A Primer for Psychotherapists

THE PATIENT

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THE PATIENT

Psychological Appraisal

Before he enters your office door, the patient has happily escaped being labeled with the imposing but humanly empty diagnostic terms of clinical psychiatry. He is neither a "compulsive" nor a "hysteric," but a human being like any other— a labile organism adapting to a culture. A psychologically more understanding view of him can be obtained from the consideration of three aspects which he presents: (a) his organism, (b) his ego, and (c) his environment.

Organism.—That the patient has a body and a concept of it is important to remember however psychologically or culturally minded the therapist may become. Satisfying biological needs for food, drink, warmth, shelter, etc. occupy a share of his thinking in adjusting to both physical and cultural conditions. What he thinks of his body as a source of pleasure or discomfort and how he perceives reality in terms of this body concept are integral to all of his ideas and imagery. Body size or shape, beauty or ugliness, wholeness or handicap, and skill or clumsiness also may represent significant determinants in psychological processes.

Equally important for the psychotherapist to realize is the impact various bodily illnesses have had on the patient's concept of himself. In addition, these illnesses have subjected him to interpersonal experiences in doctor-patient relationships which will have relevance to his approach to you.

Ego.—Here I use the term "ego" to mean interacting wish-defense systems (including the superego as a crystallization of special systems), organized and differentiated to mediate between external world and internal strivings. The present-day ego of a patient can be understood only through consideration of its historical development through successive stages of maturation. Learning and growth experiences of childhood result in the molding, congealing, and solidifying of the ego process which become characteristic for the patient in the management of his life. Using E. Erikson's attractive terms, in forming his unconscious life-plan, a person organizes his past experience to prepare for and meet the future.

This ego serves the patient well if it can make a reasonable judgment of the consequences of his behavior, tolerate the tensions of inevitable reality frustrations, and allow sufficient impulse-

gratification. A less reliable ego will fail in one or all of these functions. An ego may be further implemented by an above-average intellect, a vigorous competitive drive, or certain talents and skills.

Environment.—By "environment" let us understand culture, i.e., the mores and values of a social group, or according to C. Kluckhohn, "a set of explicit and implicit designs for living which people who live together share." His family as a lever through which a culture exerts its force, his job, his friendships, and perhaps his religion involve activities through which the patient strives to obtain material and moral supplies, and all combine to regulate his social status and self-esteem.

I have mentioned these three personal aspects of the patient (organism, ego, cultural environment) at this time, not as a reverent bow to the traditional cliché of "the patient as a whole," but to encourage you when evaluating a patient to think frequently in these terms rather than in those of diagnostic entities. Even after you have made a clinical and dynamic diagnosis, for whatever therapeutic, prognostic, or administrative reasons, it is therapeutically important not to view the patient as a static nosological entity but as a group of dynamic forces in flux as they advance, shift, and retreat in the interpersonal relationships of a culture.

Who Comes to Therapy

When we consider that people who seek psychotherapy are stigmatized in spite of a historically recent but glacially slow change in this cultural attitude, it is amazing that so many do come. Though of all types of personality, the inpiduals who look for such help often have traits in common.

For example, persons from the two lowest socioeconomic groups (lower-lower and upper-lower in L. Warner's hierarchy) rarely come spontaneously and voluntarily. They are directed to see a psychiatrist by either their physicians, a casework agency, a court, or a clinic. In each of these instances the patient is forced to come by some implied threat, otherwise he would never consider consulting a psychotherapist voluntarily. A few upper-lowers with extreme magical hopes or the prospect of secondary gains are exceptions to this. Most patients who come under their own motivational steam represent the middle and upper groups.

Another common denominator is the degree of education and literacy. Those who are accustomed

to dealing in words and ideas and who think about their thoughts and behavior comprise the bulk of patients who spontaneously apply for psychotherapy.

A third characteristic is a type of character formation. If all or most of a person's character traits are ego-syntonic and cause him few reality difficulties, he feels no need for psychotherapy. It is when an important character trait fails in its defensive function or produces some discomforting reality frustration that the patient seeks help. Yet there are certain neurotic characters with one or both of the latter conditions who usually avoid psychotherapy. Antisocial characters ("psychopaths"), some sexual deviants (voyeurs, sexual masochists, etc.), many alcohol and drug addicts, and other impulsive personalities rarely wish sincerely to change their basic personality structure. They come to the psychotherapist only when forced, for secondary gains, or if they develop extremely unpleasant symptoms. Hence it is usually the case that most voluntary patients possess a character structure of some reliability and social conformity.

Why He Comes

Next let us consider forces which propel people toward psychotherapy, omitting such obvious motives as to obey a court order, to obtain case-work funds, to insure continuation of a pension, etc.

Some patients are referred for psychotherapy who have consulted their physicians for physical symptoms and learned that no organic basis for them could be found. Two factors play a part here: (a) the patient's readiness and willingness to accept such a maneuver and (b) the skill of the doctor in advising such a referral. Many patients with physical symptoms are unable to accept the idea of psychotherapy and its implications and either don't show up or break off after a couple of interviews. A few others are able to see their symptoms as a result of internal emotional conflicts and profit from a psychotherapeutic experience. Some doctors with a genuine feeling for people are quite gifted in suggesting psychotherapy without assaulting the patient's self-esteem and without making him feel that he is being sloughed off as a nuisance. There are others, however, who make a mess of things by curtly dismissing the patient as a "neurotic who ought to be psychoanalyzed" or by promising the patient a quick cure if he will just stop bothering him and see a psychiatrist a few times.

Other people who may influence the patient to come include friends and relatives. It is futile to attempt psychotherapy with someone who comes only to appease a goading relative or loved one. These patients lump you with their dominators, and the resultant transference resistances augur a poor prognosis for therapy.

Among more intrapersonal and conscious forces are those represented in the motives of the intellectually curious (writers, artists), searchers for keys (cultists, mystics), and the current normality worshipers. For these persons the therapist may be only a teacher of lore, and, though the therapy may add some halo of prestige to the patient in the eyes of his comrades, it usually does little to change his neurosis.

Finally, the patient may feel an urge to apply for psychotherapy when he suffers various unpleasant symptoms while realizing that they are in some way connected with his own emotional-psychological make-up and that with help the latter can be changed. He is, of course, a suitable patient, in contrast to the former examples.

This leads us to discuss further the various criteria which help in the selection of cases for psychotherapy.

Who is Chosen

Psychotherapy is not for everyone. This undemocratic fact may conflict with your belief as a physician that all who ask for help should receive it. However, it is an unshirkable reality that there are many people with neuroses who do not respond to the psychotherapeutic process (at least the one described in this book) favorably and proportionately enough to make the time and effort put in by both parties worthwhile. Hence one should have some ideas about which patients to send away and which to attempt to treat.

Freud felt that a suitable person for psychotherapy was one with a "reasonable degree of education and a fairly reliable character." Perhaps we can elaborate on and add to these qualifications through a description of two abstractions—the most suitable and the least suitable patient. Neither one of these persons exists, but as abstractions they will serve to clarify our topic.

Most Suitable Type.—He, or she, is someone between sixteen and fifty years of age and of average or above-average intelligence. (I omit any consideration of child therapy in this volume). His intellect allows him to be articulate and imaginative in expressing himself and to be able to grasp another's almost purely verbal communications. He has shown some achievement in a competitive job or a social group. He is not criminal, and his neurosis does not completely handicap him. A reasonable part of his ego permits him to step back and observe himself with some objectivity. He can see fate as mostly character and not as the "rough tyranny of circumstance." He shows courage in facing and in revealing unflattering aspects of himself. His reality situation is not overwhelming, and the secondary gains his neurosis gleans from it are small. He readily grasps the idea of participating with the therapist to form a team engaged in a joint effort. Finally, he wishes (consciously, anyway) to change his attitudes or ways of life in order to help himself, and he makes sincere attempts to do so.

Least Suitable Type.—He, or she, is of low or below- average intelligence and is generally unthinking in relation to himself. Either his complaints are all physical or else he views them as the result of some organic disease. His environment provides maximal secondary gains for a hardy neurosis. Magical thinking plays a large part in his thought processes, and his reality sense is severely impaired. A speech or hearing handicap and a language or culture barrier may further complicate matters. A storm of acute affects may make him unreachable through words, or, though he is calm, he may not "get" the therapist's questions and the simplest interpretations may soar over his head. His character is infantile, and his impulses are voiceless. He might be thought of by anyone as an unreliable person.

These overdrawn abstractions designate opposite ends of a broad scale with many intermediate variations. In choosing a patient for psychotherapy with the hope of a successful outcome, it is understandably wiser to select the person who stands closer in the scale to the most suitable. The actual technique of selection and rejection of patients is discussed in Chapter 6.

What He Fears

Every patient has certain conscious and unconscious fears and hopes regarding psychotherapy before as well as during the process. This and the following section will deal briefly with some of them.

Among the fears concerning therapy which may loom in the patient's consciousness is that of being found crazy. Or he may dread that he will be told that he is basically a homosexual or some other (to him) loathsome type of deviant. He may worry that your interpretations will one day constitute a surprise ambush, suddenly uncovering some very disturbing aspect of himself. Many patients are frightened that they will become too dependent on the therapist, thus giving him too great a power over their lives. Some fear his contempt, and others fear his love.

Unconsciously the patient's chief fear is that of changing his neurotic structures, since they are at least familiar, if unsuccessful, solutions and they provide some gratifications. Each patient also has his own particular unconscious fear of psychotherapy depending on the various meanings it may have for him.

What He Hopes

Again using the pision between "conscious" and "unconscious," every patient naturally has the conscious hope of being helped. In the process he may expect that he will be guided and advised, taught and encouraged. Also he hopes a change will happen to him spontaneously, without willful effort on his part.

Unconsciously the patient has a magical belief in the therapist's parental omnipotent ability "to make it better." He hopes to impress you favorably and thereby gain your love and admiration, perhaps even permanently, as in a friendship or marriage. Though it is a contradiction, side by side with this desire may be the wish to make your office an arena and therapy a duel. Also there are patients with an unconscious wish for punishment who hope that the therapy will not succeed, thus proving that they are really hopeless. To the apprentice this concept often seems to be merely a comforting rationalization for therapeutic failure, but at one time or another he will be in a position to observe just such a mechanism in action.

Thus far we have considered the patient actually before he has become a participant in psychotherapy. Since therapy is a process involving two people, we should now examine in some detail the other person before we describe what goes on between them.