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Varieties of Psychotherapy

A talk given to MIASMA (Mental Illness Association Social and Medical Aspects), Cambridge, 6 March 1961

You will more often hear discussed varieties of illness than varieties of therapy. Naturally, the two are interrelated, and I shall need to talk about illness first and therapy later.

I am a psychoanalyst, and you will not mind if I say that the basis of psychotherapy is the psychoanalytic training. This includes the personal analysis of the student analyst. Apart from such a training, it is psychoanalytic theory and psychoanalytic metapsychology that influence all dynamic psychology, ot whatever school.

There are, however, many varieties of psychotherapy, and these should depend for their existence not on the views of the practitioner, but on the need of the patient or of the case. Let us say that, where possible, we advise psychoanalysis, but where this is not possible or where there are arguments against, then an appropriate modification may be devised.

Of the many patients who come to me one way or another, only a very small percentage do in fact get psychoanalytic treatment, although I work at the centre of the psychoanalytic world.

I could talk about the technical modifications that are called for when the patient is psychotic or borderline, but it is not this that I wish to discuss here.

My special interest here is in the way in which a trained

analyst can do something other than analysis and do it usefully. This is important when, as is usual, a limited amount of time is available for treatment. Often these other treatments can look better than the treatments that I personally feel have a more profound effect, i.e. psychoanalysis.

First let me say that one essential of psychotherapy is that no other treatment shall be mixed up with it. It is not possible to do the work if the idea of a possible shock therapy is looming large, as this alters the whole clinical picture. The patient either fears or secretly longs for the physical treatment (or both), and the psychotherapist never meets the patient's real personal problem.

On the other hand, I must take for granted adequate physical care of the body.

The next thing is, what is our aim? Do we wish to do as much as possible or as little? In psychoanalysis we ask ourselves: how much can we do? At the other extreme, in my hospital clinic, our motto is: how little need we do? This makes us always aware of the economic aspect of the case; also, it makes us look for the central illness in a family, or for the social illness, so that we may avoid wasting our time and someone's money by giving treatments to the secondary characters in a family drama. There is nothing original in this, but you will perhaps like to hear a psychoanalyst say this, since analysts are especially liable to get bogged down in long treatments in the course of which they may lose sight of an adverse external factor.

And then, how much of the patient's difficulties belong simply to the fact that no one has ever intelligently listened? I very quickly discovered as long as forty years ago that the taking of case histories from mothers is in itself a psychotherapy if it be well done. Time must be allowed and a non-moralistic attitude naturally adopted, and when the mother has come to the end of saying what is in her mind, she may add: 'Now I understand how the present symptoms fit into the whole pattern of the child's life in the family, and I can manage now, simply because you let me get at the

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whole story in my own way and in my own time.' This is not only a matter that concerns parents who bring their children; adults say this about themselves, and psychoanalysis could be said to be one long, very long, history-taking.

You know, of course, of the transference in psychoanalysis. In the psychoanalytic setting patients bring samples of their past and of their inner reality and expose them in the fantasy that belongs to their ever-changing relationship to the analyst. In this way the unconscious can gradually be made conscious. Once this process has started up and the unconscious cooperation of the patient has been gained, there is always much to be done; hence the length of the average treatment. It is interesting to examine the first interviews. If a psychoanalytic treatment is starting, the analyst is careful not to be too clever at the beginning; and there is a good reason for this. The patient brings to the first interviews all his belief and all his suspicion. These extremes must be allowed to find real expression. If the analyst does too much at the beginning, the patient either runs away or else, out of fear, develops a most splendid belief and becomes almost as if hypnotized.

Before I go further I must mention some other assumptions. There can be no reserved area in the patient. Psychotherapy does not prescribe for a patient's religion, his cultural interest or his private life, but a patient who keeps part of himself completely defended is avoiding the dependence that is inherent in the process. You will see that this dependence carries with it a corresponding thing in the therapist, a professional reliability which is even more important than the reliability of the doctor in ordinary medical practice. It is interesting that the Hippocratic oath which founded the medical practice recognized this with crude clarity.

Again, by the theory that underlies all our work, a disorder that is not physically caused and that is therefore psychological represents a hitch in the individual's emotional development. Psychotherapy aims simply and solely at undoing the hitch, so that development may take place where formerly it could not.

In another, though parallel, language, psychological disorder is immaturity, immaturity of the emotional growth of the individual; and this growth includes the evolution of the individual's capacity to be related to people and to the environment generally.

In order to make myself clear I must give you a view of psychological disorder, of the categories of personal immaturity, even if this involves a gross simplification of a highly complex matter. I make three categories. The first of these brings to mind the term 'psychoneurosis'. Here are all the disorders of individuals who were well-enough cared for in the early stages to be in a position, developmentally, to meet and to fail, to some extent, to contain the difficulties that are inherent in the full life, a life in which the individual rides and is not ridden by the instincts. I must include in with this the more 'normal' varieties of depression.

The second of these categories brings to mind the word 'psychosis'. Here, something went wrong in the area of the very early details of infant nurture, the result being a disturbance of the basic structuring of the individual's personality. This basic fault, as Balint[1] has called it, may have produced an infantile or childhood psychosis, or difficulties at later stages may have exposed a fault in ego structure which had passed unnoticed. Patients in this category were never healthy enough to become psychoneurotic.

The third category I reserve for the in-betweens, those individuals who started well enough, but whose environment failed them at some point, or repeatedly, or over a long period of time. These are children or adolescents or adults who could rightly claim: 'All was well until . . . and my personal life cannot be developed unless the environment acknowledges its debt to me,' but of course it is not usual for the deprivation and the suffering it produces to be available to consciousness, so that instead of the words we find clinically an attitude, one which displays an antisocial tendency, and

1. M. Balint, *The Basic Fault*, London, Tavistock Publications, 1968.

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which may crystallize into delinquency and into recidivism.

For the moment, then, you are looking at psychological illness through the wrong end of three telescopes. Through one telescope you see reactive depression, which has to do with the destructive urges that accompany loving impulses in two-body relationships (basically, infant and mother), and also you see psychoneurosis, which has to do with ambivalence, that is to say, coexisting love and hate, which belongs to triangular relationships (basically, child and two parents), the relationship being experienced both heterosexually and homosexually, in varying proportions.

Through the second telescope you see the very early stages of emotional development becoming distorted by faulty infant care. I admit that some infants are more difficult to nurture than others, but as we are not out to blame anyone, we can ascribe the cause of illness here to a failure in nurture. What we see is a failure of the structuring of the personal self, and the capacity of the self for relating to objects that are of the environment. I would like to dig this rich seam with you, but I must not do so.

Through this telescope we see the various failures which produce the clinical picture of schizophrenia, or which produce the psychotic undercurrents that disturb the even flow of life of many of us who manage to get labelled normal, healthy, mature.

When we look at illness in this way, we only see exaggerations of elements in our own selves; we do not see anything which would put psychiatrically ill people in a place apart. Hence the strain inherent in treating or in nursing ill people psychologically, rather than by drugs and by the so-called physical treatments.

The third telescope takes our attention away from the difficulties inherent in life to disturbances which have a different nature, for the deprived person is prevented from getting at his or her own inherent problems by a grudge, a justified claim for a mending of an almost remembered insult. We in this room are probably not in this category, not even slightly.

Most of us can say of our parents: 'They made mistakes, they constantly frustrated us, and it fell to their lot to introduce us to the Reality Principle, arch-enemy of spontaneity, creativity and the sense of Real, BUT they never really let us down.' It is this being let down that constitutes the basis for the anti-social tendency, and however much we dislike our bicycles being stolen, or having to use the police to prevent violence, we do see, we understand, why this boy or that girl forces us to meet a challenge, whether by stealing or by destructiveness.

I have done as much as I can allow myself to build up a theoretical background for my brief description of some varieties of psychotherapy.

Category 1: Psychoneurosis

If illness in this category needs treatment, we would like to provide psychoanalysis, a professional setting of general reliability in which the repressed unconscious may become conscious. This is brought about as a result of the appearance in the 'transference' of innumerable samples of the patient's personal conflicts. In a favourable case the defences against anxiety that arise out of the instinctual life and its imaginative elaboration become less and less rigid, and more and more under the patient's deliberate control system.

Category 2: Failure in Early Nurture

In so far as illness of this kind needs treatment, we need to provide opportunity for the patient to have experiences that properly belong to infancy under conditions of extreme dependence. We see that such conditions may be found apart from organized psychotherapy, for instance, in friendship, in nursing care that may be provided on account of physical illness, in cultural experiences, including for some those that are called religious. A family that continues to care for a child provides opportunities for regression to dependence even of a high order; and it is indeed a regular feature of

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family life, well embedded in a social milieu, this going on being available to re-establish and to emphasize elements of care that belong initially to infant care. You will agree that some children enjoy their families and their growing independence, while others continue to use their families psychotherapeutically.

Professional social work comes in here, as an attempt to give professionally the help which would be provided non-professionally by parents and by families and by social units. The social worker, on the whole, is not a psychotherapist in the sense described in Category 1. The social worker is a psychotherapist, however, in meeting Category 2 needs.

You will see that a great deal that a mother does with an infant could be called 'holding'. Not only is actual holding very important, and a delicate matter that can only be delicately done by the right people, but also much of infant nurture is an ever-widening interpretation of the word 'holding'. Holding comes to include all physical management, in so far as it is done in adaptation to an infant's needs. Gradually a child values being let go, and this corresponds with the presentation to the child of the Reality Principle, which at first clashes with the Pleasure Principle (omnipotence abrogated). The family continues this holding, and society holds the family.

Casework might be described as the professionalized aspect of this normal function of parents and of local social units, a 'holding' of persons and of situations, while growth tendencies are given a chance. These growth tendencies are present all the time in every individual, except where hopelessness (because of repeated environmental failure) has led to an organized withdrawal. The tendencies have been described in terms of integration, of the psyche coming to terms with the body, the one becoming linked with the other, and of the development of a capacity for relating to objects. These processes go ahead unless blocked by failures of holding and of the meeting of the individual's creative impulses.

Category 3: Deprivation

Where patients are dominated by a *deprivation* area in their past history, the treatment needs to be adapted to this fact. As persons they may be normal, neurotic or psychotic. One can hardly see what is the personal pattern, because whenever hope begins to become alive, the boy or girl produces a symptom (stealing or being stolen from, destructiveness or being destroyed) which forces the environment to notice and to act. Action is usually punitive, but what the patient needs, of course, is a full acknowledgement and full payment. As I have said, this very often cannot be done because so much is unavailable to consciousness, but it is important that a serious digging done in the early stages of an antisocial career quite frequently does produce the clue and the solution. A study of delinquency should be started as a study of the antisocial in relatively normal children whose homes are intact, and here I find it frequently possible to track down the deprivation and the extreme suffering that resulted and which altered the whole course of the child's development. (I have published cases, and I can give other examples if there is time.)[2]

The point here is that society is left with all the untreated and untreatable cases in which the antisocial tendency has built up into a stabilized delinquency. Here the need is for the provision of specialized environments, and these must be divided into two kinds:

1. Those which hope to socialize the children they are holding.

2. Those which are merely designed to keep their children in order to preserve society from them until these boys and girls are too old to be detained, and until they go out into the world as adults who will repeatedly get into trouble. This latter kind of institution may run most smoothly when very strictly administered.

Can it be seen that it is very dangerous to base a system of

2. Examples can be found in *Therapeutic Consultations in Child Psychiatry*, London, Hogarth Press, 1971. [Eds.]

child care on the work done in homes for the maladjusted, and especially on the 'successful' management of delinquents in detention centres?

On the basis of what I have said, it is now perhaps possible to compare the three types of psychotherapy.

Naturally, a practising psychiatrist needs to be able to pass easily from one kind of therapy to another, and indeed to do all kinds at one and the same time if necessary, as need arises.

Illness of psychotic quality (Category 2) demands of us that we organize a complex kind of 'holding', including, if necessary, physical care. Here the professional therapist or nurse comes in when the patient's immediate environment fails to cope. As a friend of mine (the late John Rickman) said, 'Insanity is not being able to find anyone to stand you,' and here there are two factors: the degree of illness in the patient and the ability of the environment to tolerate the symptoms. In this way there are some in the world who are more ill than some of those who are in mental hospitals.

Psychotherapy of the kind I am referring to can look like friendship, but it is not friendship because the therapist is paid and only sees the patient for a limited period by appointment, and, moreover, only over a limited course of time, since the aim in every therapy is to arrive at a point at which the professional relationship ends because the patient's life and living takes over and the therapist passes on to the next job.

A therapist is like other professional people in that in his job his behaviour is at a higher standard than it is in his private life. He is punctual, he adapts himself to his patient's needs, and he does not live out his own frustrated urges in his contact with his patients.

It will be evident that patients who are very ill in this category do put a very great strain on the integrity of the therapist, since they do need human contact, and real feelings, and yet they need to place an absolute reliance on the relationship in which they are maximally dependent. The greatest difficulties come when there has been a seduction in the patient's childhood, in which case there must be ex-

perienced in the course of the treatment a delusion that the therapist is repeating seduction. Naturally, recovery depends on the undoing of this childhood seduction, which brought the child prematurely to a real, instead of an imaginary, sexual life, and spoiled the child's perquisite: unlimited play.

In therapy designed to deal with psychoneurotic illness (Category 1), the classical psychoanalytic setting devised by Freud can be easily attained, since the patient brings to the treatment a degree of belief and a capacity to trust. With all this taken for granted, the analyst has the opportunity to allow the transference to develop in its own way, and instead of the patient's delusions, there come into the material of the analysis dreams, imagination and ideas expressed in symbolic form which can be interpreted according to the process as it develops through the unconscious cooperation of the patient.

This is all I have time to say about the psychoanalytic technique, which can be learned, and which is difficult enough, but not as exhausting as therapy designed to meet psychotic disorder.

Psychotherapy designed to deal with an antisocial tendency in a patient only works, as I have said, if the patient is near the beginning of his or her antisocial career, before secondary gains and delinquent skills have become established. It is only in the early stages that the patient knows he (or she) is a patient, and actually feels a need to get to the roots of the disturbance. Where work is possible along these lines, the doctor and the patient settle down to a sort of detective story, using any clues that may be available, including what is known of the past history of the case, and the work is done in a thin layer that is somewhere between the deeply buried unconscious and the conscious life and memory system of the patient.

This layer that is between the unconscious and the conscious is occupied in normal people by cultural pursuits. The cultural life of the delinquent is notoriously thin, because there is no freedom in such a case except in a flight either to the unremembered dream or to reality. Any attempt to ex-

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plore the intermediate area leads not to art or religion or playing, but to antisocial behaviour that is compulsive and inherently unrewarding to the individual, as well as hurtful to society.