A Primer for Psychotherapists

PSYCHOTHERAPY

It's Aim and It's Basic Theory

Kenneth Mark Colby M.D.

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Table of Contents

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Aim

The goal of psychotherapy is to relieve the patient of distressing neurotic symptoms or discordant personality characteristics which interfere with his satisfactory adaptation to a world of people and events.

Sweeping as it sounds, this aim is actually a limited one, as the practicing psychotherapist well recognizes. Psychotherapy-including its most extensive form, psychoanalysis—is repair work. This view cannot be overemphasized. A psychotherapist should not expect great transformations equivalent to a psychological rebirth or a complete reorganization of the patient's personality. The results which can be achieved in this repair work are limited by the caliber of the original material (constitution plus young ego), the degree of damage (infantile traumas and adult frustrations), and what remains to be worked with (adult ego plus the reality situation). In people, as in clothes, some materials are finer to begin with and a repaired article is never as good as the new one. Since psychotherapy is confined to repair work, this limited aim may conflict with the beginning therapist's ambitions as well as with the patient's hopes. This point will be further discussed in Chapters 2 and 3.

The goal is further circumscribed by the aim of therapy to deal only with those areas of the personality producing major disturbances. Aspects of the patient's character which are ego-syntonic and which he wants to keep are better left alone unless they are inextricably bound up with his neurotic symptoms. For example, an overtly homosexual man who develops a phobia and who wishes to retain his sexual orientation can be treated for the phobia without seeking the goal of changing his homosexual character structure to a heterosexual one. Likewise, a deeply religious patient who desires relief from an anxiety neurosis without loss of his religious beliefs is entitled to psychotherapy devoid of the aim of altering these convictions. It sometimes does happen during therapy that patients change their views on what aspects of their personality they wish to retain, particularly when this appears necessary in order to be rid of unpleasant symptoms. However, such changes are secondary outcomes and not the initial sought-after goal.

In speaking of the goal of psychotherapy, the term "cure" frequently intrudes. It requires definition. If by "cure" we mean relief of the patient's current neurotic difficulties, then that is certainly our goal. If by "cure" we mean a lifelong freedom from emotional conflict and psychological problems, then that cannot be our goal. Just as a person may suffer pneumonia, a fracture, and diabetes during his lifetime and require particular minimizing and separate treatment for each condition, so another person may experience at different times a depression, impotence, and a phobia, each requiring psychotherapy as the condition arises. Our aim is to treat the presenting problems, hoping that the work will strengthen the patient against further neurotic difficulties but realizing that therapy cannot guarantee a psychological prophylaxis.

Finally, it is not the goal of psychotherapy to produce an ideal or model person. Everyone in life must learn to withstand a certain amount of emotional tension. That the patient who has undergone psychotherapy is one who is placid, emotionless, lovable, good-natured, and guiltless, no matter what happens to him, is an illusion in which neither the patient nor the therapist must invest, however strongly our culture insists on worshiping such a psychological saint.

All this, to be sure, is the therapist's concept of the goal, and it may differ widely from what some patients have in mind when coming to be helped. Since in our time and culture the psychotherapist has come to represent an amalgam of oracle, sage, and healer, those ridden by anxieties, who in other times might have relied upon other resources, now sometimes turn to him for "happiness" or a spiritual code to live by. There is much suffering and unhappiness in the world which psychotherapy can do nothing about. And establishing rules of conduct is not our province. Hence patients searching for happiness in terms of formulas or right-wrong precepts are certain to be disappointed by a psychotherapy which has the goal only of relieving neurotic or psychotic distress.

Basic Theory

We assume that, before a therapist attempts any psychotherapy, he will have acquired a familiar acquaintance both with the main clinical facts about neurotic and psychotic behavior and with convenient working concepts of a dynamic- genetic-structural-economic nature to use in understanding this behavior. These data are admirably, if tortuously, collected in Otto Fenichel's Psychoanalytic *Theory*

of Neurosis, a book which must be read very slowly, in small doses, patiently and repeatedly. However, a few aspects of the theory can profitably be reviewed at this point. All the psychotherapeutic recommendations to be made are well founded in this logically uniform theoretical system as well as in practical experience.

Our theory begins with Freud's concept of the mind as an apparatus which attempts to deal with entering volumes of excitation in order to preserve the equilibrium of a rest state. The term "rest" is not to be taken in an absolute or static sense, but as implying a flux of energy changes within a limited range. As stimuli disturb the rest state by increasing tension, the mind seeks to discharge or bind this tension. Mental stimuli may be external or internal. External stimuli are those features of the surrounding environment perceived by the organism. Internal stimuli are those impulses (sexual and aggressive wishes) set going by biochemical energy changes. The young and growing mind learns, in integrating its internal needs with its environment, through thousands of reward-punishment experiences, to curb, moderate, channelize, displace, and postpone its wishes.

More specifically, a wish (internal tension-producing stimulus) may be totally gratified (tension discharged), totally denied (tension bound), or both gratified and denied (partially discharged, partially bound). The binding process is thought of in terms of defenses. In topographic terms, wish- impulses from the id are regulated by the defenses of the ego and superego.

In the normal state there is a harmonious relationship between wishes and defenses so that tensions are successfully managed with a satisfactory preservation of a relative rest state. A neurosis, on the contrary, is characterized (but not defined) by a neurotic conflict. That is, the compromise achieved by a wish and a conflicting defense has not successfully discharged or bound tension. Various clinical symptoms result from this type of conflict. We speak of a neurotic conflict, but there is usually more than one in a given neurosis. Since we treat them one at a time, it becomes a matter of convenience to speak of "conflict" in the singular. For the most part the patient is unaware of the nature, extent, or significance of his conflicts. Being unconscious and hence inaccessible, neurotic conflicts exert an all the greater influence on his mental life.

In theory, the goal of psychotherapy is to produce a favorable change in the disturbed balance of a

conflictual wish- defense system, thus allowing a fuller gratification of the wish or at least a more suitable compromise. Since we cannot, to any great extent, influence by psychological means the origin of biological processes per se (wish-impulses), in therapy we manage a wish-defense conflict by modifying the defense or ego component. Ideally we would like solely to attenuate or eradicate a pathogenic defense, but in actual practice, we probably annul some defenses while reinforcing others, the latter aiding binding rather than discharging functions. With the return of a relative equilibrium in a wish-defense conflict, tension diminishes and the symptoms decrease or vanish.

Next, let us consider the theory of the maneuvers by which this goal is reached. As the patient talks, the therapist listens and tries in his own mind to sort out, from the mass of thoughts, memories, and feelings the patient presents, an important neurotic conflict or group of conflicts. That is, the therapist attempts to see clearly the wish-defense system involved in a symptom-producing conflict. By various tactics (see below) he then brings this area to the attention of the patient in whom up until that time the ingredients of the conflict have been unconscious. As the defense of the conflict is brought to the patient's consciousness through verbalization, the motivation for the defense (affects of anxiety, guilt, shame, disgust regarding the wish) receives attention in terms of the patient's present and past life experience. Thereby the patient's "reasonable adult ego" is given the freedom to judge and relinquish this particular anachronistic defense as its motivation is seen to be of infantile origin.

Such is the strategy. The tactics by which the therapist influences a patient in this way now deserve comment. Statements by the therapist, i.e., interpositions and interpretations, are the chief tools used to change the defense or ego component of a neurotic conflict. These statements are made in reference to the patient's communications in two main areas, transferences and resistances, which represent the neurotic defenses in action in the therapy situation. By transference we mean the repetitious attempt, made unknowingly by the patient, to perceive and treat the therapist as an important figure of his childhood. *Resistances* are those defenses which operate in and against the therapeutic process to prevent an uncovering and a dissolution of the neurotic conflict. Thus, in theory, a transference is one form of resistance. Illustrations of types of interpretations, transferences, and resistances are given in Chapter 7.

By now surely an important question has arisen. Isn't all this psychoanalysis? Freud said that any

therapy which handles transference and resistance is psychoanalysis. Indeed, as presented, our theory of neurosis and our concept of the dynamics of cure are psychoanalytic. But though the theory is the same, the actual practice is somewhat different. These differences between psychotherapy and psychoanalysis are determined by several factors, the more important of which are mentioned below.

Time considerations are outstanding determinants in distinguishing psychotherapy from classical psychoanalysis. Since in psychotherapy both the therapist and the patient have less time available than is necessary for psychoanalysis, the frequency of interviews and the total duration of therapy are less. The time pressure prompts the therapist to be more active in questioning and in focusing the patient's attention on a significant conflict. This in turn means that the patient's communications are less in the nature of prolonged free association than they are a combination of conversation and associations. In psychotherapy, early childhood is less thoroughly explored and dreams are not exhaustively interpreted. The cases selected for psychotherapy (cf. Chapter 2) differ in some respects from analytic cases, as may the degree to which a therapeutic goal is attainable. In psychotherapy probably more pathogenic defenses are strengthened, by support, guidance, and reassurance, than in psychoanalysis, which attempts primarily to eradicate defenses. Finally, whether the full transference neurosis, in which most or all of the patient's conflicts become centered about the therapist, theoretically can or should be avoided in psychotherapy is a much discussed question. In practice, though the transference neurosis may not develop to the degree observed in psychoanalysis, there is always a transference aspect and in some cases it may blossom with full intensity. Thus psychotherapy and psychoanalysis have a similar theory of neurosis and treatment, but they differ quantitatively and to some extent qualitatively in their theory, and hence practice, of technique.

With this sketch of the psychotherapeutic aim and its theory in mind, let us now turn to the subject and object of these concepts—the patient.