

## What Should I Say? What Should I Do?

*By George Rosenfeld, Ph.D.*

After having provided 40-thousand hours of psychotherapy in the past 31 years, I still wonder what to do and what to say. My excellent graduate education at the University of Minnesota helped me start, but became outdated as knowledge expanded and trends changed. I was educated before the field was aware of the pervasive and influential impact of sexual abuse, domestic violence, fatherless households, learning disabilities, substance abuse and personality disorders in a time before brain imaging, deprofessionalization, cultural diversity, methamphetamines, Managed Care and the domination of Cognitive-Behavioral approaches. I am sure that thirty years from now, today's education and practice standards will seem more primitive and obsolete than my training now seems to me. Clearly being a psychotherapist requires adapting to constant change and constantly changing.

**You have to be able to tolerate ambiguity and be flexible.** The basic premises of psychotherapy are still being debated. There are conflicting theories about the nature of human beings which generate different treatment models that focus on different things. Behaviorists use behavior modification, and believe that feelings don't count in causing behavior. Dialectical Behavior Therapy focuses on changing feelings and contends that feelings cause thoughts and pathology. Psychoanalysis focuses on bringing the unconscious into awareness and contends that the unconscious causes feelings; while Rational-Emotive and Cognitive-Behavioral models focus on changing cognitions and stipulate that conscious cognitions cause feelings. Some theorists focus on the client's beliefs about the causes of their behavior and some believe that the client's expectations cause feelings and behavior. Psychiatrists emphasize that neurotransmitters and chemicals cause feelings and behavior and focus on chemical changes.

Some therapies focus on the past, others on the present or future. Some focus on problems, some on solutions and others ignore problems and emphasize installing strengths and hopes. Some encourage expressing feelings to reduce them (abreaction and catharsis) while others emphasize suppression and control. Some think the cure is in the relationship while others emphasize evidence-based techniques. Some focus on insight to achieve behavioral change, while others do not think insight is a necessary or sufficient precondition to change. Some challenge and confront while others nurture and support. Some emphasize change, some acceptance. For the same problem therapists recommend different modes of therapy (Medication, Individual, Family, Group, etc.). Therapists have different models for how long therapy should last and who should choose the problem to remediate. It is rare to find one generally accepted theory or approach to a client's problem. There are usually many ways to deal with problems, and senior therapists will disagree on how to prioritize interventions.

**So, what guides you to the most appropriate interventions?** Client characteristics are crucial. Their diagnosis informs the choice. There are empirically based interventions that have become the generally accepted standard of care for some diagnostic categories. Research has shown that exposure and response-prevention for Compulsions; Applied Behavior Analysis for Autism; Cognitive-Behavioral Therapy and medication for Depression; DBT for Borderlines; Wet-Stop like devices for Enuresis; medication, behavior modification, Child Guidance Counseling, education about the disorder, and Educational Advocacy for Attention Deficit Hyperactivity Disorder; and exposure, medication and Cognitive-Behavioral Therapy for fears and anxiety are effective. In fact, it may be unethical not to include such interventions in your treatment plan. The research also helps you exclude treatments, such as insight-oriented psychotherapy for Conduct Disorder, Attention Deficit Hyperactivity Disorder, Schizophrenia, etc.

The client's level of motivation helps determine the choice and timing of interventions. Probably the most common mistake therapists make is to offer an intervention before the client is ready. Some clients are well defended. Some enter therapy because others coerced them, they want validation or support, they

want someone else changed, etc. They are not ready to start changing themselves. Clients often progress from denying and minimizing to acknowledging problems and then seeking solutions with varying levels of commitment to the treatment process. We have to make our choice of intervention fit their present awareness and motivation to change. Suggesting an intervention to a client, who does not recognize he has a problem, is doomed to failure. First the client might be helped to see how his behaviors cause him negative consequences and then helped to avoid these consequences. Acknowledging that he has a problem beyond these consequences may not be necessary.

The intervention should match the client's developmental level. Someone whose level of moral development is based on the consequences he receives would not be a good candidate for an intervention to control his anger based on teaching empathy for others. A concrete thinker needs a concrete solution, such as role-plays in which the client practices telling the teacher instead of hitting, or counting to ten, or walking away, saying, "I'm rubber you're glue. Whatever you say bounces off me and sticks to you." Someone who seeks immediate gratification probably requires immediate rewards. An abstract thinker might benefit from an insight-oriented intervention, such as realizing that when they are angry they are being like the father they disliked. Treatment might focus on mastering the developmental tasks the client is failing, while using the skills acquired from previous developmental levels.

The client's strengths and weaknesses (insight, judgment, ability to learn, social support, ability to attach and care about others, ability to observe thoughts and feelings, physical health, attention span, etc.) influence the choice of intervention. Past treatments can influence choices of interventions. Clients can often identify what has been helpful and what has been ineffective in their past attempts to deal with a problem. Knowing this can shorten what is sometimes a trial and error process of finding the most helpful intervention.

A client's present situation and stresses can determine the intervention. Their family dynamics and social environment contribute. A child's needs might not be able to be met by a chaotic parent, so the therapist might seek help from a Grandparent, Big Brother, teacher or after-school program to supply the routines and consistency the child needs. Maslow's hierarchy helps us set priorities. A homeless or hungry client needs shelter and food, first. An abused client needs to be safe, first. A client's insurance, transportation, finances, etc. can impact choice of intervention.

If you are too comfortable doing your routine, perhaps its not being adjusted to the individual client's needs. Sometimes you don't know if you are helping or making things worse. We are engaged in a task where progress and our contribution to it are difficult to measure. This often leaves us humble. Beware the over confident therapist. He or she may be delusional.

*George Rosenfeld, Ph.D., is a clinical psychologist at Sutter Counseling Center in Sacramento, where he treats children and families. He is an Assistant Professor at the Professional School of Psychology.*