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Development of specialties – Psychological therapies and psychoanalysis

‘Men are disturbed not by things but by the views which they take of them.’
Epictetus: The Enchiridion

Psychotherapies of every sort have been practiced from time immemorial. Patients have always valued a caring professional who listens to their troubles. The medical psychotherapies used today were developed over the past two centuries. Mesmerism, hypnotism, conditioning, psychoanalysis, behavioural therapies, provided different inputs to psychological treatments. There are many varieties of psychotherapy varying between the extremes of one off counselling to years of full-scale psychoanalysis. Recently more scientific study of the effectiveness of various types of psychological treatments has made it possible to know which are more effective than others. At present behavioural cognitive methods appear to be the most efficient. Psychotherapy is provided by many different disciplines. The majority of psychotherapists are not members of the medical profession. There remains much confusion about the terms psychiatrist, psychologist, psychotherapist, psychoanalyst and the general public needs to understand the meaning of all these.

Psychotherapy, the talking treatment, has a long history. Two developments in the last century are the basis of most psychotherapy today; the psychoanalysis of Sigmund Freud and behavioural approaches. These followed after Mesmerism and hypnotism in the previous century. This online archive gives an account of psychotherapy from the viewpoint of a general psychiatrist. It considers who provides psychotherapy and how its effectiveness can be measured. Today there are many approaches which are not in the sole possession of doctors but are carried out by a wide range of disciplines. A discussion of psychoanalysis at the Annual General Meeting of the Medico-Psychological Association in the 1920s shows very different views held by members of the same profession eighty years ago. There are similar differing views today. The roots of modern psychological treatments can be found in primitive medicine, shamanism, religion, faith-healing and hypnotism. A fragment of a manuscript in the

Library of Trinity College Dublin described a man called Antiphon who in the year 400 BC was said to have rented a room near the centre of Corinth, and to have announced that he was able to cure cases of acute mental distress by enquiring about the causes of the disorder and by talking encouragingly to the patients. Such ‘talking cures’ existed in antiquity and were practised by many different groups.

Psychotherapies are practised by psychologists, nurses and many others. The term ‘counsellor’ can refer to people with almost any training or no training at all. There remains much confusion between the meanings of the terms psychotherapist, psychologist, psychiatrist and psychoanalyst. There remains uncertainty about the theories underlying various types of psychotherapy and its practice and training each requires. Psychotherapy can be a nebulous term with widely differing connotations and some controversy over its value continues. Many psychotherapy schools, each with its own theories on psychopathology and a particular set of techniques, compete with one another. There can also be difficulty in arriving at an acceptable definition of psychotherapy itself. The term is loosely used to mean helping, treating, advising, guiding, reassuring, educating and even influencing. Contemporary definitions lay particular emphasis on the general relief of suffering through psychological means by a trained professional. This involves the setting up of a relationship between therapist and patient and primarily employs the use of words.

Features which appear common to all forms of psychotherapy include: a confiding relationship, which occurs in a healing setting. This is founded on some rationale of therapy and involves a therapeutic procedure. At one time there were limitations on the

types of patient who were thought to be suitable for some types of psychotherapy and it was once suggested that candidates for psychotherapy should show: no evidence of serious physical or psychotic illness; no serious drug addiction, no sexual deviation or sociopathic disorder; no discernible and lasting problems in personal relationships; no evidence suggesting the need for hospital admission; and at least average intelligence and active motivation and finances for treatment. This would exclude practically everybody apart from the worried well in the USA and is not the case in National Health Service (NHS) psychotherapy today, where there has been increasing emphasis on cognitive behavioural psychotherapy as part of the treatment plan for psychoses. As well as this psychotherapy can be used to help cancer patients, those with learning disability, eating disorders and addiction.

Different theoretical approaches to psychotherapy can include cognitive, behavioural systemic and dynamic. Treatment may involve crisis intervention, supportive psychotherapy for chronically disabled psychiatric patients, family therapy, brief focussed psychotherapy, long-term individual psychotherapy (for example psychoanalysis) and group psychotherapy. The quintessence of psychotherapy in general is an interpersonal process in which a therapist helps a person with problems to function more satisfactorily. More than one therapist and more than one patient may be involved at the same time. Common to all psychotherapy however is a relationship which is emotionally charged and confidential and in which both therapist and patient agree on a rationale to serve as an explanation of the patient's problems and of the methods to deal with them.

The types of human misery or malfunctioning that have been treated by psychotherapy range from gross behavioural deficits to tension headaches or general feelings of dissatisfaction with life. They have common features that justify grouping them together. All are characterised by distress in the afflicted person caused by failure to cope with some aspect of living. At one extreme the failure may be produced by overwhelming stress, as in reactions to disaster which cover the gamut of psychopathological manifestations. At the other extreme, some people sag under ordinary life experiences. Psychotherapies cannot be understood apart from the cultures in which they function. Attitudes and values of the groups to which patients and therapists belong as well as those of the larger society influence who comes to treatment, in what circumstances, who is entitled to conduct psychotherapy, and the nature of its goals. When it is a culturally approved institution it can offer status and other rewards for its practitioners.

THE HISTORICAL ROOTS OF PRESENT DAY PSYCHOTHERAPIES

ANIMAL MAGNETISM

Miraculous cures attributed to supranormal interventions have been found in most civilisations and continue today and 'animal magnetism' played a role intermediate between magic treatments and psychological therapies. The studies which it provoked paved the way for the analyses of pathological psychology and gave a particular direction to part of the science of psychology. Friedrich (Franz) Anton Mesmer, 1734–1815, gave his name to the doctrine which was at first known as 'Mesmerism', and he is considered its founder. Mesmer, who had studied medicine at Vienna, but is generally thought of as a charlatan, claimed to be able to cure many diseases by means

of his 'animal magnetism'. (Initially he stroked bodies with magnets but, having observed a priest who effected cures by manipulation alone, abandoned the use of magnets and supposed that some kind of occult force resided in himself by which he could influence others.) He spoke of strange powers then very little understood: forces of 'magnetism', of 'electricity', of 'nervous forces': 'Planetary influence,' he said, 'exerts itself on the human body by means of a universal fluid in which all bodies are immersed.' Sickness was only an aberration in the harmonious distribution of these fluids; its treatment consisted in re-establishing this harmony by an application of the 'magnetism' that emanates from a living being.

The second period of animal magnetism began when the persons being 'magnetized' apparently went peacefully to sleep and entered into a curious state when they could move and speak and perform without effort whatever was suggested. They did not retain any memory of all this after waking. This state was called somnambulism by analogy to those natural somnambulisms (sleep walking) of which many examples were known. This led to the development of what we now know as 'hypnotism'. It involved bringing about in a person a profound and distinct psychological change and the subsequent restoration of the person in question to his normal state without difficulty. This change was produced without the use of any drugs. There was then study of people who were hypnotised in the search for possible ways to transform mental states, which included study of the parts played by emotion, attention, and fatigue. The movements and acts that a word could evoke in somnambulists and the hallucination that it could produce were studied in detail, including suggestions whose execution was delayed. Towards 1840 animal magnetism had a period of development

and of success that should not be forgotten in order to appreciate other later movements of like enthusiasm.

HYPNOTISM

Hypnotism was a psychological method of treatment that has been widely used. The term referred to the condition of trance could be induced in many normal persons. Such a state could be deliberately induced by others, through their own efforts, or spontaneously, often under the influence of some special emotional excitement. Braid, a Manchester surgeon had observed mesmerism and became convinced that the phenomena elicited were subjective in origin and introduced the term 'hypnotism' in place of 'mesmerism' laying the foundations for its study. His view was that it was a state brought about by suggestion. Hypnotism was used in surgery for a time, to alleviate pain, before the discovery and development of anaesthetics. Charcot, a French neurologist, revived the study of hypnotism and noted that many of the phenomena that could be brought about by hypnosis (paralyses, contractures, anaesthesias, blindness etc.) were identical with spontaneous symptoms of a particular disorder, 'hysteria'. Charcot inferred that hypnosis was an artificially created hysteria, a conclusion which, though generally abandoned by psychopathologists, might have had some truth in it. The essence of the hypnotic state appeared to depend on the existence of a peculiar rapport between the subject and the hypnotist, which could be an emotional relationship of intense concentration.

AUTO SUGGESTION AND PERSUASION

Another example of an early psychotherapeutic technique had been introduced to medicine by a French psychotherapist (Emile Coué) in the early twentieth century. He had studied hypnotism but his system dealt principally with the power of imagination as opposed to that of the will. He claimed that by means of auto suggestion ideas which tended to cause illness could be eliminated by the will. His system was applied to both physical and mental illnesses. He emphasised that he was not primarily a healer but one who taught others to heal themselves. He believed that all suggestion was of this type and that a second individual was not necessary, although emotional forces, directly or indirectly, between two persons would probably be involved in most cases. Persuasion was the method in which a patient took an active role in modifying his mental state. The patient's reason was appealed to and from the explanations given him he was led to see there was no logical basis for his symptoms. The good results he reported may have been due to the fact that some illnesses were self limiting or ran cyclical courses. There is also a 'placebo response' the phenomenon that when comparing a treatment blindly against an inert non-treatment many patients (sometimes 50%) who do not receive the active treatment, get better anyway. All that remains of Couéism today is his formula 'Every day and in every way I am becoming better and better'. Couéism had some features in common with cognitive behaviour therapy. As hypnosis was a forerunner of analytic therapy Coué's positive thinking with emphasis on reason and on the patient's 'self-talk' can be seen as an early unsophisticated form of cognitive therapy.

ANIMAL STUDIES, PAVLOV AND CONDITIONED REFLEXES

During the first decade of the 20th century C. Lloyd Morgan, a British psychologist, was the founder of a school of animal psychology breaking away from the traditional interpretations of animal behaviour. He first emphasised the necessity of tracing all the steps in any act before its interpretation became possible, noting the trial and error nature of all animal learning. Work started by animal psychologists and the concepts they used led to the development of behavioural studies in humans. This led eventually to behavioural methods of psychological treatment. Ivan Pavlov, a psychologist who was awarded a Nobel Prize in 1904, elucidated what he called conditioned reflexes, the finding that a new stimulus could be substituted by repeated pairings for one originally effective in bringing about a specific reaction. Pavlovian conditioning linked stimuli to naturally occurring physiological responses. The study of conditioned reflexes was extended to studies in humans, and influenced the early behaviourists.

BEHAVIOURISM

Psychologists observed behaviour like the phenomena of all other natural sciences. They did experiments with perception and sensation but ignored the cerebral aspects, for example when they found that animals could distinguish different coloured lights or different shapes. In their objective studies of man early behaviourists discounted anything they could call consciousness, sensation, perception, imagery or will. They reached a conclusion that all such terms could be dropped out of the description of man's activity. All behaviourist observations could apparently be presented in the form of stimulus and response. John B. Watson in the USA developed these studies which were forerunners of various behavioural psychotherapies today. An organism was seen

to 'respond' to conditions (stimuli) set by the outer environment and inner biological processes. Behaviourism aimed to make a fresh start, breaking both with current theories and with traditional concepts and terminology. The aim was to discard introspection so that psychology might become a more purely objective, experimental branch of natural science.

Some psychologists studying human beings began to make a complete record of all data, such as environment, education, physical condition and intellectual attainments, of each individual. This became an attempt to organise all methods of psychology in a comprehensive survey of the individual. Behaviourism in an extreme form would exclude everything which could not be stated in the terms of organic response referring to nerves, muscles and glands. Some psychologists were concerned with defining what the mind was: the others considered only what it did.

PSYCHODYNAMIC SCHOOLS OF PSYCHOTHERAPY: PSYCHOANALYSIS

Psychodynamic methods of psychotherapy are variations of the psychoanalytical system of treatment evolved by Sigmund Freud. He produced a set of theories about human behaviour, both normal and abnormal, including psychic determinism, early determinants of personality and behaviour and the structure of the mind. His theories underwent numerous revisions over the course of his life. Freud, who initially used hypnosis as a treatment found that his investigations had led him to the conclusion that the nature of the hypnotic rapport was a particular kind of erotic relationship of which the subject was quite unaware and that this was due to a reanimation in the subject's

‘unconscious mind’ of an infantile dependence on the parents. Psychoanalytic psychotherapy involved the patient’s disclosure of whatever entered his mind (‘free association’), the transference of infantile and childlike feelings and attitudes to the therapist and the development of a ‘transference neurosis’. Freud interpreted this with the aim of insight with changes in behaviour and personality.

A further stage in the development of medical psychology was experimental work in the 1880’s. Pierre Janet, a French psychologist and Director of the Psychological Laboratory at la Salpêtrière, had demonstrated the presence of mental processes, which he called ‘subconscious’ of which the subject was unaware. He described a large number of hysterical symptoms in terms of mental dissociations and the nature and origin of these, with the belief that the condition was favoured by such factors as fatigue, shock, distress, or grief. At the end of his account of ‘Animal magnetism’ Janet wrote:

‘Psychoanalysis is to-day the last incarnation of those practices at once magical and psychological that characterised magnetism. It maintains the same characteristics, the use of imagination and the lack of criticism, the vaulting ambition, the contagious fascination, the struggle against orthodox science. It is probable that it will also meet with undeserved appreciation and decline; but, like magnetism and hypnotism, it will have played a great rôle and will have given a useful impulse to the study of psychology.’

DEVELOPMENTS IN PSYCHOANALYSIS

‘Psychoanalysis’ developed from studying patients with the milder neuroses (obsessions, phobias and hysterical symptoms as well as disorders of character and sexual inhibitions or abnormalities). An attempt to explain these symptoms was made using Freud’s theories which suggested they originated through the energy of a mental

process being withheld from conscious influence and being directed into a bodily symptom (conversion). An hysterical symptom would be a substitute for an omitted mental act and an unconscious recollection of a previous experience. This theory initially led to good results in treatment being reported but it was found they were not permanent and Freud's theory was further developed that the improvements observed depended on the personal relation between the patient and the physician. For many years the data on which psychoanalytic theory rested came from the psychoanalysts' consulting rooms, where patients in conflict told their life stories to their analysts. Little provision could be made in that setting for experimental manipulation, for independent observation, or for testing the generality of the formulations.

The term psychoanalysis later came to have two meanings: the science of unconscious mental processes (or depth psychology) and a particular method of treating nervous disorders. A further development in psychoanalytic theory was the view that in order to become a psychoanalyst it was necessary, as part of the training, to have been psychoanalysed. This led to criticisms that those learning the technique were influenced into holding a set of similar beliefs. The psychoanalytic movement developed in the first three decades of the twentieth century with many changes in theory developed by Freud himself and further changes produced by his followers. Some of these remained as Freudian psychoanalysts but others such as Carl Jung and Alfred Adler developed their own doctrines.

JUNG AND ADLER

The main developments in Jung's theory, which he preferred to call 'Analytical Psychology' were his distinction of four primary functions of mind (thinking, feeling, sensation, intuition) and classification of people as introverted or extroverted. He drew attention to a possibility of cooperation between the 'conscious' and 'unconscious' mind, the latter being for him that part of the mind which was undeveloped, rather than repressed and included both a personal factor and a collective factor or disposition inherited from ancestors (the Collective Unconscious).

Alfred Adler was another psychiatrist who joined the psychoanalytic movement of Freud but withdrew from it to found his own school when he believed that Freud over-emphasised the sexual motives of human thought and behaviour and underestimated people's striving for superiority and power. His doctrines were sometimes called 'Individual Psychology'.

LATER DEVELOPMENT IN PSYCHOANALYTIC AND PSYCHODYNAMIC PSYCHOTHERAPIES

After the First World War there were marked advances in the development of psychoanalysis. During the War concern for psychiatric casualties, often described as 'shell shock' had led to treatment of soldiers using some psychoanalytical concepts. Psychoanalysis nevertheless remained a controversial treatment. Members of the Medico-Psychological Association held widely differing views of it as is shown in an

Annexe to this chapter. Psychoanalysis expanded steadily in many countries gaining many enthusiastic adherents but also much suspicion and hostility from the psychiatric establishment. The psychoanalysts remained isolated in close-knit groups with their own teaching systems independent of the official medical curriculum. (The Tavistock Clinic was the major centre in the UK) They had different outcome criteria, insight being the most important. The use of their therapeutic technique was generally restricted to a small number of mostly neurotic patients seen in out-patient clinics or, more often, in private practice.

There was an emigration of German and Austrian psychoanalysts to the USA after 1933. Psychoanalysis had been condemned by the Nazi regime and Jewish books including Freud's had been publicly burned. In the USA the role of psychogenic factors and the study of intra psychic factors led to many variations from Freud's orthodoxy. There was less concern for his traditional clinical approach. The disorders of hospitalised psychotic patients could be interpreted according to psychoanalytical theory, but treatment was mostly reserved for out-patient neurotic private patients. In public opinion in the USA and to a certain extent in general medical opinion also, psychiatry was assumed to be a science based on the theories of Freud, which could give insights into all aspects of human behaviour.

In Britain the key post-war developments were the split between Anna Freud and Melanie Klein. Anna Freud's work was more in the classical Freudian tradition. Klein was very influential. She introduced object relations theory which became the dominant model in psychoanalysis. Therapists use the concepts of splitting and

projective identification which have proved helpful in understanding patients with personality disorders. Winnicott, Fairbairn and Guntrip further developed these ideas which are known as the British Object Relations School. The influence on current psychotherapy practice is seen in the use of the therapist's countertransference as a major source of information about the patient's psychopathology and an emphasis on the therapeutic relationship as the vehicle for change in therapy. There were other developments such as Murray Jackson's use of psychoanalytical ideas with psychotic in-patients and Malan who pioneered brief dynamic therapy. Although psychoanalysts started with the treatment of neuroses they now treat a wider range of problems such as personality disorder. A. Ryle has developed a cognitive analytic therapy which is a 16 week structured therapy and brings aspects of psychoanalytic and cognitive behavioural theories specifically to treat Health Service patients in a cost effective way.

FREUD'S LEGACY

Present day psychotherapy owes much to Sigmund Freud's achievements. He influenced thinking in the Twentieth Century. There is little doubt of his genius, but there is uncertainty as to its content. When he died in 1940 Auden wrote: 'Freud is no more a person now but a whole climate of opinion' (*Horizon*, 1940, 117–154). Freud wrote in such a way that his ideas have influenced much more than attempts to treat minor nervous disorders. His ideas can be found in the writings of literary critics and the minds of opera producers. At present his concepts are more powerful in the Arts than in Medicine. Freud wrote magnificently and some people have seen him as the last of the great Victorian novelists with an insight into minds, (normal and abnormal),

similar to that of writers such as Fyodor Dostoevsky. Other people see similarities between psychoanalysis and a religion or cult, with arcane dogmas that can only be properly understood by the initiated or psychoanalysed. Karl Popper pointed out that Psychoanalysis and Marxism had much in common in that both of them had an infinitely flexible theoretical basis so that the theory could always be changed to deal with any criticism and thus they should not be considered science. Another view is that Freud's essential role was as a teacher (akin to an Old Testament prophet) who has taught us to think differently about human behaviour and the way the mind works. Nevertheless present day psychotherapies owe much to his influence and ideas. Some psychoanalysts abandoned much of Freud's theories in order to develop new short term effective treatments. It is simplest to think of Freud as a genius even if there remains uncertainty about his theories.

THE INFLUENCE OF TWO WORLD WARS ON BRITISH PSYCHOTHERAPY

It was the impact on psychiatry of the so-called 'shell-shock' of World War I that led to the change to a new functional approach. Maghull Hospital became for a while a central training ground for psychodynamic psychiatrists under the direction of R. G. Rows. W. H. R. Rivers was an experimental psychologist and anthropologist who was familiar with the works of Freud though he differed from him by interpreting dreams literally, rather than symbolically. He took at face value what men said they dreamed of war experiences and horror. He was introduced, at Maghull, to psychotherapy of the war neuroses. His work became famous through the autobiography of Siegfried Sassoon, whom he treated at Craiglockhart Hospital, where milieu therapy was

practised. Rivers died in 1922, but he had left his stamp on the 'new psychiatry', a psychodynamic view of mind and its disorders.

Just as World War I was a turning point for psychotherapy through the treatment of shell-shock, so World War II was a turning point for the application of a psychodynamic social psychology to institutions. J.R. Rees, Director of the Tavistock Clinic, became Director of British Army Psychiatry, and under his leadership psychoanalysts found themselves actively involved with others in the treatment of the war neuroses, and the selection and training of officers and other ranks. W.R. Bion and T.F. Main are amongst the most significant of these workers. These Tavistock members maintained collegial links with each other throughout the war years. They brought significant innovations into military psychiatry and army policy including the role of group therapy in military hospitals. These innovations also included a method for the selection of officers (W.R. Bion and the War Office Selection Board). Another innovation was the concept of the therapeutic community developed by Maxwell Jones at Dingleton and T.F. Main at the Cassell Hospital. Foulkes's use of group therapy was another development. The Northfield Experiment led on to group analysis developed through the work of Foulkes and Anthony. Psychoanalysts were also used to prepare propaganda and analyse the mentality of enemies. Henry Dicks was prominent in this field. British military psychiatry and psychotherapy was a world leader in World War Two but much of this expertise was lost by the time of the Falklands War.

BEHAVIOURAL SCHOOLS OF PSYCHOTHERAPY

B.F. Skinner in the USA was an influential exponent of behaviourism who favoured the controlled scientific study of response as the most direct means of elucidating man's nature. He was attracted to psychology by Ivan Pavlov's work on conditioned reflexes and the ideas of J.B. Watson. His conditioning was based on the fact that if a behaviour is rewarded the frequency of the behaviour will increase. One of his inventions (the Skinner box) has been adopted in pharmaceutical research to observe how drugs modify animal behaviour. He formulated principles of operant, conditioning and programmed learning which he envisaged would be accomplished through the use of teaching machines. Central to his approach was the concept of reinforcement or reward.

DEVELOPMENTS IN THE BEHAVIOURAL PSYCHOTHERAPIES

'Behaviour therapy' was further developed in the 1950s and adopted by more psychotherapists during the next decade. Some of the behaviour therapy techniques at that time included the explicit use of positive reinforcement and its corollaries, the manipulation of environmental events and other operant conditioning strategies. Some concentrated mainly on the treatment of phobias and obsessive compulsive behaviour by the use of anxiety reduction methods and exposure (flooding). Joseph Wolpe, who was a psychoanalyst by training developed short time limited therapies, introducing systematic desensitisation. He took behavioural principles and produced one of the first treatment manuals. In England Isaac Marks, who was committed to vigorous empiricism, introduced exposure therapy as another method for deconditioning these associations. These principles have been applied to reducing maladaptive behaviour

and increasing adaptive behaviour in children, people with learning difficulties and people with chronic psychoses (such as schizophrenia). The effective utilization of these techniques did not require medical training, but medical screening of cases to be treated by non-medical therapists was desirable to exclude other (physical) problems. The conventional training obtained in most graduate courses in clinical psychology had previously had an emphasis on Freudian theories.

THE EXISTENTIALIST-HUMANIST SCHOOLS

The Existentialist-Humanist schools of psychotherapy which could be labelled 'humanistic and interpretative' were more a way of approaching the study of man than a distinct school or systematic theory of knowledge. The psychotherapies derived from their ideas (unlike those of Freud) did not lead to a formal school of psychotherapy with a body of systematic theory and method. They led to a group of related therapies (e.g. Gestalt, Bioenergetics) which shared some theoretical propositions but differed widely in how they were practiced. The practice of psychotherapy for them could embrace many different underlying theories on which they were based. It can also be seen that there are certain similarities in their practice.

COGNITIVE-BEHAVIOURAL THERAPY

Cognitive therapy is a form of psychotherapy which has been carefully studied and is widely used in short term psychotherapy today. The rationale was developed by Aaron Beck (a psychiatrist, who had trained as a psychoanalyst). He developed his cognitive model in the course of observations in treatment followed by research in the 1960s.

Cognitive therapy has been described as an active, directive, time-limited, structured approach which is used to treat various psychiatric disorders (for example, depression, anxiety, phobias). It is based on the underlying theoretical rationale that an individual's affect and behaviour are largely determined by the way in which he structures the world. His 'cognitions' (verbal or pictorial 'events' in his stream of consciousness) are based on attitudes or assumptions ('schemas'), developed from previous experiences. For example, a person may interpret all experiences in terms of whether he is competent and adequate. He reacts to situations in terms of adequacy even when his attitude and assumptions are unrelated to whether or not he is personally competent.

The techniques used in this cognitive model of psychopathology are designed to identify, reality-test, and correct distorted conceptualisations and the dysfunctional beliefs ('schemas') underlying these 'cognitions'. The patient should learn to master problems and situations which he previously considered insuperable by re-evaluating and correcting his thinking. The cognitive therapist helps the patient to think and act more realistically and adaptively about his psychological problems and thus reduce symptoms.

This approach consists of highly specific learning experiences designed to teach a patient to monitor his negative, automatic thoughts (cognitions); to recognise the connections between cognition, affect and behaviour; to examine the evidence for and against his distorted automatic thought; to substitute more reality-oriented interpretations for these biased cognitions; and to learn to identify and alter the dysfunctional beliefs which predispose him to distort his experiences. One of the

components of this learning model of psychotherapy is that the patient begins to incorporate many of the therapeutic techniques of the therapist. Patients find themselves spontaneously assuming the role of the therapist in questioning some of their conclusions or predictions. The therapist should be continuously active and interacting with the patient and engaged the patient's participation and collaboration.

The general assumptions on which cognitive therapy is based include the following:

perception and experiencing in general are active processes which involve both
inspective and introspective data

the patient's cognitions represent a synthesis of internal and external stimuli

how a person appraises a situation is generally evident in his cognitions
(thoughts and visual images)

these cognitions constitute the person's 'stream of consciousness' or
phenomenal field, which reflects the person's configuration of himself, his
world, his past and future

alterations in the content of the person's underlying cognitive structures affect
his or her affective state and behavioural pattern

through psychological therapy a patient can become aware of his cognitive
distortions

correction of these faulty dysfunctional constructs can lead to clinical
improvement.

Therapy generally consists of 15–25 sessions at weekly intervals. The frequency is then tapered to once every 2 weeks for the last few visits and after the completion of

the regular course of treatment follow up visits may be scheduled on a regular basis or may be left to the discretion of the patient. The average patient might return for three or four such visits during the year following termination of formal therapy.

Cognitive therapy is now probably more widely used in the UK than any other type of psychotherapy with a wide range of applications. The National Institute for Clinical Excellence (NICE) include recommendation for its use for schizophrenia, post-traumatic stress disorder (PTSD), panic and depression, which place it at the heart of the non-pharmacological treatment of these disorders. I have described it in more detail than some other forms of psychotherapy. One of the reasons for its wider use is that it has developed an evidence base when other psychotherapies have yet to do so.

GROUP AND FAMILY PSYCHOTHERAPIES

Psychotherapies can also include treating more than a single individual at the same time. This can range from advice given by a marriage counsellor to a couple to including the whole family in the treatment of a child and finally to treating a group of patients with the same problems. The theoretical underpinning of all of these can come from any of the existing theories held by psychotherapists. Self-help groups can be seen as a form of group psychotherapy.

GROUP TREATMENT

For many years specialists, who had been working with neurotic and psychotic patients capable of being helped by psychotherapy, have been oppressed by the amount of work that needed to be undertaken and the impossibility of having enough trained

workers with enough time to undertake all the necessary treatment. Largely for this reason, and partly because of certain experiments in the field of group dynamics, psychotherapeutic procedures with groups had been started and considerable advances had been made during the years of the Second World War, both in the Services and in civilian life. Some of the groups had been run on didactic lines, in which techniques of suggestion and re-education had led to discussions and to talks about the nature of emotional illness and its relation to symptom formation. It was possible in this way to deal with a group of patients, in the same way that one might deal with an individual patient whom one was hoping to help by this line of explanation and re-education.

When several patients are treated together, certain psychological processes develop which do not occur in individual therapy. These processes are useful both in psychiatric treatment and in the general practice of medicine where groups may be used to support patients or their relatives. These additional factors are:

1. group support which can help the members through difficult periods in treatment or in their lives outside
2. learning from others (e.g. how others in the group have overcome problems similar to the patient's own)
3. testing opinions against those of others (this procedure is often more effective in changing beliefs and attitudes than advice from a doctor)
4. practising social behaviour especially for those who are shy or socially awkward.

In group therapy, close relationships develop between patients as well as between each patient and the therapist. An important task of the therapist is to ensure that these relationships do not become too intense, and particularly that they do not continue outside the group meetings.

Group therapy can be used for the purposes for which individual therapy is used, that is for support, problem solving, behavioural treatment, and dynamic psychotherapy. The length of treatment, the intensity of involvement of patients, and the techniques vary according to the purpose, as they do with individual therapy.

SELF-HELP GROUPS

These groups are organised by people with a shared problem, such as obesity, alcoholism, post-natal depression, or the rearing of a child with a congenital disorder. They meet without a professional therapist and are often led by a person who has overcome the problem. Alcoholics Anonymous is an example of such a group. There is also guided self help, bibliotherapy, information on the Web and therapy delivered by the Internet, on CD-roms without ever seeing a therapist. There is now some empirical evidence that CBT based self help materials such as books and computer packages may help in the treatment of depression and anxiety disorders.

All group treatments, in which the essential processes of the group itself are used as the primary tool of treatment, is 'group psychotherapy proper'. The major therapeutic effect is obtained from the interactions between members of the group, as well as with the therapist. In most forms of group psychotherapy, the relationships between the

patients in the group have as much therapeutic potential as those between each patient and the therapist. Three aims of treatment can be maintenance, restoration and reconstruction. Supportive psychotherapies emphasise the use of supportive techniques, and do not promote processes which aim to change the patient. Supportive group psychotherapy can offer some advantages over individual supportive psychotherapy, in which, even if patient and therapist meet relatively infrequently, the opportunity for the patient to become dependent on the therapist is greater.

FAMILY/SYSTEMS THERAPY

The term 'family therapy' covers a variety of approaches. At one extreme, family therapy is a method drawn from one or more of a range of schools which uses systemic approaches to help the individual patient who is the locus of psychopathology. At the other extreme, family therapy is a way of thinking about psychotherapy; the intervention may involve the individual alone, a couple, the nuclear family, or an extended network; however, the focus is not so much on the individual but rather the relationships between people. According to this view psychopathology reflects recurring, problematic interactional patterns among family members and between the family and, possibly, other social institutions, including doctors and helping agencies. This is especially relevant when the designated patient is a child. Midway between these two positions is one that views the family as acting potentially either as a resource or a liability for an identified patient. This can be important when dealing with patients with schizophrenia and their families.

In the past 150 years new academic disciplines, among them anthropology, sociology, and social history, have devoted considerable attention to the various forms of family structure found in different cultures at different historical periods. Constrained perhaps by Western medicine's focus on the individual patient, psychiatry has been slow to develop an interest in the family other than as a source of genetically transmitted diseases. Most family therapy is in a sense systemic and 'Systems Therapy' seeks to elucidate the family system through a series of questions. The therapist sets out not to become emotionally involved with the family processes nor to align his or herself with any particular family members. A form of questioning is used, in which the perspective of each family member is examined in order to elaborate a hypothesis. These questions address differences or comparisons, and relationships which can highlight conflict between differing demands within the family. This may be a way forward and lead to change. There are now many different forms of family therapy. One concept that is found in many of them has been called 'reframing' where a therapist endeavours to get the family to look at their problems in different ways and from a new viewpoint. Knowing about different approaches provides a range of styles or strategies when thinking about a family. Such variety of activities however makes it more difficult for them to be studied scientifically.

EFFICACY OF VARIOUS FORMS OF TREATMENT

A problem in assessing efficacy of treatments is knowing whether the effects are due to the specific treatment or to the therapist (this was well discussed by T.A. Ross in *The Common Neuroses*, 1923). The apparent responses to some therapies, for example cognitive-behavioural therapy (CBT) and complementary and alternative medicine

(CAM) might be due less to the specific effect of the treatment than to the approach of the therapist, or the broad context in which the treatment is delivered. Individual effectiveness can vary from none to 80% of patients whose symptoms improve. The effectiveness may result from the therapeutic bond between the therapist and patient, expectation of a positive outcome by the patient (the placebo effect) and acceptance by the patient of the need for change. Patients hope for a trusted doctor with a good bedside manner with some of the attributes of scientist, healer, priest and prophet. Much study of the attributes of the successful therapist needs to be done. It has been said that people with woolly minds drift into psychotherapy and this appears to be the case with some of the more curious branches of the many psychotherapies. Future careful scientific study should help to clarify the importance of the therapy and the therapist. Randomised controlled studies can clarify which therapies are most effective.

CURRENT MODELS OF PSYCHOTHERAPY IN THE UK

There is still much uncertainty in the mind of the general public as to the meaning of this word. There is equal uncertainty about the term 'counsellor'. People have little idea of the very large numbers of theories that underlie these activities. For example, the majority of psychoanalysts today are not trained physicians, though some have a medical degree as well as their psychoanalytical training.

In the UK there is a Council for Psychotherapy (UKCP) which includes all those organisations which provide a recognised training in their discipline. This includes

many sections. The British Association of Behavioural and Cognitive Therapy (BABCP) has by far the most members but in recent times it and the British Analytic Psychotherapy (BAP) and the British Psychological Society (BPS) have all withdrawn from the UKCP. Attempts to regulate psychotherapy (e.g. the Allardyce Bill) have been noble in their effort but so far unsuccessful. The two main groupings in the UKCP were cognitive behavioural or psychodynamic the latter using ideas from the work of Freud. There were 78 different groups offering training. The main types of psychotherapy training available today include:

- psychoanalytic and psychodynamic using ideas and concepts from the work of Freud

- hypnopsychotherapy

- family, couple, sexual and systemic

- humanistic and integrative

- experiential constructivist

- behavioural-cognitive.

There are many different psychotherapies but no single treatment called psychotherapy. In practice the great bulk of functional nervous disorders are treated by general practitioners, clinical psychologists, nurses or other ‘counsellors’ who may or may not have medical training. If general practitioners or others cannot do the work it cannot be done at all for these conditions are among the commonest met in general practice and by other doctors in all specialities. If a general practitioner is to undertake this work, or arrange for another person in his practice to do so, the treatment must be simple and reasonably short. It is important that the outcomes of all these are carefully

studied and followed up in a scientific way (randomly assigned controlled trials). Although there are many types of psychotherapy these have to be integrated into a total scheme of treatment and planned as part of a care programme.

CONCLUSION

There have been considerable advances in psychotherapy in recent years. For the first half of the twentieth century it was hoped, and by some believed, that psychoanalysis unlocked an understanding of unconscious processes in the mind which would solve many problems. This proved to be an illusion but psychoanalysts helped to develop new and more effective therapies. The greatest change in the past 50 years has been a more scientific analysis of the effectiveness of various forms of treatment. There has been particular study of brief time-limited therapies. Some psychoanalysts who were looking for shorter treatments introduced modifications involving behavioural methods. Psychotherapy is accumulating a scientific evidence base. This is mainly CBT but there is evidence for dynamic therapy. There is still debate about whether some therapies are more effective for certain problems, for example for depression it might be that more structured and focused therapies (whether they be CBT, IPT or brief dynamic) would be more effective than non-directive therapies. Currently more psychotherapy is given by psychologists nurses and others than by doctors. Cognitive behavioural psychotherapy is considered to be the most effective treatment at present. Practitioners of psychotherapy should be honest about what they can and cannot do, be modest about the state of knowledge of the subject, and inform the public intelligently and accurately about the nature of their activities. It would be desirable to see an end to proclamations of the superiority of any technique over others unless supported by clear

evidence. Psychotherapies of the future should show flexibility eventually leading to a united science of psychotherapy. This will depend on careful controlled scientific assessment.

PSYCHOTHERAPY AND THE COLLEGE

The Psychological Medicine Committee of the R.M.P.A. comprised many psychoanalysts, most of whom were medically qualified; those not medically qualified could be Associates. Most of them were based in central London. This became the Psychotherapy Specialist Section in 1971 following the transformation of the R.M.P.A. into the College. The Faculty of Psychotherapy was developed from this latter and today both psychoanalysts and cognitive behavioural therapists are represented on it. The Faculty has the responsibility to oversee training programmes for psychiatrists in the disciplines of psychotherapy. Such training programmes are no longer restricted to London but are active in every region in the country.

The first documentation of a meeting of the Executive Committee of the Psychotherapy Specialist Section are the minutes from September 27, 1971. With Heinz Wolff in the Chair and Irwin Kreeger as Hon. Secretary they gathered at the Royal Society of Medicine. A major topic of discussion was the relationship between the Royal College's ideas on psychotherapy training and the training offered by Analytic Institutes. By 1975, with Dr Kreeger in the Chair, the Executive Committee's attention had turned to the issue of psychotherapy manpower. Particular focus was given to the fact that psychotherapy was not recognised as a specialty in Scotland, although eight consultant psychiatrists spent 70% of their time in the practice and

teaching of psychotherapy. The Section discussed the ratio of consultant psychotherapy posts to SR psychotherapy training posts at their Executive meeting in November 1980. All of these issues remain a matter of on-going discussion today. Two more issues that are familiar to the present Faculty Executive are minuted in the December 1985 meeting: namely psychotherapy training for general psychiatrists and the registration of psychotherapists. Jonathan Pedder was in the Chair and Pamela Ashurst was Hon. Secretary. It was agreed that Mark Aveline and Pamela Ashurst would send details of their services (Nottingham and Southampton respectively) to Frank Margerison who would draw up a document detailing the minimum requirements of a district and/or regional psychotherapy service. During the mid-late 1980s and early 1990s the Psychotherapy Faculty Conference occurred in a two-yearly rotation with the Association of University Teachers in Psychotherapy (AUTP). The AUTP conference was held in Oxford with lectures and plenaries on a range of topical issues. The Faculty Conference was held in Cambridge adopting a large/small group format.

Training both for SHOs and SpRs has always been on the agenda. The standards for SHO mandatory training are now high and many areas are having difficulty achieving them. The Faculty is anxious to get the manpower to do so. SpR training is now so rigorous that it is difficult to complete it in three years. The last 15 years have seen many psychotherapy services expand by employing non-medical psychotherapists. The Faculty has also worked with the UKCP (UK Council of Psychotherapists) from the outset with its aim of registering psychotherapists. Despite good research evidence for psychotherapies in all areas of medicine psychotherapy services are often the first

service threatened in times of financial trouble. The Faculty has often had to defend threatened services, supported by the College.

THE POSITION OF BEHAVIOURAL AND COGNITIVE PSYCHOTHERAPY (BCP)

The issue of the position of Behavioural Psychotherapy within the Psychotherapy Section was raised first when Dr Michael Crowe was on the Committee in Dr Irving Kreeger's chairmanship in about 1975. There was always a tension between the various theoretical groups within psychotherapy in the College, and he was co-opted to the committee in order to represent the behavioural viewpoint at that time. The numbers of consultant psychotherapists were fairly small, possibly 80 full-time consultants in the country (almost all psychodynamically trained), and there was a projected need for one post per 200 000 population, making about 250 consultant posts. Thus there was a constant pressure within the Section to increase the number of consultant posts. Against this there were only two behavioural psychotherapy consultant posts in the country, and about four academics (honorary consultants) who had specialised in the field. There were even fewer consultants in the other main theoretical orientation, systemic family therapy. It was difficult to reach agreement on the best way forward, but it was agreed that it was inequitable that there were so few consultant posts in behavioural psychotherapy, and the committee was in favour of increasing these if possible – but not at the expense of posts in dynamic psychotherapy. The position continued into the 1980s, with only one or two new posts in behavioural psychotherapy being created, usually at the initiative of local hospitals who wanted to increase the behavioural input to treatment and training.

A group of behavioural psychotherapists was formed in about 1988, including a large number of consultant psychiatrists who were not designated as consultant psychotherapists, but had a special interest in the field. This group, the Association of Behavioural Clinicians, functioned outside the College, but its members were always in touch with the Psychotherapy Section. They organised twice yearly conferences, and encouraged trainees to take up this type of work and to present cases. There was a strong wish by some of these clinicians to leave the Psychotherapy Section altogether, and form a Special Interest Group either free-standing or within the General Psychiatry Section. Indeed, at one stage they had amassed fifty signatures to propose a Special Interest Group in behavioural psychotherapy. However, the general view of the College hierarchy was that this was not a valid type of 'special interest'. The decision was made to maintain the status quo within the Psychotherapy Section, and the group concurred with this. In the early 1990s this group moved within the Psychotherapy Section, and became the Behavioural and Cognitive Psychotherapy Subgroup of the Section (later Faculty). They held conferences as before, and met usually by teleconference, with the minutes reported to the Section/Faculty. This situation continues and there is always at least one behavioural cognitive representative on the Faculty Executive, by co-option if necessary as it has been very difficult to have BCP psychotherapists elected to the Executive. There is still also an imbalance of consultant posts throughout the country, but local pressure is resulting in some psychotherapy consultant posts being redesignated as BCP, while others are created from new money.

There has always been a somewhat uncomfortable mix between these two groups of practitioners, and their differences have sometimes emerged in a painful manner in

committees and appointments panels. However, they have collaborated well in both the drawing up of training schedules in psychotherapy, and in the inspection of programmes both for general and higher psychiatric training. They have also collaborated well in the representation of the College on the UK Council for Psychotherapy and the working groups in Parliament seeking to set up a national system for the registration of psychotherapists. Perhaps the best solution would be a general increase in the number of consultant posts in psychotherapy, with a proportionally greater increase in BCP posts. It will be many years before this can be achieved. The other issue is the fact that psychiatrists, even those with a full-time post in psychotherapy, are very much in the minority of psychotherapists nationally. The psychodynamic field has many psychologists and lay psychotherapists, some of whom hold senior positions in the training organisations. The behavioural and cognitive psychotherapists include a large number of psychologists and also many nurse therapists, on whom many of the psychiatric training programmes rely to supplement the training of junior staff. Registration, to maintain standards, is a key issue for these groups.

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