First Things First

What is psychotherapy? If we ask several people, we may get many different answers. Psychotherapists are seen on television and in the movies, and some are even heard dispensing advice on our radios every day. Despite the visibility of psychotherapy today, many people still seem to be unsure of what it entails. For some, it is a scientific approach to problem solving; for others, an almost mystical experience. Some therapists describe what they do in terms of changing dysfunctional behavior and thought patterns, while others talk about exploring intangible unconscious feelings and beliefs. Some therapists invite you to lie on a couch; others may have you invite the participant to scream or beat on a pillow.

It seems likely that the actual practice of psychotherapy is so varied that most attempts to define it meaningfully are doomed to failure. In fact, it may make more sense to talk about “them” rather than “it.” Psychotherapies have in common that some person or persons, called “therapists,” are hired by another person or persons, called “clients” or “patients,” to help those clients solve some sort of personal or social problem. The goal of such a relationship between these parties is to assist the clients to feel better and function more effectively. Beyond that, the arguments start.

This is a book for people who are performing, or who intend to perform, psychotherapy. It is not a book just for one particular kind of therapist, working exclusively within a single framework. It is a book about being out there, in the trenches, working with real clients in real situations. We, your authors, are both practicing psychotherapists who work with lots of different people who have many kinds of problems. To do so effectively, we have found it is useful to borrow ideas, insights, and techniques from many different sources. Of course, we try to approach each client with a conceptual underpinning in mind, a theory that helps us plan what we are doing and where we are going. For the purposes of this book, it is not important to know the specific theory of therapy to which we subscribe.
We believe that this book transcends theory in that the ideas presented here are not incompatible with most theoretical orientations. We like to think that becoming a therapist is a developmental process; in other words, you need to walk before you can run. There may be a time and place to align oneself professionally with a particular theory, but we are not there yet!

Even though this is not a theoretically oriented book and all of us are eager to plunge into the real “how to” of working with clients, we do need to take a few pages here at the beginning to clarify what will happen in the book and to familiarize ourselves with each other. This will help us communicate smoothly throughout our time together. The process of getting acquainted is a major purpose of this first chapter. We will talk a bit about psychotherapy in general and where it has come from. We will discuss the bewildering variety of forms and shapes it is packaged in today. We will look briefly at the evidence of its effectiveness. Finally, we will lay out a few of the basic assumptions on which therapy depends. Then we will be ready to move into the work itself.

So, first of all, what is psychotherapy really all about? Do people really need the services of a psychotherapist? Surely, people can manage to survive and grow and overcome problems on their own—what did they do before we had psychotherapy? Of course, most people can handle the problems life presents on their own, but not everyone can. It is when a person feels overwhelmed and unhappy and the natural process of coping breaks down, gets blocked, or is not moving along as quickly or as directly as he or she may want. Then it is time to call on a therapist. The therapist’s job is to step in to help when the natural growth process is not handling things well enough.

And how does a therapist step in? What does she do that makes her different from a friend or a pastor or a mother or a bartender or a hairdresser? Here is where variety rears its interesting head. Depending on what she believes about how people get and stay stuck, the therapist will do different things. But all therapists do what they do from a common perspective, and that is what makes us therapists: we create and work within a relationship in a way that focuses on the other person and his needs. We develop a form of being-with this person that is unique in that it involves genuine two-way contact at a deep level of knowing and caring, and yet has as its purpose the personal growth and enrichment of only one of the two participants.

We do not mean to imply that the therapist is not enriched through her relationships with clients. If she is doing her job well, she will and must grow as a result. But her growth and learning are incidental side benefits. The primary goal of the therapeutic relationship is the enrichment of the client. Some other professionals, such as lawyers, doctors, and teachers, have a similar one-way focus. But only in psychotherapy is a personal relationship with another human being the primary vehicle through which changes in feeling, thinking, and behaving are expected to occur. It is the use of a relationship to effect positive change...
and growth that makes the relationship we develop with others unique and unlike any other relationship.

**Therapy Then and Now**

The history of psychotherapy, as with so many other aspects of Western culture, really begins with the ancient Greeks. Classical Greek culture recognized disease, both physical and mental, as a natural rather than a supernatural process, and the Greeks identified different kinds of mental dysfunction. Their distinctions may have been crude by modern standards, but the classifications have a familiar flavor even today. While they did not recognize the healing potential of a relationship with a therapist, they began a tradition of treating mental illness through professional intervention.

This tradition spread through the developed nations of the Near East, and by the eighth century many large hospitals in cities such as Baghdad and Damascus had psychiatric sections for treatment of mental illness. The West lagged far behind, but in the thirteenth century hospitals in major cities in France, England, Germany, and Switzerland were providing psychiatric care for the mentally ill. The mental health movement in the West was held back, though, by the conflicting opinions present in the Middle Ages. One popular opinion was that “madness” occurred as a result of natural causes and deserved humane treatment; the competing view was that psychopathology was caused by the presence of evil demons. As a result of this latter view, treatment included exorcism and other agonizing actions intended to drive the evil spirit from the possessed individual’s body (Barlow & Durand, 1999).

By the middle of the seventeenth century, superstitious views of mental illness were on the wane, at least among the better educated. But what replaced them was not much more enlightened, and in some cases treatments for mental illness would now be considered torture (e.g., bloodletting, temperature extremes, and isolation). There was at least as much concern in those days with protecting the sane from the insane as there was in curing mental illness. Mentally ill people were considered dangerous and unpredictable and were usually locked up when their behavior became too bizarre to be ignored.

Gradually, these views changed. By the eighteenth century, psychosocial models of mental illness predominated and moral therapy was coming into practice. A basic principle of moral therapy is that patients should receive treatment in “normal” settings so as to encourage and reinforce social interaction. Restraints were eliminated and emphasis was placed on education. Moral therapy was found to produce improvements in up to 75 percent of patients. Perhaps even more important was the reform influence of moral therapy: treatment centers were made more humane and treatments were less oppressive and more therapeutic.

Soon, psychiatry became a true science. The Age of Enlightenment was one whose physicians and scholars glorified logic and reason and saw logical thought
as the birthright of all humans. As reason was their highest god, how they symp-
thathized with those who had lost reason! They believed that through reason and
good will, humanity could attain perfection. Thus they overcame the fatalist be-
lief in the incurability of insanity and founded numerous institutions for the men-
tally sick. Their reform movements put a stop to much of the abuse of psychiatric
patients who had formerly been locked away like prisoners. The main goal of
these therapeutic pioneers was to convince the public that inmates were “men-
tally ill” and in need of treatment, rather than “mad” and in need of shackles.

The movement continued: studies of hysteria and neurosis, treatment through
diet and drugs, environmental manipulation. There is not space here to trace the
development of the great treatment centers in France and Germany, the use of
hypnosis as a treatment method, and the gradual realization that something could
be done with and for patients by talking with them in one way or another. Of
course, the great milepost along this developmental road was the work of Sig-
mund Freud, the young neurologist-turned-psychiatrist whose books shocked his
own generation and have shaped the course of psychiatry and psychotherapy con-
tinuing into our own time. Freud’s talking cure, or psychoanalysis, as it came to
be called, spread throughout the Western world in the waning years of the nine-
teenth century and by the early 1900s had become the predominant—virtually
the only—acceptable psychotherapeutic method. So it remained, right up to the
cataclysmic years of World War II. Many of the other influential theorists who
came after Freud had their roots and training in traditional psychoanalytic prin-
ciples. The only real rival to Freud’s preeminence in the world of psychiatric treat-
ment as the Big War wound down was a young American from Illinois named
Carl Rogers. Who ever thought this Midwestern farm boy would make a differ-
ence? But he did, and the difference was enormous.

The Rogerian, client-centered approach was a harbinger of things to come.
Rogers emphasized the importance of the therapeutic relationship over specific
techniques. Other approaches began to appear: Taft and Allen’s “relationship ther-
apy,” Frohman’s “brief psychotherapy,” Hertzberg’s “active psychotherapy,” and
Thorne’s “directive psychotherapy.” Greater changes were occurring in two major
areas. First, the community mental health movement was gaining momentum,
bringing in its wake an emphasis on social and cultural factors in treatment, sanc-
tioning the practice of nonanalytically trained therapists (scandalously, many of
them were not even medical doctors!), and popularizing the notion of psycho-
therapy for the middle and lower classes. Second, the behavioral psychologists had
begun to move beyond rats and pigeons and were applying their theories of learn-
ing to human beings with great and well-publicized success. The dam had broken,
and the full flood of mental health enthusiasm was about to inundate the country.

And what a flood it has been! The late 1960s and the 1970s saw the flow-
ering of the human-potential movement, through which everyone was to experi-
ence consciousness raising. The question became not are you in therapy, but with
whom! Commercial ventures such as Lifespring and EST sprang up to introduce suburbanites to self-awareness and the power of getting “It.” Marriage encounter groups became available for couples, primarily through churches; children and parents were invited to family weekends; treatment centers for every sort of psychiatric ailment and nonailment emerged almost overnight. The variety of approaches, theories, and fads has grown in an equally bewildering way.

**The Therapy Depot**

In 1920 there was one psychotherapeutic approach; in 1930 there were, perhaps, half a dozen, all but one of generally minor influence. Then a virtual explosion occurred. Psychotherapy, like nearly everything else, changed dramatically in the 1940s, and it will never be the same again. Theories of psychotherapy began popping up everywhere and continue to abound. Karasu (1986) estimated that there were, at the time, over 400 forms of psychotherapy; no doubt the numbers have continued to grow. It is even possible to buy Consumer’s Guides to therapies, road maps through the jungle of competing approaches and claims. This quality of competition is one of the more disturbing aspects of the modern mental health scene. Norcross (1986) reported that the proliferation of therapy systems creates a pandemonium of curative claims. He stressed the need for integration rather than the development of additional theories. There are many signs present since the 1980s that psychotherapy is moving toward eclecticism and integration. Goldfried and Castonguay (1992) describe this movement as combining the best of differing orientations so that effective treatments can be developed; eclectic approaches to therapy transcend any single theoretical orientation. The trend toward integration seems to be based on the notion that no single theory can account for the complexities of a given client and his troubles (Corey, 2001).

A major event in determining the kinds of therapy that are generally available today is the advent of managed care. Counselors and therapists now must fight their way through an alphabet soup of PPOs, HMOs, and PCPs and must sometimes obtain permission from insurance providers for every session they schedule with a client. Not only is the number of sessions regulated, but, increasingly, even the kind of treatment that must be provided for a given diagnostic category is being standardized and prescribed for practitioners (Erskine, 1998). In a discussion of the psychotherapeutic implications of managed care, Weiss and Weiss (1998) comment, “The rise of the managed care approach to controlling health care costs has made it next to impossible to work in any kind of real depth with the majority of people whose insurance will only cover the psychological equivalent of first aid” (pp. 45–46). Some therapists, concerned over the likelihood of having to curtail services to people in need of help, and also over the ethical implications of reporting confidential information about their clients to insurance companies, choose not to deal with the managed-care system at all and work only with clients
who can afford to pay out-of-pocket for their therapy. Others remain within the system, even though this usually means that their clients will have fewer sessions, spaced farther apart, than either client or therapist would wish, and that writing reports and filling out forms will require time that could better be spent in more therapeutic activities.

Despite the presence of many and varied competing approaches, and of the still-developing shadow of managed care, it is possible to discover some order among the confusion. To do so, it is more useful to look at the similarities of the various approaches to therapy than to focus on their differences. We are used to shouting about differences, to championing theory A because it takes into account the trauma of birth or theory B because it assumes that all humans are capable of logic or theory C because it focuses on the here-and-now. We are less used to noticing similarities, and that is probably misleading. All psychotherapists do more of what we hold in common than of what is unique to one or a few systems. Were it not so, this book could not be written, for this is a book about psychotherapy, singular, not about psychotherapies, plural. It is a book about our common ground, a book based on the beliefs and skills and attitudes that undergird our diversity of specializations. Lazarus (1986) describes the characteristics of a successful therapist that are necessary regardless of theoretical orientation: genuine respect for people, nonjudgmental attitude, warmth, humor, and authenticity. Tools and techniques are helpful, but creating and maintaining a therapeutic relationship is the most important skill needed by a psychotherapist. Even though the field does seem to be moving toward delineating which approach works best with a particular client with a particular problem, nevertheless we therapists need to be open to all that our disagreeing colleagues can teach us and to remember that we are more alike than different.

Evaluating Outcomes

Back in the early 1950s, just as the psychotherapeutic kettle was beginning to come to a boil, an Englishman named Hans Eysenck added a new and startling ingredient. Having spent much effort in an investigation of therapeutic effectiveness, he concluded that “roughly two-thirds of a group of neurotic patients will recover or improve to a marked extent within about two years of the onset of their illness, whether they are treated by means of psychotherapy or not” (Eysenck, 1952, p. 322). As one might imagine, the mental health community’s reaction to that statement was disbelief. Immediate arguments against Eysenck’s study emerged, including questions about the data he used, the control groups, and the therapists in these studies.

In the early 1970s, researchers went back to Eysenck’s original data and concluded that there were significant errors in his research and statistical procedures. However, their work seemed only to get the ball rolling as far as treatment
efficacy research is concerned. Since that time, efforts to tackle the evaluation problem have tended to use sophisticated statistical methods to combine and re-analyze large numbers of smaller-scale studies. Luborsky, Singer, and Luborsky (1975) were among the first to examine comparisons of group versus individual therapy, time-limited versus unlimited, client-centered versus other traditional approaches, and behavior therapy versus psychodynamic therapy. Although they found that a high percentage of those who seek psychotherapy benefit from it, they were unable to find consistent differences in effectiveness among the kinds of treatment they looked at—anywhere! In 1977, Smith and Glass published the results of an even more massive project, which involved reanalysis of data from close to 400 individual studies. They found that, overall, psychotherapy was clearly beneficial; on the average, the typical therapy client is better off after treatment than 75 percent of untreated individuals. However, the Smith team found only negligible differences in the effects of types of therapy (behavioral versus non-behavioral), or even between experienced and inexperienced therapists. Even twenty years later, Luborsky et al. (1993) evaluated outcomes for different types of therapy and found only small and insignificant differences.

Despite the inability to uncover differences in the types of therapy used, one thing at least seems clear: therapy is helpful. In fact, recent research has demonstrated psychotherapy’s effectiveness even with individuals with personality disorders, previously believed to be very difficult if not impossible to treat. Perry, Banon, and Ianni (1999) found that psychodynamic, cognitive behavior, mixed, and supportive psychotherapies were all effective treatments for personality disorders and may even be associated with a sevenfold faster rate of recovery when compared with the natural course of the disorders.

In spite of these kinds of experimental findings, some people are still skeptical. For many, there is still a cloud of suspicion about what psychotherapists do. They wonder if psychotherapy is really just a big scam, if so-called therapists are just letting people talk and then taking their money. If some therapies (and some therapists) are good and some not so good, how can a prospective client know the difference? This is only complicated by the fact that experimental determination of the effectiveness of psychotherapy is so difficult.

For one thing, improvement in mental health is often hard to define in any specific, measurable way. The variables are elusive; the criteria are slippery. What exactly does one measure to determine progress? If the client says he feels better, does he really feel better? Perhaps he is just saying that to please the therapist, or maybe to convince himself. Should the therapist give the client some kind of test then, to see if his scores after therapy look different from those on tests he took when he started? But if they do look different, who is to say that the scores reflect real, meaningful changes? And, if they do not look different, perhaps the test failed to measure what the real changes were. We could ask the therapist herself whether the treatment was effective, but she would obviously
be biased in her reporting. What therapist wouldn’t want to report progress in her client?

Perhaps a more objective approach would be better: what sorts of actual behavior could we look for that would indicate improvement? That depends on what was wrong in the first place, on the environmental constraints, on the number and kinds of options actually available for this or that client. Does it really make sense to look at psychotherapy as a single kind of treatment when there are so many different activities that fall into that category? Maybe one kind of therapy is effective with some clients but not with others; maybe some kinds of mental health problems are amenable to some psychotherapeutic treatments but not to others. This latter view appears to be gaining credence: more and more, researchers are asking not “what works in therapy?” but “what works best for what kind of client in what circumstances?”

Therapists out in practice do not know if they have been vindicated or betrayed by all this research. Most studies do seem to support the effectiveness of therapy, to be sure, but what is this about everybody’s method working about as well as everybody else’s? Or about inexperienced therapists being as helpful as experienced ones? Did we really need to subject ourselves to years of training? Surely, the research cannot be right. We know that what we do with clients works better than Brand X therapy. . . . In fact, the current trend of outcome research claims that even the researchers tend to be biased in favor of their brand of therapy: Luborsky and his colleagues (1999) contend that the researchers performing the treatment outcome studies generally reported finding the most favorable results when they are measuring their own style of therapy. If the researchers themselves are biased, can anyone believe what they say, or what the research claims?

There is, in all of this activity, one important aspect of therapy that the outcome research people seem to have overlooked, and it is an important one indeed: what goes on inside the client, where no one else can see? Psychotherapy is intended not only to “cure” some specific disorder, but also to help people get through a troubled period in their lives with a minimum of pain and a maximum of growth and learning. For some clients, psychotherapy may not so much “cure” the problem as make its duration shorter and its distress more bearable. Aspirin, one of the last century’s true wonder drugs, is used much more to help us feel better than to cure our illnesses; a cast on an arm or leg doesn’t heal the broken bone but rather provides support and protection while the bone heals itself. The unique contribution of psychotherapy may work in much the same way: within the protection and support of a therapeutic relationship, the client can learn to heal himself. Therapeutic techniques may provide direction, but the relationship is the common—and most critical—element in the process.

We believe that psychotherapy may, in some cases, truly cure. It invites clients to grow and change and see things in ways that would have been impossible
without therapy. We believe that in many other instances psychotherapy substanti-ially shortens the duration of an illness (and we could spend a great deal of time, indeed, trying to define what is meant by the word *illness*). We believe that, even when it neither cures nor significantly hastens the self-curative process, psychotherapy may significantly decrease the pain, anxiety, and other debilitating emotional symptoms that accompany illness. For some troubled people, just the supportive presence and keen listening of the psychotherapist is comforting. Finally, although research seems to have overlooked this possibility, psychotherapy has enormous potential as a preventive measure. Engaging in therapy at the point where things are just beginning to go wrong may allow a person to avoid a full-fledged illness (either emotional or physical) later on. Further, therapy may prevent disturbances in the next generation: the client who deals with his own experience of abuse, incest, emotional deprivation, or addiction is far less likely to invite his children into the same torment. In sparing them an abused childhood, he may also be sparing them his own disorder.

All of these statements are beliefs, matters of faith and hope, rather than facts. We have no data to support them, no research to prove their validity. Yet it is just such beliefs, borne out in session after session with client after client, that keep us working as psychotherapists. Research has a long way to go before it will be able to test hypotheses such as these. In fact, it may be time for practitioners to turn the tables on researchers and to ask seriously if traditional *research* does work. Garfield (1992) writes that the variables that influence therapy are extremely difficult to control and evaluate. It is impossible to achieve the kind of control in therapy outcome research that one can achieve in laboratory studies. Will traditional research ever be able to measure the subtleties of what goes on in that incredibly complex relationship called psychotherapy? There are so many variables involved: therapist characteristics, client characteristics, presenting problems, cultural milieu, and so on. Can they all possibly be accounted for? It may be that the researchers will need to develop a new approach, less “scientific” perhaps, if they are ever to understand precisely what is happening in psychotherapy. What an exciting challenge that could be! But, although fascinating, this is a digression. Let us return to the business at hand: the practice of psychotherapy.

**Theory, Assumptions, Values**

Having emphasized that there are many theories of therapy guiding modern psychotherapeutic practice, and that nobody has been able to demonstrate the superiority or correctness of any one over all of the others, we are now going to insist that every therapist needs also to be a theorist. A contradiction? We don’t think so. We are convinced that without an underlying structure to support and organize her work, the therapist cannot ever know what she has accomplished, much less plan coherently what she intends to do next.
Actually, everyone really does have a theory of personality and, if they think about it at all, a theory of therapy. One’s theory can be found embedded in one’s answers to questions like, “What made George the way he is?” and “Why does the Swenson kid constantly get into trouble?” and “Why does Jen always seem to find the wrong boyfriend?” The danger in naive, nonconceptualized theory, though, is that it is so often full of contradictions, inconsistencies, superstitions, and outdated information. It is only through bringing our assumptions out into the open, laying them out in an organized fashion, that we can decide what parts of them we want to keep and what parts we are better off without.

By learning about the theories of our older, possibly wiser, colleagues, we expand our own possibilities. When reading Freud, Rogers, or Perls, you are introduced to ideas that you might never have thought of on your own. You can accept them or reject them; but even if you choose to reject them, you are the richer for having thought through your reasons for doing so. There is something to be learned even from a theory that we reject. Each of us will find some theoretical stances more attractive and comfortable than others—and that’s just fine. Above all, it is probably critical to the success of the psychotherapy that the therapist feels comfortable with her chosen approach. Your approach should be something that becomes like a second skin for you. If that’s true, you will remember it more clearly and use it more appropriately. Theoretical frames that don’t fit your personality will be awkward and uncongenial, and you will be awkward and unnatural using them. Imagine your grandfather wearing an earring and baggy pants: he would feel uncomfortable, and probably look silly as well. Using a theoretical frame that doesn’t fit can make us feel just as uncomfortable, and sometimes look just as silly! Our theories do need to grow and change, of course, as we learn from others. But they must still be ours: we need to work each idea through, refine it, and integrate it into the other things we believe. Only then will we be comfortable using it with our clients. One of us (MK), for instance, tends to be quite nondirective as a therapist; this feels natural to her and is consistent with her usual style of relating. The other (JM) is more active, often suggesting ideas and experiments for her clients to try out—and this, too, is consistent with how she acts outside of therapy. Both of these therapeutic styles are based on clear theoretical ideas, a clear sense of what we are doing and why we are doing it. That’s what gives our work focus and direction, makes it more than a bag of unrelated tricks and techniques.

While therapists find it relatively easy to agree to disagree about specific theories, we do need some consensus about the assumptions and values that the theories are built on. These assumptions guide the way we think about problems, conceptualize them, set them up to be solved. Psychotherapy is, in the last analysis, doing something about problems. We, authors and readers of this book, will need to agree on this point if we are to think together about how this “doing something about problems” is to be accomplished.
There are two basic assumptions without which psychotherapy cannot be performed successfully. The first of these has to do with the worthiness of the therapeutic enterprise. Harris (1994) suggests that the expectancies a therapist brings to the clinical relationship can act as a self-fulfilling prophecy. In other words, if the therapist has a positive initial expectancy and the client senses that expectancy, treatment will be enhanced. The therapist’s belief in the process invites the client to believe, and clients who believe are likely to benefit. Conversely, if we do not have faith in what we are doing, we are no better than charlatans or con artists.

The second assumption shared by all successful therapists is that our clients are capable of change and of making choices about their changes. This is a belief about the nature of humans; it is untestable because it is a philosophy rather than a fact. It is a faith in the human ability to be (or at least to become) free to learn what we need to know and to make responsible choices on the basis of that knowledge. All psychotherapists, from client-centered to behavioral to existential, must share this faith. It is one of the great paradoxes of orthodox behavioral therapy that believing all behaviors to be shaped by external stimuli, nevertheless the therapist first attempts to discover what behaviors the client wants to change. It is one of the great paradoxes of existential therapy that knowing that the world we live in seems “meaningless,” the existentialist then works to help the client to create meaning in life and live with the human condition, anxiety. Whatever the science of stimulus and response or the philosophy of existential angst may say, however, one’s phenomenological experience is of making choices and decisions, and having one’s life changed by those choices and decisions. Psychotherapy is based on that phenomenological truth, as important to us therapists as it is to our clients.

Moving beyond these two fundamental and essential assumptions, we discover a host of questions about people and how they function. These are the questions on which therapists may legitimately differ, the questions that each of us must consider and answer in terms of our own beliefs. Four of these questions, we believe, are critical in determining the way we behave as therapists. They pose issues on which each of us must take a stand. They are

1. How/why do people get to be the way they are?
2. How/why do they maintain their thoughts and feelings and behaviors in a particular maladaptive or pain-producing pattern?
3. How can I facilitate their changing that pattern?
4. What kinds and directions of change am I willing to support and assist?

Your answers to these questions may shift over time; you may not believe today what you will believe ten years from now. However, you must believe something, and you must know what that something is. The answers to these questions, and
all the others that grow out of them, are the foundation on which the whole structure of your therapeutic skill is built. Without a foundation, that skill collapses into an unrelated heap of tricks and panaceas, equally confusing to both you and your client.

With clear, consistent answers to the four questions, you are ready to become a therapist: acting spontaneously, genuinely, using your creativity with confidence as you construct your behavior from moment to moment, secure in the knowledge that you are operating out of a consistent frame of reference. You can do what “feels right,” trusting that later, when you have time to analyze what happened in those fast-moving interactions, the feelings will fit your professional beliefs. You will be able to be calm in the face of the client’s anxiety and agitation, grounded and optimistic in the face of the client’s despair, able to accompany the client through his pain and rage while at the same time sensing the healing potential that he brings with him on that journey.

Not all therapists operate at this level, nor do any of us do so all the time. It’s an ideal, something to aim for. Somehow, it’s all right to not quite live up to it, not in every session. As long as we continue to learn, to grow, to improve our skills, always building on a firm and consistent set of beliefs about ourselves and fellow humans, we can be pleased with our work and our competence. In fact, one of the sustaining attractive features of psychotherapy for us is the fact that we can always learn and grow and get better at what we do.

This brings us to the end of the introduction, the end of the beginning, and the beginning of the main course. What are the skills that contribute to good psychotherapy? How do we continue to grow and to improve on them? It is a long journey that we are embarking on, one that will probably last our lifetime and affect the lifetimes of many others. We have opened the door; shall we go in?