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Lecture

The Essence of Psychotherapy

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Summary: Psychotherapy and the changes it produces can be understood in terms of simple basic essentials. Intensive and longstanding clinical experience demonstrates its therapeutic potency. Those factors in the therapist which are most important in leading to change are described. The significance of the therapeutic relationship is discussed, as well as the necessity of its candid and intensive examination during the therapy, if marked change is to occur. What is *not* psychotherapy is also explored.

In most areas of medicine, just as in most areas of life, things often seem more complicated than they really are. Some of the most important and effective medical treatments can be reduced, when they are clearly understood, to surprisingly simple factors. It is my aim to describe, as I currently understand it, the essence of psychotherapy. I believe that such essence is not very complicated, nor is it the least mysterious. I feel that it is possible to reduce the process to elements with which all people are familiar.

Whereas this might sound like an acceptable aim, it is sometimes responded to unfavourably by psychiatrists, especially those whose special area of interest is psychotherapy. Why would this be the case? First of all, many of us are loath, after so many years of undergraduate and graduate and postgraduate study to have what we do reduced to simple elements, for then it might seem that we had wasted much effort, and, also, that others with much less training might perform as well. Second, when what we do is so much an art and so little a science, (even when it is most fully informed by science), we fear that those who seek our help will lose confidence in us if we remove those mystifying trappings which have encouraged them to hold us in awe. Third, because of the attacks upon psychiatry in general and psychotherapy in particular which are mounted by those hostile to such pursuits, we harbour doubts as to their validity or effectiveness, and we are afraid that focussing too clearly upon what really is involved may only serve to demonstrate that the entire field is one of illusion and not one of substance. Fourth, one of the endearing qualities of many physicians, most particularly psychiatrists, is that we take ourselves too seriously. The origins of such an attitude are not too difficult to discern: we have had to be so zealous to become medical students and then doctors and then specialists; and we deal with illness and death. But when we become humourless, and when we take our role to be so serious a one that critical scrutiny of it is not welcomed, then we are in grave danger of being pedantic and, more significant, ineffective.

Whatever reluctance is generated by these four reasons, and by any others, I believe it is necessary for us to take a careful look at psychotherapy, and to separate the substance from the dross.

My training was rather typical of many of us who have ended up being psychotherapists: first, basic science, then medicine, then psychiatry and then psychoanalysis. I do not view these several portions of my education and training as progressive, each one being a further advance on the former. On the contrary, I see each of them as being the basis of a valid profession in its own right. A person thus trained has four professions which exist in him simultaneously. It would be foolish and wasteful to put aside the basic scientist for ever when one has become a psychiatrist. And it would be a great loss, and unnecessary, to abandon the physician when one is being a psychoanalyst. It is most desirable, if one can do so, to keep each of these four professional identities alive within

oneself so that one's work can be simultaneously informed by each of them.

There is an activity which a person thus trained can practise as part of his work, that we call psychotherapy. I define psychotherapy in a generic way to encompass all treatments wherein a trained person comes together with a person seeking help and, by listening to him and talking with him, helps him. The role of the psychotherapist is not new. People have always and will always require help that can only come from other people. Every society has those who can be expected to be helpful with personal, social and emotional problems. They include the physician, the shaman, the minister, the wizard, the psychic, the judge, and many others. A modern form is that of the psychotherapist.

Psychotherapy comes in many forms, and comprises a spectrum of activities. At one end are the most dilute, where the patient is seen only once or a few times or, if over a period of time, infrequently. At the other end are the most intensive, and this is where we find psychoanalysis, where people are seen most days for an agreed duration, over a period of years. Between these two extremes is a multiplicity of approaches, each of which has its proponents and its adherents. One form which has attracted many practitioners, is a derivative of psychoanalysis. It shares with psychoanalysis the goal of achieving important and lasting change in patients. It is less frequent, perhaps once or twice a week, has the patient sitting up facing the therapist, rather than lying on a couch with an analyst behind him. But it may go on for months or even years and attempts, as does psychoanalysis, to explore as many aspects as possible of the patient's inner and outer life. This variety has been designated psychoanalytically oriented psychotherapy, psychoanalytically informed psychotherapy, intensive psychotherapy or, most simply, dynamic psychotherapy. It is this form of psychotherapy which interests me the most, for it makes use of much that has been learned in psychoanalysis, and yet requires considerably less time of the patient and the therapist. For this reason it has been seen by many serious psychotherapists as an excellent compromise: one which allows much to be accomplished in a relatively economic way.

I describe this spectrum in order to point out that there are many valid forms which psychotherapy can take, and not to suggest the superiority or inferiority of one form over the others. In fact I do not feel that any single form, far from being superior, is ever indicated in all situations. Not everyone would be helped more by more frequent sessions. Not everybody would achieve more with more intensive, deeper work. For any one person, in any given situation or clinical state, benefit could be derived from any number of psychotherapeutic options. We must be wary of the practitioner who claims that there is only one way to proceed: he is likely to be an adherent or a disciple, rather than a well equipped therapist.

Having defined psychotherapy and having indicated that it takes numerous forms, I will now consider the question of what it may accomplish. This in turn can be divided into two component questions: the first is: 'Does it accomplish anything?'; the second is: 'If it does, how does it do so?' Investigators, especially during the past ten years, have directed their attention to both these questions through research studies of psychotherapy. Whereas there is much that remains to be elucidated, much has already been demonstrated through objective studies. Over the next decade or two more will be proven. However, enough such work has already been done to demonstrate that there is some significant therapeutic potency in most forms of psychotherapy.

My own approach has not been that of the investigator who, eliminating as many factors as possible, comparing to controls, using disciplined techniques and even equipment brings the scientific method to bear upon the question. I have used, rather, that more informal approach of the clinician, who makes his observations as he goes, of his patient, of himself, of his method and of his result. The modes of treatment which I have employed were, in the beginning what I had been taught would be effective. At The Johns Hopkins Hospital where I took most of my psychiatric residency training the method of choice was dynamic psychotherapy. During my year at the Maudsley Hospital I found organic treatments much to the forefront, but even there, in the psychotherapy firm of Willi Hoffer, a comparable psychotherapy was used and taught. That is the point at which my psychotherapeutic armamentarium began to develop. That became modified because of those teachers whose work I observed and whose words I heard and read. My psychoanalytic training, including personal psychoanalysis, gave me the opportunity to observe *that* most frequent and intensive form of psychotherapy.

To this training were added two elements which made a considerable difference to the form taken by my work. The first comprised my own personal idiosyncratic qualities: my personality, my character, my values, my attitudes, my prejudices, my hesitations, my ambitions, my goals, my curiosities, all these and many more. Whatever I had been taught, whatever I had managed to learn, whatever the effect of my being an analysand had upon me, I was still undeniably and characteristically only me, and all that I did in the course of my psychotherapeutic work gave evidence of that. That element for a time diminished when, being a

candidate in psychoanalytic training, I hesitated to inject too much of myself into the process. That led to a more stilted, less immediate and less effective psychotherapy; as further time passed, so did that excessive need to 'keep myself out of the therapy'.

The second important element which was added to my training was the experience of doing the clinical work itself. Over the past 22 years of the practice of psychiatry, whatever other activities I engaged in, a large part of my professional time has always been taken up with the practice of psychotherapy. Many patients came, some of them stayed for a long time, and then they left. They taught me about psychotherapy in a variety of ways. Their symptoms decreased or disappeared and their characteristic modes of adapting to life altered. They shared with me their histories, their feelings, and themselves, the latter through the painful and eventually trusting relationships they established with me. They taught me by telling me what they thought of what I did and how I was. They told me what they liked and what they wanted, what they hated and feared and would not tolerate. They left mostly satisfied that they had been helped in very important ways. A few could not be helped, and let me know how disappointed they were that that was the case.

I saw them change and I felt myself change. I came to understand that both people who have engaged in a serious psychotherapeutic relationship leave in a different condition from that in which they arrived. The patient, if he is fortunate enough to improve, is satisfied, perhaps even grateful. The therapist also has reason to be grateful, for he has the opportunity to do the most interesting work, to be allowed intimacy with many worthwhile people and, as a result, to grow through the richness and variety of that experience.

Many people, despite what I have said about the positive findings of research outcome studies, still put the challenging question: 'But how do you know that psychotherapy helps change people?' To me that question is no longer in doubt. Clinical results cannot be interpreted in any other way. Let me give examples:

A 17-year-old girl comes for treatment. She is habituated to several drugs, has been admitted to three hospitals, has failed at school. She had made several abortive suicidal attempts, and is estranged from her family. After being seen once a week for five years she holds a steady job, is unhappy only rarely, has good friends and a stable relationship with her family. Three years later she is a leader, although young, in her chosen field, well married, and excited by the pleasures and prospects of her life.

A 30-year-old woman, married to a lawyer, is seen in the emergency room of a general hospital. She is cowering with fear in the throes of an acute psychotic break, which is the first she has experienced. The psychosis clears with outpatient antipsychotic medication and support.

She continues in outpatient psychotherapy, once a week, dealing with the problems in her marriage and her intensive anxieties, fears and depressiveness, all of which, she becomes aware, have existed throughout her life. After another three and a half years she is on no medication, only occasionally feels depression that lasts more than a few hours. Her life is socially active and she is preparing for a new career. She says that she feels secure within herself in a way she has never known, and can hardly believe how different she feels herself to be.

A 50-year-old man is an acknowledged leader in his profession, but he is chronically suicidal. He has always worked successfully, and has always felt let down by others. He has been full of self-doubts and anxieties, though others may have seen him as justifiably self-assured. He is very lonely, feeling that he has no friends. He is certain that his life is running downhill.

He is seen once a week for six years, then gradually cuts back to one visit a month. He finds his life satisfying now, sometimes even exciting. He chooses as friends those few people whom he finds can show serious interest in him, values them and feels they value him. He says: "For the first time now I am glad to be alive".

These are very brief vignettes. They are not controlled studies, nor do they allow us to know what would have occurred with simply the passage of time. In all three cases, however, both the patients and the therapist were convinced that the therapeutic experience had been an undeniable element in bringing about irrefutable and major change in the patient. It is on the basis of a great many such experiences that I take the position that psychotherapy does help. The changes which have taken place are considerable, involving first the presenting symptoms and then the patient's entire sense of well-being and style of life. Having satisfied myself that such changes could not be by chance, and could not have occurred without the psychotherapeutic intervention, I then turned to a consideration of the question of how psychotherapy helps.

My first approach to this question was as follows: Surely no one knows as much about the helpfulness of the process of psychotherapy as the consumer, that is, the patient. After him, it is likely that the next best informed person is the therapist. With that in mind I have asked both patients and therapists what they considered to be of significance in the therapeutic process (Greben, 1977).

Many of the therapists had four sources of information: what they had experienced as students, as therapists, as patients or analysands (often with more than one therapist or analyst) and as relatives of others who had been treated or analysed. In virtually every instance those queried spoke most convincingly, not just of the process they had undergone, but of the person with whom the experience had taken place—the therapist. It becomes clear upon such enquiries

that the cardinal therapeutic forces must be divided into two major portions, namely, who the therapist is and what the therapist does. Neither one of these can be ignored if we are to understand the process. I would like to consider each of these two in turn. In addition, it has been evident that those two factors acted upon the patient in part directly but also, in important part, through the agency of the relationship which was established between the two parties. I intend to explore, as well, aspects of that therapeutic relationship.

What do I mean by the question of who the therapist is? I mean that it matters who he happens to be, and that encompassed in that are his constitutional endowment, his life's experience, his training, and his professional experience. Included are such personal qualities as his values, his attitudes, his personality style and his character. Having said that it becomes evident that the therapist's features which may affect a therapeutic experience are legion in number.

However, not all qualities are equally significant. When one questions patients and therapists carefully one finds that certain of these qualities on the part of the therapist are especially important: they are sought by potential patients when they are looking for a therapist; they are valued by the patient and found to be therapeutic when they are discovered in the therapist; and they are remembered fondly and with gratitude by the former patient who feels that he has been helped.

Before I enumerate what I take to be some of the most significant of such qualities in the therapist it is worth wondering what gives them an importance that is agreed upon by virtually all patients. The answer is, simply, that these are the qualities that all human beings need, and hence yearn for, in other human beings. They represent the prerequisite for a good human attachment for any of us. They give us the sense of being cared for, tended to, valued, wanted, even loved. And these are what, for a lifetime, human beings strive to find. We may be so defensively rejecting as to appear not to want the loving attention of others, but that is not the case. We portray ourselves as independent and self-sustaining because we have been hurt so much and have felt rejected so often. Still at bottom we yearn for the same thing. When we are antagonistic, misanthropic (or even misogynistic), contemptuous, even mad, we still need and want these same qualities. We seek them everywhere in life. In therapy we cannot do without them, for the therapist who lacks these qualities will not win our trust and hence, will not get us to abandon our unsuccessful defensive postures. We will not show ourselves to an untrustworthy, uncaring stranger: nor will we allow ourselves to see ourselves in such company.

What I have just indicated to be universal emotional needs of people then dictate where most of the therapist's qualities which I will list arise. But there is also a set of opposite needs that people have if they are to prosper. People need limits, for part of loving or caring for someone is to set him realistic goals and limits. Therefore the therapist must not just be caring in a positive way, he must be caring by saying 'no', in one way or another.

For all of these reasons, some of the most important qualities required by a therapist are the following: empathic concern, respectfulness, realistic hopefulness, self-awareness, reliability and strength.

It is the last of these, 'strength', which is the most complex, for it includes both the strength to say 'yes' and the strength to say 'no'. Patients in psychotherapy do not improve in a vacuum: they require a relationship with a strong and known person, with whom to share themselves and against whom to measure themselves. The therapist must be strong enough not to be hopeful just in the beginning, but to keep hope alive through discouraging months and years.

I said that my enquiries and observations have led me to believe that these are amongst the most important qualities needed by a therapist. There are others that are also of great significance. A therapist should be fair. He should have the ability to use humour, including with respect to himself. It is important that he have some self-assurance without undue arrogance.

All of these qualities are to be looked for in a relative, not an absolute way, otherwise we would see the therapist as needing to be such a paragon that we would all give up before we began. Still, short of idealizing the therapist's necessary qualities, we must not deceive ourselves into thinking that what he is as a person does not matter.

Once at a university meeting I presented a paper on supervision in psychotherapy (Greben, 1979) and referred to those personal qualities required by psychotherapists. The first question asked by a member of the audience was: "What do you do if the person you are training has none of these qualities you have listed?" I could only reply with another question: "What would you do if you ran a music school and the person who applied had no musical talent?" Still we must set realistic goals: we must not expect every psychotherapist to be a virtuoso. There is a place for members of the therapeutic orchestra: it is only that we should not pretend that individual and personal qualities do not matter. After all, it is only when we recognize what really matters that we can encourage students and practitioners in that direction.

Having looked at 'who the therapist is', the next question to address is 'what the therapist does'.

There are two ways in which the therapist takes part in the therapy. The first way is through actions which he undertakes, mostly spoken, and these are interventions. The second way is through relating to the patient, being involved with him, reacting to him, and establishing what is known as the therapeutic relationship. Each of these two ways is influenced by who the therapist is, for no two therapists will act in exactly the same ways. I will discuss in turn each of these two ways whereby therapists function.

Interventions, those activities which are undertaken by the therapist are for the most part, verbal. Less obvious are all those non-verbal choices which he makes, and they also act upon the patient.

Verbal interventions carry the cognitive portion of the therapy. They convey feelings and they convey understanding. All therapies, even those which are not considered insight-seeking, lead to new understanding. For example, it may be the goal of the behaviour therapy to help a patient get out of the house and walk to the neighbourhood store. Even when no discussion occurs about the cause of the difficulty, and interventions are entirely directed towards the behavioural symptom, the patient will end the therapy knowing more about himself: in this case his fears, his hesitancies and even his strengths. However, insight-seeking therapy makes its explicit goal the acquisition of understanding. Some therapists, especially psychoanalysts, have taken the extreme position that the only understanding which leads to change is that which results from deep interpretations, that is, remarks by the therapist which make the patient aware of that which has been unconscious. I agree with the view that such revelations are important. I disagree entirely with the idea that they are ever, even in psychoanalysis, the only source of change (Greben, 1981a).

The psychotherapies which seek insight lead to understanding on the part of the patient through a variety of avenues. The patient understands by virtue of his own efforts to get what lies hidden or obscured within himself. When he speaks about all manner of things he learns through what he himself discovers. Further understanding comes from the therapist's interventions of many kinds: from single responses which support or which question what the patient has put forward; from clarifications whereby the therapist attempts to understand; even through misunderstandings which, ultimately seen to be errors, help to reveal the truth. The understanding, then, which both patient and therapist achieve, comes through a host of interactions, responses, queries, and conjectures. This is a rather trial and error, even hit and miss matter, certainly not a bull's-eye approach, but it is in reality the way in which effective therapy proceeds.

What is the subject matter of these interventions undertaken by the therapist? Here, too, there are conventional opinions which need to be questioned. Is it sufficient merely to expose, to explore, then to understand? I do not believe so. The goal of all therapies must be change, and without change therapy is an idle exercise. Simply to analyze for the pleasure of analysing would be a precious pursuit, though some have thought that, as some form of art, such behaviour is warranted (Dongier, 1981). As a physician who is paid for his services, I expect my work to produce a result, and, in the case of psychotherapy, that result will be change.

The therapist must in some ways address himself to destructive, constricting or self-defeating behaviour. He must somehow stand on the side of constructive and effective living on the part of the patient. To say that the therapist must not reveal his position on such matters is foolish. Can the therapist not enter into the fact that the patient is depressed, or suicidal, or homicidal, or a thief, or a hermit? Can he not let his feelings be known about the patient's use of drugs or avoidance of work or repeated involvement with destructive partners? Of course not. A *sine qua non* of psychotherapy is that the therapist must stand for what is right and best both for the patient and for society: it is not possible for the therapist to stand nowhere. In all therapies, including psychoanalysis, the therapist will be for some things and against other things. The excessively or deceptively passive therapist may choose not to show such leanings, but many of them will be known to the patient none-the-less. When a non-interventionist position is taken too far, endless therapy can occur without effect; many of the failures of psychotherapy can be attributed to the fact that therapists have worked in this misguided way (Greben and Lesser, 1976).

I have described, then, some of the interventions of the therapist. The final arena of the therapist's activity which I want to comment upon is the therapeutic relationship. We divide that relationship arbitrarily into three portions, for that makes it easier to think about and discuss. Two real people come together, and have a real relationship. They learn to work together on the tasks which psychotherapy involves, and so there is a working alliance. Their view of each other will be distorted by their own residual neurotic problems, carried over from their earlier years, and these distortions on the patient's part constitute transference, on the therapist's part countertransference.

If I look back upon those patients whom I have seen change a great deal, I know that the 'heat' was within the therapeutic relationship. That was the crucible in which change occurred and without which the therapy would have been a sterile endeavour. When

I remember what happened over the years with those three patients I have described, I remember them in a highly personal way. The relationship I had with each of those people was very idiosyncratic for the two of us. There was struggle and fear and closeness and love and terror. There was intimacy and outrage, concern and humiliation. Through all of those feelings we struggled to know the patient and came in the process to know me. The patient learned in many ways that I was to be trusted, and I learned the same thing about the patient. It was in no case a dry academic experience. It was boring at times, but largely exciting, always challenging and often demanding. In short, it was not an exercise comparable to a physical examination carried out by a doctor upon a patient. Rather it was a journey of importance, more to the patient who had come seeking help, but in fact to both participants. It was a process which carried on throughout the course of therapy and left both patient and therapist altered by the experience.

Such experience is the heart of psychotherapy. There is nothing mysterious about it, nothing which is not known elsewhere in life. But it is one of life's most profound experiences: for it is a context in which risks are taken, and one learns to expose oneself to and admit one's needs for and dependence upon another. When that occurs anywhere in life, many good things can happen, and people change irreversibly. Such change is not unique. It is only the change of growth and integration which comes when one can successfully engage in trusting emotional intimacy with another person. A security can be thereby incorporated into the person involved which can come about in no other way.

The therapeutic relationship is at the absolute heart of psychotherapy, and is the vehicle whereby therapeutic change occurs. There is nothing in this conclusion which should surprise any serious student of human beings. People need, in order to become self-confident and emotionally strong, to have within them the sense of having been cared for by someone whom they love and respect. When parenting or teaching are successful, this ingredient has been present. When psychotherapy is successful, the same is the case. It is within the context of the therapeutic relationship that the qualities of the therapist which I earlier enumerated are active and effective. It is here that the patient needs to feel the *empathic concern* of the therapist, and be dealt with *respectfully*. He must be kept going by the therapist's *hopefulness* (Frank, 1975), which must be soundly *realistic*. He must recognize that the therapist's knowledge of the patient can be trusted because the therapist does not only understand others, he *understands himself* in a comparable way, recognizing and accepting both strengths and weaknesses. His learning to trust that the therapist means what he says and delivers what he promises will be based upon the *reliability* of the therapist. Finally, when he tests the therapist he will find him strong, not in a rigid, brittle way, but in a flexible but firm way. This *strength* will provide a framework within which, in the therapeutic relationship, the patient can comfortably learn and grow.

There is one aspect of what I have described which I would like to amplify. I stated that what the therapist does includes verbal interventions. The question now becomes, what is the content of his interventions? The answer is simple: the principal cognitive purpose of the therapy is to find and reveal truth, simple truth. The entire purpose of clarifications and interpretations is to discover and reveal the truth, the reality of everything about the patient: his past history, his internal emotional experiences, his current life out in his world, and, finally, his relationship with the therapist. Here is where the therapist's ability to understand and to describe will be tested. The more clearly he sees and conveys reality to the patient, the better served the patient will be.

I would like to underscore the last of those areas which I have just said will be examined by therapist and patient, namely, their own relationship. This is a watershed feature which separates the most effective insight therapies from others. There is an intensity and immediacy which will be missing from the therapeutic experience if the scrutiny of the two participants is not turned upon what happens and is felt between them. The more candid and inclusive the exploration of this area can be, the more likely is the therapy to have marked effect upon the patient.

I have thus far outlined what I see as the essential ingredients of successful psychotherapy—no more and no less. I would like to conclude by pointing out some of what psychotherapy is *not*, for some of the problems in its practice have arisen out of an unnecessary and artificial superstructure which is often constructed around it.

Psychotherapy cannot rest upon any limited theoretical base. There is no single cardinal problem which accounts for the troubles of mankind: not aggression, not sexual inhibition, not trauma during birth, not narcissistic self-love, not incestuous conflict, not errors in the rapprochement phase of separation-individuation, not any one area of content over all others. Stress and strain arise from a myriad of sources. Successful psychotherapy seeks to reveal and understand all those sources.

Psychotherapy is not silence (Greben, 1981b). Sitting and listening, doing nothing active to forward the process, putting no demands upon or challenge to the patient, is not psychotherapy. Further, rational-

izations that such passive neglect is necessary so that the patient will 'take responsibility for himself' are invalid, and say much more about the therapist than they do about the patient.

Psychotherapy is not the exclusive domain of any one group, with all others to be considered poachers. The secrets of psychotherapeutic groups, clubs, guilds or institutes are no secrets at all. All intelligent, curious and honest therapists can do very good work in this field. Those who claim special knowledge, who have elaborate rites of passage, who indulge in mystifying private congresses have left the field of psychotherapy and wandered into the field of religion. Hierarchical pyramids have nothing to do with psychotherapy: they have to do with the ageless problem of man's unresolved ambitions, greed and hunger for power. At its most ludicrous, this situation deteriorates into self-glorifying institutes vying for candidates, posturing with self-importance, and, through their own confusion, substituting bureaucracy where therapeutic validity is called for.

Last of all, psychotherapy is not a set of elaborate rules about what one may not do: rules about when to speak or not to speak, how to handle vacations, how to deal with missed hours, and so on. It is something much more simple than that. It is the meeting and working together of two people; it is hard honest work.

You might say, it is a labour of love.

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