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Research Article

Psychotherapy Defined and Described: A Primer for Novice Clinical Interviewers

Travis J. Pashak*

Saginaw Valley State University, Michigan, USA

ARTICLE INFO

Article history:

Received: 31 December, 2019

Accepted: 25 January, 2020

Published: 31 January, 2020

Keywords:

psychotherapy

active listening

scanning-and-focusing

curiosity

advice

ABSTRACT

This brief article consists of an attempt to broadly and inclusively define psychotherapy, as well as to provide a description of several basic skillsets for entry-level clinical interviewers, psychotherapists, counselors, and social workers. The paper overviews four crucial points about therapy, namely that interviewers should engage in active listening, scanning-and-focusing, open-minded curiosity, and the avoidance of advice-giving. The paper concludes with a concise summary and encouragement for budding therapists.

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Psychotherapy Defined and Described: A Primer for Novice Clinical Interviewers

With this brief essay, I aim to provide a basic definition of psychotherapy and describe a few of the critical skillsets and interactional styles necessary for early therapists to grow into successful interviewers. I envision a paper such as this to be useful for college/university courses such as Abnormal Psychology or Introduction to Clinical Psychology, or perhaps as an overview for first-year professional/graduate students. I believe this paper is necessary because many materials in this topic area presume in readers a base understanding of what psychotherapy is and focus instead on higher-level issues (e.g., mechanics of particular interventions, empirical evidence of certain approaches) – meanwhile leaving unaddressed the nature of therapy itself, which early students need to grasp. While the art and science of psychotherapy are enacted in an enormous diversity of specific forms, and each clinician is afforded some flexibility to bring their own authentic approach to the work, I nevertheless hope for the guidance presented here to be applicable as broadly as possible and to as many future therapists as possible.

Defining Psychotherapy

So, what exactly is psychotherapy? Well, first we should examine the term itself: “therapy” simply means treatment. Hence, oncologists

employ chemotherapy (i.e., chemical/drug-based treatment), immunotherapy (i.e., immune-system-based treatment), and radiotherapy (i.e., radiation-based treatment) for various forms of cancer; physical therapists utilize physiologically/kinesiologically-informed treatments of a manual/movement sort for issues of injury/pain/mobility; pharmacists engage in pharmacotherapy (i.e., medical/pharmaceutical treatment) for a wide variety of diseases and disorders, and so on. Thus, it stands to reason that *psychotherapy* implies some kind of psychological treatment, and this is indeed the case – but what does that mean? What does it look like? If not chemical, physical, or medical, then what are the tools of psychotherapy?

To attempt to characterize psychotherapy as inclusively as possible to its many manifestations, I will offer the following definition: *psychotherapy is a healing relationship between two or more people, including a trained professional, built upon communication aimed at the maximization of mental health for those seeking treatment, and occurring within ethical guidelines.* By saying *healing relationship*, I am highlighting the fact that the tools of psychotherapy are the people involved, and their thoughts/feelings/behaviors toward and about one another. By saying *trained professional*, I am highlighting that psychotherapy skills are not to be equated with naturally occurring phenomena of familial/friendly relationships, but rather are the result of effortful studying and supervised practice. By saying *communication*, I

*Correspondence to: Travis J. Pashak, Saginaw Valley State University, Michigan, USA; E-mail: tjpashak@SVSU.edu

am highlighting that the vehicle of treatment in psychotherapy is verbal and non-verbal ideas exchanged between people. By saying *mental health*, I am highlighting that the goals of psychotherapy range widely but should always involve the positive growth, enhanced functioning, and minimized mental/behavioral suffering of the treatment-seeking parties. And by saying *ethical guidelines*, I am highlighting that the professional practice of mental health treatments is informed by a focus upon the values and moralities involved – including a desire to be helpful, an aim to avoid harm, a respect for privacy/confidentiality, a pursuit of justice, and a plethora of other ethical considerations.

At this juncture, new students to psychotherapy may be painting the above definition onto their pre-existing notions of mental health treatments, so a brief mentioning of what is *not* integral to psychotherapy may be helpful. Despite common media portrayals and public misconception, one should notice that psychotherapy does not require or mandate: that those seeking treatment are assigned a diagnosis; that those seeking treatment must lie on a couch; that those seeking treatment must be assessed using responses to inkblots; that the relationship is a one-on-one series of meetings high in frequency or close in temporal proximity; that the person seeking help is given assignments/homework/suggestions; that the clinician is available instantly on-demand; that medications are prescribed; and that the treatment-provider can personally relate to the topics discussed due to similar prior lived experience. These and other assumptions about psychotherapy can be potentially damaging or misleading – while they are each possible, and do occur in some mental health treatment capacities, none are inherent or essential to the definition of psychotherapy.

One further point about terminology is warranted here: while “psychotherapy” has been the primary term used thus far to refer to the mentally healing relationship, other terms are often used to denote the practice of mostly the same shared principles: clinical interviewing, psychological intervention, behavior modification, talk therapy, counseling, consulting, coaching, social work, and others. And psychotherapy skills are conducted not solely by clinical psychologists, but also a variety of other professionals such as counseling psychologists, counselors, social workers, psychiatric nurses, mental health technicians, crisis responders, and others. Hence, for the remainder of this brief piece, I will refer to the professional activity of psychotherapy – the healing relationships focused on mental health with any of the above providers – as simply “therapy.”

As a last component of defining therapy, I would like to underscore its vast diversity. As already noted, therapy is done by a variety of professionals, but it also occurs in a wide array of fashions. Therapy is provided to children, adolescents, and adults. Therapy is conducted with individuals, couples, families, and groups. Therapy is located in hospitals, schools, businesses, prisons, military centers, and private practices. Therapy is concluded in sometimes 15 minutes, sometimes 15 weeks, sometimes 15 years. Therapy is offered in structures ranging from tightly manualized to flexibly nondirective. Therapy is delivered in-person, over the phone, via text-message, and online. Therapy is practiced within theoretical orientation frameworks which some estimate to be as numerous as over 400 modalities or even 500 modalities [1, 2]. To be sure, therapy is not one monolithic endeavor but rather a diverse family of related professional activities. With this established, I will

describe what I believe to be several crucial aspects of an effective therapy mindset – relevant within and across various styles and specialties.

Describing Psychotherapy

I Therapy Involves Active Listening

Counter to what many assume, therapy is much more about listening than speaking. A strong therapist’s most important asset is likely their ability to ask effective questions, rather than their ability to give wise answers. It is for this reason that “interviewing” is such an apt synonym for therapy, as it really is a series of questions more than all else! For the therapy interview to be truly person-centered, growth-oriented, and helpful, the combination of great questions and active listening must be present [3].

Therapy is not simply the act of hearing another person’s words. What makes the process of *active listening* unique and powerful beyond the listening which takes place in everyday conversation is that the therapist is simultaneously taking in the client’s words, weaving together an understanding of the narrative presented, showing the client that they comprehend, and gently encouraging them to continue – all while keeping the focus upon the client. When listening actively, the therapist may communicate in subtle ways (e.g., head nod, “mm-hmm,” furrowed brow) or in more explicit ways (e.g., paraphrasing, asking for elaboration, directly encouraging them to go on), but will regardless move the client to feel heard and understood.

Active listening may sound like an obvious component of therapy, and a rather simple idea on its face, but it can be quite difficult to accomplish, particularly in the early stages of one’s career. Common difficulties for beginning therapists include dominating the conversation, directing too strongly rather than giving the client space to lead, and getting caught up in one’s own head trying to think of the next question rather than settling into the moment of what the client is saying at that point in time. Gripping the reins too tightly can often stifle the otherwise organic nature of the interview; but with practice, therapists can learn to take comfort in not knowing where the discussion will go, but nevertheless knowing that active listening tends to lead to the right places. When in doubt, open-ended questions (most easily identified as those question sentences which start with *how* or *what*) are a reliable way to spur dialogue and begin listening actively.

Listen to understand, not to respond – then the responding will come naturally. Early therapists will invariably find that truly *active* listening is actually quite effortful and taxing, hence the name. Listening, itself, is a crucially active agent of the psychotherapeutic intervention, and must be respected as such before any other tactics are introduced.

II Therapy Involves Scanning-and-Focusing

As noted, therapy sessions occur for a wide variety of reasons and serve myriad purposes. While there may be stark differences in functionality between an intake session with an anxious adolescent, a 33rd follow-up session with a bereaved widowed adult, and a crisis call with a depressed young adult contemplating suicide, each will in some way incorporate the practice of *scanning-and-focusing*. This is the practice by which

interviewers explore the range of relevant topics/content on the client's mind (i.e., scanning) and thereafter select certain topic areas to pursue further (i.e., focusing). Even in a relatively nondirective session, the clinician inevitably engages in some steering through the questions they choose to ask and the topics in which they pursue more detail.

To make sense of scanning-and-focusing as a therapeutic endeavor, one can imagine that it is somewhat like changing the zoom on a camera or telescope. For some prompts, the therapist may desire a sky-high overview for informing their background understanding of the individual (e.g., "tell me about your childhood," "how would you describe your religious or spiritual identity?"), whereas for other topics a much deeper microscopic perspective is warranted (e.g., "when you say that you feel guilty about what happened, can you elaborate on the exact thoughts and emotions?" "when you say that you've been restricting your eating lately, can you specify that further for me – what did you eat yesterday?").

Another potentially helpful analogy is to envision an internet search—first the broad search terms are established, then the link headings are examined, and only after parsing the most helpful content (in our sense, often the most affectively-loaded or goal-relevant content) does the interviewer dive in to explore further. And while this process is certainly driven in part by the therapist's choosing of topic areas to explore, it also honors the client's pursuing of whatever they may deem the most strongly relevant to their concerns and ambitions. Scanning over the array of potential discussion areas and focusing in on those most impactful issues, collaboratively, is certainly an important component of the therapeutic alliance [4].

Beginning therapists will often wonder *how* to appropriately engage in scanning-and-focusing. They may be apprehensive of spending too much of session scanning, or oppositely of pursuing a topic too quickly only to eventually find that it was a conversational "rabbit hole," ultimately of little significance. One important consideration is to ensure that the client is building autonomy in the therapy relationship, and this can be enacted in encouraging their input within the scanning-and-focusing (e.g., "of the issues you've mentioned, which should we explore first today?"). Another consideration is that in many sessions, the therapist only asks around 10 to 20 substantial questions. If novice interviewers enter the session with the mindset that they *only get ten good questions* with which to bolster alliance, insight, and change, they may find it much easier to focus in on effective topics rather than peripheral life details.

III Therapy Involves Open-Minded Curiosity

To conduct effective therapy, the interviewer must be a relatively open-minded individual who values their clients in order to remain consistently *curious* about their lives and experiences. In short, therapists need to like people and find them fascinating. One way to enact this pointer for beginning therapists is to view therapy sessions (especially the intake and early follow-ups) as somewhat like one-sided platonic "dates." I am certainly not advising a romantic view of the client, but instead encouraging a focus upon developing a warm connection, getting to know the client deeply, and facilitating their trust in the therapist. Together, these and other factors comprise what is called rapport or the therapeutic alliance, and any sort of judgmentalism/close-mindedness

from the therapist can easily diminish this bond. Curiosity is also crucial in how it contributes to therapists' multicultural competence – retaining a stance of open-mindedness toward clients, rather than presumption or stereotyping based on any identity characteristics, is an absolute necessity for ethical practice [5].

The importance of curiosity is also highlighted by the goals of the therapy itself. Many times, clients will report at intake that they are pursuing counseling in reaction to some difficulty or set of symptoms but will not divulge until several sessions later the more significant/pressing issues to which they attribute more distress. This phenomenon of delayed transparency is sometimes referred to as the *Ticket of Admission Problem* and makes a great deal of sense from the client's perspective [6]. An open-minded therapist who continues to seek deeper understanding of the client will eventually uncover such issues, which may have been too sensitive/embarrassing/painful to share in the first meeting (or may have not yet been conscious). Meanwhile, a closed-off therapist who clings to the goals listed in the referral notice, or who is too concrete to approach the relationship with flexibility, will unfortunately miss these opportunities to better serve their patients.

How should aspiring therapists practice open-mindedness and curiosity with their clients? The adoption of an empathic mindset is of great importance here [7]. In any given life episode which the client discusses, try to imagine what is seen/heard and thought/felt. Try to embody the client's self, but not without hanging on to an outsider's perspective. Put yourself in the client's shoes, but not just their shoes on *your* feet – rather, their shoes on *their* feet; envision their prior life experiences, their style of existing, but all whilst retaining your own outer vantage point [8]. See it all simultaneously, with an appreciation and awe for the rich complexity and depth. Now, from this point of utter immersive fascination, what becomes especially interesting? What becomes confusing? What becomes contradictory? What strikes emotional pain? What feels urgent? These are the areas to explore, and the questions which arise from these places are the ways to connect deeply and nonjudgmentally with the client.

IV Therapy is Not Advice

As a last stylistic pointer to budding clinicians, I would like to emphasize that therapy is *not advice*. Therapy is a process of active listening focused on the client, scanning-and-focusing upon various areas of relevant life content, and remaining open-minded and curious about the client. For many early clinicians, a bit of exploration is quickly followed by a desire to prescribe a solution – and while this is usually well-intentioned, it unfortunately tends to disrupt the progress of the interviewing relationship. An interviewer will know that they have accidentally fallen into this trap when they receive a "yes, but..." sort of response from the patient. Consider this – if the client is the one living their life every day, and one simple piece of advice would solve their psychopathology, does it not seem likely they would have already had time to think of it? Interestingly, the title of a mindfulness guide offers a pithy way to encapsulate this principle: "don't just do something, sit there" [9]. In other words, feeling compelled to spring into action with just the right solution is likelier to detract from effectiveness than promote it. Be patient and resist the urge to solve the client's problems – it is far more transformative to gently guide the client toward solving problems themselves of their own accord and creativity.

Advice-giving is also problematic in how it focuses the conversation on the interviewer (i.e., centering their ideas rather than the patient's ideas) and limits the range of perspectives to the frame-of-reference of the clinician instead of working within the client's frame. This can inadvertently galvanize a power differential between client and clinician, erupt friction of differing culturally contextual perspectives on the issue at hand, and erode the client's sense of trust and respect for the therapist. While this may seem surprising, and clients do occasionally ask directly for advice, advice itself is not an appropriate route to successful mental health treatments.

Underneath the mentality that therapy is not advice is the acceptance that clinicians are in fact human too, and are not inherently more stable, wise, or insightful than those we serve. The desire to advise is likely a result of the difficulty in sitting with another person's struggles, but that mutual enduring of life's challenges is exactly what clinicians are called to do. Good therapy is not an attempt at fortune-telling or an assignment to go home and *fix* oneself *per se*; it is a relationship built on validation, empathy, and compassion for the human condition and mental suffering. As Rogers frequently argued, it is the relationship itself – a warm, genuine, accepting therapeutic bond – which is healing, not any specific set of suggestions or solutions given as directions from the therapist [10].

Conclusion

In this brief essay, I have attempted to articulate a definition of psychotherapy and compile a few crucial stylistic pointers for beginning therapists. Namely, I suggest that interviewers listen actively, practice the art of scanning-and-focusing, remain open-minded and curious about their clients, and resist the common urge to provide advice. Certainly,

the guidance provided here is not comprehensive, but I believe that equipped with these basic skills, interviewers can begin to further grow their professionalism and mental health care expertise. Be a dynamic therapist, ask well-crafted questions, retain empathy and acceptance, and stay curious!

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