On the Essence of Psychotherapy

August 02, 2012 | Major Depressive Disorder [1], Cultural Psychiatry [2], Addiction [3]
By Stephen B. Levine, MD [4]

Psychotherapy is a rubric—an umbrella under which a vast array of differing interventions exist. Its diverse forms are supported by different ideologies and vocabularies.

Disturbances of thinking, feeling, perception, and behavior constitute the formal domain of the mental health professions. By defining psychiatry’s arena of responsibility in this manner, our vocabulary emphasizes psychopathology. We tend to assume that the problems brought to our attention are manifestations of an underlying disorder. We routinely interchange the adjectives mental, emotional, and psychiatric to modify disorder, disturbance, illness, or disease to explain our interventions. In this way, psychiatrists treat illness just as medical and surgical colleagues do.

Psychiatry needs these terms to help early-career psychiatrists make their transitions from basic medical education to the domain of psychiatry. As psychiatrists, we gather experience in outpatient settings and our understanding of the nature and sources of psychopathology changes. We become more aware of the process of personal, highly individualized development. This not only helps us clarify what may be pathological and why it is, but it also enables us to realize that other domains are invaluable to our work. As we come to understand motivation; interpersonal relationships; sexuality; adaptations to life changes; religious, cultural, and economic forces; ethical/moral standards; existential issues; etc, our discrete illness model becomes less compelling.

What is psychotherapy?
Psychotherapy is a rubric—an umbrella under which a vast array of differing interventions exist. Its diverse forms are supported by different ideologies and vocabularies. No one brand of psychotherapy is applicable to everything that ails humans. A professional’s preferred form of psychotherapy often generates passion, identity, and affiliation patterns.

The central idea of psychotherapy is the desire to understand what led to the patient’s current predicament and past predicaments. The goal is to take the mystery away to better position ourselves to remove or attenuate the patient’s symptoms. Psychotherapy is a purposeful, professional, intimate, conversational process that focuses on the patient’s subjective, interpersonal, developmental, and biological life in order to benefit the patient. Psychotherapy has rules for its conduct, concepts about its processes, and ethical obligations. Psychotherapy rests on a core assumption: emotional growth and symptom relief can occur through relationships. Ultimately, this assumption requires faith. Many people indirectly express their faith by participating in psychotherapy or by showing disappointment when they receive an intervention without psychotherapy. Not every person who seeks psychiatric help believes in the core
assumption, however. Disbelievers (and some believers) may want something else at a particular time—for example, hospitalization, medication, agreement with their position in a conflict, or to be found competent to continue administering their affairs.

The basic tool of psychotherapy. A refined quality of listening is our basic tool. Refined listening rests on our pleasure in and appreciation of the patient's narrative. We strive to comprehend what is being said, noting the style of the narrative and wondering about what is not being said. We seek to understand the emotional tone of the patient's words by observing the postural and facial expressions that accompany the narrative. We listen in an effort to recognize the patient's meanings, to create a bond with the patient, and to derive our separate meanings from the narrative.

The therapeutic alliance. The patient is always evaluating us. In the early sessions, we are auditioning to be the patient's therapist. Only if we pass our audition, does the therapeutic alliance begin. Later in therapy, the patient's new negative evaluation of us can lead to an abrupt cessation of our work together. Nonetheless, our refined listening creates a therapeutic alliance. The therapeutic alliance is the culturally approved bond that enables further revelation and a deepening trust.

The therapeutic alliance constantly evolves in distinctive ways. The continuing conversation within the therapeutic alliance, the patient's changing life circumstances, and the evolution of the therapist's skills, knowledge, perspective, and style all contribute to the uniqueness of psychotherapy.

While doctor-patient interactions are by nature one of a kind, they are not chaotically idiosyncratic. They are unique only within an ethical framework shaped by 5000 years of professional tradition. The rules for professional behavior are subtly incorporated within the therapist and the patient. Patients have expectations about how therapists are supposed to behave and what they can and cannot do to relieve suffering. These rules are referred to as boundaries. Clinicians are expected to continue to learn throughout their careers about patterns of suffering and their means of relief. The major reason psychotherapists can be helpful is their commitment to understand the sources of their patients' suffering.

Listening. The obvious object of our listening is the patient's narrative. We listen to what occurs between us during the session and, in the subsequent session, we listen to the patient's thoughts that occurred between our meetings. We also listen to our own feelings, thoughts, and memories that arise during and after the session with our patient. Some of the patient's thoughts and reactions to us during and between sessions is transference. Because of the psychoanalytic origin of the term, transference is often erroneously assumed to not exist in other forms of therapy. Transference is a human rather than an ideological experience. Transference originates in unconscious processes that mysteriously link us with the patient's past through his or her thoughts, feelings, and perceptions of us. It sometimes surfaces during a session, but most of its manifestations arise between sessions. Transferences reside in the patient's privacy and tend to be kept from the therapist.

The state of the art of modern psychiatry

While psychiatry has long been valued as the caretaker of highly prevalent mental disorders, psychiatrists have always been second-class citizens in the “house of medicine.” Psychiatry seems less scientifically grounded than other specialties, although psychiatrists routinely overestimate the validity of what occurs in medicine. Medicine has officially embraced evidence-based-medicine standards, and psychiatry has dutifully followed, even though the work typically does not lend itself to the drug/surgery/disease model. In psychiatry, there is a great gap between evidence-based therapy, which establishes the scientific knowledge base for efficacy of an intervention, and evidence-based practice, which applies that therapy to less highly selected patients with the same disorder.

We have to accept what psychiatry is. We change our nosology every decade, we label many activities as therapy, we employ a plethora of nonmedical practitioners, and we rarely have any actionable scientifically verified therapy advances that can be readily translated into professional behavioral change in the community. During the 1990s, the “decade of the brain” failed to find a molecular basis for mental illnesses and failed to identify effective drugs to treat them, as the NIMH predicted in 1989. During the next decade, “brain imaging,” our rhetoric about etiology changed, but this costly technology has not led to advances in treatment.

There has been skepticism about psychotherapy-less psychiatry based on the Sequenced Treatment Alternative to Relieve Depression (STAR*D) study and the Clinical Antipsychotic Trials of Intervention
Effectiveness (CATIE) results, the continuing shambles of state mental health systems, the meteoric rise of attention deficit disorder treatments, Pharma’s failure to publish negative findings, and the financial conflicts of interest of some of our luminaries. One might think this would increase psychiatry’s interest in its psychotherapy processes. Despite demonstrations of effectiveness of various psychotherapies, our field continues to rest heavily on organic etiologies and medication interventions.

The public seems to know that our field deals with soft, subjective phenomena and that psychiatric intervention can be useful when people are overwhelmed. The educated public does not actually believe that emotional decompensations are simply caused by biochemical aberrations. They know that emotional life is changeable and that the past inevitably influences the present. They know that working through any life-changing event is an essential human process that occurs with or without psychotherapeutic assistance.

The public and our profession do not readily grasp how psychotherapy works, however. I offer an explanation: comprehending, respecting, and eventually reframing the individual meanings that people take from their life experiences are the key processes of psychotherapy.

Eight related core concepts about psychotherapy

1. **The patient’s trust is required.** Patients begin with varying degrees of trust. Trust is facilitated by the therapist’s interest in helping the patient, the capacity to ask intelligent questions, and knowledge about the patient’s diagnostic category.

2. **The therapist must provide a respectful psychological intimacy.** Patient trust is undermined by poor intimacy skills, such as lack of evident interest, criticism, and failure to comprehend the narrative.

3. **It is vital for the psychiatrist to understand the patient’s predicament.** Understanding what led to the predicament is a multistep process that is not complete after the first session. Over time, the history becomes multidimensional; both the therapist and the patient grasp the individuality and the complexity of the situation. The predicament must be understood in ordinary human terms rather than professional jargon.

4. **The therapist is a person of great interest to the patient.** The therapist should assume the patient will have many changing feelings about him or her and will be reticent to share most of them in therapy.

5. **The attachment to the therapist should be perceived, acknowledged, and respected.** It should be discussed, in particular, when a separation or termination is approaching. Therapists are not readily interchangeable.

6. **The therapist should not assume that patients believe that they have revealed the whole story.** Rather, the therapist should assume that the patient has told as much of the story as he was able to tell at this point in their relationship.

7. **Symptoms can get better!** There is often an initial improvement that results from the new good attachment to a therapist. Complete symptom disappearance usually requires a significant change in understanding, social circumstances, or maturation.

8. **The therapist should behave in a warm, friendly manner, unarmed of revealing minor aspects of his personal life.** Psychotherapy is a conversation between 2 human beings!

References:

References


Source URL: [http://www.psychiatrictimes.com/major-depressive-disorder/essence-psychotherapy](http://www.psychiatrictimes.com/major-depressive-disorder/essence-psychotherapy)

Links:


