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How Psychotherapy Constructs (and uses) its Own Concepts

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ABSTRACT

The aim of the article is to establish how the meanings in psychotherapy are built, and how psychotherapeutic intervention is possible. The distress psychotherapy addresses stems from the denial of fundamental human needs. The denial occurs during personal growth, due to a failure in key interpersonal relationship. Psychotherapy aims to correct and repair the negative effects of these failures. The therapist – patient relationship is fundamental to achieving this change.

1. Introduction

In this article, drawing inspiration from the topic proposed by the journal Archives of European Society of Medicine, I intend to reflect first of all on how the typical meanings of psychotherapy are constructed, that is, that part of psychology that aims to treat a certain type of human distress. In fact, every theory, or specific way of looking at reality and intervening in it, constructs its own set of concepts, and therefore meanings, which must then be used for intervention in the typical field of each individual science.

In the field of psychotherapy, this question: 'How are meanings constructed?' is even more important than in medicine. Medicine has a thousand-year history – from Hippocrates (5th century BC) onwards – while psychotherapy is a much younger theory and practice: from the mid-19th century, if we also include hypnosis among the early forms of psychotherapy. Medicine has constructed a sufficiently precise idea of what it should deal with and of the methods shared by all those working in the field, while in the field of psychotherapy we find different approaches, which translate into different modes of intervention. I can mention the most widespread approaches today, without claiming to be exhaustive.

1. The cognitive-behavioural approach, which attributes the origin of distress to erroneous and dysfunctional beliefs, which inevitably translate into maladaptive behaviours. These erroneous beliefs can be corrected, thus achieving a change in the undesirable behaviour.

2. The humanistic approach, which emphasises the originality of human existence and the potential for development, and therefore also for healing, that each person carries within them. Change is therefore entrusted to creative encounters between people, in this case the therapist-patient encounter.

3. The systemic-relational approach, which sees the root of distress in the repetitive and oppressive ways in which communication is often structured, primarily within the family group. It therefore proposes to modify these rigid patterns, in which the individual finds themselves trapped.

4. Finally, the psychodynamic approach. In reality, this approach encompasses quite different perspectives, in which, however, some common threads can be recognised. First of all, the idea that human behaviour is driven not so much by 'rational' consideration of what is useful to us, but also by forces ('dynamis') of which we are unaware, linked to experiences in the present but also in the past, perhaps in the early years of our lives. Psychotherapeutic intervention aims to make the patient aware of these forces so that they can be controlled and guided. These theories undoubtedly refer to Freud's work, but do not require acceptance of his entire complex theoretical elaboration. The author of this article identifies with the analytical-transactional approach, which in turn can be considered part of the broader psychodynamic approach. The transactional analytical therapists seeks the meaning of the symptoms experienced by the patient in relation to their life experiences; they investigate the connection between what manifests itself today and what the patient has experienced in their history, especially during childhood; they pay attention not only to thoughts but also to emotions; they are sensitive to everything that happens in the therapist-patient relationship, believing that this is where the problems of those who resort to psychotherapy are expressed.

We can now consider the effectiveness of psychotherapy as a method of treating a certain type of distress, which we agree to call psychological, to be recognised. This statement is not to be taken for granted, as throughout the history of psychotherapy, there have also been those who have argued that it is useless[1]. However, this denialist thesis has stimulated more accurate research into the results of treatments. This research now allows us to say that the changes promoted by psychotherapeutic interventions are 'evidence-based' [2] . This evidence is not identical across the various approaches in the field of psychotherapy. As far as the psychodynamic approach is concerned, we can say that, while other types of intervention, such as cognitive-behavioural therapy, seem to have a more immediate effect, the effects of psychodynamic therapy are more lasting over time, above all because the patient acquires something new, namely an ability to know themselves, which is the best guarantee of maintaining good health[3].

In this article, I do not question the effectiveness of psychotherapy, but I propose to reflect on *how it works,* i.e. to highlight the reasons why certain interventions within the therapeutic relationship are possible and effective. In this research, I take into account the fact that psychotherapy, although relatively young, has a history, and that within this history there have been fundamental steps that are worth dwelling on.

The method that the authors cited use to support their claims is the clinical method, i.e. based on observation of what the patient manifests. This also applies to the claims I make myself, i.e. referring to my professional experience. Since we are dealing with psychological distress, and therefore with the experience of another person, the therapist's diagnosis and intervention will be based not only on observation, but also – and above all – on the results of a dialogue. The clinician not only listens, but also asks questions. The questions arise from the clinician's hypotheses about the origin of the problem presented. There is therefore an inevitable circle between theory and observation: I observe what the theory tells me to observe. The scientifically correct clinician will be one who is willing to modify their theory when the data obtained from observation and dialogue with the patient contradict it in an indisputable way.

Among the foundations that make psychotherapy possible, I consider important the thesis that a person's lived experience, and therefore also the experience of therapy, is not a fact of the physical world like any other,

but has its own originality, which requires an appropriate methodology to be understood.

Based on a methodology that refers to Transactional Analysis, I propose to highlight some fundamental lines of intervention on human distress, inspired by a psychodynamic perspective. I will therefore refer to the literature on the subject and, naturally, to my therapeutic practice. To develop this topic, it is useful to take a historical perspective.

2. A dissatisfied biologist.

In the late 19th century, a Viennese physician who had devoted years of his professional life to research in the field of biology set out to construct a scientific psychology. The project was ambitious: 'to represent psychic processes as quantitative states of identifiable material particles, in order to make them clear and indisputable"[4]. It was clearly a question of constructing psychology as a natural science. However, given that this doctor was interested not only in being a scientist but also in treating patients, we must assume that this natural science was ultimately intended to serve the purpose of treatment.

The 'Project' was not published; it was found much later among Freud's papers. On the contrary, a few years later (1900), F. published a book with a very different title and content: 'The Interpretation of Dreams' [5]. We can observe that when we interpret, we interpret a language. Freud's work also interprets a language, albeit a singular one: that of dreams. It can be said that this shift gave rise to a specific treatment of psychological suffering, different from medical treatment. I believe we can say that the doctor considers the human subject as a living organism, endowed with its own dynamic equilibrium which, as long as it is maintained, allows the unfolding of that activity we call life. The physician uses all possible scientific contributions (physics, chemistry, biology) to investigate the causes that disturb this balance and restore its functional dynamics. Starting from the interpretation of dreams, the psychotherapist approaches man from another point of view: man as a producer of languages and therefore of meanings. Man as 'animal simbolicum'[6] . That is, as an organism whose essential activity is to communicate, to come into contact with other organisms that resemble it, through languages that can be very different, such as simple words, poetry, myth and science. This characteristic, which Cassirer affirmed from a philosophical point of view, can have a scientific basis if we systematically study the world of signs, as U. Eco, among others, has done[7]. For semiology, the symbolic nature of man lies in the construction of a system of signs that serve man himself to name things, and thus bring order to the world, and to establish a relationship with others. Signs have meaning by virtue of a code and therefore require an interpretative capacity. Interpretative capacity is something that each of us builds up from childhood in order to be able to live among others, but it is by no means a given. In any case, human beings are only human to the extent that they are capable of developing and understanding language. One consequence of this human characteristic is that discomfort, when it arises, also finds expression in the field of linguistic communication. Just as with language, and through language, it is possible to intervene to help resolve that discomfort.

3. Some moments in this story.

The discomfort manifests itself today, in the present. But is its root also in the present? One thesis of the psychodynamic approach is that the root is also, and sometimes above all, in the past. Hence the focus of Freudian analysis on the recovery of past events, precisely those of which the patient initially has absolutely no memory. But therapeutic practice has highlighted an inevitable question: is it because the patient remembers what had been put aside, excluded as unacceptable and therefore forgotten, that they feel better? Or rather, because they experience the relationship with the therapist as something new and positive, can the patient allow themselves to remember and thus free themselves from the burden of the past? This is the thesis of an innovator such as F. Alexander[8]. What happens in the therapeutic relationship is an experience that repairs the negative experiences of the past and, precisely because it repairs them, allows us to understand their meaning. Thus, attention to language – or rather, languages, since human beings communicate through more than one symbolic code – shifts to the fact that communicating means establishing a relationship with another person, another subject. Moreover, it is not only the memory of the past that is important, but what happens in the present moment.

But what happens in the therapeutic relationship that allows it to 'repair' what has been negative, sometimes traumatic, in the patient's history? Certainly, a deep understanding of this person's experience and needs is achieved. This understanding is something that the patient has clearly never received, at least not in this way and with this depth. In this way, our reflection shifts to two important themes: the possibility of understanding the other and the needs of the human subject. The first of these themes was influenced by Freud's aspiration for perfectly objective knowledge, in the wake of the scientific vision of the 19th century. If the therapist possesses the right theoretical knowledge, Freud believes, and if he avoids reacting to the distorted view that the patient inevitably has of him (transference!), he will be able to clarify what is obscure to the patient and thus alleviate the burden of his symptoms.

This is certainly true in many cases, but it cannot be considered the rule. In the history of psychoanalysis, someone understood more clearly, at some point, that knowing another person is different from knowing an object in the world. It is something in which understanding the other's emotions is fundamental, hence the name 'empathy'. Certainly, therapist and patient arrive at a shared understanding if the therapy is successful, but this result is possible because there has been emotional sharing along the way. H. Kohut deserves credit for highlighting this fundamental aspect of the therapeutic relationship[9].

The other point concerns the needs of the human subject. This is something that is not easy to define, but at the same

time has undeniable importance[10]. Analysis is relatively easy as long as it concerns needs related to the organism in its physical-chemical reality. The human organism needs to breathe, to feed, to rest after a certain period of activity. As a member of the human species, it feels the urge to reproduce and therefore sexual desire. But as an animal symbolicum, it also has another sphere of needs: the need to communicate, the need for its communicative gesture to be accepted and reciprocated. The cognitive function, a wonderful discovery of the human cub, translates into the need for ever broader knowledge, including self-knowledge. It can be said that every typical human capacity, from the moment it becomes possible, demands to be realised: its realisation becomes a need. It is intuitive that the failure to realise any of these needs, even if compatible with life, results in suffering. It is also clear that the therapist cannot intervene in the material reality of the need. Therapy intervenes in the space between the unmet need and the way in which a person has translated, in their own mind and symbols, what has been missing in their experience.

Freud highlighted the area of the unconscious, linking it to a rejected and silenced need, the sexual need. He sought signs of it in dream images, in patients' symptoms, but also in the 'pathology of everyday life'. Today, it is clear that there is not only the unconscious resulting from repression, as identified by Freud's analysis. There is also the unconscious of experiences that have never reached consciousness but are nonetheless significant in the construction of a life[10]. More generally, the mind has a wide range of responses to experiences that have denied the radical needs of the human subject. These responses are an attempt at a solution that is sometimes successful, while at other times, often, it builds a new barrier that prevents a return to an authentic experience of reality, even if the traumatic events are now in the past. This is the area of psychotherapy: understanding how a certain interpretation of the events of one's life has been constructed, especially those related to the relationship with the figures who guided us in our early years. Understanding what was missing and finding guidance to rework, with respect to what was missing, a happier response than the one we have constructed and which may have accompanied us for years. It is clear that this path is a challenge, as there is no guarantee that it will reach its destination. For the positive outcome of this journey, it is important that a relationship of full collaboration is established between two people, the therapist and the patient.

4. What heals?

Given the importance of this question, I prefer to propose two possible solutions, different but not antithetical, present in the world of psychotherapy. As we know, Freud believed that the patient's discomfort was due to the denial of a fundamental need, the sexual one, and that this denial determined the descent into the unconscious of everything related to sexuality. What has become unconscious has not disappeared and translates into negative behaviours in the subject's life – the symptoms – which are compromised between denying the need altogether and allowing it to reappear. Hence the work to recover what the patient does not remember, not by chance, but because remembering it would mean bringing to consciousness what would be 'dangerous' to see clearly. Hence the patient's 'resistance' and the work of analysis as overcoming resistance. But resistance – this is Freud's next discovery – emerges precisely in the relationship with the therapist, the patient initially approaches the therapist with trust. But then projects onto him – precisely because he becomes an important figure – everything negative he has experienced in his relationships with the most significant figures in his life; first and foremost, according to Freud, the father figure. This is where the discovery of transference lies. It is a fundamental moment in treatment because it brings the most problematic aspects of the patient's life into the here and now. It is not something that is 'told', but something that is experienced[11]. It is essential that the therapist is able to see this connection and that the patient is able to accept this interpretation without becoming defensive. Once the patient understands the meaning of their behaviour towards the therapist and accepts the discomfort of this discovery, it becomes possible for them to abandon that behaviour in other areas of their life. I think it is important to emphasise that, even in the Freudian view, the central steps of therapy are not purely cognitive, but involve self-questioning, an inevitable emotional impact, something important that happens in the relationship with the therapist.

As we know, Freud believed that in order for the complex phenomenon of transference and its resolution to occur, it was necessary to subject the therapeutic relationship to strict rules, starting with the use of the couch, which prevents face-to-face contact between therapist and patient.

In the history of psychotherapy, not everyone has considered these strict rules necessary, or at least beneficial. A change in the context in which therapy is practised implies a change in the interpretation of the patient's distress. If the patient's distress is believed to be mainly due to failures in the fundamental relationships in their life, the relationship with the therapist will be seen as an important element of healing and will therefore be made freer, albeit within precise professional limits. If these failures belong to the past, and therefore to a very different time in one's life, it is understood that their memory, and even the understanding of their meaning, are generally not clear to the consciousness. Successful psychotherapy expands the boundaries of consciousness, even if it does not refer to the classic Freudian distinction between the conscious, preconscious and unconscious.

On the basis of these premises, it is worth responding to an objection that is often raised against psychotherapy. If we believe that in our present, we are still experiencing the effects of relational failures that belong to our history, what effect of change can deepen our knowledge of them have? What has been has been, and the past cannot be changed. This objection implies a view of time as a rigid succession, in which each moment is closed in on itself. Fortunately, this is not the case. The past influences the present based on how we still interpret it today, and the emotions we invested in the events of that past continue to be present in our lives today. Therapy means reliving, to some extent, those same emotions and discovering, as we experience them, that another

response was and is possible. In conclusion, it is also possible to free ourselves from the influence of the past, if necessary. Rather, the objection reminds us that therapeutic work is not pure knowledge, but much more. It means a different interpretation of ourselves, and this is not possible without significant emotional involvement. There are powerful moments in the development of therapy. Beyond these powerful moments, it is the patient who reworks what they have experienced and understood, relates it to their own problems and experiences, and gradually gives the latter a different interpretation. Above all, they acquire greater freedom in their affections and behaviours.

5. The narrative of change.

Since human beings are symbolic animals, it is natural for them to construct narratives around their world, the world of the sacred and their own existence. All peoples, in fact, have constructed narratives of this kind, narratives that serve to define their place in the world and the meaning of their existence. But in the part of history with which I naturally identify most, the history of the West, something important happened at a certain point: people began to wonder whether those stories were really true. Thus Xenophanes, one of the first Greek philosophers, doubts that the gods are really as described in the mythical narratives of his people[13]. And Anaximander proposes an explanation (we could say scientific-philosophical) of the origin of this world in which the gods play no role[14]. And Plato will say that above Mythos there is Logos, that is, the rational explanation of the world and man's place in it (although, on some issues, Plato himself seems to say that it is not really possible to move from Mythos to Logos...)[15]. This brief fragment of the history of thought explains my certain distrust of the spread, in today's culture, of the term 'narrative'; as if by this term we meant that an explanation is unattainable and that everyone can tell their own story... On the contrary, even when it comes to human suffering, I believe we must seek an explanation within a theory and perhaps question different theories. Narrative is the next step, it is making the theory communicable, as well as showing the practical consequences of a certain theoretical core.

However, in the theoretical orientation of Transactional Analysis, there is room for a slightly different use of the term narrative. After all, says E. Berne, creator of Transactional Analysis, through our symptoms and personal characteristics, each of us stages a narrative, the title of which could be: this is me. Here too, we can talk about the response to a need, that of defining one's identity. A need that becomes real by virtue of our mind's ability to reflect on itself, an ability that makes it possible to ask the question: who am I? Defining my identity means that certain behaviours, thoughts and feelings are compatible with the idea I have of myself, while others are not. This inevitably leads to a restriction of what in theory would be my possibilities and, in the extreme, to a certain repetitiveness in the content of my life. When identity has been achieved in a fundamentally healthy way, repetition includes significant space for creativity. Sometimes, however, identity has been constructed at a high price: the denial of concrete personal possibilities. The theme of repetition was first highlighted by Freud, who noted an inevitable repetition of certain behaviours, even if disturbing, in the patients who came to him for help[16]. And the therapeutic process ultimately led to the choice of different options.

E. Berne was very attentive to the theme of repetition, identifying in a 'life script' the repetition of behaviours that are not actually beneficial to life: a life script arises from our response to what has happened in our relationships with the key figures in our history[17]. The script, says Berne, is, for the actor, a pre-written text that he must adhere to. Our life can be lived as a script that we have actually written ourselves, but to which we feel obliged, just like an actor to the text of a comedy or tragedy. Berne saw above all the negative value of the script, as a sequence in which we feel trapped. Instead, we can see the repetitive aspects of our lives as the result of a struggle to construct our identity, starting from the inputs of our biology and the messages received from those who brought us into the world. My identity involves a choice: I must be myself and not someone else. It involves yeses and nos. Undoubtedly, this mix of yeses and non can be experienced rigidly or with reasonable flexibility. The conquest of identity can also fail, it can stop at the level of an internal conflict rather than a synthesis of one's personal characteristics. In any case, the way we live our lives is a narrative, it has meaning and a certain coherence, even if at times a different narrative would have been desirable.

Research in this field can be carried out not only through therapeutic experience, but also through the stories of characters whose biographies we know. An exciting investigation into the struggle for identity of a man who left his mark on Western history is, for example, E. Erikson's study, 'The Young Luther'[18].

6. The irrepressible subjectivity.

What I have said so far implies that, in the field of therapeutic practice, we can talk about subjects interacting with each other. As a therapist, I am a human subject who relates to another human subject. Not simply to another organism.

We saw a different approach in Freud's early writings, a project that was later abandoned. In that perspective, what we consider psychological would be reducible to quantity and movement, that is, to something purely physical. Although psychoanalysis then took a different path, in contemporary culture the philosophy that refers to logical empiricism has taken a similar direction. In fact, there is talk of 'physicalism', or the assertion that 'mental states are states of the body: mental events are physical events' [19]. But it was precisely an author who identified with this perspective, T. Nagel, who published an essay in 1974 with a curious title: 'What Is It Like to Be a Bat?'.[20]The inspiration for the article came from the bats that lived in the attic of his country house, which came out at dusk and flew in search of their food, insects, but sometimes got lost and ended up in the rooms of their host. Nagel knows what it's like to deal with a frightened bat in his bedroom, but he also wonders: what does the bat feel? We must assume that, having a brain and sense organs, the bat has its own experience: but what can we

know about it? We can make assumptions, using our imagination, imagining, for example, what it would be like to fly, orienting ourselves, like bats, with a kind of sonar. But in the end, the bat's own experience is not accessible to us. The same applies to other animals more or less similar to us, but also to human beings who suffer from sensory limitations. How could we give a man who has been blind since birth the experience of seeing colours? Yet his experience, like that of the bat, is a fact that we cannot ignore if we are trying to construct a science of man. A physicalist conception cannot explain this. Nagel hypothesises the construction of an objective phenomenology that should better approximate the experience of the other, animal or human, although, to be honest, it is not very clear to me what he means by 'objective phenomenology'. Focusing on the subject's point of view as indispensable allows Nagel to study the mind-body problem from a new perspective; an exciting topic that, however, goes beyond the scope of this article. From the point of view of my research, Nagel helps us to support the scientific nature of a profession, such as that of the psychotherapist, which is based on the encounter of two subjectivities; to the extent that any science of man encounters – or clashes with? – a subjective experience that appears irreducible to the objectivity that science seeks. We must reckon with the concluding statement of another philosopher, A. Seth, in his commentary (fifty years later, in 2024) on Nagel's work: 'Only a bat will really know what it means to be a bat' [21]. We must also say: only a patient will really know what it means to be *that patient?* Ultimately yes, but with one important distinction. The bat lost in Prof. Nagel's house has only one interest: finding its way back to its cave. The patient, on the other hand, but also any other human being with whom we interact, has an interest in communicating with us, and does so with a system of signs that has been constructed socially, not by a single individual. Language creates a common area between me and the other, and our individuality, mine and the other's, is constructed within this area. Their experience will never be my experience, but it will not be an alien experience. Except in dramatic cases of serious pathologies (such as autism!), we have grown up as human beings within the same symbolic world. This makes mutual communication and even change possible.

7. Conclusions

At this point, we can summarise the main conclusions of our work.

1. Psychological distress arises from the denial, not episodic but lasting over time, and especially during the age of development, of the fundamental needs of the human subject. This is not to deny the importance of a genetic component (which would require a separate study)[22], which can be considered as the basis on which the effects of the environmental component are grafted. The latter mainly concerns the quality of the relationships that a person has been able to enjoy. This environmental-relational component is certainly of great importance, and it is in this area that psychotherapy intervenes.
2. Throughout their lives, individuals seek ways to defend themselves against this denial. However, defence mechanisms are often complex and prevent those who have developed them from having positive and productive relationships with the world in which they live.
3. The psychotherapist's job is to reconstruct the fundamental points of this story, only a small part of which is clear in the mind of the person who experienced it; to help the person take care of needs that have not been recognised and find a response that is compatible with the present reality; to dissolve defences that are no longer necessary.
4. This work requires the ability to tune in to the patient's thoughts and feelings, and therefore a good use of what has been called 'emotional intelligence'. It also requires the ability to establish a collaborative relationship with the patient, overcoming the moments of conflict that are almost inevitable during the course of therapy.

In conclusion, it can be said that psychotherapy represents the human capacity to repair the damage caused by defective interpersonal relationships.

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