social environment. Patients and therapists can easily come to the clinical situation with widely diverging views of what their respective roles should be. This partially explains why psychotherapy relationships can vary so greatly.

A person's view of self, and the behavior that arises out of that view, is also influenced by the appraisal of one's place in his or her relational context. People define themselves in terms of their relationships. What distinguishes this kind of role-taking from the more general kind of role-taking just discussed is that the emphasis here is not on defining oneself in terms of a socially-created niche but in terms of how one is fitting together with another person. Establishing a sense of where one stands in a relationship determines, to a great extent, how one chooses to interact with that individual. Thus, a patient responds to a highly esteemed therapist with a great deal of deference because of the patient's sense of who he or she is in relation to the therapist.

A persons' situational identity is not always

clearcut and can be influenced by the nuances of the immediate interactional context. The patient who sees himself as an unwanted load on a seemingly uninterested and over-burdened therapist may abruptly change that view if the therapist begins to respond in a way that suggests real interest and concern. It follows, then, that a person's sense of self-in-the-relationship is far from fixed and can, in fact, be quite volatile.

How easily the image of one's self-in-the-relationship can be dislodged is partially a function of the relationship's history. If the pattern of the interaction has been relatively stable over a period of time it is much more likely (for better or worse) that the accompanying view of the self-in-the-relationship will also be firmly entrenched. This explains how ongoing stable relationships, including those in therapy, are so resistant to change. Even if one participant decides to start responding differently, these images of self are likely to remain fixed and, as a consequence, the behavior that they generate will persist in spite of a shift in the immediate interactional context.

A very important type of self cognition has nothing to do with how a person actually sees him or herself. These images of self, instead, correspond to what the person would ideally like to be. Together they

comprise what might be called the person's "ideal self". This constellation of self-images is extremely important in shaping a person's behavior, especially in a context like therapy, where the goal for many is self-improvement (i.e., the moving toward this ideal self).

Much of the patient's dissatisfaction and motivation in therapy can be understood in terms of the tension between the current appraisal of his or her "real" self and his or her ideal self. A patient's behavior both in and out of therapy, becomes much more understandable when we consider it as an attempt (often misguided, unfortunately) to close the gap between these two images of self. For example, the depressed patient who obsesses over his inability to be "happy" may be laboring under the impression that, ideally, one should be happy. His behavior in therapy reflects the striving for this self-ideal.

The question of how this "ideal self" is generated or modified is an extremely complex one which cannot be comprehensively addressed here. However, one important point should be made in this regard. Images of an "ideal self" are not immutably fixed and are, under certain circumstances, amenable to change. Perhaps the most important junctures in an individual's development involves modification in the image of this ideal self. Significant relationships with influential and respected others are

very likely to be central in altering these important inner ideals. The experience of psychotherapy is potentially one such experience. Thus, a patient's ideal self not only guides his or her interaction in therapy but, in some case, is modified by the experience of the therapy as well.

Not only is a person's behavior guided by an "ideal self" but it is also propelled by what I have termed the "to-be-shared-self". The "to-be-shared-self" is essentially the picture that a person wishes to convey (i.e., share) about him or her self. It corresponds to those aspects of one's self-image that one hopes to reveal. Much of human interactional behavior can be understood in these terms. People engage in behaviors that, among many other things, selectively project certain aspects of themselves. This is certainly true in psychotherapy. The way in which a patient talks about him or herself invariably carries a crucial message (communicated in varying degrees of explicitness) about what exactly the patient wants to be known and understood about himself. This inner image of the "to-be-shared-self" is what directs, at least on one level, the patient's communication.

This "to-be-shared-self" may or may not have anything to do with the person's sense of his or her real

self. In a defensive posture, an individual is most likely to attempt to convey an image of self that is false. However, in an emotionally safe situation, one may try to convey what he or she feels to be his real self. Thus, the task of understanding interactional behavior using the concept of the "to-be-shared-self" is doubly complicated. Not only must one ascertain the nature of the self images that are trying to be conveyed but one must also ascertain whether these images are real (i.e. non-defensively motivated) or not.

Simply identifying the to-be-shared-self that lies behind any piece of interaction behavior is not enough for a complete understanding of that behavior. A full explanation requires that we understand why such an image of self was chosen to be conveyed in the first place. In other words, conveying a particular image of self is only a means to a more basic interactional end. A truly complete analysis would include an attempt to identify this underlying motivation.

3) Image of the Relationship

In the course of interacting with others, people continuously develop inner maps of their relationships. These inner representations play a central role in shaping the interactional-cognitive stance out of which behavior

emerges. The task here is to tease apart what goes into these images. What emerges is how complex the seemingly simple notion of "image of the relationship" can turn out to be.

At the most obvious level, individuals are guided by their sense of the relationship's social identity. Once a person identifies him or herself as being engaged in a certain kind of relationship (e.g. "a business transaction," "singles bar conversation," "family re-union talk," or "psychotherapy") one must follow a set of behavioral parameters if one wishes to stay appropriate. Simply knowing the label that someone attaches to a particular interaction is only a starting point. We must also ascertain the kinds of behavioral expectations and constraints that such a person attaches to such a label.

This notion is actually very close to our previously discussed idea of role-taking. The difference is that what is being defined in this case is the identity and proper functioning of a two person interactional system. Of course, what emerges from this relational identity is that each individual is given a role through which he or she can help maintain the integrity of the entire system.

Not only do people identify their relationship in terms provided by the larger social context (e.g. "dating

behavior," "bus-stop interaction," "teacher-pupil relationship," etc.) but they also view their relationships in much more individualized ways. What we are referring to here is an individual's more personalized sense of a relationship. This involves the complex, and often highly idiosyncratic, mixture of images that come to represent one's view of a relationship. Two examples of how one might sense a relationship include:

- 1) "Our relationship was playfully competitive and was supported by a large amount of mutual respect" or,
- 2) "Our relationship was superficially cordial, although there has been very little effort to develop a genuine rapport."

Out of the "sense of the relationship" emerges a set of expectations, usually unstated, about how one should conduct oneself in the relationship. The reason why relationships have continuity and what might be called inertia is partly because people interact according to these rather stable images. Thus, the patient who views his relationship with a therapist as one where he can openly share his thoughts and feelings, is very likely to structure his behavior around this working image of the relationship.

Closely attached to this individualized image of the relationship is the person's evaluation of the rela-

tionship. People are continuously passing judgements and reacting emotionally to the kinds of relationships they develop. Put another way, people react to their views of an interaction along a positive-negative continuum; a person likes or dislikes, to varying degrees, the nature of the relationship.

This evaluative dimension plays a very important role in shaping a person's overall stance in a relationship. At the most straightforward level (which is certainly not always the case), a person is more likely to engage in behaviors which attempt to maintain the present course of a relationship if the relationship is viewed in positive terms. More commonly, however, the link between these evaluative responses and a course of behavior is less direct and mediated by a host of complicating factors. For example, a common occurrence in therapy is a great deal of ambivalence about the dependence that is built into the therapeutic situation. On one level, the support feels good and is gratifying but on another level, the thought of seeing oneself in such a dependent relationship can evoke images of immaturity, weakness, and even dangerous vulnerability. It is only in response to a complex (and perhaps painful) mingling of these divergent evaluations that one decides on a course of action.

Just as one has an ideal self, one also has images

of the ideal relationship. People have implicit images of what form the various relationships of their life should take. These images form the backdrop of not only how one goes about evaluating one's relationships but also play an important role in guiding one's interactional behavior. A father relates to his daughter, in part, based on an image of what he feels to be an ideal father-daughter relationship. The tension one feels when a relationship does not feel right is partially the result of the discrepancy of one's view of the actual relationship and the image of what one ideally wishes the relationship to be like. Because such images usually go unarticulated and unexamined, their influence can be deceptively powerful.

An extremely important feature of one's interaction cognitive stance involves the assessment of the immediate interactional context. This is the constantly shifting sense that one has of an interaction. This image of the interactional context can be influenced by something as prominent as an impending separation or as minute as subtle shift in one interactant's facial features. Our understanding of interactional behavior tends to overlook context at this level. Interaction is largely explained in terms of the enduring images or, when context is considered, only at the most macroscopic levels. What is often overlooked is how every moment of

an interaction can provide a powerful new context for directing each interactant's behavior.

Part of the reason why this component of an individual interactional stance is so often overlooked is that we tend not to think, and remember, our relationships in such microscopic terms. Our sense of the immediate interactive context is happening so quickly that we depend on it almost reflexively and rarely keep track of it on a conscious level. It would probably get in our way if we were to become overly self-conscious about it. However, if we were to freeze an interaction for a closer inspection, we would find that the direction of the interaction is powerfully shaped by the immediate context, a context whose features are usually immediately forgotten or ignored in our retrospective efforts to make sense of the interaction.

This sense of the status of the relationship is related but distinct from the feedback that one is constantly getting from the other participant in the interaction. The emphasis here is on the immediate relational context, not on the ongoing sense of the other. For example, patients often behave quite differently after a session is formally "over" and are being escorted out of the office. In this case, the patient's sense in a shift in the interactional context (i.e., "the session is over")

is largely responsible for the shift in behavior. A much more subtle shift may be the result of a slight shift in posture of many therapists who regularly become more active in the latter part of their sessions. This shift in posture is interpreted by the patient that the session has reached the stage where the therapist is going to start "giving" and the patient should shift his stance accordingly. The patient's image of the interactional context has changed.

4) Internal Schemata

In discussing the various images that go into shaping a person's interactional-cognitive stance we have periodically alluded to the fact that these images are influenced, to a great extent, by pre-existing cognitive templates. The power of these pre-existing schemata to shape images is so important that this topic deserves a separate discussion.

Our working images of Self, of Other, and of the Relationship are not generated out of thin air, based only upon the incoming raw data of one's experience. These images can instead be seen as being the product of both incoming data and pre-existing latent images that are activated by certain features of a person's experience. Thus, a patient's working image of his or her therapist at

any point in time may be shaped, to varying degrees, by internal schemata. These internal schemata are a function of the patient's personal history and may or may not prevent the patient from accurately seeing the "real" therapist. The act of seeing a therapist in terms of pre-existing images is classically known as transference. Clinically, this is an extremely useful concept, for it gives us a handle on understanding how a patient goes about distorting his or her world. What this means in terms of characterizing a person's interactional-cognitive stance is that it alerts us to another important source, other than the data of one's experience, from which images of Self, Other, and the Relationship are created.

For example, immediately following the announcement that he was going to be seen once, instead of twice, a week, a patient describes his therapist as being out of touch with how bad his difficulties currently are and as incorrectly seeing him as improving. In this case, it appeared that such a move on the part of the therapist activated a latent, but powerful, internal image of an insensitive caretaker who tends to "wean too early", that is, withdraws support on the incorrect assumption that the patient can handle things on his own. This image was, indeed, consistent with the patient's early history as an independent young child who impressed everyone with his

apparent self-sufficiency. The point here is that an internal image was activated in this patient that served to dominate how the patient was to subsequently "see" the therapist.

5) Cognitive Style

A very different approach toward characterizing an individual's interactional-cognitive stance involves looking at the person's rules for processing information. This approach looks at a person's cognitive stance in terms of its software--the redundant patterns in which information is gathered, stored, and ultimately transformed into interactional meanings. Other terms which capture some of what is being discussed here include "heuristics", "interpretive rules", and "cognitive style".

The emphasis here is on characterizing process rather than content; i.e., looking at how information is being used rather than on identifying the content of this information. Thus, describing a paranoid person's interactional-cognitive stance only in terms of a long list of threatening images misses a critical point. This person's stance toward the world should also be characterized in terms of a cognitive style--a style whose effect is to produce such consistent images.

The line between process and informational content

is far from clear cut. For example, a patient whose image of self has recently shifted from that of being inferior and incompetent to one of competence may also shift in his style of engaging the world; possibly shifting from a rather tight obsessiveness to a more expansive looseness. In this case, a shift in a specific cluster of cognitions about himself brought about a change in the style in which he processed and responded to the world.

6) Plan of Action

The "components" of the interactional-cognitive set that we have discussed thus far are concerned primarily with images of a person's self and the social world. The emphasis has been primarily on identifying the types of mental pictures that shape one's interactional stance. However, the process by which these images actually shape behavior has only been indirectly alluded to. The focus of this discussion--"plans of action"--attempts to look more closely at those cognitions which more directly guide one's behavior.

A plan of action might be defined as those cognitions which organize and direct a person's behavior. In stressing this notion, we are underlining the point of view that people play an active, intentional, role in

their relationships. That is, people are more than just passive responders to their external environment. They are directed by internally generated ideas (i.e. "plans of action") about how they want to behave. Thus, relationships, including the psychotherapy relationship, can best be seen as a dance, of sorts, with each participant moving to their own set of relational intentionalities.

Again, it should be stressed that such "plans of action" do not exist as isolated mental entities but instead are intermingled with the other aspects of one's interactional-cognitive stance. A "plan of action" is that part of this constellation of meanings that is, in a sense, most proximal to a person's actual behavior. It answers the question, "So what should I do now?". For example, a patient's persistent efforts to get advice from a therapist is a direct outgrowth of certain images that are held about oneself, the therapist, and the relationship (Possibly this patient views psychotherapy in terms of a doctor-relationship; alternatively, the patient may have an unrealistic image of the therapist as all-knowing and omnipotent). Out of these images emerges a plan of action.

While understanding psychotherapy in terms of the motivational context can be a powerful way of looking at the clinical exchange it also poses some difficulties. In

the first place, there is rarely only one "plan of action" behind any piece of interaction. Anyone who has sat through a case conference where every participant seems to hold a different, but equally plausible, understanding of a patient's behavior, can readily testify to this. This suggests that interactional behavior can best be seen as the result of a number of converging internal plans. This, unfortunately, can make the task of identifying a person's internal motivational stance extremely complex and laced with a great deal of indeterminacy.

For example, a female patient describing a troubling incident that she has recently had with her mother might be understood in terms of a number of "plans of action". Most immediately, she may simply be trying to offer a coherent and meaningful account of the incident. Her plan of action, at this level, might be "Describe the incident". Somewhat less immediately, she may be trying to convey a sense of how painful her relationship with her mother can be. Her operating plan might be, "Try to get the therapist to understand how difficult my mother is."

At a much broader level, her narrative might be part of a larger effort to gain the emotional support of those around her. In her own words, her plan might be "By conveying a sense of how inadequately my mother cares for me, I am trying to gain the emotional support of those

around me, including the therapist." At a still broader level, the story might be part of the patient's general effort to arrive at a comfortable pleasure/pain balance. In this case, the patient's goal might be: "Try to increase the likelihood that I will experience as favorable as possible pleasure/pain balance."

In this example, the various plans that can be attached to this one piece of behavior can be differentiated along a continuum of generality, ranging from the broadest life-plans (e.g., "to arrive at a favorable pleasure/pain balance") to much more narrowly focused and immediate sub-plans (e.g., "to describe the incident with mother"). Since every piece of behavior can be potentially viewed at any place along this continuum, the task of identifying plans of action can be quite unwieldy, unless one imposes some kind of guidelines as to what level of generality will be used to infer these plans. In psychotherapy, we usually restrict ourselves to considering patient plans that are clinically relevant, and to consider therapist plans in terms of therapeutic strategy. It should be recognized, however, that the parameters used to determine which plans are important are somewhat arbitrary. Important breakthroughs in clinical theory often call into question these boundaries and force us to look in another direction for these plans.

The difficulty of understanding interactional behavior in terms of a "plan of action" is not only because plans can exist at different levels of generality. Even within a certain level of generality, different (and even contradictory) plans can be inferred. For example, a patient who comes to therapy in a very productive and cooperative state, exclaiming that the previous session (in which he had been extremely uncooperative and negative about the therapy) was a turning point for him, may have had a genuine breakthrough and is now trying to move forward in the therapy. Alternatively, his "good" behavior may be in response to the fear that he has hurt the therapist and, as a response, he is out to make amends.

Another complicating feature of "plans of action" is that they are often quite labile. They are being formulated and reformulated from moment to moment in response to shifts in the larger cognitive net in which they are embedded. This larger net of cognitions (i.e., the interactional-cognitive stance) is, in turn, constantly adjusting to the meanings that are emerging from the person's ongoing experience of the interaction. Once again, the image of a three-dimensional flexible jig-saw puzzle of interlocking mental images comes to mind. A shift in any one meaning in this larger puzzle might result in a shift in the entire structure of the cognitive net, with

the result that one's "plans of action" also end up shifting.

The task of inferring a plan of action is further complicated by the fact that most people are not completely aware of (or are unable to precisely articulate) the plans under which they are operating. If we were to abruptly stop a therapy session and ask therapist and patient to describe the respective plans of action, it is very likely that each would be at a loss for words. Plans of action often direct behavior without being accessible in easily retrievable verbal form. Thus, there does not exist some final authority upon which to determine the "real" plan of action. However, through the careful and methodical use of video and audio tape, it does appear that such inference can be arrived at through a fairly structured process of consensual validation.

7) State

Our last approach toward understanding a person's interactional-cognitive stance takes a very different track--a track that may be considered somewhat out-of-step with the approaches so far discussed. We are forced, however, to take the risk of expanding our conceptual framework to include such "messy" terrain because this perspective seems so very important in our common-

sense view of human interaction.

In simplest terms, people's actions toward one another arise out of their mental "state". The concept of "state" was briefly discussed much earlier and it might be useful to repeat its definition. "State" refers to the organized constellation of emotional, perceptive, cognitive, and behavioral tendencies which we commonly label as one's "mood". While a straightforward reading of this definition of "state" can easily keep us within the boundaries of a purely cognitive (mentalistic) framework, if we read between the lines, it also hints at the possibility of viewing behavior in terms that are more than just cognitive. If a person's "organized constellation of emotional, perceptual, cognitive, and behavioral tendencies" are seen as only indicators of something more basic going on with an individual, then we are left with an interesting possibility. Perhaps a person's "state" can best be explained in terms of the status of the person's cognitive hardware. What is being suggested here is that the notion of state demands that we look at people and their interactional behavior in terms of the physical status of their cognitive wiring.

From this perspective, patterns of thinking, feeling, and behaving can be seen as a function of discrete and identifiable physical conditions (i.e.

"states"). At this point in our research technology, however, we cannot characterize these conditions in physical terms. They can only be characterized by their observable psychological endpoints. What this suggests is that the status of an individual's cognitive hardware can result to a predictable constellation of inter-related cognitions.

The physical to cognitive link is by no means one way. A persons' thoughts and mental imagery can also push one into a particular state. Therapists who employ mental imagery to induce relaxation are directly exploiting this connection. To further complicate matters, physical and environmental influences can also influence a person's state. Thus, while the self-observation that one is being socially competent may switch one into a relaxed and confident state, it is also true that alcohol might do the same thing.

This final perspective complicates matters because we are, in essence, suggesting that people are more than just purely cognitive creatures--that we act on more than just thought. The notion of "state" has been used to expand our conception of how behavior is generated so that the physical status of one's mental apparatus is also considered into the equation.

We have just completed a rather exhaustive

discussion of the various ways in which one can go about analyzing the interactional-cognitive stance of an individual. What hopefully stands out above all of the details of this presentation is the centrality of this concept in understanding the pragmatics of the therapeutic relationship. This notion is our primary conceptual tool for understanding how the therapeutic interaction takes on a particular direction and shape. Before leaving this topic, I would like to share some additional refinements to our working notion of the "cognitive-interactional stance".

One interesting view of this notion of the "interactional-cognitive stance" is that it represents the mental "black-box" that transforms input, in the form of sensory data from the world and existing mental images, into output, in the form of a behavioral response. The input end of the box contains the perceptual and interpretive apparatus which are employed in order to apprehend and make sense of the world. Further toward the middle of the box are the mental templates and images which are activated by a particular patterning of environmental stimuli. It is on the basis of these existing schemata that one makes sense (both consciously and unconsciously) of one's current situation. The output end of this box contains those assumptions and mental operations that transform these activated images into "plans of action". The

"plans of action" are response-oriented schemata that guide our behavior.

While this metaphor of a compartmentalized "black box" of mental functioning is an appealing way to begin to order our thoughts on the subject, we should quickly make explicit its limitations. We are essentially trying to construct a cybernetic information processing model of the therapeutic interaction. We have to be careful about the words and metaphors that we use to depict this view of human functioning. Most of our tools of discourse are based on a Newtonian, and not a cybernetic view of the world. Thus, it is easy to begin using language or images that have an overly linear feel to them. We should be turning away from this "billiard-ball" view of causality. Instead we should be trying to model how information interacts and how meanings emerge. To view cognitive phenomena in an overly step-wise manner glosses over the complexity of how mental constructs are processed.

Thus, a more cybernetic view of the "interactional cognitive set" is that of a collection of various bits of information that are combined and arranged into a variety of mental images. The bulk of our discussion has essentially revolved around how one might organize these bits of lower order information into useful clusters of meaning. We highlight three higher order images: Images of

self, Image of the Other; Image of the Relationship. These various thought fragments, as well as composite images, are continuously interacting with each other through the exchange of information (and not energy). Thus, these interactions might be seen in terms of accommodation rather than in terms of causation. One possible area of inquiry that might shed some light on how such accommodation takes place is from information processing theory and artificial intelligence.

Having completed this detailed excursion into the cognitive pragmatics responsible for guiding the course of the patient-therapist interaction, we can conclude this chapter by restating in its most basic form, the essence of Channel of Influence #3: Patients are continuously stepping outside of their experience of the clinical interaction and developing images and evaluations of themselves. These self-impressions can, under certain conditions, meaningfully alter the patient's enduring sense of self. In the following chapter, I more directly address the issue of how such alterations take place.

C H A P T E R V I I
THE PROCESS OF CHANGE

Our Overall Framework

Before we move into the details of the change process it may be useful to step back a bit in order to present a clearer picture of the larger framework in which this discussion is embedded.

When we are talking about the three channels of influence we are essentially talking about three different types (admittedly interconnected) of environmental stimuli which can potentially be the basis for therapeutic influence. Channel #1 stresses the content of the therapist consciously motivated verbal interventions. Channel #2 highlights the analogic communicational behavior out of which the therapists' working image of the patient is inferred. Finally, Channel #3 stresses the nature of the therapist-patient interaction.

The factors which shape these three types of environmental stimuli are complex and multifaceted. This thesis has focused only on the factors responsible for shaping Channel #3, which has just been discussed in great detail under the heading, "The Pragmatics of the

Therapeutic Interaction." Time constraints have, unfortunately, made it impossible to look at those factors behind the first two types of environmental stimuli. Such an analysis would undoubtedly have given us a much wider picture of the clinical process. In particular, it would have forced us to more closely examine the inner processing done by the therapist to arrive at a verbal intervention (Channel #1) or interactional stance (Channel #2).

What these three types of environmental stimuli have in common, in terms of the perspective being developed here, is that they form the objective basis, for the patient's inner experience of the therapeutic situation. However, the link between the objective properties of the therapeutic dialogue and changes in the patient's self-concept is often far from direct. This is especially true for Channels #2 and #3 when the messages from the therapist and the interaction are not explicitly stated. In these instances, the link between environmental stimuli and inner experience is mediated by a complex process of meaning making.

This process of meaning making differs for each individual. Everyone has a personal set of interpretive rules and cognitive templates that are used to make sense of their world. Thus, the way an individual apprehends the clinical situation can be quite idiosyncratic and

unpredictable. This makes the task of characterizing exactly how the therapeutic interaction is influencing the patient's self concept extremely difficult for the outside observer. The clinical process must ultimately be understood by looking through the eyes (both conscious and unconscious) of the patient. For example, consider the patient who is convinced that he is lacking in any basic worth. This patient expects to see his experience, including the therapeutic experience, in ways which confirm this view of himself. In this case, the pre-existing template, "I lack basic worth," is a powerful lens shaping this patient's view of and response to the therapeutic interaction. For this patient, a therapist's stance of concern is seen as pity, while the very act of coming to therapy is seen as an indicator of one's abnormality.

An all-important subset of the meanings which make up a patient's total experience of the clinical situation are those impressions that define the patient's self. It is out of this constant stream of self-impressions that a patient begins to fashion and refashion a core sense of self. In modelling this process, it is important that we not limit ourselves to thinking only in terms of composite self-identities or higher-order self-cognitions. In fact, many of the self-impressions that are apprehended from the therapeutic transaction are quite limited in their focus.

Thus, change in psychotherapy, at this microscopic level, involves the acquisition of small bits and pieces of information about the self. Whether they are based on the therapist's direct verbal interventions (Channel #1), the therapist's interactional posture (Channel #2), or the patterning of the interaction (Channel #3), these communications are likely to revolve around discrete aspects of the person's entire constellation of self-images. As we shall later see, this has important implications about how we might understand the process of change.

Hewitt's (1984) analysis is again useful. It provides us with a framework to classify the various kinds of self-impressions that one might experience during the course of an interaction. Thus, these self-impressions might revolve around one's role or identity; around one's traits or qualities; or around one's self-evaluations. In addition, these messages about the self may be at different levels of generality, ranging from situationally specific self-images to those that are more enduring and inclusive.

Change, according to the model being presented here, involves the acquisition of new ways to look at self. It means operating from a new constellation of self-cognitions. Emerging from the patient's phenomenology of the therapeutic interaction, certain images and

impressions about the patient are able to alter or even dislodge those that had previously directed the patient's way of being in the world. The important question at this point is what are the factors that facilitate this process.

Factors Facilitating Change

One way to approach this question is to consider the nature of the self-impressions which are apprehended during the course of the therapeutic interaction. Obviously, if change is going to happen, these incoming self-impressions must be somehow different than those that already exist in the patient's self-system.

There are a number of implications to this. It is clear that the patient must somehow be exposed to something different. Using our framework, this could involve the therapist communicating a novel way of understanding the patient, it could involve a therapist taking on an atypical posture toward the patient, or it could involve having the therapist engage in a new pattern of relating. There is very little opportunity for change if the patient's environment remains the same. This is perhaps the prime tactical consideration for a therapist using this orientation.

However, just because a patient is exposed to dif-

ferent environmental stimuli does not guarantee that he or she will also develop different, and possible change facilitating, self-impressions. Many patients are so rigid in their way of perceiving and interpreting their experience that they can easily bend a therapist's best efforts to create new meanings back into old and familiar patterns. Thus, a therapist must often go beyond simply creating an atypical interactional context if the patient's self-system is going to change. They also have to alter the patient's ways of making sense of the clinical situation.

To further complicate matters, too much novelty will discourage change. As most therapists quickly learn, introducing too much divergence into the clinical situation is likely to shut the patient off. Thus, it is only when the discrepancy between incoming and existing self-images stay within manageable limits that patients are open to influence.

Revisions of the self-concept are most meaningful when they occur at a level that is both enduring and generalizable. This suggests that meaningful change involve higher order self-cognitions and/or a change in the entire gestalt of the self-system. This can occur in a number of ways. A patient may be exposed to one of those rare clinical situations that powerfully challenges the patient's highest order conceptions of self. In a

somewhat related fashion, a patient may experience a therapy in a way that effectively alters a very small but extremely important "lynchpin" impression of self. By altering this one key element of the self-matrix the patient's entire view of self is drastically altered. For example, consider a recent patient of mine whose avoidant and obsessive qualities were threatening to completely undermine his ability to effectively live. Although he had an intricate and, at times, convincing rationale for his difficulties, it soon became apparent that much of his pattern of dealing with the world was largely to accommodate his discomfort with unstructured social interactions. This discomfort, in turn, arose out of a basic conviction that he was uncontrollably needy and dependent and that, as such, could not be tolerated by another in a relationship. Consequently, this patient's entire existence was devoted to either avoiding relationships or, when he was forced to interact, to be in complete control. His fear was that if his dependency was to leak out, he would quickly be seen as undesirable and a "drain". If this basic assumption about himself were to shift, however, it is reasonable that many other features of his self-system would also change, including all of those cognitions that kept him isolated and pre-occupied about staying in absolute control. Thus, by strategically

altering this one constellation of self-impressions it is possible that through a "domino" effect the patient's entire stance toward the environment might change.

Meaningful change, however, is more likely to be much less dramatic. If most of the self-impressions that get communicated during the therapeutic interaction are generally confined to small, lower-order parts of the patient's self-system, as I have previously suggested, then change involves the progressive accumulation of these rather focussed new meanings about the self. Thus, dramatic personality change would be the result of many small changes that eventually reach a point where a major shift in the entire gestalt (along with revisions in higher-order self-cognitions) is catalyzed.

Somewhat related to this, is the common observation that change occurs well after a session, or even an entire therapy, is over. What might be happening here is that the results of the many small self-concept changes that have occurred in the course of the therapy have stayed below this crucial threshold point and thus, have remained "invisible". However, the cumulative effect of these unexpressed revisions is to make the entire self-structure vulnerable to a drastic shift, given the right configuration of environmental stimuli. When the patient is later exposed to a trigger situation, meaningful but

delayed change occurs. This concept of threshold allows us to stress the importance of microscopic self-changes and also acknowledge the fact of discontinuous change.

Finally, certain aspects of the patient's self-system are, at times, more susceptible to influence. In a sense, individuals are primed to respond to particular kinds of interactional experiences. For example, an over-protected adolescent may respond dramatically to a therapy that generates self-images having to do with independence and autonomy. This same adolescent, however, may have very little reaction to an equally atypical interaction that, in contrast, is structured to bring out the teenager's caretaking qualities. In this case, those self-images having to do with mastery and autonomy are more salient to the patient's developmental struggle, and thus, they are more likely to bring about change.

What this suggests is that change is not a random process determined only by the self-impressions that are generated in response to relating to the world and others. Rather, people have internal plans that determine what kinds of new self-images they are more likely to incorporate. The crucial clinical task then becomes identifying the latent self-images that are "waiting" to be tapped and then to structure the therapeutic interaction accordingly. What clinicians must ultimately rely on to

get a sense of these inner plans, even more than formal development theory, is a well-tuned sense of empathy.

"Empathy" in this case refers to the accurate identification of those latent images of self that the patient is ready to incorporate into his or her view of self.

The nature of the therapeutic relationship is perhaps even more important than the nature of the communicated self images.¹ In a non-facilitative relationship, even the best formulated intervention will have little effect. There are certain qualities in a therapist-patient relationship that facilitate the process of influence. In fact, a whole literature exists in social psychology that attempts to address the issue of interpersonal influence. The intent here is not to cover in any systematic fashion this large area of theory and research. For an extensive discussion of this literature from a clinical perspective see Strong and Claiborn (1982). Instead, the discussion will be limited to considering two factors which seem especially important to any model of therapeutic

¹It should be noted that these two concepts, i.e., the nature of the therapeutic relationship and the nature of the communicated self-images are, in reality, very interrelated. After all, the nature of the therapist's interactional stance (Channel #2) determines both the self-message and the relational context in which the message is communicated. Likewise, the nature of the relationship (Channel #3) serves as both the message and the medium in which it is delivered.

influence.

The first factor concerns interpersonal power. The more power the patient attributes to the therapist, the greater the likelihood that the therapist's view of the world (including the therapist's view of the patient) will be incorporated into the patient's own view. Power, in this sense, is related to how willing the patient is willing to see things like the therapist.

The second factor involves the "significance" of the therapeutic relationship. More precisely, the more the patient is dependent on the therapist, the more likely is the patient to alter his or her way of viewing the world (including the view of self) in order to stay on congruent terms with the therapist. If the patient has little need for the relationship, there is likely to be little interpersonal pressure to accommodate to the terms of the relationship--terms which may require a shift in the way one looks at reality.

This viewpoint has an obvious clinical implication. Before therapists can exert any influence, they first have to make sure that they are indeed in a position where influence is possible. Thus, much of the work of doing therapy is maneuvering the relationship toward this end.

C H A P T E R V I I I

A CASE ILLUSTRATION

What follows is an attempt to make more concrete one of the central features of the conceptual framework developed in the preceeding pages. Using process vignettes from an actual psychotherapy case, I illustrate how the therapeutic interaction can alter important aspects of the patient's enduring sense of self ("channel of influence #3" in the above scheme). In particular, this case material demonstrates how the therapist-patient interaction can generate meanings which can confirm or disconfirm important elements of the patient's self-system. I present three vignettes from the case, two which serve to confirm the patient's self-concept and might be considered stable sequences and one which serves to disconfirm the patient's self-concept, that is, an unstable sequence.

The case involved a young man in his late twenties who was convinced that he was not capable of engaging in satisfying relationships. In his mind, he was an intolerable drain destined to repel anyone who was able to get close to him. This case discussion uses actual sequences of therapist-patient interaction to show how this central

self-impression was both reinforced and challenged in the course of the therapy. As of this writing, the author is currently involved in the case as the therapist.

As has been repeatedly stressed, the self-concept is an interlocking constellation of cognitive and affective mental structures. In order to meaningfully examine the fate of any one element in this overall complex a great deal of context is necessary. Thus, this case illustration includes much more than just the analysis of isolated segments of process data but also includes a great deal of background material as well.

Mr. Smith was a bright young man who came to psychotherapy because of a paralyzing inability to choose a career direction. As a result, he had become increasingly depressed and reclusive, spending most of his time unproductively obsessing over all of the career options available to him. He felt he had been floundering for far too long and was beginning to fear that he was destined to be a failure.

Up until the previous year, Mr. Smith had ambitiously pursued a corporate career, and had, in a very short time, successfully positioned himself as a junior manager doing personnel work for a large corporation. However, he had become extremely uncomfortable with some

of the responsibilities of his new position and had left his position hoping to "find himself" and to pursue a career direction more compatible with his personality.

It was clear that Mr. Smith's career confusion was closely related to deeper psychological issues concerning interpersonal relationships and a maladaptive self-image. While Mr. Smith thrived on the respect and admiration that came with working with others in a managerial capacity, he was also frightened of the social contact that was also required of such a position. Mr. Smith found it impossible to comfortably engage in all but the most structured and task oriented situations. He hated what he termed the "cocktail socializing" that was required of a corporate junior executive. Mr. Smith quit several promising positions because of the painful anxiety he felt about the social demands of his position.

Behind his reservations about socializing was the fear that, without the structure of a task orientation, he would be exposed as socially inadequate and, ultimately, undesirable. One of the most prominent features to this negative view of himself was that he would become an uncomfortable drain on those around him. Mr. Smith believed that his interpersonal needs would prove to be overwhelming to those around him. He was convinced that

he could not be satisfied or comforted by another individual and, were he to let his real self out with all of these needs, he would only be left wanting more, frustrated, and disappointed. Mr. Smith's response was to vigilantly guard against revealing himself and to structure his life to avoid real emotional contact.

This appraisal of himself not only left him isolated, but also served to reinforce Mr. Smith's total preoccupation with becoming a career success. If he could only become somebody of importance, he would finally be in the position to relate with others and gain their respect and appreciation. Until he achieved such status, relationships made him feel much too vulnerable. Mr. Smith's existence was dominated by an all-out drive to prove himself in a career. He proudly labelled himself a workaholic and said he would not hesitate to work twenty-hours, seven days a week if he could only find a job to which he felt committed. The problem for Mr. Smith, however, was that he was unable to make such a commitment.

Mr. Smith's uncertainties in choosing a career direction only reinforced his view that he was an intolerable drain to those around him. For while he was caught up in a desperate struggle to find a career, Mr. Smith saw relationships in terms of this all-encompassing

pre-occupation. What he hoped to extract from those who were closest to him was some guidance as to what he should be doing with his life. In a sense, he harbored the magical expectation that someone around him might be able to free him from his predicament. Thus, the assessment that his needs were impossible to meet was borne out in reality. Perhaps we can schematize this constellation of Mr. Smith's self system in the following manner (Figure 2).

Vignette #1: A Stable Sequence

The following exchange came during the ninth session of Mr. Smith's therapy. In the previous session, Mr. Smith had been told that sessions would soon be scheduled only once instead of twice a week. Mr. Smith came to the session visibly upset and extremely negative about his life in general and the therapy in particular. It eventually emerged that he felt the therapist had decided to cut back on the sessions based on the incorrect assumption that things were getting better. Mr. Smith was adamant in stressing how desperate he continued to feel and that he had made very little progress toward finding a career direction. According to Mr. Smith, the understanding about himself and his situation that he had

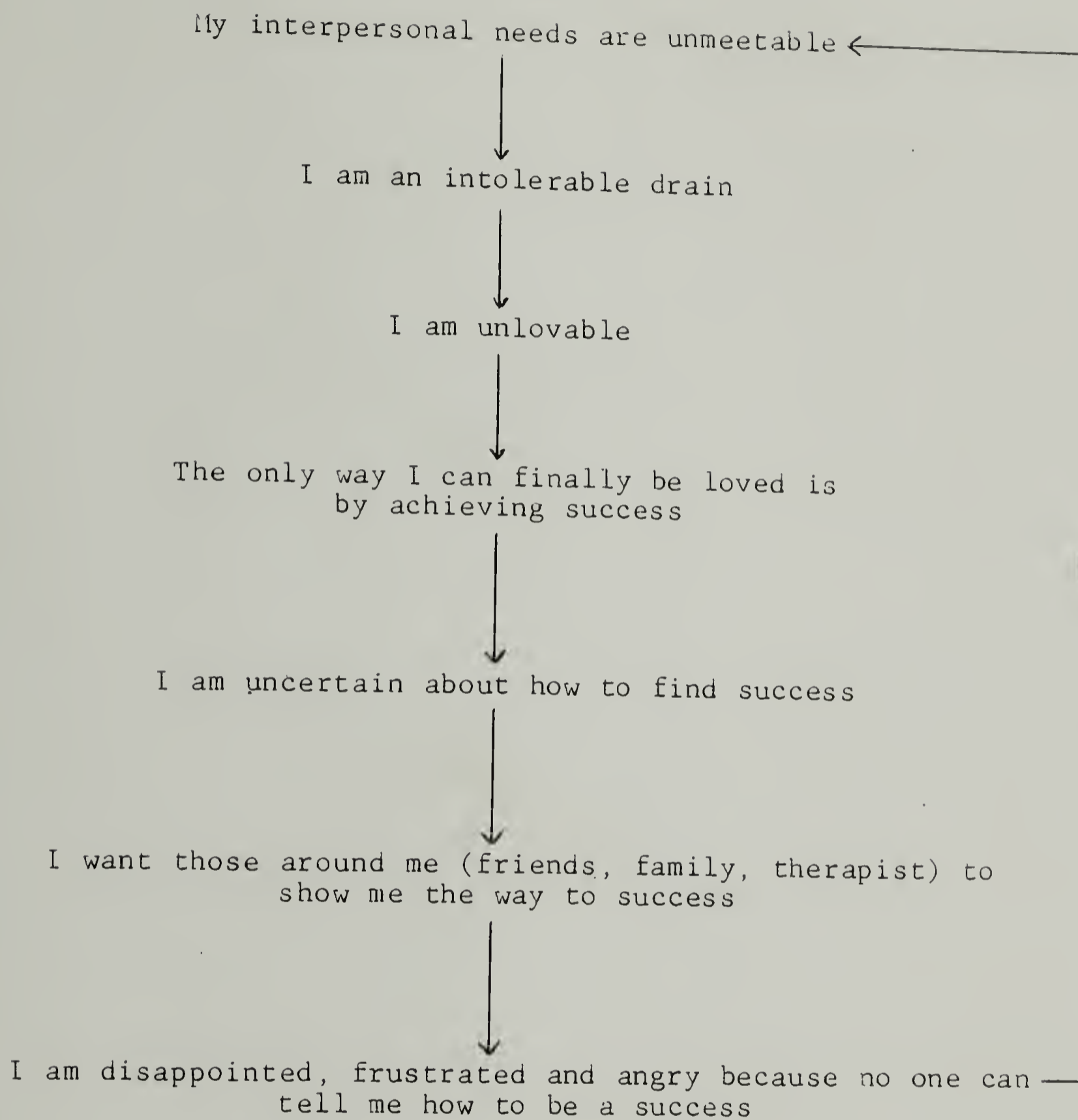


Figure 2. Explication of Mr. Smith's "I am a drain" self-conception

gained in the first month of therapy was proving to be useless.

In the following passage we see how Mr. Smith's reaction to the therapist's decision to cut back the frequency of his session quickly escalates in an angry attack on the therapy.

Mr. Smith: I get the idea that you're saying that before twice a week was saying that we needed to do a lot of work (pressured delivery, stumbling over his words). Now that it's once a week I get the assumption that we've made a lot of headway and yet I understand myself better.

Therapist: Uh huh.

Mr. Smith: But I can't apply it any better. That really the reason where I was before cause I had a pretty good idea of who I was but I just couldn't apply it and I still . . . that's when I first talked to you I said to you I had done an awful lot of thought on myself (angry demanding tone of voice) but I don't know how to apply it. I'm no better off now and I don't know where we are heading. We could talk more about who I am and I could understand myself 100% but I still won't know how to go out and find something that fits it.

Therapist: You're feeling that my decision to go to once a week is somehow a misperception that things are getting better.

Mr. Smith: Yeah.

Therapist: And that actually what you're trying to do is to work harder and that cutting back to once a week is kind of like saying "relax, things are going ok."

Mr. Smith: I don't know. I am curious if that's the reasoning behind it. I don't know if anything is any better except that I understand myself a little better.

Therapist: Do you think that I've looked at what has happened over the last few sessions and have concluded that things are better for you? And that's not true?

Mr. Smith: I understand myself better. But I don't consider that . . . that not the real . . . I mean . . . If I don't understand myself 100% that wouldn't be a major hurdle for me. As I said, my major hurdle in coming to you and major hurdle for my suicidal problem and everything else is that I don't know how to apply any of this.

Mr. Smith continues along this vein for a while and finally concludes:

Mr. Smith: At this point I feel still as helpless as I did two months ago. Like I say I understand myself a little better but I really do not believe that if we talk once a week for two years and I know myself 100% that it's going to make a shit of difference as to when I walk out of here my ability to apply it and find something that's satisfying to do the rest of my life. That's the major problem and I don't think we've dealt with it.

Therapist: I think my suggestion to cut back to once a week has really gotten you upset.

Mr. Smith: When you first mentioned I thought, "I don't give a shit. Fine, he thinks things are going places once a week and this will be worthless." And I just said, "Jesus we were making some headway and I began to know myself better" and I thought "that was going to leading someplace. Now obviously he thinks that's a good success and he's going to say. Well, we'll just slowly take it on and on and I'll be sitting at home for another year. My late twenties will be spent watching "The Price is Right."

He later continues on this theme; emphasizing how utterly

dependent on the therapy he has become.

Mr. Smith: I guess I'm just grabbing at straws. I don't know what the answers are and I'm certainly having no luck outside of here and I was trying to use this as a possibility for finding something and it its down to one hour a week and there are seven days each week and twenty-four hours each day and I'm looking forward to one hour a week and the rest of the week I am doing nothing I don't know. It just seems how much can that one hour a week be?

Mr. Smith is clearly feeling abandoned. What is interesting, however, is that the terms he sets for the relationship to be satisfying (that he be somehow guided to the right career) are impossible to meet, whether the sessions are once, twice, or even five times a week.

Mr. Smith: (extremely agitated and tearful) I don't want to commit suicide. (raising his voice) Yet I have no idea what to do. I'm tired of sitting at home. (crying)

Therapist: Last time we talked about your relationships in the corporate situation. You talked about how relationships are so difficult in that environment. How you feel vulnerable because you don't feel you have complete control and that you are required to get things done socially, which you hate.

Mr. Smith: (much calmer) The problem was that I never felt qualified for my jobs. I didn't have the right tools and it only got worse in my last job.

Taking the cue from the therapist, Mr. Smith calms down and proceeds to spend the remainder of the session exploring why his past jobs did not fit. With the therapist actively leading the way with questions, Mr. Smith

eventually shares that much of his discomfort is because he feels so awkward around his fellow workers. He finally suggests that the reason he feels so ill at ease is that he doesn't feel "there is much to me" when it comes to sharing himself in a social situation.

While Mr. Smith does begin to engage in some personal exploration, the dominant tone of the interaction remains essentially the same: Mr. Smith crying out for a solution to his difficulties. At the end of the session, the therapist finally gives him a "solution," of sorts:

Therapist: In order to deal more comfortably with the demands of living, it looks like you may have to deal with people on terms that include more than just work.

In a sense, the therapist has responded to Mr. Smith's pleas and has offered a solution. In the above passage, the therapist has "agreed" to play out the relationship on Mr. Smith's terms. The therapist is somehow supposed to guide Mr. Smith to a decision about how to direct his life. It's an untenable position, however, for Mr. Smith is set to do battle with anyone who tells him to do something which he feels is not himself.

Thus, the dialogue following the above observation by the therapist proceeds as follows:

Mr. Smith: (raised voice, argumentative) I don't know about that. Some people out there are able to just work and be successful. There

are lots of people like me out there . . . So why can't I find one of the niches? (demanding tone)

Therapist: I have a feeling that if you went down the want ads, almost all of them would require that you deal with people.

Mr. Smith: You are probably right. Most jobs are social and not for workaholics. So what can I do? Maybe you can give me some mind exercises to get me out of this. I'm totally stuck. I have some understanding about who I am, but I don't know how to apply it. (agitated and demanding tone)

As long as Mr. Smith successfully pushes the therapeutic interaction into the familiar "help me figure out my career direction" mode, his enduring sense of himself as a noxious drain will continuously be confirmed.

Vignette #2: Another Stable Sequence

The second illustrative sequence comes at the very end of session #13. Once again we see Mr. Smith making an impossible demand on the therapist. In this case it comes as a request for an extra session just as he is leaving the therapy room.

Therapist: I see our time is up.

Mr. Smith: If it . . . You know is it possible to get one appointment maybe in the next week or two? (tentative sounding)

Therapist: Um. (undecided tone)

Mr. Smith: I don't want to . . . we can discuss the possibility when you might be available

because I don't want to say right now but I was thinking earlier this week that I'd really like to talk with you an extra day this week and I don't want to set it up on a regular basis but being that January is when I am supposed to be starting my accounting course.

Therapist: Let's meet at our regular time next week and we can talk about it some more. I think I'd like to talk about that.

Mr. Smith: You sound like a parent. (laughing)
That means no.

Therapist: Well, we can talk about it.

(Patient exits)

Mr. Smith is so ready to see himself as an unwanted burden that he assumes the therapist neutral response (ie, "let's talk about it") means that his request will be rejected. Mr. Smith has "carefully" constructed an interpersonal situation that guarantees that his self-schemata will remain intact.

Vignette #3: An Unstable Sequence

In the following sequence, the therapist engages Mr. Smith in a way that challenges his belief that he is an intolerable drain. In this exchange, Mr. Smith begins to share himself in a way that is satisfying to both him and the therapist. In so doing, Mr. Smith has a new way of looking at himself: That he is not toxic and that he has the capacity to engage in mutually gratifying rela-

tionships.

The following dialogue comes immediately after Mr. Smith has described his uncertainty about beginning a training program in a new career direction, accounting. He finally exclaims, in exasperation, that his situation is too complicated and confusing to piece together a logical resolution. The therapist uses this opportunity to push Mr. Smith to consider something he is not used to exploring, his emotions.

Therapist: I was just commenting on the style you are approaching this with. How if you could fit the whole puzzle together just kind of logically

Mr. Smith: (overlapping) I'd feel good about it.

Therapist: If there is a strand out of place

Mr. Smith: (overlapping) It's not right.
(enthusiastic agreement)

Therapist: You'll feel all confused or feeling like you're not going to be able to have the answer.

Mr. Smith: That's right. But then how . . . how?

Therapist: I guess I'm raising the possibility that decisions are made on terms other than that way.

Mr. Smith: Than just logic.

Therapist: Just piecing the puzzle together. That there are feelings involved in people's decisions.

Mr. Smith: But isn't that when people make wrong decisions? Often times people make wrong decisions because they let feelings come into it. (questioning tone) Isn't that true?

Therapist: What do you think?

Mr. Smith: You're finally talking! And I like to hear you talk. You don't like to give me much information you're finally talking (smiling) and he throws it back at me. OK. What do you think. Um. (pause)

Mr. Smith proceeds to go into a rather intellectualized discussion of his position on feelings, saying that they usually get in the way of success. In the midst of this rather detached monologue the therapist breaks in:

Therapist: (overlapping) How would feelings lead you astray? Can you imagine a situation?

Mr. Smith: Well. Feelings even led me astray last year. By spending so much time with Mary and by constantly putting off doing something and by thinking, "Well, it will work out. Maybe I'll work part time because that way I can just stay next to Mary until she moves away."

Therapist: (cutting in) What were those feelings? with Mary?

Mr. Smith: I like that situation and I was letting I mean it was really comfortable and so why not just stay for awhile. And see what it did it wasted a year. Logically when I quit my job last year I should have started something new. If it meant moving, just move, "sorry, Mary."

Mr. Smith proceeds to talk in a revealing manner about his feelings about relationships. The discussion eventually turns to a consideration of whether or not he feels him-

self to be a drain to those around him.

Mr. Smith: In most cases, my presence isn't usually a drain. Number one I wouldn't discuss my problems at length, that just isn't me. Instead, we usually talk about them.

Therapist: Sounds like you're pretty vigilant not to let that draining part of you out.

Mr. Smith: Uhuh. (agreeing enthusiastically)

Therapist: But that, also a lot of pressure on you. You're constantly producing for the other person, keeping them entertained, taking care of their needs.

Mr. Smith: (pain in his voice) I haven't found anybody that really wants to sit down and discuss me. People like to discuss themselves. I've never found anyone who would sit down and say "cut the horseshit, what's really going on with you? Not the light side of you but I want to know how you feel about it." I can do that with other people and I do sometimes. But no one ever does that with me. I don't think a lot of people really care . . . Let's face it, I have not made a lot of deep relationships so that could be part of it but umm I think a lot of people just get frustrated if you have a serious problem.

Mr. Smith ends the session by expanding on this theme and sharing how disappointed he has recently felt by his parents because they were not responding to his current difficulties in a way that felt supportive. His tone is pensive and much softer than his usual gruff, businessman's style.

In response to the therapist's active invitation to look at feelings, the tone of the interaction has

shifted. In this exchange, Mr. Smith is no longer caught up in the frustrating struggle to get the therapist to help solve his career dilemma. Instead, he is using the therapist as an empathetic audience for some difficult and highly guarded feelings. Mr. Smith is sharing that he feels uncared for. He has taken some time off from his battle to be a success and is allowing himself the luxury of being "held." He has successfully made a connection that provides him with the experiential basis toward disconfirming the enduring sense of himself as being incapable of participating in a mutually satisfying relationship. From this, Mr. Smith might begin to establish a more secure sense of his own inadequacy and lovability.

This, in turn, might serve to take some of the pressure off his career effort. Having discovered that he is "good" enough to engage in a satisfying relationship, his self-esteem no longer has to rest exclusively on his ability to perform in an occupation. This may lighten his burden whenever he sets out to accomplish a career goal and free him to at last constructively engage in a career direction.

The obvious question at this point is how are we to know whether this clinical exchange is truly representative of a transformative interactional sequence.

Besides evaluating the process data's "face validity" (i.e., does it seem like an interactional sequence that challenges enduring conceptions of the patient's self?), are there any other more formal ways of assessing how transformative this sequence was?

An important starting point, is to carefully determine whether the interaction was being experienced as truly atypical by the patient. In other words, did Mr. Smith feel he was engaging in an interaction that challenged his usual way of looking at himself? Specifically, did he feel that his needs were being met in the interaction in a way that was mutually satisfying? If this were the case and Mr. Smith truly experienced himself as being successfully held, then the conditions were set to alter the enduring image of himself as an intolerable drain.

There are several indications that suggest that this sequence of interaction was being experienced in such a way. Mr. Smith's musculature and posture were quite different. He was less stiff and seemed much more relaxed during this passage. His voice seemed much less pressured and much more pensive. The therapist's own feelings also suggested that something different was happening. The therapist was feeling much closer and more helpful. The

therapist also experienced himself as being less pressured into a task-oriented stance and much more emotionally involved. While each of these indicators are not conclusive in themselves, as a composite they strongly suggest that Mr. Smith did indeed experience this moment of therapy in an atypical manner.

The second approach to evaluating whether this interaction was transformative would be to evaluate its effects. In other words, are there indications that Mr. Smith's image of self changed as a result of this exchange? More specifically, are there any signs that Mr. Smith, following this session, was no longer as convinced that he was incapable of engaging in a mutually satisfying relationship? If such signs were apparent, then we can assume that this interaction may have facilitated an alteration in this aspect of Mr. Smith's self-concept.

As of this writing (one month after session #13) Mr. Smith has not given any clear cut indications of such a cognitive shift. Part of the difficulty is that Mr. Smith is facing yet another career crisis (he no longer wishes to pursue accounting as a career) and has, predictably, become much more defensive and rigid in his approach to relating with his therapist. Finding a career niche once again completely dominates his attention.

The problem in obtaining this kind of confirmation is that such signs are typically not direct or immediate. Just because this sequence of interaction has not resulted in some observable change does not necessarily mean that change has not happened. The effects might be very significant at the cognitive level but have not had time or the opportunity for a behavioral expression.

C H A P T E R I X

CONCLUDING REMARKS

Toward Evaluating the Model

Let us conclude by considering several ways in which we might go about evaluating this model of psychotherapy. In other words, what are some of the methods and criteria which we might use to assess the value of the ideas which I have just presented. Time constraints have unfortunately made it impossible to pursue any of these strategies of evaluation in any systematic way. They are offered here as possible directions for future work.

We might begin by checking the model against the guiding assumptions which provided the original direction for this effort. Below is a list of those initial assumptions:

- 1) The centrality of the therapeutic relationship
- 2) The importance of looking at interpersonal processes
- 3) The importance of inner experience
- 4) The appropriateness of a cybernetic epistemology

- 5) The importance of the notion of fit
- 6) The importance of the therapist's personality
- 7) The similarity between the psychotherapy relationship and other relationships in facilitating change
- 8) The importance of self/object representations

As one goes through this list it is comforting to discover that, for the most part, our working model is consistent with these initial assumptions. While this is certainly not the most powerful criteria upon which to evaluate the model, it at least demonstrates that there is a basic level of internal consistency in our theoretical effort.

Another approach towards evaluating this theoretical model asks whether the model accurately represents "reality". In other words, can we verify the model through direct observation. In terms of Channel #1 (i.e., influence through direct intervention), it is relatively easy to envision, in general terms, a rather straightforward methodology that tests whether this framework can be usefully applied to the clinical situation. It can be divided into three steps:

- 1) Define and isolate the exact dimensions of the patient's self-concept toward which a particular therapist's intervention is addressing itself.

- 2) Systematically determine the pre-intervention status of these aspects of the patient's self-concept.
- 3) Systematically determine the post-intervention status of the same dimensions of the patient's self-concept which were originally targeted.

Step #1, characterizing the nature of the therapist's intervention, is relatively uncomplicated for Channel #1 type of influence. In this situation, we have easily observable and delimited behavior (i.e., the therapist's verbal intervention) upon which to base our observations. If we can agree on what the therapist is saying about the patient's self-concept, then we have basically accomplished step #1 in this method. This is in sharp contrast to the difficulty which confronts us when we attempt steps #2 and #3. These steps involve variables referring to the status of the patient's self-image, a cognitive entity which is basically invisible. The difficult challenge here is to find observable indicators, in the form of concrete patient behavior, of the status of the patient's self-system. As inferential as it must be, this pre- and post-intervention assessment of the patient's self-image is absolutely crucial if we are to be able to conclusively "observe" this kind of influence.

If the systematic verification of Channel #1 is difficult, then verification of Channels #2 and #3 is next

to impossible. What is particularly difficult in these models of influence is that the therapist intervention is not really observable and can only be inferred. Thus, all three steps are based on a great deal of inference, leaving us without a firm anchoring point. It is very likely that a group of observers will not be able to agree on the exact nature of the therapist's intervention (i.e., exactly how the therapist behavior is challenging the patient's self-system). Even if this major obstacle could be overcome, the difficulty remains as to how to assess its impact and whether change has indeed come about.

This is not to say that such verification is out of the question. However, if one wishes to systematically observe therapeutic process using these perspectives, one has to spend a great deal of effort carefully identifying the observable derivatives of these hypothesized cognitive processes.

The value of a theoretical model does not solely rest on its ability to generate observable constructs. Much more important is the ability to foster understanding. This is especially important when we begin to grapple with process phenomenon, such as the therapeutic interaction. In these cases, the most pressing need is to somehow develop an explanatory narrative that allows us to link events over time. In the face of a

constant stream of complex data, we need something that helps us begin to see the story line. Unfortunately, this view offers much less in the way of a method for assessing the merits of a theoretical perspective. When one relies on the criteria of observation, you either see the hypothesized construct or you don't. But when the criteria is the ability to generate understanding, we are on much softer ground. This is not to suggest, however, that such a criteria lacks value. For most clinical theory stands or falls on the basis of whether it generates that very personal and subjective click of understanding.

One way in which we might test this model of psychotherapy along these lines would be to see how well it can transform raw clinical data (preferably videotaped psychotherapy sessions) into meaningful case conceptualization. What would be particularly telling would be whether it shaped and ordered our perceptions of the therapist-patient interaction in ways which illuminated the presence or absence of change.

This brings us to another closely related approach to evaluating our model of psychotherapy process. It is based on the idea that psychotherapy, at its root, is an enterprise devoted to the process of facilitating change. It follows then, that good or valuable clinical theory must ultimately serve as a useful guide toward developing

strategies for change. In other words, we must not forget to judge our model of therapy in terms of its usefulness; that is, whether it helps therapists become more effective agents of change.

This is not to suggest that clinical theory must reduce itself to becoming only prescriptive in nature. We certainly have enough "how to" manuals of psychotherapeutic technique. However, models of psychotherapy that have no implications for how one should go about understanding and facilitating the process of change ultimately lose an important source of meaning.

One can imagine an interesting experiment to test this model along these lines. Simply let a team of clinicians immerse themselves in this perspective for a period of time and have them keep track of their effectiveness of their work. Specifically we would want to know whether such a perspective improved their ability to understand, either as individuals or as a group, the case material. More importantly, however, we would want to see whether the effectiveness of these clinicians changed significantly. If this group of clinicians felt more effective in doing their work and attributed it to their new model for understanding the clinical process, then it is very likely that the model has some utility. It is exactly this kind of experimentation that has led to such a boom

in the whole area of family therapy.

A final way to evaluate this theory is in terms of aesthetics. On this score, I must admit that the framework I have developed is far from elegant. Rather than appeal to one's sense of theoretical simplicity, I have, instead, set out to develop a comprehensive view of the process of therapeutic influence. While this approach might accurately mirror the complexity of the phenomenon which it is attempting to describe, it also can feel cumbersome, and, at times, tedious. The alternative to such a "try to capture it all" approach is to go out on a limb and to push a particular aspect of the entire picture as the one of significance. Such a commitment not only takes a certain amount of courage (which I do not have at this point) but also allows one to present a much more focused and parsimonious model of psychotherapy.

Clinical Implications

While this model has been primarily descriptive, rather than prescriptive, in emphasis, it nevertheless has the ability to come down from the clouds and offer some practical guidelines about how to think about clinical practice. We can summarize some of these clinical implications in the following step-by-step description of its view of the primary tasks of the therapist.

- 1) Identify the constellations of self-images that are responsible for the patient's difficulties. This may require a great deal of exploration and digging since many important features of an individual's self-image may not be part of his or her conscious awareness.
- 2) Identify the key elements in the patient's constellation of self-images. In other words, identify those self-cognitions which are most responsible for shaping the entire structure of the person's self-system. If these "lynch-pin" cognitions can be identified, they offer the therapist a very focused way to bring about change.
- 3) Identify those self-cognitions that are open to change. Patients often come in with hidden scripts on how they would like to change. It is extremely important that the therapist gain a sense of this pre-set script for this will direct the therapist toward those aspects of self most amenable to influence.
- 4) Having identified those self-cognitions that are the most productive targets, the therapist must develop strategies to bring about the desired change. This involves picking the best combination of channels to use to foster the change. An integral part of the change process involves the encouragement (via any of the 3 channels) of new self-structures that can replace those that are currently maladaptive.

The clinical implications of our model certainly extend beyond this brief list. The purpose of this list is simply to offer a representative outline of how this model of psychotherapy process can generate an approach to actual clinical technique.

Personal Reflections

This thesis began with some personal reflection on the status of clinical theory. I would like to end by returning to that initial theme. Only this time, my reactions are the product of having spent several years immersed in the topic.

Most importantly, I have gained a healthy respect for the utter complexity of the subject area. As much as we may try, the task of making sense of the therapeutic interaction and the process of change cannot be reduced to simple formulae. There is good reason why the subject has spawned such a diverse array of theoretical perspectives. Such complexity can be overwhelming and it is often tempting to throw in the conceptual towel. One form that this takes for many clinicians is that formal theory is deemed irrelevant and too clumsy for an "art form" as subtle as psychotherapy. In this case, common sense and one's personal intuition are seen as the legitimate guides to doing psychotherapy. Alternatively, clinicians often rush out and uncritically adopt existing theory. The difficulty here is that such ideas are often blindly accepted only to buffer one from the many uncertainties of the clinical situation. Both of these approaches suggest that one has, to a degree, given up on developing a theoretical

perspective that is personally meaningful.

In the course of working on this thesis I have often been frustrated with the complexity of the subject matter and have often felt that there would never be any way to make sense of the clinical interaction in a way that was personally meaningful. However, I emerge from this project with a degree of optimism. I come away feeling that I have finally been able to piece together a view of the clinical interaction that has a great deal of potential. To be sure, it is, in many ways, still in a very primitive form. At least now I feel pointed in a promising direction. What is perhaps most exciting about this model is that it begins to integrate four diverse perspectives: cognitive-self-theory, psychoanalytic theory, communication theory, and information processing theory into what is potentially a very powerful synthesis.

My optimism has been especially bolstered in the course of doing my own actual clinical work. As my theoretical ideas have coalesced into a more organized framework. I have been pleasantly surprised that my ability to understand what is going on with my clients has also gained a degree of clarity. What this suggests is that the next step in developing this model should more directly involve case material. The purpose here would be to see which aspects of the model are the most helpful in

organizing and making sense of actual clinical data.

Finally, if this thesis has taught me anything, it has taught me that theory does not necessarily appear, ready made, in one inspired flash of brilliance. Instead, it is more likely to be hammered out in a gradual process of successive approximation. As I have discovered over the last months, this is far from a painless experience, for it requires that one repeatedly face the realization that one's conceptual efforts are not completely adequate and that they must, in a sense, be given up for the overall process to once again move forward. If one is going to actively engage in theory construction, one has to accept the ephemeral character of the ideas that we labor so hard to develop. Seen in this light, theory building is an evolutionary process of ideas moving and changing through time. It is a process that, in spite of our best efforts, is never finished. It is in this spirit that I share this Master's thesis.

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