TO BE OR NOT TO BE – HAMLET AND THE PSYCHOTHERAPEUTIC TECHNIQUE: ABOUT THERAPEUTIC ALLIANCE, GROWTH AND EFFECTIVE THERAPY

Arno Remmers

M.D., psychotherapist, International Trainer of PPT (Germany), private lecturer and supervisor at the Wiesbaden Academy for Psychotherapy (WIAP)
Email:
arno@arem.de

Abstract

It is possible to construct a helping alliance for the best results in therapy by keeping in mind this helpful process of therapy, starting with building an attachment which will be needed for the interactive differentiation of the therapy contract, goals, and the client's own activity between the sessions, and finally using feedback at the end of each session. The therapeutic alliance will grow by changes, in crisis situations and thresholds within therapy. It is essential that we know the partners of the clients and let them know about us, in order to facilitate our clients' growth and to lessen side effects, and that we include the interaction with the social environment of the clients, and finish with the feedback about the therapy process.

Keywords: therapeutic alliance, stages of interaction, Balance Model, Positive Psychotherapy

Introduction

As workers in a healing profession, we have to care about the existential questions in our patients' lives. They suffer from these, whether it is in a panic attack, feeling that they are going to die, in a depression with a lack of feelings altogether, or in a compulsive obsessive disorder with the feeling that they must always do something meaningless. The patients usually have high expectations and get hope in the moment they make an appointment with us. We have the task to cope with their existential questions, how to live with depressive phases, how to survive a borderline personality diagnosis, or how to cope with life as unpredictable and with its finite nature.

Methodology

As a therapist, who mainly did not have the experience of such symptoms as my patients experience, but has had long years of training in specific treatment methods, I wonder: Who am I in this encounter with my patient? Whom could I be for my client? How am I in this relation with my client? What is it that really counts in psychotherapy, what is it that really helps?

Surprisingly enough - it is not the method or theory that is the healing aid, its influence is not more than 15% on the outcome of therapy. Such data is supported by the newest publications such as Bruce Wampold's in the Conference on Systemic Research on 8.-11. March 2017 in Heidelberg. It might disappoint us as therapists learning or even teaching psychotherapeutic methods, that it is not the psychotherapeutic method which we identify with, but the patients' factors, patients' expectations and the therapeutic relation that have the strongest effect on the outcome in treatment (Norcross, 2009). The 'best method' or the 'excellent technique' are not what they seem to be - they are not the most important basis on which to help our clients to have a better life. Still, the psychotherapeutic

method as such seems to be necessary in any case; for me, myself, as a therapist I feel the need to develop an identification with one of the theoretical models (Kernberg, 2005), to understand myself and the clients' world better by means of a clear, logical, and 'empirically based' theory.

After passing the psychotherapeutic school, experiencing psychotherapy, applying interventions, learning from our patients how to act or what to do, as therapists, we soon come to Hamlet's question - To be or not to be, or as formulated for therapists: To be, or how to be? In order to survive as therapists. The question brings me back to reflect on the real person I am, playing therapeutic roles, back to the therapeutic relations we have, to the patterns we create with each other, to the meaning we find together in a therapeutic setting. I might be identified with a method I like, with a theory I believe in, and still - research has been showing for a long time that it is not very important to my clients which theory I apply to their disorders. Rather, it is important if I have a healing personality. Still, it helps me to survive when I can identify with a specific method of psychotherapy.

A psychotherapeutic school with its theory and teachings of interventions can help me to grow as a therapeutic personality. A theoretical explanation of disorders gives me an inner working model. The methodology helps me to reflect myself, using terms from the methods I believe in, and gives me a belief that it is useful for us and the clients. The methods become inner working models. In this way, I can understand, can see a meaning, and can manage a situation, concerning the salutogenetic principles of Antonovsky (Antonovsky, 1997). In the spectrum between facts and religion, we can either see our method as a nice, empirically-based, logical theory or as a problem-management tool, "nice to have". It might provide a strong basis for what we experience with each other in a therapeutic process, and an aid in finding out what helps my clients to organise themselves better. We might become believers in a psychotherapeutic faith and identity so as to be united with others who believe in the same idea. It will give us a strong feeling of being on the 'right side'. So, we might feel safe and separated from dangerous others, being members of a strong community of the 'best psychotherapists ever' united with the label of the best method ever found, as in a religious community.

So I come back to the question: To be, or how to be as a therapist? The real medicine in psychotherapy is the therapeutic alliance, at least the recent research does not show other results.[1] The psychotherapist, as a person, as a human, is in interaction with the client. The alliance with each other is the helpful ingredient, valid for all kinds of methods, as Michael Balint quoted 1973: "...the most frequently-given medicine is the doctor himself. This is not medicine in a package, but an atmosphere in which the patient perceives another medicine" (Boncheva, 2004).

Results

The "person" - in Latin: *per - sonare*, means "to sound through the mask of the actor on the stage" in theatre, on the ancient Greek background πρόσωπον/prosopon = face. Carl Gustav Jung (1971) defines the "Persona" as "the mask or face with which the human shows himself to the world."

So, let us reflect on the question: What are the real influences of our trainings, the psychotherapeutic methods, of the therapist's personality, experience and training, the influence of the patients themselves, and that of the environment of the clients on the outcome of treatment?

Extra-therapeutic factors seem to play the biggest role in good results from therapy, that means, the nature of the patient's disorder as such, the severity of symptoms, the readiness for changes, the characteristics of the individual personality, the social environment, together these make up some 40%. This is what family therapy works with - to involve the family as the most important part of the social environment, and Positive Psychotherapy also includes the family and the wider social environment as much as possible.

The **quality of the therapeutic relation**, in a broader sense, the therapeutic alliance and the person of the therapist, has an influence of around 30% in all modalities. Psychodynamic methods explicitly focus on the patterns of therapeutic relation, the contents and dynamics, and resistance as a field of therapeutic training in conflict management. In Client-Centered Therapy (C. Rogers) the therapeutic relation is seen as the healing agent. Also in CBT, the therapeutic relation plays this important role but usually is not reflected as such. The **therapeutic alliance** is considered the most robust process variable, much associated with positive therapeutic outcome in a variety of psychotherapeutic models, as was stated by Alexander, L. B.&Luborsky, L. (1986) Gaston, L.&Luborsky, L. (1993), the

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[1] „The well-known "common factors model of psychotherapy" postulates that in order to explain treatment success of different approaches to psychotherapy or counselling, a set of common factors (such as clients' social and biographical context, life events during therapy, strength of clients' motivation, therapists' personal qualities and the therapeutic relationship) are much more responsible as compared to particular methods or techniques for specific problems and disorders (e.g. systematic desensitization for phobic disorders)...

" http://www.isr2017.com/news_events/

alliance is found to be the predictor of the efficacy of counselling and therapy, also by Horvath, A. O., Del Re, A. C., Flückiger, C., & Symonds, D. (2011). Shedler and Leichsenring found the same (Mellado et al., 2017).

The **hope of the client**, a perspective of help soon to come, the belief in healing, ca. 15%, and therapy techniques and methods have an influence of ca. up to max. 15% on the outcome of therapy, all these results are cited by Hubble, Duncan, and Miller 2001 (Hubble et al., 2009). The hope of the client is focussed on interventions, in Humanistic Therapy, in Positive Psychotherapy, in Systemic Therapy, or in Positive Psychology. In Cognitive Behaviour Therapy the frequent reflection of the goals of the therapy has the indirect function of focusing on a symptom-changing orientated future, so it might create hope, depending on the way it is reflected as a feedback in the therapeutic relation.

In one of the biggest meta-studies of that time, Grawe (1994) described as the main factors of a good outcome in psychotherapy: **Active help in problem solving, motivational clearing** (concerning values and goals), and again - the quality of the **therapeutic relation**. It seems that the personal influence or the **personality of the therapist** is linked to one of the strongest factors in the outcome of psychotherapy.

All this is the therapist's perspective. What do **patients** say? What were their expectations and what did actually help them? Sloane et al found (1975):

"The helpful person or personality of the therapist," (as when patients say "My therapist!")

"Help me to understand my problem," (see understandability of Antonovsky, or clearing of Grawe)

"Encourage me, help me to do something, to encounter the difficulties" (active help in problem solving)

"Give me the possibility to talk with an understanding person" (quality of the therapeutic relation)

"Help me to understand myself" (interactive encounter with an emotionally important person in the therapeutic alliance)

To summarize the most important factors in psychotherapeutic treatment:

- Quality of the Therapeutic Relation
- Understanding and Clearing
- Aid in Constructive Conflict-Solving
- Optimism to Find and to Give Help
- Motivation and Active Participation
- Personality and Maturity of the Therapist
- This is valid for all Methods (Grawe et al., 1994)

How can we reach this quality and alliance in our own therapies? What does this mean, as my personality as a therapist is as it is, and it will not change much? And: What does all that has been mentioned mean for our own practice? What do psychotherapeutic modalities offer for that?

A **therapeutic alliance**, the "helping alliance" (Luborsky 1976), is reached and supported in **different methods**:

- Personality orientated Psychodynamic Therapy by being a Model, by Parenting (Rudolf), Transference Focussed (Kernberg, 2005), or Ressource Orientation (Wöller).

- Conflict orientated psychodynamic therapies work with countertransference and resistance as part of founding the alliance, overcoming difficulties together and creating in that a way to solve inner and interpersonal conflicts.

- In Gestalt Therapy equality of patients' and therapists' feelings and positions are an important part of constructing a strong alliance.

- The Humanistic therapies focus on empathy, authenticity, being yourself.

- Positive Psychotherapy uses the same fundamental humanistic understanding of the therapeutic relation, and adds interactivity, self-help orientation, an understandable language and theory.

- Cognitive Behavioural Therapy uses goal orientation and encouraging active patient-s exposition and confrontation to support the working alliance.

What does it mean to create a "therapeutic alliance"? Rudolf (1991) answered this question already, and as research, it seems to be valid today: "...both partners need to **develop the belief, that they** themselves and the counterpart **are suitable** for the common therapeutic enterprise, and that they might/can lean on a **personal appreciation** for the other. The patient needs to come to the **conclusion, that the therapist can help** him because of his means; on the other side, the therapist needs to leave the impression that the patient is someone whom **he can help** and whom he **is able to accept** so far, furthermore that he is **motivated** to give therapeutic help. After all, both partners must develop the **same view of the problem** and the **same perspective for solutions**." (Rudolf, 1991)

As I have been working for 3 decades as a psychotherapist and teaching psychotherapy since 1992 in Germany and in other countries, working in psychosomatic medicine, in mental health, in hospitals and with outpatients, I asked myself the question: **what is common, what is different** in these different **settings and therapeutic relations**, and in founding a **good therapeutic alliance**? I want to show you how I like to work to reach a good therapeutic alliance as a family therapist, a psychotherapist and counsellor, a medical doctor or in psychiatry:

Four situations show the different positions of a family therapist, counsellor and psychotherapist, medical doctor, and in psychiatric treatment:

- a family with child behaviour problems,
- a depressive patient,
- a medical doctor's patient with a sleeping disorder,
- a paranoid psychosis.

As a therapist or doctor I have in mind my role, how to be, how to work with

• my feelings as a therapist, i. e. to be neutral and to hold in my feelings as a doctor, or to use them in psychodynamic psychotherapy to work with counter transference

• how I understand the contents of conflicts as a family therapist, or how I need to act as in psychiatry, not feeling understood by the psychotic patient,

• how to moderate a psychotherapeutic process or how to guide the patient in medicine or psychiatry,

• how to be sensitive for intuition in psychodynamic therapy, or how to plan for the suffering patient in medical treatment and CBT.

There result four areas of the therapist's mind sets:

• feelings vs neutrality

• contents understanding and self help vs treatment planning, psychoeducation and active help

• listening, interacting vs guiding and acting

• to open oneself for intuitions vs. to have clear plans, tasks and duties

For different patients I will need flexibility on a continuum between these attitudes, relative to the personality and situation of the client/patient. They are different in conflict management, psychotherapy, social work, health care, or medical treatment. I have to adapt to the severity of depression, anxiety disorders, or to the level of integration in personality disorder or psychosis, giving room or being active, feeling or being neutral, acting or letting the client think and change. We will give the emotional safe space and setting to the patient, being interested mindfully to understand the hidden links as a psychotherapist. "The medical doctor, in the role of communicator, has an intensive contact with the disorder or disease. The subjective information coming from the experience of the patient in contact with the doctor and the disease does not (usually) have a communicative value [for the medical doctor]" (Boncheva, 2004).

A constructive path for a therapeutic alliance is to see the patient as the specialist for his feelings and experience of the disorder, while the doctor will be the specialist to make the experience understandable. As medical doctor I will give my knowledge about disorder and treatment to the patient, in psychotherapy I will use my knowledge about communication and contents of problems. The feedback quality in our encounter will be more around the effects of treatment and the patient's activity, in medicine and psychiatry. Feedback is effective for a helpful alliance when we do it regularly, concerning the therapeutic relation[2].

Especially in times of thresholds or changes in consultation and psychotherapy. This will support the client's making good progress.

To work with the Social Environment of the clients:

Especially in children's therapy, we need the family therapy approach as a helpful alliance with the family, not just treating the child. In Youth therapy persons from the social environment of the adults also can be invited, if the client wishes. Christian Reimer suggested that, in therapy, we should "get to know the unknown third" (Reimer&Rüger, 2012) - the partner or family of the client should know about us or meet us, if the client wishes, and the therapist should get to know the partner of the patient, to lessen the side effects of therapy, and to broaden the therapeutic alliance.

The development of interaction in our therapy sessions follows **three Stages of Interaction**:

Attachment - differentiation - detachment, in a process of interaction, understanding and cooperation. They are the natural way of human encounters in many languages, as "hello!, how are you?, see you later!", or like our attitudes in phases of treatment:

1. Attachment: The patient's feeling of a person taking time for her or him and the patience in listening and really being interested in his or her problem is the starting point to have trust in you as a person and hope for the future and the outcome.

2. Differentiation is the phase of learning from each other and to clear the unknown: What is it about, what is the problem content, what is needed?

3. Detachment means looking forward, means the feedback about the session (Engster & Wampold, 1996), and preparing for the time after therapy, self help and future goals

An example to help us analyse the stages of interaction: Sometimes patients come and ask me immediately for diagnosis or for a prescription of medical drugs, or a plan for therapy. Then I remind the patient of the proverb "If you give somebody a fish, you feed him once, if you teach him fishing, he can feed his family a whole life long." I will go back to attachment, to have a human link first, to give the patient a space in which to feel free, to have time, to feel my patience, before we start with the subjects and contents of therapy. Lievegoed said: "A talk, or a talking culture, include, that a human encounters oneself in the self of the other."

To start and moderate the therapeutic process with **attachment**, to go through **differentiation** of contents and dynamics, to organise a good **detachment**, introducing the client's self help, seems to me important in all kinds of therapeutic encounters, and seems to be important to have

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[2] „1. Create a „Culture of Feedback", 2. Integrate alliance and outcome feedback into clinical care, 3. Learn to „fail successfully" in: Evidence Based Practice/Medicine (EBM) vs. Practice Based Evidence (PBE). Feedback as the main important tool. Scott D Miller, International Center for

Clinical Excellence: The Heart and Soul of Change: What Works in Therapy p. 21. http://www.scottdmiller.com/

a fruitful therapeutic alliance. Three phases of therapist - patient relations and interactions have already been described by V. von Gebsattel (1954) and V. Frankl (1953), later put into practice in Positive Psychotherapy as "the three stages of interaction" by their student N. Peseschkian (1977).

As you saw before, I must be clear about my role in creating a good therapeutic alliance, and need instruments to help the client and me to get a better understanding of the client's situation, of the function of the symptom, of the resources, and of myself in therapeutic encounters. For this I use the **Balance Model** (Peseschkian, 1977, similar to Jung, 1971) for reflecting the therapeutic alliance:

- Feelings and Observations,
- Knowledge and Action,
- Relation and Relational Pattern,
- Expectations and Imaginations.

With the Balance model, the patient and I can describe in a visualised way

- the symptom areas, better understand the everyday life of the client, and how the energy of this client is balanced,
- the influence of the symptoms on these areas of life, so to say, the function of the symptoms,
- resources and how to encourage them,
- goals and plans of self help for the patient,
- personality capacities (like the structural capacities of personality, OPD-2),
- finally the goals and objectives of therapy.

I usually start this balance model together with my client so as to have a clear understanding, to encourage the patient, to prepare self help, and to understand the environment of my client. This provides a simple but effective way to help construct a strong helping alliance. In addition, I can use the Balance Model for myself as a therapist, to understand the therapeutic relation as a mirror of the patient's unconscious contents, when I describe in the four areas, **how I feel with the client**, to find out what it means:

- feelings and emotions,
- rational thoughts,
- relational patterns with the client,
- intuition, fantasy.

The balance model helps me to understand my own countertransference in psychotherapy, to understand the contents of the inner conflict dynamic, to co-operate as "partners, that are on the same level of being" (Gebsattel, 1954). Within the four areas of my countertransference, described in the Balance Model, I can go to supervision after treatment and share with my supervisor what I experienced with my client.

After clearing the situation, the symptoms and their functions, the resources, and the goals, we can continue with a positive connotation of the function of the symptom,

with language pictures, or transcultural comparisons of the family concepts, and we will go to the contents of resources, concepts and conflict ambivalence.

The contents of resources and of conflicts can be described psychodynamically according to the OPD, or in Positive Psychotherapy as "Actual Capacities" to work with the clients in understandable terms. Differentiation of contents and capacities of the behaviour, perception and interaction is now possible. The work with the subconscious contents and concepts is easily understandable for the client with the terms defined as actual capacities such as trust, politeness, openness, punctuality or hope. This is taught in seminars for Positive Psychotherapy in order for both client and therapist to have a better therapeutic relation and greater satisfaction during and after the therapy.

In psychotherapeutic trainings we can train therapists to gain **five main competencies** to create a helpful therapeutic alliance concerning feelings, contents, resources, therapy cooperation and self help with

The Five Steps of Building a Helpful Alliance in Treatment[3]

1. Observation, Distancing

... to listen with patience, empathy and to add different points of view

2. Differentiation and Verbalisation

... to ask exactly to define contents, history, dynamics and possibilities

3. Situative Encouragement

...to accompany the patient and to encourage his self help

4. Verbalisation

...to focus on conflicts by consultation and to mediate responsibility for the consequences of changes

5. Broadening of the goals

...to see the future after conflict solving is no longer in the center

To train the capacity for observation and distancing, so to be able to listen with patience, empathy and to add different points of view, we need to train to be sensitive to our own emotions. We can reflect on them by being open to our own associations, thoughts, fantasies and feelings, as in the psychoanalytic freedom of free association. Combined with the courage to accept the different and perhaps strange feelings of fantasies, this will help us to change the points of view in therapy and to understand better our countertransference experience.

To train the capacity to differentiate, to ask exactly to define contents, patients and family history, the dynamics and possibilities, we need to understand the contents in episodes, description or countertransference. Theory of the

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[3] see also Peseschkian N: Psychosomatik und Positive Psychotherapy, 1991; Remmers A: 1997, Boncheva I: 2004

psychotherapeutic methods we have learned will offer the terms for that, such as terms for conflict and structure in psychodynamic therapy (OPD), schema, cognition or patterns in CBT, or actual capacities and the balance model in Positive Psychotherapy, and these terms can be easy for the clients to understand.

The step of situative encouragement, a term close to Alfred Adlers way of treatment, means to accompany the patient and to encourage his self help. We can train therapists to become stronger models for the patient in interacting and understanding, relation and balance.

The capacity to focus on conflicts by consultation and to mediate responsibility for the consequences of changes in the step of verbalisation means to be emotionally open for changes and conflicts in the therapeutic encounter as such, representing the reality outside of therapy. Therapists need to be trained for this by finding out their own inner conflicts in self-discovery, in training groups, and after therapy sessions in supervision.

Broadening the goals of the client, it is not possible to see the future after conflict solving has been removed from the center of my perspective if I only have relief from the symptoms in mind. This also means that therapists must be able to learn continuously, to be open to new ways, to learn from each feedback from the client. Feedback culture needs to be installed early in therapy to have a good and fruitful therapeutic alliance and to learn from each other. This is what we are doing here in our conference - to learn from each other. In each new therapy I start to learn again from this individual patient, as well as in the discussions with you now.

Conclusion

It is possible to construct a helping alliance for the best results in therapy by keeping in mind this helpful process of therapy, starting with building an attachment which will be needed for the interactive differentiation of the therapy contract, goals, and the client's own activity between the sessions, and finally using feedback at the end of each session. The therapeutic alliance will grow by changes, in crisis situations and thresholds within therapy. It is essential, in order to facilitate our clients' growth and to lessen side effects, that we know the partners of the clients and let them know about us, that we include the interaction with the social environment of the clients, and finish with the feedback about the therapy process.

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