

Chapter 31

Psychotherapy

Like Chapters 29 and 30, this chapter will be about giving and getting help at the higher levels—chiefly at the levels of system concepts such as the self-concept (or self-image) and the level of principles such as morality. We get help at those levels from parents, clergy, teachers, fellow members of 12-step support groups such as Alcoholics Anonymous, and astrologers. Increasingly, we get help also from secular professionals and semi-professionals such as psychiatrists, clinical psychologists, and social workers, to name a few. Kirk and Kutchins (1992, p. 8) reported that between 1975 and 1990, the number of psychiatrists in the United States grew to 1.4 times their earlier number—from 26 to 36 thousand. The number of clinical psychologists grew 2.8 times to 42 thousand, of clinical social workers 3.2 times to 80 thousand, and of marriage and family counselors 6.7 times to 40 thousand. Considering the growth in those professions (all the rates are much greater than the growth of the general population) I was not surprised to come upon an article in TIME magazine by Wendy Cole (2000) entitled “The (Un)Therapists” describing the work of people who call themselves coaches. The members of this new (or newly named) profession are not the managers of athletic teams, but simply people who offer help of any sort to other people. Coaches, Cole says, do most of their coaching over the telephone. Any matter of concern is grist for a coach. No license, diploma, or certificate is required.

In this chapter, I examine the elusive benefits of psychotherapy, and especially the highly institutionalized forms of therapy that require the doctoral degree for their practice—chiefly psychiatry, clinical psychology, and clinical social work. I will present evidence that attempts to help people do (on the average) help people, but evidence also that having more training or experience, or even having specially licensed kinds of training, does little if anything, on

the average, to increase the benefit. Furthermore, I will offer some reasons to doubt the very existence of some of the “illnesses” from which many psychotherapists want to rescue us. Psychotherapy is an example of inventiveness at the very highest levels of control. Its conception results in very complex patterns of social interaction.

Wendy Cole wrote, “The field [of coaching] seems to be prospering precisely because it is not therapy.” I will not quibble about what should be called therapy and what should not. Nor will I be talking in this chapter about helping with troubles we get into with malfunctioning or misapplied *things*—automobiles, houses, or can openers—but about helping with the troubles we get into with other people or ourselves. I will be dealing with the realm of clinical psychology, a good part of psychiatry, most of psychoanalysis, some of counseling, and no doubt some of coaching—the realm at the higher levels of control that makes use of language and has control of the kind of perception we call, roughly, understanding. For that realm of trouble, I think the term “psychotherapy” is close enough. I also include the method of levels (see Chapter 30) under that heading.

I will focus here on modes of interaction between therapist and client when the therapist is a member of a mental-health profession. I will devote the most space to diagnosis and efficacy. By an effective procedure, I mean that after I have done it, I like the resulting condition better than the earlier condition. A therapist calls her therapy effective if she (the therapist) likes the behavior of the client better after the therapy than before. Typically, any sort of therapist will consider a therapy to be effective if the client comes to feel relieved of internal conflict or of behavior in which the client was engaging even though he (the client) deplored it afterward. From the viewpoint of PCT, the client engaging in deplored

activity is suffering internal conflict—he wants to do it and simultaneously does not want to do it. That is, the client shows up with a worry or behavior of which he wants to rid himself. As Timothy Carey (2000, p. 15) puts it, “the common ingredient. . . seems to be a feeling of distress.”

If, after some therapy, the behavior of the client seems to the therapist to indicate that the client is suffering less conflict than before, the therapist will usually claim the therapy to have been effective. That is usually true even if the chief or only kind of behavioral evidence the therapist has observed is the report by the client that he feels less conflict. I am not belittling that evidence. A report from the client is usually the best evidence available that something useful to the client has happened and is likely to continue.

From the viewpoint of the PCT therapist (or guide), the client is hunting for some way to resolve a conflict. Using the method of levels (MOL) the task the therapist accepts is that of helping the client to turn his attention to that higher level when the utterances of the client hint that the client is about to do so. The MOL therapist does not claim to know better than the client the internal standards that may be in conflict nor the most effective level of the control hierarchy from which to set in motion a reorganization.

From the viewpoint of a traditional therapist, there is something malfunctioning inside the client, and the therapist’s task is to ascertain what is malfunctioning and then to do something to correct it—to prescribe a treatment to bring back correct functioning. The assumption of the therapist is that she (the therapist) knows more about what can be malfunctioning and what can be done about it than the client does. Implicitly or explicitly, the therapist invites the client, too, to adopt that assumption.

From that traditional viewpoint, the first task is to perform a diagnosis. Doing that requires a list of possible malfunctions—a list of names of things that can go wrong. Therapists construct their lists from various sources. One source is the therapeutic theory to which the therapist subscribes—Freudian, Rogerian, rational-emotive, cognitive-behavioral, pharmaceutical, or whatever. Another source is the range of environmental circumstances with which the clients must cope. A therapist with an office on Park Avenue in Manhattan will have a list of diagnostic categories different from a psychiatric social worker with clients on welfare.

Because lists with such origins are highly idiosyncratic, many therapists and researchers have wanted to have a standard list to which they could turn. Such a list might increase the agreement among therapists and among researchers on the diagnosis. The list would also enable therapists to say to insurance companies and to judges that they are conforming, in their diagnosis, to the best standards of their profession. Over several decades, several lists of diagnostic categories have been compiled and reshaped into the volume now published by the American Psychiatric Association—the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV, 1994). I will say more about the DSM below.

The second task of the traditional therapist is to choose a treatment to go along with the diagnostic category chosen. If you are a historian of psychological research or of psychotherapy, you can say a great deal about traditional psychological treatments. Library shelves sag with tomes on the topic. If, however, you want to know where to find an effective mode of psychological helping, the library shelves will not help you much. One kind of treatment seems to be about as effective (or ineffective) as another. I will say more about efficacy below.

You will have noticed that in the method of levels (MOL), the concepts of diagnosis and treatment vanish. You might be tempted to say that both diagnosis and treatment go on at the same time during the helping conversation. You might wish to say that the client does his own diagnosis and chooses his own treatment. I prefer to say that the concepts of diagnosis and treatment simply get in the way. They are conceptual inventions built on analogies from the practice of medicine that make more trouble than they are worth. Yet on their face, they seem to make sense. Can we simply jettison them with no loss? My proposal to discard them may seem outrageous, but remember that I am talking about the overall functioning of a living creature. Diagnosis and treatment are certainly useful concepts for repairing automobiles, radios, TVs, and even the physical functioning of living bodies. But not for helping people resolve their conflicts.

POSTULATES

A physician looks for conditions or actions on the part of the client that she thinks are good things or bad things for a body to be doing. That attitude yields useful results when examining physical functioning. Is blood leaking from your body? That's bad! Let's stop the leak! Nobody is going to complain about that attitude toward that kind of event. The goal of keeping the blood in the body so it can nourish and clean our tissues is a goal everyone can cherish. Of course, some ways of stopping the leak are better than others. Ways that help the body's own feedback loops to manage the healing of the wound are generally best. It took a while for surgeons to learn about the biological standards maintained by the immune system. There are some ways of helping that the body will reject, no matter how good your intentions may be—no matter what *you* think are good and bad things for that body to be doing. Nevertheless, in dealing with physical events and simple processes (such as leakage, breakage, or too hot or cold) it often helps to bring conditions back toward “normal.” If you have a broken leg, a simple crutch is helpful. If you are shivering, a warm coat is welcome.

With psychological matters, the attitude of looking for good and bad events will not work nearly as well as it does in physical medicine. Particular actions (events) do not tell us (they are not diagnostic) about neural functioning. If a client walks down the street shouting about her handsome father, that act gives you no information about the functioning of her control hierarchy.

If something or someone makes it too difficult for us to take some particular action, we will find another to serve the same purpose. If I cannot find some legal kind of employment that will bring me money, I will beg, borrow, steal, or kill to get it. (I don't mean to imply that only unemployed people beg, borrow, steal, and kill; kings and captains of industry do, too.) The fact that we do not like the actions of a person does not mean that his feedback loops are defective.

In short, whether diagnosis and treatment seem reasonable parts of psychological helping will depend on your theory of human functioning. In Table 31–1, I have tried to summarize the crucial postulates of traditional theory and of perceptual control theory.

In Table 31–1, I use the term “traditional theory” to include both “scientific” or scholarly theory on the one hand and popular, common, folk, or general theory on the other hand, since both classes of theory use the postulates I list here at left. But now I must be careful of how I write. The table says that the two classes of theory, traditional on the one hand and PCT on the other, postulate certain characteristics of living things. But only people can postulate; theories merely lie there on the page after people have written them there. If you go to an actual, live, human therapist and ask whether my table describes the theory to which she subscribes, she will very likely say something like this: “Well, mostly, yes, except. . .”. A table like this can be only an average or majority-vote characterization of the way people in a category talk or act.

I mean to say in Table 31–1 that when therapists or researchers act in certain ways, they are acting *as if* those postulates are faithful descriptions of reality. For example, to look for a diagnostic category in the traditional manner is to look for an entity, a “thing,” syndrome, or condition that can be caused in a linear sequence. Let's say that you perceive a pretty good match between the behavior you have seen on the part of the client and a category of “depression” that you found in the Diagnostic and Statistical Manual. When you look for a thing like that, you are acting as if there is some sort of causal thing inside the person that is causing the symptoms (actions) specified in the DSM for the category of depression. And you are acting as if that is the end of the story. The story goes that the thing (such as depression) causes a cluster of actions, so if you do something to make the actions stop, you will know that you have somehow caused the unwanted thing to go away or at least to become unable to bring about those unwanted actions. You are *not* acting as if those unwanted actions—unwanted either by the client or the therapist—are themselves causes of some perceptions, wanted or unwanted. The possibility that the actions are purposely taken by the client to aid the control of some perceptions, but at the same time cause a worsening of the control of others, thus producing a conflict, is not part of the causal postulate.

To expect observed actions to tell a story about internal standards and processes is to forget (or be ignorant of) the Requisites for a Particular Act (which you can find reprinted in the Introduction to Part VI). Actions are chosen (even if unconsciously) for a purpose; they are not simply emitted by some internal

Table 31-1
Postulates of Traditional Theory and of Perceptual Control Theory of living creatures

Traditional Theory

Causation:

linear, straight-line, from input to output. It is episodic: a stimulus or influence sets off a response action.

Unit of observation or analysis:

the unit or episode begins with an environmental event, condition, or stimulus and ends with an organismic response or action. The responses, whether by one person or many, are assumed to be interchangeable for purposes of interpreting the data.

Origin of action:

Action is set off either by (1) an internal urge (motive, need) or (2) an external stimulus (event, condition). Most subtheories prefer one or the other of these origins.

Purpose:

Strict behaviorism rejects purpose. Other subtheories recognize purposiveness in action but do not make a technical concept of it.

Levels:

A few subtheories postulate levels of motives but are vague about relationships between them.

Research:

The count of arbitrarily specified actions (sometimes the count from a single person but usually the pooled count from several persons) authorizes further research into a hypothesis. Comparison with a working model is not required.

Perceptual Control Theory

Causation:

circular, each function in the control loop being both a cause and an effect. Continuous: control never ceases.

Unit of observation or analysis:

none; observation and action are both assumed to be continuous. Observation necessarily begins and ends at arbitrary times. Each action is assumed to be new (or continuously changing), providing its part of continuous control.

Origin of action:

Action arises simultaneously from both the organism (because of the internal standard or reference perception) and the opportunities for control available in the environment.

Purpose:

is given by the reference perception.

Levels:

Higher levels determine the reference perceptions at lower levels. Perceptions at one level are orthogonal to those at another. Intrinsic (genetic) reference signals bring about reorganizations independently of the control hierarchy.

Research:

The usefulness of a hypothesis is determined by the closeness of fit by the model to the observed control by a single organism. The Test for the Controlled Quantity can be used to hunt for controlled variables. A count of responses is not taken.