Psychotherapy Guidebook

Intensive Psychotherapy

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DEFINITION

Intensive Psychotherapy is best thought of as psychoanalysis with parameters; that is to say, a form of psychoanalytic treatment modified to suit the nature of the patient involved. If we define psychoanalysis as a treatment characterized by a frequency of at least four sessions each week during which a transference neurosis develops and is resolved by proper interpretation, we can compare Intensive Psychotherapy against this procedure. In Intensive Psychotherapy, the patient comes in less frequently, usually twice or at most three times weekly, may or may not lie on the couch, and does not ordinarily form a full-blown transference neurosis. Although strong transference reactions do develop and are usually interpreted, the curative factors in Intensive Psychotherapy are out of a multiple of influences, of which interpretation of transference is just one. In psychoanalysis, on the other hand, interpretation of the transference neurosis is thought to be the major and central curative factor.

HISTORY

Freud is the discoverer and founder of Intensive Psychotherapy as he was, of course, the discoverer and founder of psychoanalysis. All the principles of understanding and dealing with patients in Intensive Psychotherapy are based completely on the Freudian psychoanalytic point of view, and all interventions in Intensive Psychotherapy are based on our metapsychological understanding of the patient at any given time. All interventions are verbal only; at no time is any form of physical or social contact with the patient ever employed, and the treatment is always of one individual patient with no other person or persons present, except in certain unavoidable emergency situations.

No person should be allowed to practice Intensive Psychotherapy without undergoing several years of Intensive Psychotherapy or, better yet, personal psychoanalysis himself, and with satisfactory termination of personal therapy. Without a deep and thoroughgoing personal treatment, it is impossible to avoid major counter-transference floundering and both exploitation and retaliation against patients. It is easier to exploit patients in Intensive Psychotherapy and to become lost in counter-transference than it is in psychoanalysis, because in the latter the rules are more clear cut, whereas in Intensive Psychotherapy a combination of supportive, educative, and interpretative interventions is often called for, as well as the use of psychopharmacologic agents.

Psychoanalysis was designed by Freud for a very specific type of patient, those with transference neuroses. These conditions, such as certain phobias, obsessions, anxiety states, hysterical symptoms, and the like, were discovered to be based on infantile neuroses formed during the time of the resolution of the Oedipus complex, at around five years of age. Such patients were assumed to have traversed the first three or four years of life reasonably well, and to have a cohesive sense of self and, with resolution of the Oedipus complex, a fairly solid repression barrier, intact ego, and strong superego. Tensions between the id, ego, and superego produced first repression, which was unsuccessful, and then recourse to symptom formation to aid repression. Patients with emotional disorders forming prior to the Oedipal period were considered untreatable by psychoanalysis, according to Freud.

The increasing plethora of such "preoedipal" disorders, such as schizoid personalities, schizophrenics, many depressive disorders, certain perversions, borderline patients (Chessick, 1977), and many personality disorders forced psychoanalysts to reevaluate their treatment. One group of psychoanalysts, such as the Kleinians and others, rewrote Freud's theories entirely in order to justify the application of his psychoanalysis to preoedipal disorders; this group has more adherents in England. American pioneers such as Alexander, Fromm-Reichmann, and many others introduced a variety of so-called parameters, modifying the formal rules and regulations of psychoanalysis to fit these patients. For example, patients with personality

disorders who engage in dangerous behavior must be warned by the therapist of the consequences of such behavior to themselves, and in some cases the therapist must even intervene directly. This would represent an unavoidable modification or parameter from the classic psychoanalytic paradigm of interpretation of the transference neurosis and compromise the neutrality of the therapist. The development of Intensive Psychotherapy out of psychoanalysis and the historical roots of the various techniques used in Intensive Psychotherapy are traced in my book Great Ideas in Psychotherapy, which is understandable to the educated lay reader.

TECHNIQUE

In the communication with the patient, every detail of the therapist's behavior, office, atmosphere of treatment, and speech has an effect on the patient and fosters pacification, unification, resolution of defects in development (especially of narcissistic formations), and strengthens the adaptive and defensive functions of the ego. In later phases of treatment the procedure resembles more and more a formal psychoanalysis. There is a difference of opinion among authors as to whether the patient should begin immediately on the couch four times weekly even though parameters have to be introduced. Psychoanalysts tend to this latter procedure; psychiatrists and other nonpsychoanalysts tend to see the patient less frequently and sitting up. It remains moot as to which approach is best, as the basic principles of

treatment are the same either way. More details of the technique and practice of Intensive Psychotherapy are given in my book How Psychotherapy Heals.

APPLICATIONS

Intensive Psychotherapy is a highly effective procedure for the treatment of a large variety of emotional disorders that are not suitable or amenable for psychoanalysis. It is the treatment of choice for schizophrenia, borderline patients, personality disorders (except for the addictions), and psychosomatic conditions. It is second choice for a large number of patients who cannot afford to find the time for formal psychoanalysis. The goals are less far reaching in Intensive Psychotherapy than in psychoanalysis; the therapist is more satisfied with limited structural change, resumption of normal developmental lines, and better adaptation. Sometimes he must help the patient accept residual deficits and scars from early infancy. The danger of placing such preoedipal disorders in formal psychoanalysis rather than Intensive Psychotherapy lies in raising the patient's hopes for extensive intrapsychic rearrangement, which is often not possible when such profound early psychological destruction has occurred.