*British Journal of Psychiatry* (1987), **151**, 283–287

**Annotation**

# Psychotherapy Today

## Further Consideration of the Essence of Psychotherapy*

STANLEY E. GREBEN

Despite swings between over-valuation and rejection of psychotherapy on the part of some psychiatrists, there remains a valid and necessary place for psychotherapy in psychiatry. The essential elements of that place are described.

Six years ago, I endeavoured to abstract what it is that matters and is effective in the practice of psychotherapy (Greben, 1981). There have since been important shifts in the attitudes of psychiatrists toward the value or lack thereof of psychotherapy. At the same time, many other professionals have become active in psychotherapeutic work. Members of the public, needing help for symptoms that discomfit them and diminish the quality of their lives, are often hard pressed to find useful help, both within and without medical facilities.

My awareness of this circumstance has been heightened by responses of both professional and lay people to views expressed in my book, *Love's Labor* (Greben, 1984). Patients and family members, some of whom are psychiatrists, expressed concern, dismay, even outrage, at ways in which they or others had been dealt with in psychotherapy. We need to address these concerns, if we intend psychotherapy to be a respectable component of our therapeutic armoury.

I intend to set out my current view of what should be the place and use of psychotherapy, from the vantage point of one who is a medical specialist in psychiatry and also a psychoanalyst, working in a teaching general hospital. I will also deal with issues that are important to other professionals in the health field, as well as to the consumers of our services. I hope to bring perspective to an area which is of great importance, not only to those of us who work in it, but to Western society in general.

In examining factors which I feel to be effective in bringing about change through psychotherapy (Greben, 1977), I began with the proposition that psychotherapy *does* lead to changes in patients, and that this has been amply demonstrated by numerous studies (Smith *et al*, 1980; Karasu, 1982), as well as by the observations of experienced clinicians. The challenge was to then demonstrate what are the reasons for the improvements that occur. As I set out in that instance with the relatively optimistic point of view that psychotherapy does work, I set out in this instance with the relatively optimistic view that much excellent psychotherapeutic work is taking place. At the same time, a considerable amount of work has been done that is not acceptable, and has not met justified expectations of those who have sought help.

### Influences of society upon psychotherapy

As medical scientists, we prefer to think of the scientific part of our work as freestanding from popular attitudes in society, but of course it is not. Even 'hard' basic sciences are subject to the pull of current public attitudes. With psychotherapy, a number of external influences have played an important part in the directions which both our theory and practice have taken.

Freud developed psychoanalysis in Vienna at the turn of the century. Despite a milieu of relative psychological repression and denial, in a stratified society where surface and depth were so at odds, he was able to be candid and revealing about his feelings and findings. That candour was essential to the beginnings of a profession devoted to the uncovering and revelation of realistic truth. Freud's discoveries were of course consistent with the content of classical writings of centuries before: the authors of the Scriptures, Roman and Greek philosophers, Shakespeare, and Dickens clearly understood these principles. As Freud indicated, he became famous revealing "what every nursemaid knows".

The Second World War displaced European psychoanalysts, principally to England and the United States, and that which had been of mild influence came to be of much greater influence. They became, especially if their direct lineage could be drawn to Freud, a kind of guru. In those years, many people in Western society were uncertain about themselves, and about the form and direction which it was best for life to take. Scientists seemed to have important

*Based on a lecture given to the Department of Psychiatry, University of Western Ontario, October 1986.

answers to the dilemmas that faced most people. Fear, ennui and insecurity abounded. The American child psychiatrist, Leo Kanner, alarmed by this phenomenon, wrote a book entitled *In Defence of Mothers* (Kanner, 1962).

After the war, psychoanalysis dominated psychiatry, and also had a powerful general influence upon Western society. Much has since changed. Too much was expected of psychoanalysis by its practitioners, consumers and general adherents, and so disillusionment ensued. Many reasoned that helping people live more fruitfully and happily did not necessarily require years of formal training and personal psychoanalytic treatment. Anti-traditionalism thrived in all areas, and psychotherapy was no exception. Beginning among other places in Big Sur, California, everything old was rejected and everything new was attempted. Touching, holding, in addition to talking, was tried. All manner of theories were expounded and, for a time, cherished.

As we emerge from all that to a time when traditional and conservative values are coming once again to the fore, the work of Freud, Jung, Winnicott, Klein, Greenson and many others has not disappeared. Still, the influence of freer psychotherapy which demands more participation of the therapist has continued, and is likely to have a lasting effect upon the development of a general psychotherapy.

Another important and wholesome recent influence upon psychotherapy has been the view that people have a right to receive something evident and helpful when they spend time, money and energy seeking help. Numerous psychoanalysts took, in past years, the view: "I don't try to help people, I analyse them. Analysis is an art." Many people today do not accept that view. Correctly, professional practitioners are now being held to more account, both by those who provide financial support and by those who are the objects of that work.

Another societal influence upon the practice of psychotherapy arises out of the growing intention of people to live in more natural ways, avoiding the noxious effects of poisons and of disuse. Such 'holistic' approaches presume that that which is closer to nature and the experiences of our ancestors is most likely to suit us well, and do us the least harm. For all psychotherapists, an understanding of Oedipus and Psyche is insufficient. For the physician psychotherapist this carries particular implications, for he is expected to understand, not simply to dismiss, the significance for health of nutrition, exercise, meditation, hypnosis, yoga, and other special practices which have withstood, presumably for good reasons, the practical test of time. He must, for example, know the work of Benson (1974), so that he can assess his patient's search for techniques that will induce the relaxation response. All physicians must know the accumulated evidence of the benefit of a diet which is low in fat, simple sugars and salt, and high in complex carbohydrate and fibre. They must be equally cognisant of the multiple benefits of avoiding underuse of the body, recognising that the release of endorphins and epinephrine into the bloodstream has a profound effect upon mood and mentation and, aware of the dangers of substance abuse for the relief of the effects of stress and unhappiness, should encourage patients in the less dangerous habituation of regular and sustained athletic activities. Similarly, the psychotherapist who ignores the place of humour in becoming and continuing to feel well (Cousins, 1979) will be a very limited psychotherapist indeed. In short, we have ample proof that insular psychotherapies are inadequate and cannot succeed.

Another attitude has been growing in strength and popularity that must be paid heed to by psychiatrists. Considerable dissatisfaction is being expressed about the ways in which health care is provided. In part this arises because of a general deterioration in the quality of caring for others in everyday life. In part it relates to the cost of physicians' services, both physical and psychological. Complaints are now openly heard that physicians are more technicians and less care-givers. More demand is being made for humane, individual care of patients. This dissatisfaction, on the part of both physicians and patients, demands redress.

This trend has considerable significance for psychotherapists. Ten and twenty years ago I knew of patients in intensive psychotherapy or psychoanalysis whose therapists said literally nothing for months on end of several-times-weekly treatment. Today, when patients have come to feel more deserving of humane, active treatment, such neglect, even when benign, is less likely to be tolerated. This is a very good thing. The days when psychotherapists were gratefully attended and paid for just being present in the room are passing or passed. We are being expected, as are all professionals who are paid for their time and services, to produce something that will be useful and valuable to the patient.

One encouraging manifestation of these changed attitudes has been the establishment of a new international journal entitled *Humane Medicine*. Its stated purpose is: ". . . to provide a vehicle for communication among all those who have something to share about ministry to the whole person – to body, mind and spirit" (Oreopoulos, 1985). The provision of such a forum, bringing together the concerns of both health care professionals and their clients or patients, bespeaks a new attitude that has profound implications for the practice of psychotherapy. That attitude expects people to be treated well and respectfully, and to be given something valuable for the time, energy and money which they invest in the pursuit of health and comfort. A main goal of psychotherapy is the growth, maturation and psychological development of the patient, and these can take place only under the conditions that are currently being expected of us (Marmor, 1977).

Overall, those influences in society which currently pull us more into the mainstream, are likely to improve both our relations with our patients and the ways and degree to which we are able to be of help to them.

### Influences of other professions upon psychotherapy in psychiatry

In recent years there have also been important relevant changes in the attitudes and activities of our fellow professionals, and in our attitudes toward them. Some psychiatrists adhere to the view that psychotherapy is a medical act only, and can properly be undertaken only by medical personnel. This is not a view that can be logically supported, since the largest part of what is done, most of

the time, in psychotherapy is psychological, and has not to do with physical or medical matters. Others hold the opposite view: that psychotherapy is not a medical act, and that medical training is irrelevant to its performance. This view is also illogical, for much that presents as psychological disturbance originates in medical disease, and much that is treated solely by psychological means cries out for biochemical or other medical therapy.

A reasonable view would be that there is a place for psychotherapy to be practised by both medical and non-medical professionals, and that the advantages and limitations of the training and experience of each specific profession need to be recognised. From the vantage point of psychiatry, psychotherapy must continue to be taught, studied, and practised as an indigenous part of psychiatry (Katz, 1986). At the same time, it is appropriate that we find ways of co-operating with members of other professions, not just competing, in this area of our work.

In the history of psychotherapy, both as a science and as an art, a major role has been played by both physicians and non-medical workers, most obviously within psychoanalysis, but also in the field of psychotherapy research. It is healthy for psychotherapy that workers come to it from several professions, for in that way the effect of blind spots that exist in each profession is reduced. The territory of psychotherapy is large, and research by both physicians and others has produced fruitful results.

### Influence of attitudes of psychiatrists and other medical psychotherapists upon psychotherapy

In recent years, some medical practitioners, including psychiatrists, have been prepared to eliminate psychotherapy as an indigenous part of psychiatry, and to delegate its practice to others. This tendency is against the entire history of the profession of medicine and of the specialty of psychiatry. There are training programmes for residents in psychiatry in which psychotherapy supervision for residents has been given over to a psychologist. There are hospitals in which suitability of a patient for psychotherapy is determined not by a psychiatrist, but again by a psychologist. This is not the major trend in psychiatry, but it should be strongly discouraged. For psychiatrists to relinquish the study, practice and teaching of psychotherapy is to be absolutely avoided, since doing so would lead them to be not medical psychologists, to use an old term, but behavioural physicians, and would justify the apprehensions, fears and even expectations of those who see medical practitioners as becoming more and more technicians, and less and less clinicians.

Another attitude which has hindered the development of the most useful general medical psychotherapy has arisen out of the use of our most important medical tool, the scientific method. This tool will always be the most reliable means of drawing trustworthy conclusions within any arena. Still, out of excessive respect for that method, we have tended to eliminate common-sense observations that mean so much in the learning that occurs in all areas of life. The psychotherapeutic process is both simple and complicated. In being scientific, we demand studies so rigorous, to prove the obvious, that no one is able to devise them. Who demands a study to prove whether a university education leads to change in students exposed to it? Further, we take hypotheses which had some value as such, and make them rigid dicta that are expected to stand forever unchanged. Freud altered his views, by and large, throughout his career. Many psychoanalysts who followed him took his tentative hypotheses as established gospel, and considered all efforts to change them as heretical. Theoreticians in psychotherapy have understandably sought to reduce the pathological factors present to the smallest possible number, seeing all human neurosis through the framework of one or another over-simplified theory. The Procrustean bed of Oedipus cannot begin to accommodate the complex sources of disease and behavioural disorder that confront psychotherapeutic clinicians. We must avoid excessive generalisation and undue simplification. If there is a universal rule about human behaviour and pain, it is that character is so complex and human interactions so idiosyncratic that useful psychotherapy demands an entirely individual approach to each patient. We must avoid automatism, and retain our individual styles in approaching our individual patients, with their highly individual discomforts and disorders.

We have often carried diagnosis to extremes whereby a popular current way of looking at a common difficulty makes us see something esoteric in that which is not. In the past two decades the unhappy and regrettable ways in which stresses and lacks in Western society have moulded people, especially young people, have made us designate disorders or syndromes which we then discover on all sides. For a time everyone is hysterical, then passive–aggressive, then narcissistic, then borderline, next whatever comes along. Different experts propose different approaches for dealing with those who demonstrate hallmark symptoms of these 'new' disorders. It is doubtful that those approaches contribute much that is new, and they may divert the therapist from his most useful stance – that of an interested, enquiring, empathic, informed and open-minded clinician.

The struggle in psychiatry with the tendency to divide the person into body and mind has been a long and difficult one (Eisenberg, 1986). As a physician training in psychiatry in the 1950s I was exposed to two quite opposite views in regard to serious depressive disorders. Clinicians who were either psychoanalysts or else psychiatrists who felt that the only fundamental treatment was psychoanalytically oriented psychotherapy believed that severe depression was entirely a psychological matter, despite the fact that vegetative signs and behavioural symptoms of all seriously depressed patients were the same. The obvious need for organic (that is, biochemical and neurophysiological) explanations of the signs and symptoms was not seized upon. We used electroshock when the severity of the disorder demanded it, but with regret and often with disparaging references to 'the little black box'. Other clinicians, understanding that the depressed state must have biochemical underpinnings, prescribed biological treatments only. They considered it misguided and contra-indicated to 'waste time' talking to patients who suffered from such biological disorders, even when the cause was seen to be 'reactive' rather than genetic and familial, that is, 'constitutional'.

There has been a considerable improvement in this dichotomous situation. Today many psychiatrists are prepared to offer both biological and psychotherapeutic treatments to such patients. They hold that serious depressive disorder can arise in various ways. There may be a strong constitutional imperative or, at least, vulnerability, or it may result from the effects of "the slings and arrows of outrageous fortune". Whatever the aetiology, it is a situation in which biochemical change has occurred in the brain. To shorten the duration of pain, to forestall the possibility of violent behaviour, biological treatments (ordinarily chemical) are often or usually indicated. At the same time, some appropriate psychotherapy is equally indicated to deal with numerous factors: low self-esteem, the psychosocial causes that contributed to the development of the disorder, and, most important, the qualities of character that helped create the problem and threaten to do so again if untreated.

Such a multidimensional approach to psychiatry sees the presence of a psychotherapeutic component of treatment as not only acceptable, but essential. Psychotherapy must be recognised today as the potent tool that it is, one that does not exist in a vacuum: a flexible, variable, individually tailored treatment that takes its place as one amongst important equal companion treatments.

## The essence of psychotherapy within psychiatry

What then is an appropriate psychotherapy for psychiatrists today? Often in the past, psychiatric psychotherapists have claimed to be super sub-specialists, and have disparaged other than their own small area of special interest, be it psychoanalysis, family therapy, group therapy, behaviour therapy, or cognitive therapy. As I have pointed out elsewhere (Greben, 1984), it appears that most practitioners are more flexible and use more varying approaches than they imply publicly. Still, many therapists have restricted themselves to one technique only and this is as unsatisfactory as when a general psychiatrist is familiar with only one antidepressant or one major tranquilliser.

The general public has often been mystified by our language and our excessive contractions, but so have educated people in a variety of fields and professions. Somehow, our ways of understanding people must be less different than they have thus far been from the ways in which people have always been seen. We cannot improve upon Shakespeare and Dickens and Tolstoy, in terms of how a person is to be understood. That is, we must in the end return to everyday language and everyday formulations. For when we cannot be understood by intelligent people outside our own profession, then in truth we are not being understood by one another, and that in turn means that we are not being understood by ourselves.

What, then, are the implications of all this for psychotherapy in psychiatry? I would say that the following principles obtain:

- There can be no psychiatry without psychotherapy. In one form or another, psychotherapy is an essential treatment method, among numerous others, that are the tools of psychiatry.
- There is no single superior psychotherapy. More intensive work is better for some patients and worse for others.
- A psychiatrist needs to be competent in the use of psychotherapy and must be equally competent in the use of biological treatments, which currently largely means medications. If his training is deficient in this area, then he must have a colleague to whom he can refer his patients for such consideration.
- There is no reason to hesitate to combine biological treatments with psychotherapy, since the former in many instances will shorten the painful period for the patient, lessen the danger of suicide, make admission to hospital less often necessary, and render the patient better able to engage in the psychotherapeutic undertaking.
- A deep interest in psychotherapy does not mean that a psychiatrist should become distant or alienated from his medical colleagues. He should see himself as first a medical person, then a specialist in mental and emotional disorders and then a person with a particular interest in psychotherapy.
- Each of the various ways of applying psychotherapeutic principles has its own merit and value. Psychiatrists should be aware of the value of a therapist's meeting with more than one person – a married couple, part of or a whole family, or groups that have any of a variety of things in common.
- At the heart of all psychotherapy is the need of people in crisis to be heard, understood and helped. Therapists should be what patients need them to be: empathic, interested, concerned, reliable, respectful, and resourceful. They need to work hard at what they do, and not leave all the effort to the patient.
- The patient needs to be understood. The therapist needs to understand. On neither side is it necessary for that understanding to be perfect. The imperfection of the therapist will in the end help the patient to deal with the tendency toward idealisation of the therapist.
- In deeper psychotherapeutic work, attention to and discussion of what happens between the two participants is essential if the greatest possible degree of change is to eventuate.
- In addition to addressing symptoms, should they choose to do deeper work, psychiatrists will deal with

the underlying modes of behaviour and ways of relating to others which are best described by the word 'character'. The analysis of all aspects of character gives deeper forms of psychotherapy their greatest interest, and provides both therapist and patient with their greatest reward.

Isaac Bashevis Singer (1985), commenting upon a writer's work, said: "We always love to discuss and reveal character because human character is to us the greatest puzzle. No matter how much you know a human being you don't know him enough. Discussing character constitutes a supreme form of entertainment."

In a comparable way, attempting to understand the characters of our patients is the most challenging and entertaining aspect of the work of psychotherapists. To be humane, real people engaged in the work of psychotherapy, whether frequent and deep, or occasional and superficial, we must know and keep in mind the character of the patient, as well as his and our own humaneness. If we manage this, we will succeed in making and keeping psychotherapy, both today and tomorrow, the useful, important, even essential part of psychiatry that it must always be.

## References


BENSON, H., BEARY, J. F. & CAROL, M. P. (1974) The relaxation response. *Psychiatry*, **37**, 37–46.

COUSINS, N. (1979) *Anatomy of an Illness*. New York: W. W. Norton and Company.

EISENBERG, L. (1986) Mindlessness and brainlessness in psychiatry. *British Journal of Psychiatry*, **148**, 497–508.

GREBEN, S. E. (1977) On being therapeutic. *Canadian Psychiatric Association Journal*, **22**, 371–380.

—— (1981) The essence of psychotherapy. *British Journal of Psychiatry*, **138**, 449–455.

—— (1984) *Love's Labor: Twenty-five Years of Experience in the Practice of Psychotherapy*. New York: Schocken Books. (1985) New York: New American Library.

KANNER, L. (1962) *In Defence of Mothers: How to Bring up Children in Spite of the More Zealous Psychologists*. Springfield: C. C. Thomas.

KARASU, B. (1982) *Psychotherapy Research: Methodological and Efficacy Issues*. Washington: American Psychiatric Association.

KATZ, P. (1986) The role of the psychotherapies in the practice of psychiatry: the position of the Canadian Psychiatric Association. *Canadian Journal of Psychiatry*, **31**, 458–465.

MARMOR, J. (1977) The psychoanalyst as a person. *American Journal of Psychoanalysis*, **37**, 275–284.

OREOPOULOS, D. G. (1985) Statement of purpose. *Humane Medicine*, **1**, 2.

SINGER, I. B. & BURGIN, R. (1985) *Conversations with Isaac Bashevis Singer*. Garden City, NY: Doubleday and Company.

SMITH, M. L., GLASS, G. V. & MILLER, T. I. (1980) *The Benefits of Psychotherapy*. Baltimore: Johns Hopkins University Press.


Stanley E. Greben, MD, FRCP(C), FRCPsych, FACPsych, *Professor of Psychiatry and Professor of Psychotherapy, University of Toronto*, Room 930, Mount Sinai Hospital, 600 University Avenue, Toronto, Ontario M5G 1X5, Canada