Psychotherapy

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The subject of psychotherapy has been talked about and written about so much in recent years that it would seem that there is nothing left to say. My excuse for adding to the discussion was a suggestion from your committee that this topic would be suitable for a place in this season's series of addresses before the Henry Ford Hospital Medical Society. The importance of psychotherapy has been so emphasized through all the media of communication as to convey the idea that it is virtually all there is to psychiatry, that it is a large part of general medicine as well, that is is even on the way to becoming a new religion that if applied in the right places could save our poor old sick world.

But there are other views too. There are medical men who wouldn't listen to a lecture on psychotherapy. An eminent surgeon whose scoffing attitude was known was asked how much psychotherapy was used in his own work. "Not a damn bit," he replied emphatically. Of course that wasn't true. He was using it, even if unwittingly. No good doctor can avoid using it. Another physician told me that if a patient came to him with a hypochondriacal "organ recital" requiring psychological treatment, the kind of psychotherapy he administered was such as to make the patient angry so that he wouldn't come back. Possibly the doctor applied, unintentionally, a remedial shock therapy. Who knows?

As an introduction to our subject I should like to call attention to an article by Bowman and Rose. This article will repay careful reading. It contains many things that I might say, but it is easier to quote; besides, quoting comfortably shifts responsibility when touching upon controversial matters. Bowman and Rose conclude that the answer to the question: Do our medical colleagues know what to expect from psychotherapy, is "No." They find, to begin with, that there is confusion as to a distinction between the terms psychotherapy and psychiatry, and that in everyday usage these terms are "almost synonymous." There is no less confusion as to the distinction between the terms psychiatry and psychoanalysis, with the consequent erroneous assumption on the part of the laity and even of medical colleagues that psychotherapy and psychoanalysis are also synonymous terms.

The confusion in the minds of many physicians about what psychotherapy is and what it can do, Bowman and Rose courageously account for:

"That many nonpsychiatric physicians are confused about the methods, goals, and effectiveness of psychotherapy is in large part a reflection of the muddled state of psychiatrists themselves about the nature and status of their specialty." They document this statement by referring to The Psychiatrist, His Training and Development. As an example of the confusion referred to, Bowman and Rose comment on the repetitious use of the term psychodynamics, one of those new words that crop up in psychiatry from time to time to cover uncertainty of meaning or divergence of opinion. This word, as they put it, is "now virtually a shibboleth." Their statement referring to this part of the report is startling:

"This is a valiant attempt to formulate a scientific basis—a psychodynamics—for our psychotherapy, but it appears to us to be only partially successful. It is not surprising that the wording of the report on psychodynamics is at times almost tortured, so great are the differences among the essentially irreconcilable
opinions it must compose. A clear indication of the highly subjective nature of the opinions of the contributors to this discussion . . . is the statement which appears on page 19: 'In formulating psychodynamics, individuals tend to select their postulates with strong feelings of conviction, in accordance with private feelings of group allegiances rather than public knowledge.' We submit—if psychiatric scholars and practitioners of distinguished experience find it necessary to describe their methods of arriving at psychodynamic formulations as being mainly subjective, we ought not to be surprised at the bewilderment of our science-minded colleagues in the more concrete fields of medicine."

Ever since mental healing emerged from magic, charlatanry, or rank empirism, and struggled to become rational, if not yet quite scientific, it was recognized that the psychoneuroses were the conditions most amenable to psychotherapy—pithiatric disorders Babinski called them, i. e., brought on by suggestion and cured by the same means. And it was also a matter of common experience that the neuroses would yield to the greatest variety of treatment methods, whether applied by doctors, lay healers, and quacks, or through visits to sacred shrines.

In the paper by Bowman and Rose¹, from which I have quoted, these authors refer to the results of treatment of psychiatric disorders by different investigators and different methods with the finding that approximately the same range of favorable results followed "regardless of the methods used," and further that "the common denominator of improvement has nothing to do with the psychodynamic formulations and methods of specific psychotherapies studied, a point of view with which we readily concur." To the question whether one technique is better than another they give a forthright answer:

"In the studies which have been made thus far, comparing the effectiveness of different psychotherapeutic methods, no differences have been uncovered."

To account for the critical attitude in outside opinion toward psychiatry and in particular toward psychotherapy, and as a warning to those who would pin their faith on one or another special technique, Bowman and Rose give a final admonition:

"Most of the confusion among psychiatrists and nonpsychiatrists alike comes from our tendency to believe that psychotherapy is more exact and scientific than it is or can be."

After this jeremiad, for which—although I fully subscribe to their statements—Bowman and Rose must be held responsible, what can be said on the constructive side? We haven't yet got our definition. The Psychiatric Dictionary of Hinsie and Shatsky² defines psychotherapy as "the art of treating mental diseases;" turning to the word psychiatry, we find it defined as "the art of treating mental diseases." The second definition is better than the first, but the two terms are certainly not synonymous.

In simple language a definition might read: psychotherapy is the scientifically directed influence of the mind of the doctor on the mind of the patient in promoting health. This indicates, first, that it is a medical procedure; and second, the words 'scientifically directed' distinguish psychotherapy from faith-healing or other procedures in which the patient remains passive, bringing only his hope and awaiting the miracle. Of this more later.

A preliminary consideration is the part that psychotherapy should play specifically in psychiatric treatment, and also in medical treatment generally. From one point of view it would be correct to say that it is the important feature of all treatment,
in that it should accompany all treatment. But there has been a tendency in some quarters to carry this point of view to the extreme of making psychotherapy virtually the exclusive treatment of psychiatric disorders belonging to the so-called functional or emotional group. Overemphasis on psychotherapy involves the risk of missing fundamental organic or physiological conditions that require attention. Treatment takes its indications from etiology; and etiology is always multiform. Psychotherapy is therefore only a part, although a vital part, of what is called the Total Push. The term was coined by Myerson to bring out the fact that treatment in mental hospitals was more often than not only partial. The term total push should be unnecessary just as the expression psychosomatic medicine is unnecessary. All medicine should be psychosomatic and all treatment should be total.

In one of his lectures Huxley said that science is just trained and organized common sense. Medicine is a branch of science, and psychiatry is a branch of medicine, and psychotherapy is primarily a part of psychiatry. It is therefore essentially a medical procedure—at least it is in Michigan. Let us hope the example this state has set will be followed elsewhere.

But psychotherapy must also qualify as organized common sense. It should not be beyond the understanding of the literate layman. And the patient, if treatable at all, should be able to grasp it, or grasp at it, if only gradually—because treatment to be worth anything must be teamwork in which doctor and patient collaborate planwise. The patient is not passive and the doctor is not domineering—the one giving and the other receiving, or as one colleague facetiously remarked, the one doing and the other being done.

The doctor-patient relationship, if properly balanced and controlled (and ethically sound, it should not be necessary to add), is the crux of the matter. Therein lies the true quality of psychotherapy. The nature of the relationship is essentially educational—educational rather than instructional, having regard to the etymology of those two words. Education, drawing out, that is the important thing—obtaining the patient’s spontaneous and full expression of his own point of view to which the doctor contributes no element through either suggestion or reading-in. The autognosis, to begin with, is more useful than a diagnosis.

Association tests may sometimes offer clues, but we have to remember that there is no such thing as “free association.” For that we would have to create a situation entirely without either external or internal environment for the person being tested. The mind would have to function in vacuo, so to speak, like a disembodied spirit.

The conditions of the psychiatric interview should be the simplest, easiest, most natural possible. The couch interview is, I think, in every way objectionable. When two persons meet to discuss a problem one of them does not ordinarily lie down, although it may be understandable that sometimes the doctor might like to take the more restful position. In Joseph Wortis’ entertaining little book recently published, Fragments of an Analysis with Freud, he described in detail the manner of the analytic hour as well as its content. The session proceeded in the orthodox fashion with Wortis on the couch and Freud sitting behind the head of the couch. He explained that he had adopted that arrangement because for one thing, as he put it, “I don’t like to have people stare me in the face.” A strange thing for a physician to say! Jung offered a more explicit reason for the doctor’s position behind the patient. It gave him greater protection from the impact of the patients’ transference.
Wortis kept full notes of each session and later on sent his manuscript for advice to Havelock Ellis with whom he had discussed his project before going to Vienna. Ellis commented that the report appeared to constitute an analysis of Freud rather than of Wortis and urged publication but not during Freud's lifetime.

Prerequisite for any psychotherapy is to find out what started the trouble. I am in agreement with those who seek first of all in the patient's present situation rather than in his remote past for the significant causal factors. This does not mean that we should neglect any period in the patient's history, the data of inheritance, or life experiences throughout. It does indicate the etiologic importance of current and recent happenings and conditions in his social environment, domestic, occupational and other. The role of repression has, I suspect, been considerably exaggerated. The pathology of memory must not be overlooked, but we may as well remember too that there is such a thing as healthy forgetting. Moreover it is useful to keep in mind the real danger of inducing too much introspection in the therapeutic process. The Socratic injunction, "Know Thyself," implies wholesome introspection. But individuals differ in their capacity to introspect normally, and in many patients introspection has already grown morbid and become a symptom of illness. To turn such a patient's thoughts inward in tracing the minutiae of his life history may be directly contra-indicated. An introspection neurosis may be engrafted on the already existing psychopathology.

And now a word about words. In discussing morbid mental states it should be possible to avoid esoteric language and keep within the framework of organized common sense. Likewise, we should not feel the need to resort to complicated or speculative interpretations when simple and more obvious ones will serve. We have an ancient term for this rule—Occam's Razor. This cutting instrument is quite useful in psychiatry, and especially in psychotherapy, an excellent pruning knife for verbal excess baggage. The statement of William of Occam which came to be known as the Razor was:

"It is vain to do with more what can be done with fewer."

The fine-spun elaborations of the psychotherapeutic process that sometimes appear in print in our time are curiously reminiscent, by some puckish association of ideas, of those marvellous mechanical contraptions in the Goldberg cartoons of a few years back.

We need more semantics in psychiatry, more semantics and fewer neologisms. We are still ridiculed for our professional argot. A new word should be coined only under two conditions: (1) when it denotes a new meaning, that is, one not already covered by a term in common use; (2) when that meaning can be clearly stated so as to be understood and accepted. Words that do not meet these conditions are bound to be used differently by different writers and so acquire an ambiguous or fuzzy quality. So many conflicting views were expressed in the Conference on Psychiatric Education that the editorial committee gave up in despair. In their own words they simply "didn't try to reconcile the differences."

It is our common experience that each case is unique and cannot be fitted into any preconceived scheme. One may be permitted to suspect that the therapeutic couch may have Procrustean features. It is axiomatic that treatment must be individual and will vary from patient to patient. But what is true of the patient is also true of the doctor. The resourceful physician presumably will not attempt to follow unquestioningly any fixed school of teaching. Medical education does not standardize the personality of the doctor. Each will and should have his own manner of dealing with
patients, developing a flexible psychotherapeutic technique best suited to his own nature.

Sir William Osler was one of the most effective psychotherapists I have ever seen in action; and yet, during some 200 hours as a student under his teaching, I never heard him use the word psychotherapy, or offer any specific directions for applying it. He exemplified it in every contact with his patients.

The reverse of psychotherapy is the iatrogenic symptom, unfortunately not an uncommon reaction when the instructor accompanied by a group of students unguardedly discusses the patient's condition at the bedside. In one case, during the physical examination of an anxious patient the physician casually and unnecessarily remarked that the right breast was slightly smaller than the left. This started in her mind a new worry which grew at length into a fixed belief that the entire right side of her body was atrophied. By use of a tape measure she believed she found differences that supported her belief and eventually even experienced weakness in the right leg. In another case a neurotic youth with a functional heart condition was advised, without proper reassurance, to stay in bed for a few days. He developed panic, became obsessed with the idea of serious heart disease, and for many weeks could not be persuaded to leave his bed.

Fashions change in treatment as they do in dress. The history of psychotherapy as set forth in Bromberg's recent book is an amazing record of these changes. We used to give bitter medicine for complaints called 'imaginary'—valerian for hysteria. Incidentally there are no imaginary complaints, as that term is commonly understood. If a person imagines he is sick, he is sick, but the sickness may be in the imagination itself and not in the place where he imagines it is. As a morbid mental state it therefore becomes a psychiatric problem.

Many years ago there was the vogue of the so-called water cure, still earlier the blue glass treatment, also various shock treatments, some of them almost incredibly crude, and electrical therapy was extensively used long before Cerletti and Bini standardized it.

But we like to think the psychotherapy of today is rather more scientific than the crassly empirical methods of an earlier time. Our techniques, we trust, show a measure of organized common sense. This much I think we can say: the goal of psychotherapy is autotherapy. From the beginning, or early in the course of treatment, the patient is taking an active part in his own cure. He and the doctor are working together on a planned educational and training program. If all goes well, the patient gradually takes over more and more responsibility for the conduct of his own case. It is often possible to induce him to take constructive steps unawares. In such case the element of surprise and satisfaction when the fact of his self-directed effort is brought forcibly to his attention may lead him a good step forward. He is now answering his own questions and making his own decisions. An interesting device at this stage is to pose a hypothetical situation, not unfamiliar in his own experience, as if it were that of a friend seeking his advice. What would he offer? His reply may contain surprisingly sound therapy which can be turned to good use in his own progress in self-treatment.

In this collaboration effort the doctor tries to do what every good physician is supposed to do—make himself less necessary, eventually even unnecessary. The duration of training may be shorter or longer depending on many circumstances which will suggest themselves. No medical treatment should be extended beyond indubitable
need. There is danger that an unduly protracted therapeutic discipline may subdue the patient's mind to a morbid habit of introspection and dependence. By its very nature psychotherapy should be self-limiting. It ends as soon as the patient feels sufficiently assured and capable of taking charge of himself.

There is one point on which there could hardly be disagreement, namely, that psychotherapy is not solely the province of the specialist, i.e., the psychiatrist. Many psychiatric problems are brought first to the general physician, perhaps only to him. He should feel it his responsibility to deal with a large share of those problems. Indeed he, as the family physician, may be the most suitable person for this service. The term "general practice" surely means the whole medical field. It can not be "general" if psychiatry is left out. Alvarez in his book, The Neuroses, has much of value to say on this subject.

If medical men interested themselves more widely in the psychological side of their practice the clamor for more and ever more psychiatrists would conceivably be less urgent. It would also be measurably less, we may hazard the guess, if it were not currently so fashionable to pay frequent visits to the psychiatrist, more specifically the psychoanalyst. This addiction seems to have reached considerable proportions, and the person is not altogether a rarity who would hardly make a major move without consulting his or her analyst, who, for the devotee, appears to have taken over more or less the function of priest.

There is a special feature of psychotherapy, for those who really need it, that merits thoughtful attention, and that is the educational value of invalidism. The patient's whole attitude may be changed if he can be led to realize that a period of illness is not quite time lost, indeed that it may prove to be a good investment in future mental well-being. Experience, we are told, is the best schoolmaster; illness is an experience; its lessons should be turned to account for the information not only of the physician but for the patient as well. If his trouble has been relieved and he had taken his full share in the restoration process, he has learned something about himself and about others that he probably did not know before; he has acquired some rudiments of psychology, normal and abnormal, and should be able to make a new assessment of his own resources. The doctor will take pains to point out these possibilities and their lessons. We know from experience that this knowledge brought home to the patient can have prophylactic value as problems or difficulties threaten in days ahead.

But if psychotherapy should not be too long drawn out, neither should talks about it, like this one. Occasionally writers or speakers close by quoting a poem—usually an anticlimax. I shall not take that risk, but would like to cite one noteworthy instance of poetry reading by the patient as psychotherapy. It is from the autobiography of John Stuart Mill. In the autumn of 1828 when Mill was twenty-two he found himself heavily overworked and became deeply depressed, desperately so. By some fortunate association of ideas, he was led to take up a volume of Wordsworth's poems. This step was possibly a reaction to the attitude of his father whose driving discipline was severe and austere and who, like Plato, held poetry in low esteem. In his autobiography Mill tells us that he had "no expectation of mental relief" from reading Wordsworth, but to his surprise it brought healing. "What made Wordsworth's poems a medicine for my state of mind was that they expressed, not mere outward beauty, but states of feeling, and of thought coloured by feeling, under the excitement of beauty. They seemed to be the very culture of the feelings which I was in quest of ... And I felt myself
at once better and happier as I came under their influence. There have certainly been . . . greater poets than Wordsworth; but poetry of deeper and loftier feeling could not have done for me at that time what his did. I needed to be made to feel there was real permanent happiness in tranquil contemplation. Wordsworth taught me this, not only without turning away from, but with a greatly increased interest in the common feelings and common destiny of human beings.”

Feeling, emotions, these are conspicuous words in current psychiatric literature. We even have a new and popular euphemism for mental illness—“emotional disorder.” At any rate disturbed emotions play a central role in psychiatric conditions. In the quotation from John Stuart Mill’s autobiography, the keynote, is the line, “the very culture of the feelings”—their training, not their indulgence; their control and direction, not giving them loose rein; the effort at least to modify or inhibit their expression—*the very culture of the feelings* is a major goal of therapy. Mill found that Wordsworth’s poems can promote this culture and thus contribute to the healing process for a receptive mind.

For a final true word we turn to the *Anatomy of Melancholy*:

“An empirick oftentimes, and a silly chirugeon, doth more strange cures than a rational physician . . . because the patient puts his confidence in him, which Avicenna prefers before art, precepts, and all remedies whatsoever . . . He doth the best cures, according to Hippocrates, in whom most trust.”

BIBLIOGRAPHY