Eur. J. Psychiat. Vol. 6, N.° 1, (51-58)
January/March, 1992

Key Words: Psychotherapy.

The Stages of Psychotherapy

J.L.G. de Rivera, MD

Professor and Chairman,
Dept. of Psychiatry
Universidad de la Laguna
Tenerife, Canary Islands, Spain

ABSTRACT - The unfolding of the psychotherapeutic relationship is considered to proceed in four main stages: Commitment, Process, Change and Termination. Each stage has its own tasks and sub-stages, and has to be reasonably completed before transition to the next can take place. Relevant aspects of the Commitment stage are: perception of the therapist, motivation and technical suitability. The search for patterns, particularly the breaking of vicious circles or pathological positive feedback loops, is one of the important tasks in the process stage, as are the acquisition of new information and the consolidation of therapeutic gains. Change requires to relinquish the illness, to initiate a new healthier psychic life and to develop adequate procedures to protect and maintain the newly acquired strengths. Termination requires the development in the patient of a therapeutic attitude towards himself, and the mutual acknowledgement of independence and autonomy between patient and therapist. Each stage has its own characteristic tasks and difficulties, and requires different tactical interventions. The identification of each particular stage as psychotherapy proceeds, allows for a more effective therapeutic strategy.

It is difficult to find in the literature an adequate definition of psychotherapy, and in particular one which is sufficiently comprehensive so as to include all current systems and forms without losing conceptual accuracy. However, given the very diffuse and at times conflicting nature of the subject, one must come up with a definition which gives an outline of the field based on its very roots, and which affords a common starting point applicable to the more than 200 psychotherapeutical procedures in existence today. Despite the many differences in fundamental theory and technical detail, there are some points in which all the methods tend to coincide, namely that psychotherapy requires an interpersonal relationship, that its aim is to make the patient or client better, and that in order to do so, certain techniques or principles must be

applied. Taking those basic elements of agreement as my starting point, I would define psychotherapy as *"A purposeful and willing relationship between at least two people, one who is supposed to know what he is doing, and the other who wants help to change his life for the better"*.

My formulation deliberately excludes from the scope of the psychotherapies any kind of well intentioned, friendly conversations, as well as the nonspecific effects exerted on a person by the presence, personality or affection shown by others. Let us look in detail at some of the elements of this definition. Firstly, and most importantly, psychotherapy is above all a relationship, i.e. it requires the establishment of a coherent persistent rapport which can be maintained even during periods of physical separation. Secondly, it is a relationship with a purpose, i.e. it is not accidental nor unconditional but has an aim which justifies it and bestows meaning on it. Thirdly, is a willingly established relationship. Although this point may not be clear in therapies where the aim of the treatment and how this aim is to be achieved is not formulated, I do however consider this an essential element in the definition because it implies the need for consent, for a decision and, at least to a certain extent, for a commitment to the therapeutic relationship and its aims.

The need to have at least two people is obvious, although this does not rule out the involvement of more than two, as in the case of group psychotherapy. The therapist is "The person who knows (or is supposed to know) what he is doing", which means: 1) He is aware that he is undertaking a clinical intervention which demands professional skill, correct behaviour and responsibility; 2) He has the ability to be generous in the relationship, ready to offer something of himself without expecting the patient to meet his own affective needs; 3) He has operational knowledge of mental structure and function, of developmental, adaptative, and defensive processes, of the causes and mechanisms of psychopathology, and of the techniques required for his intented therapeutic intervention; 4) He has the necessary skills for establishing and sustaining the relationship, for obtaining and interpreting the relevant data, and for choosing and monitoring the appropiate intervention strategies (De Rivera 1982). Finally, "The person who wants help in order to change his life for the better", called the patient or the client, must add at least two ingredients to the psychotherapeutical situation: first, he/she must have a minimum amount of motivation to improve his/her life, which is neither as obvious nor as common as might first be thought. In fact, one of the therapist's main tasks is to ensure that the patient is aware of the shortcomings of his present way of life, that he wants the best for himself, and that he is prepared for cooperative work towards progress and self-development. Often, the patients are not looking for therapeutic help, but are rather trying to satisfy affective needs, to depend on someone and, occasionally, seeking masochistic punishment. Another primary task of the therapist is to transform these desires into a working alliance in pursuit. of a common goal, and if this does not come about, instead of psychotherapy one is left with one more in a series of repeated relationships which are at best sterile. In fact, turning the patient into a suitable candidate for psychotherapy and leading him/her to the point of readiness to start treatment is the most difficult, complex and frustrating task in the whole process. Once this is achieved, the rest is relatively easy.

Stages of treatment

The development of any form of psychiatric treatment, and particularly the development of psychotherapy, may be considered as divided into four stages or phases,

each of them with its own sub-phases and characteristic elements. The correct order and development of each stage is essential if therapeutical progress is to be made, and it may be necessary at times to modify the overall strategy according to the stage of the relation. Multidimensional treatment makes exhaustive use of the principle of step-by-step development, and an ongoing analysis is carried out of the necessary tactics for each step, without ever overlooking the need to adapt this to the overall strategy. Here I will describe briefly each of these stages and provide the most important definitions and conceptual limits, and will save for a future specific publication on the subject a more detailed description of the most appropriate interventions in each case.

Stages of Psychotherapeutic Relationship

1. COMMITMENT

PERCEPTION OF THE THERAPIST
MOTIVATION
TECHNICAL SUITABILITY

2. PROCESS

SEARCH FOR PATTERNS
NEW INFORMATION
CONSOLIDATION

3. CHANGE

RELINQUISH
INITIATE
SUSTAIN

4. TERMINATION

GRANTING
PERMISSION
AUTONOMY

1. The *commitment is* the initial stage in which the patient and the therapist decide to devote much of their time, energy, and capacity to establish relations to the achievement of therapeutical targets. Sometimes the therapist finds himself strongly reluctant to enter this stage, and when this is the case he must choose not to treat the patient, or at least he must delay the treatment until he has identified and remedied the causes of his reluctance. The patient can commit himself immediately, unconsciously and automatically or he may require beforehand an exploratory period. The elements influencing the decision to be taken by the patient are: 1) His perception of the therapist, or the extent to which he considers him to be competent, empathic and well disposed towards the patient, as well as whether he possesses a power which the patient lacks and would like to acquire. 2) The intensity and quality of his motivation. The most warm and skilled of therapists may immediately drive away a patient who is merely seeking to satisfy his sadomasochist needs, unless he manages to convince the patient to change his motivation or entice him with the prospects of the arduous efforts needed for the change to come about. 3) The technical suitability or the extent to which the education, personality and past experiences of the patient fit the proposed therapeutical methodology. Some patients can offer stiff resistance to certain techniques whereas they will accept others more readily, and due account must be taken of this when the initial therapeutic approach is drawn up. Sometimes it may be necessary to apply a tailor-made technique during the commitment stage, delaying the most effective and indicated methodology for later stages.

2. The *process is* the most complex stage and constitutes the central body of the treatment. It can be divided into three concurrent aspects: the search for patterns, the, gathering of new information and the consolidation. The relative importance of

each aspect varies according to the kind of problem and the type of patient but, in any case, in the initial stages of this step the sensation of psychic movement is more important than the nature of that movement. The process must make the patient experience that he is becoming aware of something, and this is more important than what he is becoming aware of.

Searching for patterns. Psychic phenomena and their behavioural manifestations do not occur just in any way, but rather they follow some more or less idiosyncratic rules and paths which we call patterns. Pathological patterns are characterized by their excessive rigidity, and by the fact that they are not in keeping with their present context, are unsuitably repetitive, and are harmful to the patient (De Rivera 1991).

Searching for patterns

REPETITIONS
TRIGGERS
VICIOUS
CIRCLES
INTERACTIONS

The identification, marking, and eradication of these patterns, with or without the patient being aware that they exist, is an essential element in the process, and is perhaps that which provides the sternest test of the therapist's technical skill. Repetitions are the most simple patterns, and they are easily identified by their inadequate presentation, with no apparent external factors which triggers them off and no obvious associative link with the general context of the situation. When such a pattern occurs regularly, the identification of the common elements in the situations in which it occurs provides the first clues as to its meaning. Sometimes, repetitive patterns are sparked off in a sudden and even dramatic fashion due to certain stimuli which are irrelevant in themselves but act like the trigger of a loaded gun ready to fire. Vicious circles are repetitive sequential patterns which are interrelated by a positive feedback effect, and these can maintain themselves indefinitely. They are extremely important in psychopathology, since they are responsible for the persistance of psychopathological states long after the disappearance of the etiological factors which initiated them. The discovering of operational vicious circles in each case must be followed by the identification of their weakest link, or the element of the circle where appropriate intervention will be more efficacious. Two typical vicious circles, described in previous work (JLG De Rivera 1981; 1984) and widespread in clinical experience, are shown below (figures 1 and 2).

The practical therapeutical applications of the analysis of vicious circles are obvious. In the case of anxiety syndromes, and to put it very simply, breaking the circle by directly counteracting the experience of anxiety through relaxation or by using psychotropic drugs may prove to be the most effective treatment with some patients. In other patients, analysing the internal conflict may be more appropriate or, still in others, modifying the behaviours giving rise to external conflicts, or supporting the most adaptable defence mechanisms and inhibiting the most unsuitable ones, could prove to be more successful. What is quite obvious is that no treatment can be effective overall if it does not break the positive feedback within the circle, even though it may be symptomatically effective in an isolated and specific manifestation of that circle. The same can be said for the vicious circle of depression in which, irrespective of the point of entry, the situation is self-sustained and can be reproduced even after an apparently effective treatment that does not solve completely the repetitive circular tendencies.

Repetitions in the relationship corre-

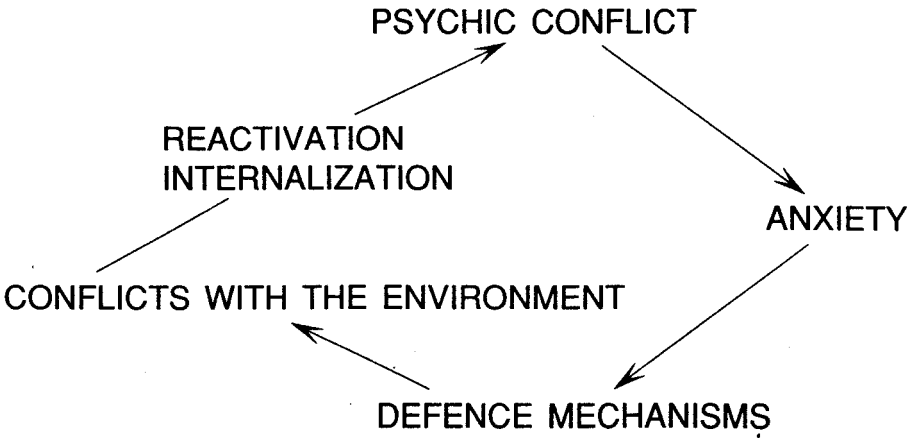

Fig. 1. The vicious circle of anxiety (JLG de Rivera 1981) generally commences with a situation of conflict involving important persons in the patient's environment, a situation which is internalized and transformed into an internal psychic conflict. Recalling this internal conflict or its nearness to the patient's consciousness generates anxiety, which in turn sets in motion automatic defence mechanisms in order to avoid the unpleasant experience. Since these mechanisms often prove to be poorly suited to the real demands of the environment, new external conflicts are originated which once more become internalized or which reactivate existing internal conflicts.

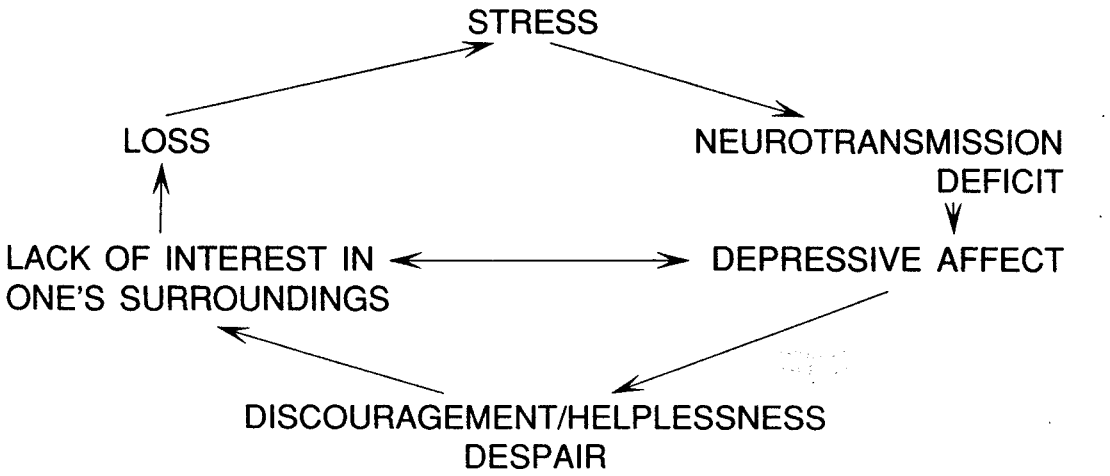

Fig. 2. The vicious circle of depression (JLG de Rivera 1984) can be caused by a loss and subsequent grief reaction which, if not solved rapidly and effectively, or if it coincides with other circumstances which are already overloading the individual's adaptation capacities, evolves into a stressful situation, the continuance of which activates neurotransmission mechanisms. The hyperactivity of these mechanisms can exhaust them, thereby inducing a catecholamine and/or serotonin deficit, which leads clinically to a depressive state. The lack of interest in his surroundings and the generalized inhibition of all activity and initiatives leave the depressive patient in a situation of competitive inferiority and he may become prone to suffer further losses readily.

spond to what is called transference in psychoanalysis when referred to the therapist. These types of transference-repetition are best handled when interpreted and corrected early when they are of a negative kind. Conversely, when they are of a manageable positive kind, they may be permitted and even reinforced throughout the whole process stage and even during the beginning of the change stage. Repetitions in relationships outside the therapeutic situation are very common and should be managed in a similar way to any other kind of repetitive pattern. Generally, even in cases where they seem to have beneficial effects, repetitive patterns are automatic, rigid and forced phenomena. A global, complete treatment should thoroughly restore the patient's freedom of action, although the correction of non- harmful relationship patterns can generally be put off until the last stage.

The acquisition of new information is the part of the process which develops in the patient the cognitive and emotional structures necessary for correcting his mistakes, offsetting his defects and solving his conflicts.

The acquisition of new information in the psychotherapeutical process

PRECEPT
EXAMPLE
DISCOVERY
CONDITIONING
SUGGESTION

Precept comprises specific orders, direct teachings or warnings, similar in all respects to those applied in traditional education. The example acts in a non-specific fashion when the therapist represents for the patient the embodiment of what the latter wants to bring about within himself, and in a specific fashion when the therapist shapes concrete actions and attitudes for the patient and monitors his learning of them. The discovery or insight can be defined as the process through which the meaning, importance, pattern and purpose of an experience is clarified. It is very similar to the creative process (De Rivera, 1978) and consists of the same stages of preparation, incubation, inspiration and elaboration. In very loose terms, it may be considered like a discovery made by the patient giving new meanings to experiences already known, but previously assessed in a different way. Conditioning involves the practical clinical application of the traditional principles of learning and behaviour modification. Suggestion, finally, is a precept which avoids and turns around the subject's conscious functions of critical evaluation, either as a result of the way it is presented, or due to the patient's state of consciousness at that particular time.

3. The *change stage follows* the process and represents its conclusion and success. There are three important aspects in this stage which need to be consolidated to ensure permanent therapeutic results. The first is the repudiation of the illness relinquishing all related elements, including pleasant ones such as the positive relation with the therapist, and useful ones such as the many ways in which responsibility can be shirked due to being ill. This process of repudiation or relinquishment is akin to grief, and the patient has to get over all his reasons for *remaining ill* and assure himself that, in spite of these reasons, he prefers his new healthy state of functioning. We must remember that, in addition to the well-known secondary gains which all pathologies involve, there is a Primary Gain which can be conceptualized as the (neurotic) prevention of a harm which seems even greater than that inflicted by the symptoms. The success of this stage requires the complete and thorough acceptance of this "Greater Evil", through the

work of the psychotherapeutic process. The other two aspects of the change are the initiation of free, appropriate and voluntary patterns of action, that replace old pathological behaviors, and the sustaining of these patterns through the creation of mental structures capable of detecting, interrupting, and neutralizing any pathological repetitive or vicious-circle mechanism which might appear. Frequently, this means the persistent adoption of mental hygiene habits and the permanent application of personal psychological techniques for preventive purposes.

4. The termination stage constitutes the "graduation" of the patient as an expert in the functioning of his own mind, and it implies that the therapist and the patient recognize each other as mature, autonomous, and independent individuals. This is the stage where positive transference relations, regressive forms of dependence, and childish idealizations have to be solved definitely. In this phase, the patient becomes aware of his own strength and realizes that he alone is responsible for his own life. The three interventions of the therapist during this stage are: 1) the abdication of his role and the granting of his teachings and methods, which now belong to the patient, 2) the handing over of permission for the patient to develop his life and act on his own responsibility and 3) the definitive acknowledgement of the patient's autonomy, and the affirmation of his own autonomy with respect to the patient. Although in some cases extremely fast, this stage often lasts longer than the rest of the treatment, either in the form of memories and fantasies concerning the therapist, particularly at times of stress, or as sporadic requests for isolated visits to the therapist.

Conclusion

The various schools, therapeutic trends and psychiatric orientations represent partial interpretations of Human Nature in general, and of psychopathology and psychotherapeutic processes in particular. Some of the factors maintaining such partial diversity may have to do with emotional peculiarities of therapists training (De Rivera 1980). A more complete view can be obtained if one accepts that the nature of both the origin of the psychopathology and the therapeutic process is multidimensional, and that some approaches may be more suited to a particular dimension than to others. Global psychotherapeutic treatment aims to establish the precise dimensions where therapeutic intervention may prove more efficacious, by borrowing techniques from diverse therapeutic methods or developing its own interventions designated to meet pre-established objectives. The formulation of how things should be once treatment has been successfully completed, that is, the goals or results to be expected, are an important aspect of the initial therapeutic contract. Unlike some therapeutic practices, which follow a path from the vague exploration of the past towards an uncertain and unknown future, I favour a method which enables the patient to determine the final aim he wishes to achieve, whereas the therapist helps him to negotiate, both consciously and unconsciously, the intermediate steps. The division of the overall therapeutical process into its component steps or stages facilitates the task, and allows to establish with a reasonable degree of accuracy the probable length of the treatment, the distance travelled, and the targets which have yet to be achieved at a given moment.

Aknowledgements

Thanks are due to Prof. A. García-Estrada for his kind advice and review of the manuscript.

References

DE RIVERA J.L.G. Creatividad y Estados de Con-

ciencia *Revista de Psicología General y Aplicada, 33:* 415-426. 1978.

DE RIVERA J.L.G. Identity and Psychiatric Training. *Psychiatric Journal of U. Ottawa, 5:* 24-27. 1980.

DE RIVERA J.L.G. La terapia de relajación en la consulta psiquiátrica interdepartamental. *Psiquis, 2:* 33-36. 1981.

DE RIVERA J.L.G. Psicoterapias y Psicoterapeutas. *Psiquis, 3:* 112-115. 1982.

DE RIVERA J.L.G. El fenómeno "circulo vicioso" en la depresión. *Psiquis, 5: 104-107.* 1984.

DE RIVERA J.L.G. and GARCIA-ESTRADA A. Psychopathology of Behaviour. In: *The European Handbook of Psychiatry and Mental Health.* A. Seva, (Ed.), Anthropos, Barcelona, pp. 590-596. 1991.

Address of the author:
J.L. González de Rivera
Avda. de Filipinas, 52
28003 Madrid
SPAIN