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Usefulness of the concepts of deficit and defect in the psychotherapeutic process

Paweł Glita

Summary

The aim of this article is to outline the usefulness of such categories as deficit and defect during the process of psychotherapy in psychodynamic terms. Because there is no one common definition of these concepts, first the author analyses how they are used in clinical practice (we talk about e.g. "cognitive" or different "emotional" deficits, "organic" or "post psychotic" defects). Sometimes these phrases have very pessimistic connotation for the outcome of psychotherapy. The author refers to different psychoanalytical theories (e.g. H. Kohut, M. Balint, H. Deutsch, F. Pine) to show that these concepts have their origins in two sources. First is the accumulation of psychological and neuropsychological knowledge on the determinants of irreversible changes in the patient's personality, which are located in his/her brain functioning, early relationships or developmental environment. The second is the strong experience of countertransference inefficacy and limits of psychotherapy as the method of facilitating positive changes in the patient's life. Clinical illustrations are used to show therapeutic implications of the concepts of deficit and defect. The author focused on the necessity of distinction between deficit and dissociation, interpersonal nature of deficit and defect diagnosis and the possible determinants and consequences of premature diagnosis of deficit or defect.

deficit / defect / psychodynamic psychotherapy

INTRODUCTION

The aim of this paper is to present clinical usefulness of concepts of deficit and defect, defined according to the contemporary psychodynamic approach. I would like to describe these concepts in two ways. In the beginning, deficit and defect will be presented as characteristics of the patient and his developmental environment. Next we will see how manifestations of these concepts can be observed in therapeutic relation. This approach corresponds well with the fact that the use of these concepts in psychotherapy draws inspiration from two sources. On one hand they are rooted in new psychological and neuropsychological theories that use their specific languages to show emotional or neuronal basis of limitations in functioning of individuals. On the other hand, experience is gained in clinical work. Even before self-psychology and neuropsychological conceptions emerged, therapists working with patients with predominance of deficit, experienced specific difficulties in the psychotherapeutic processes. Attempts to understand these patients in an intuitive and empathic way showed that they are very resistant to change and can make the therapist feel helpless, which is the second source of knowledge about deficit and defect. Therefore, many therapists find internalization of these concepts useful in the psychotherapeutic process, similarly to those of resistance or transference. In my presentation I would like to focus on countertransference and

Paweł Glita: Kraków Psychodynamic Centre, Kraków Therapy Centre, Poland. Correspondence address: Kraków Psychodynamic Centre, 56 Zamoyskiego St., 30-523 Kraków, Poland. E-mail: glita@poczta.onet.pl

dilemmas of therapists working with patients with predominance of deficit.1 Cases presented in this paper are derived from therapeutic work with adolescent and adult patients.

DEFICIT AND DEFECT AS A CHARACTERISTIC OF THE PATIENT AND HIS DEVELOPMENTAL ENVIRONMENT

Contrary to expectation, in literature, there is no definition of deficit that all authors would consent to, even though almost every therapist has some intuitive understanding of this term and some experience in working with so called 'patients with predominance of deficit'. A definition, although not explicitly formulated, that seems to be compliant with intuitive understanding presented by most therapists, can be found in "Borderline disorders", by Eda Goldstein. She writes that deficit, means 'lack or underdevelopment of some elements of personality' [5]. Such a broad definition provokes two questions: which elements of personality does the author mean and why some elements are missing or are underdeveloped. When we focus more on the language of clinical practice, we will notice, that the term 'deficit' is used mainly when we want to be more specific about the area we find underdeveloped. We can speak about 'cognitive deficits', and among them 'attention deficit', one of the elements necessary to diagnose ADHD, 'emotional deficits', 'deficits of upbringing' and also 'superego deficits' (when we want to say that someone has no 'so called' higher emotions in antisocial personality). We speak about deficit of symbolisation in psychosomatic disorders or disorders with predominance of destructive acting outs. Terms 'deficit' or 'defect' were also often used in psychiatric language to equal with the vaguely used term of 'organic disorders'. The same understanding of the term is also observable in the diagnosis of negative symptoms in psychosis, and sometimes we come across the term 'defect after psychosis'. Other examples of deficiencies are: inability to postpone instinctual gratifications, loss of 'internal caretaker' due to traumatic experience, inability to calm oneself, primary alexithymia and others. Altogether we can see that the term 'deficit' is a broad psychotherapeutic category implicitly or explicitly expressed in various nosological and psychodynamic diagnoses (such as autism, psychoses, panic anxiety, eating disorders, psychosomatic disorders and personality disorders). It seems that the term 'defect' is used in clinical language to mean a lasting or more serious damage.

A different perspective is proposed by Fred Pine [9], who introduces clear differentiation between terms 'defect' and 'deficit'. He defines deficit as 'insufficient reply from the environment, usually from primary caretakers'. Pine says that in fact there is always some kind of response, and therefore his statement is based on the assumption that optimal development of an individual requires average expected input from caregivers. Pine paraphrases Winnicott saying that: good parenthood or psychological environment, which is 'supportive enough is necessary for an individual to develop well'. We can see that in Pine's approach, deficit is a trait of the environment. What has previously been defined as a 'deficit', Pine proposes to name 'defect'. Defect, according to Pine, is something that we find inside a person, something that refers to malfunctional development of ego functions, such as: defensive, adaptative or related to reality testing. A defect would be then a result of deficit.

Among all above mentioned concepts, the one most broadly applied in contemporary psychoanalysis is 'emotional deficit'. It is due to Heinz Kohut and his successors, who created psychology of the self. Kohut turns our attention to clinical consequences of frustrating the two basic needs of the child, which constitute the future regulation of self esteem: the need of mirroring and idealisation. Establishing the concepts of "insufficiently stimulated self" and "mirror hungry personality" he shows painful consequences of the fact that the child did not receive warm enough acceptance of his need to feel important and necessary to have a strong caregiver who would provide him with feelings of security and identity. (so called self-object) [7]. The child, deprived of love, unconsciously internalizes the image of the self, as a burden, an obstacle, someone not worth of attention and love, which destructively influences his relation with

[1] In the article I use the phrase „patient with predominance of deficit" instead of „patient with deficit" or „patient with defect", because this formulation clearly shows that diagnosis of deficit or defect does not exclude presence of a conflictual (more easily modified) background of the patient's pathology.

others. It is expressed through emotional chill, total oversensitivity, inability to love or compensating facade of narcissistic superiority.

Temporarily the concept of deficit is most commonly used in opposition to conflict in discussion about genesis of severe personality disorders, such as narcissistic and borderline disorders. The 'conflict' approach is most fully represented by Kernberg and, with some differences, Masterson. Key roles in this approach are assigned to real trauma, mechanism of splitting and constitutional aggression. Representatives of self psychology stress the decisive role of deficit in aetiology of borderline disorders. As an example of such approach, Goldstein [5] proposes concepts of Adler and Buie [1]. In their theory, deficit, as specifically related to aetiology of borderline personality disorders, is defined as the child's inability to use 'evocative memory'. Evocative memory is '...a skill that appears when the child is around 18 months old. It gives the child the ability to recall the memories of an object although it is absent. It is a result of good enough mothering that the child has received before the rapprochement phase. If the child is soothed by the mother, it enables the child to internalize this ability and introject good objects. The skill of evocative memory is initially fragile and disappears when the child is separated from the mother for a longer period of time. This ability makes the child more autonomous, because the possibility to remember mother's presence makes it possible for the child to soothe itself. It helps overcome the destructive feeling of loneliness, panic or depression caused by separation from important adults." [1, quoted from 5, p., 77-78]

As Pine [9] observes, opposition conflict versus deficit seems to be false. He gives the following example. Let us imagine a child, which due to temperamental traits is challenging to his caring and empathic enough mother. Such a child would significantly test mother's level of anxiety, excitability and vulnerability to separation. If overall conditions are unfavourable, such as mother's illness, she has no chance to soothe the child. Frustration and fury collecting in the child significantly disable the child's ability to create an image of a good object, because the desire of emotional warmth remains in severe conflict and is destroyed by destructive, sadistic impulses related to trauma. In consequence, the child who grows in an environment that is caring enough is unable to use it in order to develop the ability to self consolation and create a lasting bond with domination of attachment and gratefulness. In this sense Kernberg`s conclusions related to the dominating role of innate factors, splitting and the role of real traumatic experience would not be in opposition to Kohut`s statement, that deficits are a consequence of deficiency. This mechanism seems to underlay the dramatic situation of some adoptive parents. I remember from group supervision a patient presented by my colleague. The girl undertook her therapy when she was sixteen; she was adopted when she was two years old. She was very impulsive and used to alternately experience deep hatred with following acting out behaviour and „sticking to", shortening the distance. It seemed that she was not able to accept the rules and draw from care and experiences of adoptive parents and the therapist. It was profoundly reflected in her difficulties related to later developmental phases, such as psychosexual identity. Rather then defend herself against separation from primary object, she clung on to the idealised image of her biological mother, whom she had never seen. The tendency to de-idealise parents, appearing in early adolescence, has dramatically activated her conflict rooted in early childhood and became the cause of later deficit.

The second example comes from my practice and is related to a patient, whose tendency to experience intense rage mixed with periods of great coldness, lack of empathy and resentment were in obvious conflict with the image of good family that was appearing in therapist's mind in contact with the patient. The therapist could not understand this discrepancy for a long time, until the patient revealed that when she was two, she had serious surgery. The patient knew from the mother's relation that she had to lie still in an aseptic room, where, in order to prevent infection, no one, even her mother, was allowed to touch her. Mother told her daughter that after hospitalisation she was trying to hug her, but the child was consequently pushing her away. Such 'pushing away', now in a more symbolic way, was a characteristic trait of the patient in love relations with men.

To understand these patients in the category of deficit is, naturally, a hypothesis that cannot be verified, and my intention was to underline the hermeneutic value of this concept.

Psychotherapeutic practice has been undoubtedly enriched by the introduction of conflict and deficit concepts into the diagnosis of patients. Until then, various internal conflicts were treated as psychological causes of emotional difficulties. Historically, in classical drive theory, conflicts appeared between different structural aspects of mind, such as instinctual impulses and moral bans of superego. Later on, Melanie Klein and her followers enriched this approach introducing the idea of conflict within one structure, which is visible in an ambivalent struggle of destructive tendencies and gratitude. Recognition of conflict and deficit concepts is one of the criteria differentiating between classical psychoanalysis, traditionally focused on conflictual aspects, and contemporary psychodynamic approach which tries to identify constitutional and psychological limitations of the patient. We are putting away the dichotomic, sharp division between organic and psychological deficit followed by similar division between biological treatment and psychotherapy. Patient's problems are understood as an interaction of psychological and biological factors. It is not only because we still are not able to define whether psychological factors cause organic defect or the other way round, but also because there is growing evidence that effective psychotherapy brings changes at the organic level [4].

Manifestations of deficit and conflict in psychotherapeutic relation

If we carefully analyse situations in which we, more or less openly, reach for the concepts of deficit or defect, we will observe that very often under these terms we hide our diagnostic or therapeutic helplessness. They are an elegant way of saying that we have come across a patient with an unchangeable or hardly modifiable trait. From the therapeutic point of view such attitude has no justification. I will attempt to show that during therapy we can speak of *compensation of deficit*. We could advance a thesis that an increasing popularity of this concept, as well as the whole self psychology, reflects therapists` need to have a theory that will enhance understanding of their countertransference reactions in relation with a certain group of patients for whom classical drive theory, psychology of ego and theory of Melanie Klein seem to be insufficient. Patients with deficits have always been there, and when we nowadays read Freud, Fenichel and others, we can see that their intuitions referring to the problem of deficit were expressed in discussions about traits of character that are hard to modify, i.e. oral traits. Even in psychoanalytic understanding of neurotic pathology, where the key role in formation of symptoms is played by unconscious intrapsychic conflicts, we can come across reference to a deficit trait – weakness of ego [4]. Therefore, neurosis is caused not only by conflicts, but also by weak ego, which is not able to find an effective compromise between contradictory instinctual requirements and requirements set by the reality and superego.

Ideas of deficit were present in the history of psychoanalysis both, before and after Kohut. Intuitions related to the idea of deficit, related to those of Kohut, can be found in e.g. The 'as if personality' concept, created by Helen Deutsch in the thirties of twentieth century [3]. In her article, 'Some forms of emotional disturbances and their relationship to schizophrenia' Deutsch gives examples of some patients, who were well cared for as far as material and nursing aspects were concerned. However, they were not able to create a relationship which would make it possible for them to develop stable feeling of identity. These patients, sometimes cared for by strangers during their childhood, were, like the movie character Zelig, becoming totally similar to significant others with whom they remained in a relation at the moment. That similarity was mechanical, with no spontaneous creativity. It was clearly observable when they were suddenly terminating their relationship and finding a new object they could imitate. Deutsch paid attention to certain characteristic quality of the contact with such patients, perceived even by people who were not professionally engaged in therapy. It was something awkward, something hard to give name to. Such 'awkwardness' in the process of psychoanalysis turned to be the feeling of superficial relationship, emptiness, lack of deeper, empathic relation. Talking of one of these pa-

tients, Deutsch writes: "This patient has never complained that she has no emotions, because she has never been aware of them. Her relationship with her parents has been strong enough for them to become characters in her fantasies. It has been obvious though; that these conditions were not good enough to build a warm and dynamic oedipal situation that would shape healthy psychic life, with the ability to experience both positive and negative feelings. It is not enough that the parents are just present and nurture child's fantasies. A child, if it can develop normal emotional life, has to be seduced, in a sense, by libidinal activity of parents. It has to experience warmth of mother's body and all unconsciously seducing behaviours of a loving mother, which are related to meeting child's physical needs. A child has to play with his/her father and has contact intimate enough to feel his masculinity. All this is necessary for the instinctual impulses to initiate oedipal constellation." [3] A consequence of such developmental shortages is a type of personality called by Deutsch, the 'as if personality'. It is as if this person had some feelings, passions, relations; as if it had deeply rooted identity, but turned to be 'empty'.

Kohut`s ideas are so popular that they sometimes veil another important psychoanalyst, Michael Balint. In the sixties of the 20th century, he presented the idea of "basic fault", where he presents how the child's character is shaped if its psychobiological needs emerging in preoedipal developmental phase are not met by the faulty environment. He has also advanced a thesis that only some of these consequences are reversible and in other cases psychotherapy can only teach patients how to live with some kind of defect. Balint has stressed limitations of classical psychoanalytic technique in treatment of such patients. [2]

Analysing these concepts, one may observe that this term is used not only to broaden the understanding of the patient, but also to express some countertransference reactions where some deficiency dominates. Every therapist who has worked long enough knows this feeling, sometimes present from the beginning of the contact with patient, sometimes appearing after knowing the patient little better. In our comments or behaviour, we refer to something that is obvious for us, some ability or something that complies with some cultural standards, something that should form part of a patient's experience, and we receive no answer. We feel that the patient does not understand. I can still remember the expression of a patient with alexithymia, who was clearly puzzled and disoriented when I told her that she seemed to be sad. This was not resistance in psychotherapy or simple suppression; I could feel that this woman was honestly not able to answer, even if she wanted to, although she was able to talk a lot about her somatic ailments.

How to recognise deficit and defect, and the possibilities to compensate them in the psychotherapeutic process

In the psychodynamic approach, diagnosis is a process. Phenomenological description of symptoms is merely a beginning, and in the psychotherapeutic process should be referred to, or interpreted in categories of internal life of the patient (defensive mechanisms, type of anxiety, dominating pattern of relation with the object, image of self). In this process we assume a great value of countertransference and the fact that intrapsychic problems of the patient are usually reflected in the therapeutic relation. It is not only diagnosis (as something stable) but, diagnosing, continuous formulation of hypotheses, verified by the effectiveness or ineffectiveness of therapeutic interventions. In this approach, although it may sound paradoxical, the therapist knows clearly the ailment of the patient at the end of therapy. The same rule should apply to the diagnosis of deficit and defect. Paradoxically, diagnosis of a deficit that cannot be compensated is to some degree confirmed by therapeutic failure. We can also speak about a deficit that has been compensated or weakened, which we would call a success, although some would say, that if something was changed it could not have been a deficit. It seems that the term 'defect' carries more pessimism and durability of the damage.

Due to the processual character of diagnosis, deficits should not be recognised too early, except cases when they are obvious. It happens though in clinical practice. It is difficult to remain enthusiastic, when we talk to a patient

who had another psychotic decompensation that has 'destroyed' all earlier achievements. We can read innumerable results of research stating that a good therapeutic relation is crucial to the process of healing and prevents further psychotic decompensations, but it still will be easy to question the sense of engaging once again in the psychotherapeutic contact or to initiate it in a mechanical way, denying the feeling of senselessness and pessimism. Unconsciously, we begin to treat the patient as if he was irreversibly damaged and free of internal conflicts. When in reality we know whether we have to deal with deficit or not, only after longer therapeutic process.

It is worth mentioning, that these issues should be considered especially by therapists of psychotic patients, because this group of patients evokes in therapists feelings of exhaustion and pessimism that are difficult to bear. Sometimes we resign from the work in the 'internal world of the patient' and go for psychosocial rehabilitation, and we should consider whether this decision is based on an adequate diagnosis of patients' limitations, or on generalised countertransference based reactions that prematurely exclude any elements of insight work. There also remains the question of how many non superficial, effective therapeutic relations with these patients can be carried by an average therapist.

Piotr Drozdowski has written [4], that deficit is a relational concept, which means that what appears to be a lasting deficit in one therapeutic dyad, can turn to be a deficit that can be compensated in another one. One therapist will 'warm up' a deficit, the 'not loved enough' patient, and the other will not.

I would like to stress a danger that I have come across myself, a danger of mistaking dissociation for deficit. Both psychological phenomena can give a feeling of similar inaccessibility and lack of some experiences in the patient's history of life. I have a 19 year old patient who asked for therapy two years ago. She was depressive, and in the therapist's reflection, her psychosexual identity was unclear. Initially the patient used to make me feel helpless, and terribly sleepy, no matter what my psychophysical condition was. She seemed not to react to therapy. As if she wanted to make use of it (she had strong motivation) but did not know how to do it. I had a strong feeling, that she is lacking vitality, ability to experience pleasure, also one related to puberty and instincts. My first step was to increase the number of sessions, the second, supervision, where I heard a suggestion, that we cannot exclude a deficit. Unexpectedly, during one of the sessions, the patient started to talk about her traumatic experience – when she was seven, an uncle of her tried to rape her. Since that session, my sleepiness has disappeared, and a number of conflicted aspects of her sexuality have emerged. Although I still defined some aspects of the patient's functioning as a deficit, I have changed significantly the proportion between deficit and conflict.

How the concept of deficit influences or should influence the way we work

In the psychodynamic approach, the chief curing factors are considered to be insight and identification with the therapist. Undoubtedly, when we work with a deficit patient, the latter group of factors begin to play a more important role. What we say becomes less important than how we say it or even what we are like. This is why therapists have a different ability to work with a patient with deficit. Kilingmo [6], Balint and, to some degree Kohut, wrote that when we come across an area with deficit in the patient, we should abandon our traditional, withdrawn technique and become more supportive, which we often do unconsciously if we remain in empathic contact with the patient. We could even say provocatively, that a number of therapists diagnose deficit without being aware of that. They do it every time, when they instinctively abandon expressive or insight techniques and become supportive. The classical rule of neutrality and emotional abstinence of the therapist can be very traumatising to those patients, because due to their sensitivity to emotional abandonment, it will remind them of the old traumatic experience. Instead, we could provide them with a relation which provides them, in a micro scale, with experiences that they were missing before. We could make a hypothesis here that it could be done in the best way by the youngest, engaged and idealistic therapists, who, due to little experience tend to ignore limitations of psycho-

therapy. It can be also done in a more conscious way by more experienced therapists, who are less dependent on an internal ambitious pressure of achieving quick therapeutic successes which confirm their value.[2]

A different strategy seems to be appropriate when we diagnose irreversible deficits or defects. It is advisable then to confront the patient with them (e.g. that he has a trait of character or that he is just like this), which will initiate in him a process analogical to mourning, where we will be able to accompany the patient. Moreover, there is a group of patients who require us to include some psycho educational and pedagogical elements. Patients with organic micro damages of brain require us to be flexible in technique, and to give them simple and unambiguous comments [10]. Generally speaking, diagnosis of deficits is a very difficult and subtle process. When we, as therapists, want to provide the patient with a corrective experience, it requires long term therapy.

At what developmental stage do we diagnose deficits and defects?

Most of them seem to be present since childhood, but they become clearly visible during adolescence. Adolescence is a period of developmental acceleration, and often deficits are expressed thorough some kind of developmental inhibition, which manifests itself especially when compared to other adolescents who begin to develop rapidly. It is as if other children started to run and patients with deficit remained in the starting blocks. It is also then that we observe disharmonic development of emotional and intellectual life. Deficit of superego, that could be observed earlier, becomes a real problem in adolescence. Insufficient feelings of guilt and inhibition of emotions join with better developed body and more knowledge how to break the rules avoiding consequences. In therapy of adolescents we see many teenagers, who have missed something in their development. We need to remember though, that this period of life is very flexible, and there are great chances to compensate existing deficits. Therapists should not miss this opportunity.

Finally, I would like to mention a patient who was developing towards a schizoid personality. I met Marcin for the first time when I was leading a therapeutic group for teenagers, he was 14.3 After the group had ended, Marcin remained in individual psychotherapeutic contact with me for another 7 years. During therapy I experienced a number of dilemmas related to his condition. Should I recognise some of his traits as deficits of him and his developmental environment? If yes, am I able to compensate them, or should I accept them and help the boy in getting a psychiatric pension. Such a solution would help him in his life, according to his mother, but it would also mean giving up the fight for his development. On the other hand, giving him hope that he will study and have his family, could turn to be frustrating and finally cause a serious emotional breakdown. When he was a child, he had an episode of anoxia at birth. Some of his behaviours and test results, such as dyslexia, problems in learning foreign languages, awkwardness of movements, were showing a considerable influence of biological factors in his educational and social difficulties. The patient had a good range of vocabulary, liked to engage in intellectual discussions, although it rarely led to the feeling of being close to him. It was difficult for Marcin, especially at the beginning of therapy, to define his emotional states. When he was asked about his opinion on certain issues, he used to say, that he is neutral. During the whole process I was confronted a number of times with persistent behaviours that could not be modified through confrontation. He was often late for therapy for a number of years, it was impossible to loosen psychotic symbiosis with his mother, he demanded that his father would wash him, even after he was 18, he wanted the school to adjust to his difficulties. What was most striking though, was total lack of any social contacts and no will to change this situation. Other therapists and doctors who took care of the boy were also giving signals that it was time to give up. During his earlier stay in the hospital, there were suggestions that we should accept the boy's limita-

[2] Mc Williams, in one of her books [8], refers to the practices of Frida Fromm-Reichmann in relation to the seriously ill, psychotic patients. She used to give them purposefully young, engaged therapists, who sometimes managed to help these patients, because they did not know, that they are 'incurable'.

[3] Names and some facts from life of the patients described in the article have been changed.

tions and send him to a vocational school, rather then accept his dreams of going to the university. It was difficult for me because on one hand I agreed with these opinions, on the other hand however, I disagreed with them and was competing with other specialists, because I felt in the boy, high potential for change. It was as if other therapists were divided in their countertransference reactions to those who agreed with the boy's internal pessimism and those, who against all odds believed in the possibility of change. In my opinion the key moment in therapy was the session when the boy came and decided to stop education and become a hermit in the future. In the therapist's opinion this was a key moment in therapy, because schizoid mechanisms were becoming stronger, and there was the danger that the patient will retreat from the social world, which was metaphorically described as "becoming a hermit". He also considered quitting the therapy. The therapist reacted quite emotionally, especially because he was slowly loosing hope for the boy. During next few sessions, the therapist was persuading the boy that it was a choice that would be very dangerous to him. What made the boy change his mind were his sexual needs. When the therapist said that becoming a hermit, metaphorically or verbatim, meant giving up contacts with women 'now and forever', Marcin looked as if he has been awakened. He decided that solitude, and especially lack of girlfriend, are his real problems, and this vague promise of participation in the men – women world has saved the therapy. The therapist's attitude was far from neutral. He was angry when the patient used to 'use' his problems to justify his passivity and when he did not want to resign from immature narcissistic gratifications. The patient was compensating his deficits during the therapy in various, sometimes dangerous, forms, because he did not understand some social rules. Marcin could sometimes accost unknown girls in the street or park and complain about his loneliness, he proposed them to date with him. During one of the sessions he invited the therapist to his house and demanded that the therapist invites him back and makes him acquainted with his wife, whom he wanted to know very much. Each situation required a patient explanation of the rules that Marcin could not understand or accept. The therapist was alternatively astonished with the boy's ignorance or sad. In countertransference he felt gratification for being the boy's guide in learning the world. He had a clear feeling that some of the situations are experienced by the patient for the first time in his life (like the necessity to accept that a close person is in fact separate).

Considering the therapy from the perspective of time I can see now, how some features that seemed unchangeable, turned to be modifiable. Marcin is now a young, emotionally vivid man. He understands social life rules much better and is, to some degree, separated from his mother. He began to study his dreamt studies, although some educational requirements have been lowered for him. He says that he will probably not finish studies due to difficulties in learning foreign languages, but he is beginning to get along with it. He has more social contacts, although they are short and rare. A number of these changes took place to the therapist's surprise and gave him hope that the boy can achieve more than the therapist thought.

On the other hand however, a number of behaviours remained unchanged. A requirement that Marcin undertakes group therapy for adults has never been fulfilled. He did not become more independent in hygienic issues and daily routines, and his parents could not be persuaded to set clear borders for him, although in this area neurotic shame has appeared. To the therapist's surprise, some narcissistic features of the boy turned to be difficult in modification – the need to resign from some childish pleasures, postponing of gratification, etc.

DISCUSSION

I have given this example, to underline one more aspect. Concepts of deficit and defect are very useful because if we understand them properly, they help the therapist become more patient and supportive; they cure from the overt necessity to heal the patient, setting of unrealistic therapeutic goals that would frustrate both patient and therapist. On the other hand they are dangerous, because if we misunderstand them, they can mean that we prematurely resign from therapeutic efforts, from the battle for the pa-

tient and leave behind something that could be changed.

Many authors have underlined that in the diagnostic process, the influence of unconscious countertransference on the process of understanding is not sufficiently reflected. I mention it here to counteract an erroneous notion, that if the therapist feels helpless, it is enough to diagnose the patient as 'deficit'. It can be the other way round, the patient can be mistaken for a deficit one only because the therapist for some, often personal reasons, does not give him the hope to change.

It seems that a number of issues referred to in this article require further continuation. Definitional issues, such as relation between deficit, defect and conflict need to be more precise. Types of deficits and defects in psychotherapeutic practice can be described. It would be important to focus in details on the optimal ways of working with various types of deficits.

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