THE WILL IN PSYCHOTHERAPY

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In the past, a number of philosophers, theologians, educators and moralists, perceiving the importance and value of the will, turned their attention to the study of it. After William James, however, interest in the subject waned. Both so-called scientific psychology and depth psychology have almost entirely neglected or undervalued this important psychological function. The restricted concept of the will—the Victorian will-to-power—which prevailed in the last century, contributed considerably to this depreciation.

Scientific psychology, which has been in the process of development since the later years of the last century, has sought to apply to man the quantitative techniques proper to the natural sciences, and this has permitted no more than the study of man's outward behaviour (Behaviourism). Consequently the will, fundamentally an inner subjective experience, has been de-emphasized where not positively negated.

Depth psychology, which originated with the psychoanalysis of Freud, has investigated the crucial role of the unconscious. Freud concludes that man "is lived by the unconscious"; that is, man acts not because he decides by clear-cut rational consciousness but because he is impelled towards a predetermined course of action by unconscious motivations, whose roots are in obscure instinctive forces (anxiety, fears, desires, erotic impulses). Only during the last few years has the subject of the will regained its erstwhile position as worthy of study. This has occurred with the advent of Western humanistic and existential psychology, which concerns itself with man in his totality and takes cognizance of all his aspects and dimensions (including the concept of the higher unconscious). Certain psychiatrists and psychotherapists have made this approach their special province, among them W. Kretschmer, C. G. Jung, L. H. Farber (*The Ways of the Will*, N.Y.: Basic Books, 1966), Viktor E. Frank! (*The Will to Meaning*, New York and Cleveland: World Publishing Co., 1969), and preeminently Rollo May, especially in his book, *Love and Will* (New York: W. W. Norton & Co., Inc., 1969).

Psychosynthesis, for its part, has had a major role in what might be called the "rediscovery of the will". It has devoted deep study to the nature and experience of the will, taught its development and right use, and described in detail the six stages of the volitional act. In this way psychosynthesis has restated the will's central importance both in psychology and in life in general. It is of interest to note in this connection the publication of Dr. Assagioli's book, *The Act of Will* (New York: The Viking Press, 1973), which deals entirely with this subject.

Although the will is susceptible to specific applications in a number of fields of human existence (self-formative, educational, interpersonal and social, therapeutic, etc.), I shall devote myself on this occasion exclusively to a discussion of the application of the will in psychotherapy.

The expression, psychotherapy, implies a "psychotherapeutic relationship" in that psychotherapy brings at least two people (more in the case of group therapy), the therapist and the patient, face to face. Applying the idea of the will to the field of individual psychotherapy, the spontaneous question arises, what is the aim of the psychotherapeutic relationship? Equally spontaneously comes the answer, the principal aim is the recovery of the patient. Psychotherapy thereby symbolizes a "*tending towards a goal*" (i.e., the patient's recovery), a genuine volitional act, willed, decided, programmed and executed in active collaboration between the patient and therapist, in which each participates in a specific manner.

My insistence on restating this age-old concept stems from the lesson which experience teaches: that the too obvious is often lost sight of on the way, particularly when the road is long and strewn with difficulties.

To lose sight of the end, the purpose, happens frequently in the best intentioned psychotherapy, and results from the therapist's attention remaining too focused on the means of, rather than the final objective of, psychotherapy. Some psychoanalysts are prone to err in this fashion and, as a means of effecting a cure, embark upon an investigation of the aetiology of the current illness. They thus often lose sight of the goal, and the investigation of causes becomes the principal object of the psychotherapy. The result is that often times the patient, instead of being finally cured, merely develops a thorough knowledge of his early childhood neurosis. Often, in fact, he learns how to lay bare the causes of the causes of his troubles, then the causes of the causes of the causes! This creates a regressive process, a vicious spiral, an imprisoning circle from which patients neither can nor want to escape. Consequently, it is important that psychoanalytically oriented psychotherapy always keep the therapeutic objective constantly and firmly before itself to avoid producing a therapy-induced neurosis.

Psychosynthesis, on the other hand, holds that psychotherapy is not a retrograde path leading to the causes of the current illness, but a progressive movement tending towards a cure. With this in mind we can see that the primary, fundamental aspect of the will in psychotherapy manifests itself in the patient as the "will to be cured" and in the therapist as the will to aid", to guide, to facilitate the curative process in the patient.

Psychotherapy, as an appropriate healing process, must be founded on the patient's will to be cured. If such will is lacking or, more seriously, if overpowered by self-destruction or masochistic tendencies, the therapist must arouse it. When the will to be cured is present, the therapist assumes the function of a guide, steering and directing the patient's will in a skilful and intelligent manner in compliance with the laws of psychodynamics. The role of guide is a short-lived and transitory one, the patient becoming increasingly autonomous as he learns to utilize his will by himself alone.

Psychotherapy when appropriately founded on the patient's will to be cured brings to mind Carl Rogers' "client-centered" or "non-directive" therapy, where the work of the psychotherapy is carried out by the client himself. The therapist functions only as a catalyst, or facilitating agent. In psychosynthesis, psychotherapy is more directive than client-centered therapy, so that the therapist's role is not only catalytic, but truly guiding as well.

In summary, the indispensable foundation and starting point of every successful therapeutic process is that the will to be cured must be aroused and strengthened in the patient. This means that the patient's discovery of the will in himself is a primary requirement and one that extends into his inner existential experience. He must recognize that he possesses will. This means he must discover his own personal self, and come to identify it as the center of his self-consciousness and his will.

There are two ways in which the therapist can assist this discovery. He can do so primarily with his *attitude*, which in fact must be such as to invoke the patient's will. Detachment and objectivity on the therapist's part should be ruled out in favour of participation and subjectivity. Every attitude should correspond with the subject to which it is related. The therapist's attitude includes participation, empathetic intuition and acceptance of the subject, who at that moment is bringing his world with him into that room and presenting it to the therapist. A participatory attitude of this kind, a position of respect, understanding and acceptance of the patient just as he presents himself, is of itself conducive to subjectivity and spontaneity and tends to facilitate the patient's experience of himself as a subject, i.e., as an agent, a force, a cause, as a will. In short, the patient, feeling himself treated, not as an object of study and research, but as a human being, a living person, a subject that exists, discovers in himself the presence of a strength, an energy that makes him feel capable of acting as the cause of something, of creating and constructing. He recognizes his possession of a will. He ceases to

experience himself as an "object that reacts" and knows himself instead to be a "subject that can act". Thus he discovers and experiences his capacity to will.

The importance of all this lies in the fact that the average patient has a marked weakness of the will. His awareness of this deficiency leads to his fearing the psychotherapeutic process. He is apt to feel himself to be a will-less object in the therapist's hands. This arouses a fear of being changed, transformed and cured by the therapist. The patient who really wants to be cured fears this type of treatment, because he knows full well that to "be cured" forcibly outwardly by the therapist is not the same thing as being inwardly "cured" by his own will.

In this connection I would like to quote a passage from a letter written a short time ago by a patient to whom I had offered help. "With a dash of pride and a strong dose of desperation I have, by my own efforts, tried to pull myself out of the consequences of my collapse. I am going ahead, but in what direction I don't know; and I've an inkling of an approaching storm. It is not because of this that I want to cling to you, as I have done in the past to other people. It's not right, nor does it offer salvation. With you now I feel the need simply to speak, to do exercises and let myself say things unrelated to any personal interest. I want you to be a secret witness of my existence, not its judge."

The other way in which the therapist can aid the patient to discover the will is by teaching him *active techniques* designed to reveal and develop it. There are, for example, the so-called "useless" exercises and the exercise in disidentification, the latter leading the patient gradually to acquire self-consciousness and strengthening of the will. As a result he comes to experience his own "I", as distinct from all psychic contents (emotions, impulses, desires, thoughts, sensations, etc.). He also learns to distinguish between himself and his disease, to the point of assuming a certain attitude towards it which constitutes a necessary prelude to his being able to effect a self-transformation. This differentiation then leads him to an important affirmation: "I *hav*e an illness, but I *am not* my illness". In this way the patient learns increasingly to adopt the attitude of spectator of his disorders, thus keeping himself distinct and separate from them.

It is at this moment when the patient is observing himself that the therapist must intervene in order to direct and guide the patient's gaze elsewhere, towards other modes of his being. Guided by the therapist, the patient thus acquires knowledge of the existence of these other modes apart from his symptoms, and experiences them existentially. The experience reveals to him that, in the first place, he *is not* his symptoms but has symptoms; and, secondly, that symptoms are not his only experience; he has many other experiences as well.

What has been described is the prelude to the patient's discovery by psychosynthesis of that higher part of himself, the superconscious. He becomes aware of his potentialities, his deeper aspirations, the more noble and elevated aspects of his being. He experiences positive sentiments such as joy, courage, confidence, while recognizing in himself the capacity to love. He meets with an expansion of consciousness, not in a downward direction in search of the origins of his disturbance, but rather upwards, to find aims and values that, in making life worth living, attest to the validity of a cure.

This upward expansion of consciousness is of itself therapeutic. Not only does it reveal new inner space to the patient, as a result of removing him from the self-perpetuating vicious circle created by his compulsive self-observation and anxiety-ridden preoccupation with symptoms, but by also disclosing new values it arouses in him a stronger will to be cured. In fact, that he comes to value recovery enough to create the incentive to realize it, is an indispensable condition for his developing the will to be cured. But for this to happen, the cure must generate a feeling and meaning different from a mere riddance of symptoms (negative meaning). It must be associated with the acquisition of a state of health understood in terms of a sane, full, true and genuine mode of living (positive meaning).

One of my female patients who came to me with a recurring crisis of paroxysmal tachycardia devoted the major part of each session for most of the treatment to telling me about her "palpitations". As the psychotherapy neared its final phase, however, during which the crises had ceased, she used to dwell on the fact of her being cured. She spoke less of the disappearance of her former symptoms and more of having discovered new positive values. "I feel true, genuine—now my life is full—I feel satisfied, stronger, more sure of myself—I have discovered love."

In fact, a cure understood solely in terms of symptom loss creates an inner void in the patient, which in the majority of cases tends to be filled by other symptoms, similar to or approximately equivalent to the first symptom.

And so the true will to be cured is (to echo Frankl's statement) a will to meaning associated with a personal cure. Accordingly the patient wants to be cured only if he succeeds in giving a meaning to his cure. This can occur only if to be cured means for him to grant reality to a part of himself to which he attributes high value.

In this way, to be cured is worthwhile because to live healthily is worthwhile, and that means to give reality to values and meanings. Consequently, the will to be cured is a function of *the will to live*.

In some cases the patient does not succeed in giving a meaning or value to his cure and therefore to his life, being unable to attribute a meaning to life in general, or, better, to discover one. Or he may assume that life in general has a negative meaning, the reverse of good. This makes a cure much more difficult because the will to be cured depends upon the will to live and the latter depends upon the will to believe that life in general possesses significance, and further that this significance is positive, constructive and good.

Here we must make an appeal to what Frankl calls the "will to meaning", which takes form in the acceptance of life, in an act of faith in life itself, in what Tillich terms the "courage to be". (Paul J. Tillich, *The Courage to Be*: Yale University Press, 1952.) This act of faith in life constitutes a real act of will and as such is creative, in the direction of putting life into conditions conducive to its exhibiting its good, positive and constructive face.

Up to this point we have spoken principally about the patient. But since, as we have said, the psychotherapeutic relationship is substantially one of collaboration between patient and therapist, with the common purpose to cure the patient, it is important that both the patient and the therapist give value to this common purpose. It is important to the aims of the treatment for two reasons:

1. The specific function of the therapist as guide in the patient's recovery process, being more strongly motivated, becomes reinforced and is fulfilled with added commitment and zeal.

2. This increased commitment of the therapist arouses and strengthens the patient's will to be cured. In fact, in certain cases the patient, though failing to attribute a value to his recovery, nevertheless develops a strong will to be cured, because he "believes" in the therapist. It constitutes a genuine act of confidence in the therapist on the part of the patient. The patient wants to get better, because the therapist wishes this. As a case in point I quote another of my female patients who told me one day that, while she did not regard her life and therefore her cure as having much significance, she felt strongly encouraged to get better by the fact that I was doing so much for her, and showing by my behaviour my belief that her recovery had a value.

This example seems to me to provide a clear demonstration of how in certain cases the patient's will to be cured can usually be aroused and stimulated by the value ascribed to the cure, not so much by the patient as by the therapist himself. This consequently confirms the importance and necessity of the psychotherapy essentially

conforming to a pattern of collaboration, in which not only the patient, but also the therapist must cultivate a certain degree of co-involvement and participation.

Practical application of the "will to be cured" calls for a measure of skill on the part of the therapist. We know indeed that if the will is pitted against other psychic functions such as, for instance, the emotions and imagination, it often suffers defeat. To be effectual, the will must be competently employed, with an indirect approach, by mobilizing a desired emotion against an undesirable one. It is the therapist's task to assist the will to be cured by adopting the role of guide and providing the patient with the technical means of reaching a cure. The therapist tackles this task by availing himself of the numerous techniques used in psychosynthesis, selecting those most suitable and alternating them according to each patient's needs and to the specific demands of the various phases of that patient's treatment.

Among the most frequent employed techniques in psychosynthetic therapy we have: the technique of free drawing; that of "acting as if"; the exercises in dis-identification, of the ideal model and of the sense of right proportions; the use of symbols (symbolic visualization); exercises of the will, and of transmutation and sublimation of the sexual and aggressive energies; the technique of the "waking dream"; imaginative training; the evocation of higher feelings; and many other techniques and exercises.

Under the guidance of the therapist, the patient uses his will to be cured skilfully and therefore soundly, improving and getting concrete results as the treatment proceeds. He thus acquires more and more confidence in the *possibility* of his being cured. This confidence, coupled with the earlier confidence in the feeling and value of the cure, strengthens and consolidates the will to be cured in the patient.

The therapist's guiding function diminishes as the patient becomes more autonomous and capable of self-guidance. The function is transient and gradually tends to be introjected by the patient, who thus discovers his "inner guide". In fact the therapist teaches the patient to be autonomous by educating him to use many of the techniques and exercises on his own; this is a specific characteristic of psychosynthesis.

Another important concern of the therapist is the confidence he himself has in the cure of the patient. The greater his confidence the greater is his commitment, and also, by a process of osmosis, the confidence of the patient in his cure is thereby reinforced.

Love is another aspect of the will to be cured. We have in fact seen that to be cured means to live healthily. But to live healthily means to live together with others, and with those others to learn to establish right human relations in collaboration and cooperation. To be cured means to learn to forge bonds with others, to create harmonious ties with them. "I've overcome my egotism, I've learned to love," a woman patient told me at the end of her treatment. Then she added further, "Previously I always wanted to have; to have more and more. Now instead it is only when I can give that I feel true and genuine." These words indicate that "to exist" always means to "*exist in company with others*." That isolated man does not exist is a fact, a reality. Men are linked by invisible threads, their beings interwoven with each other and with the universal life, just as at the biological level the cells of the human body are connected with each other and united to form its tissues. Hence the indispensability of succeeding in establishing harmonious interpersonal and social relations, if one is talking about a real cure.

At this level the will to be cured becomes a genuine "will to love", since love is the true force capable of cementing together the individual will with that of others. But love is also the force that enables the individual will to comply with laws which are those of the universal life, with what may be termed the cosmic will. Thus the isolated individual does not exist, because the individual is but a little part of that enormously greater aggregate, humanity. Humanity itself constitutes but a small portion of the whole universe.

Consequently to love others and love life with its laws is not so much a moral precept as an intelligent and wise concept of behaviour. It means indeed to open the eyes and become aware of the scientific reality of the world and the universe in which we live; to learn to respect, to put ourselves in tune with, and to live in harmony with this reality, which is ever so much greater than ourselves and of which we are only an infinitesimal part. We do well therefore to accept life and the universe with its laws, for this is the course of enlightened self-interest.

A will that is simply the instrument of individual self-assertiveness is less a bad will in a moral sense than a veritable scientific error. It clashes with and violates the order and harmony of the universe, its effects repercussing on itself in accordance with the principle of action and reaction. In consequence a specific characteristic of the will is to master itself, to control itself within right limits so as to achieve a harmonious match with the will of other people and the universal will.

Turning now to speak about psychotherapy from a practical standpoint, it offers the patient technical means of undergoing the experience of love and then developing it in himself. This is accomplished by means of visualization exercises that tend to evoke the desired feeling by "guided imagination", by sessions appropriately directed by the therapist, by the exercise of world synthesis, by the "as if" technique, and by the cosmic test—which helps patients overcome egocentricity, acquire right perspectives and recognize their true place in the universe—as well as by other exercises.

At this point I feel it will be helpful to pass from theory to clinical practice. Here follows an abridged account of a clinical case, that of a young man of about twenty, who had tried to commit suicide by throwing himself into a river.

At our first session the patient presented a depressed demeanour. His expression was woeful, his look vacant and indifferent. Emotionally detached and closed in upon himself, he spoke little and only when prodded. He gave the general impression of inclining towards a congeries of ideas of a melancholy kind. In explaining his suicide attempt, he told me that a fixed, obsessive idea to take his own life had come to him about a year previously. This idea had plagued him continually, repeatedly presenting itself to his consciousness and arousing in him a corresponding impulse to kill himself. About the same time this young man commenced to develop an intense phobia associated with making mistakes. It started with some banal errors (for instance, missing a bus and arriving late for work), to which he reacted with excessive anxiety. The patient began to worry a lot and was frightened of continuing to make further errors, especially in his work. He kept on repeating his mistakes, assisted by means of a developing anticipatory anxiety; the fear of making a mistake facilitated the actual errors.

Gradually the patient came to interpret the repetition of these mistakes and all other negative occurrences as evidence of an adverse destiny, as the consequence of an unavoidable fate, against which it was impossible to struggle.

This feeling of being under an evil and contrary star induced him to form an extremely pessimistic view of life. In a short time this young man had convinced himself that life was dictated by evil and injustice. He felt himself increasingly caught and imprisoned in a deadly trap.

Concurrently the idea of taking his life developed in the patient. Latterly he was dreaming a recurrent dream in which a human figure followed him, caught up with him and hurled him down from a window. At this point suicide seemed the only solution sanctioned by fate to escape, from fate itself. Paradoxically the act of suicide presented itself as the sole independent act at his disposal.

At the close of the treatment I asked the patient from what he felt he had profited most during the course of psychotherapy. His reply was mainly general. "It has been all of it together," he told me; but he gave concrete experiences on which I have based the following description of the case.

At the very first session I explained to him the attitude of dis-identification. I took my lighter and put it on the table. "This is you; its your 'I'," I told him. Then I took out a packet of cigarettes and told him they were his emotions (his fears, for instance), and then I added a large ashtray which I said was his ideas (his ideé fixe of an adverse fate, for example). I explained that usually the "I" 's function is to regulate and direct one's emotions and ideas. But it sometimes happens that the "I" becomes feeble, and emotions and ideas no longer under control begin to gad about on their own. Thus it can happen, as in his case, that an idea starts to occupy the field and develops into an ideé fixe, without the "I" in its weakness being able to prevent it doing so. The idea tends to arouse a corresponding emotion (fear, for instance) and the emotion to reinforce the idea. Thus is formed a vicious circle which is self-perpetuating, and in which the weak "I" is imprisoned. The more the "I" rebels, indeed, the more the vicious circle is consolidated.

At this point the young man, who had been concentrating intensely on what I was saying, took the large ashtray and put it in place of the lighter, remarking, "In that case it is necessary to reinforce the 'I'." This spontaneous gesture not only showed that the patient had grasped my explanation, but it also possessed a true symbolical character and was a real act of will, which was of itself a therapeutic reinforcement of his "I".

Since drawing comes easily and naturally to this patient as a medium of expression, I made frequent use of free drawing as a therapeutic technique. In the therapeutic field, in fact, the therapist does well to talk to the patient in the same idiom in which the patient expresses himself most fluently. (Not vice versa, as happens only too often).

The patient's first drawings had a macabre quality, depicting devils, monsters and blood. The first drawings revealed marked aggressiveness, as well as a vision of life directed and dominated by evil, injustice and an adverse fate. These drawings served as a catharsis for expression of the patient's repressed aggressiveness. The efficacy of the catharsis was enhanced by the use of colored drawing pencils.

The visualization exercise which proved most effective was that of the "wise old man". By its means the patient succeeded in contacting his transpersonal unconscious. The patient discovered that there existed within himself an elevated, benevolent and friendly part, capable of helping and guiding him in life. This discovery aroused in him a sense of purpose and supplied a motive for being cured.

In like manner the "cosmic test" produced a markedly positive effect on the patient through initiating him into an expansion of consciousness upwards. He reacted to the photograph showing millions of galaxies in the universe by saying spontaneously, "In that case God exists!" Thus the conception of a fundamentally well-disposed life with good and just laws gradually gained ground in his consciousness. By means of the "wise old man" exercise, as well as the cosmic exercise, the patient discovered within himself a new, benevolent world, where love and justice reign, to be contrasted with the pessimistic vision of the world previously held. At first, this new world was only just discovered; to insure its continuity it had to be protected, cultivated, trained and developed.

Subsequently I took the patient through the exercises of the chrysallis and its transformation into a butterfly—an exercise of the will, also of the growth and development of life. I then had him execute in my presence a free drawing that was to represent a true act of will. In this case the execution of the drawing took on less the characteristics of a cathartic technique—and more of a creative expression. The will to be cured guided the patient during the whole execution of the drawing. The young man drew himself as one closed and imprisoned

in a room of glass, from which he could see everything, but could do nothing, because he could not get out. He drew the wise old man, who was dying on a mountain peak close to a lake. The sage, who represented the new transpersonal world lately discovered, was dying because the patient could not go to find him. At this point the patient decided to rescue his spirituality, appealed to all his forces, discovered his will and sought an opening through which to escape from the glass room. The glass room was his old world, which constituted his prison. "Where there's a will there's a way!" He found an aperture, narrow but sufficient, and with a great effort succeeded in getting out. At once he experienced a feeling of liberation. He drew vegetation and flowers, the sun, and at length the wise old man, who had regained his vigour and awaited him jubilantly. The interpretation of the drawing is that given by the patient.

In my opinion this session was decisive and determined the whole subsequent course of the treatment. After this all the patient's drawings expressed this new, lately discovered world. The sun, which he never drew at first, became a symbol present in almost all the pictures. In the last picture, which I had him draw in my presence after making him concentrate on the question, "Who am I?", he drew the sun, the world and himself. The image of himself in the picture was at the same time smaller and bigger than the world.

The cure was not merely symbolic but real. All the phobias from which the young man was suffering have disappeared. (Besides the phobia associated with committing errors, he had experienced anxiety crises at the sight of "narrow channels of muddy water" and of any object having a lot of little holes close together.) The patient's aggressiveness and exaggerated self-assertiveness have completely lost their importance. In any case they were mainly "reactive" to his pessimistic view of a bad and unjust world (a view which was none other than a projection onto the world of the negative image he had of himself). Consequently, with the symbolic transformation of. his world vision from negative to positive, and the parallel transformation of his self-image, the young man's aggressive and self-assertive tendencies lacked nourishment and therefore diminished substantially. His disposition regained its serenity, while his entire life became filled with meaning.

I have given this brief account of a clinical case, because it seems to me to demonstrate clearly that the will, especially in the form of the will to be cured, constitutes the hub and pivot round which psychotherapy must turn. In every therapeutic situation the essential task of the therapist is to appeal to the patient's will to be cured, to arouse it if lacking, to strengthen it if weak, and to direct and guide it skilfully and intelligently towards its goal. This must be done until such time as the patient is capable of managing on his own. At this point the therapist skilfully and wisely withdraws.

An appropriate withdrawal on the part of the therapist is as essential to successful psychotherapy as appropriate direction and guidance in the beginning.