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Psychotherapy — More Than An Episode?

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The basic contention of this paper[2] is that the means of understanding used in psychotherapy, may, or even needs to be applied in a wider context than treatment of individuals.

Definition of Psychotherapy

The Psychotherapy Association of Australia defines psychotherapy as being derived from psychoanalytic theory of human behaviour and mental life and sees the individual as a dynamic system, each part of which affects the other parts. Many of these parts are unconscious, but they can be modified by insight and understanding. Transference and counter-transference are important vehicles for achieving such insight. More generally, psychotherapy is a treatment for emotional problems and involves a mutual commitment and responsibility between therapist and patient.

Structure inherent in the therapy process, the need for intervals to assimilate the wounds and the understanding from the process, and the need to terminate, all point to psychotherapy as episodic and as a treatment for individuals.

Yet if we look at the definition of psychoanalysis, from which psychotherapy is derived, we find that its scope is wider than just therapy. The other two prongs in its definition are means of investigation of the

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2. The theme for the 1982 Psychotherapy Association of Australia Annual Conference was "Psychotherapy — an Episode, or a Way of Life?" The author presented a paper on this topic, and is grateful to be able to have a second chance in which to put some of the assertions in that paper into better perspective. In particular, this paper takes into account the valuable contributions of Mr Leonardo Rodríguez's paper on the same topic which was presented at the Conference.

mind, especially of its unconscious components, and a group of psychological and psychopathological theories. (1)

Frued's enthusiasm about psychoanalysis as a psychotherapeutic concern was not great. He said, " . . . I have never been a therapeutic enthusiast; . . . " and " . . . psychoanalysis began as a method of treatment; but I did not want to commend it to your interest as a method of treatment but on account of the truths it contains, on account of the information it gives us about what concerns human beings most of all — their own nature — and on account of the connections it discloses between the most different of their activities." (2) His pragmatic use of psychoanalysis was conceptualised on a broader sociological scale. For instance, he hoped that the insights of psychoanalysis might change child rearing practices, and that this would be the greatest achievement of psychoanalysis, reaching more than a small number of neurotics which psychoanalysis as psychotherapy could only achieve. (3)

Our own definition of psychotherapy relates to therapy of individuals and to a treatment contract. What right do we have to go beyond this?

An assumption in Freud's sociological writings is the applicability of knowledge gained from individuals to society at large. It is as if non-patients, groups, and societies could be viewed as "patients" too. The affects and defences of society, its anxieties, repressions and illusions could be fed back to society in the hope that, like with patients, the unconscious could be made conscious, with beneficial results.

Clarifications of the earliest developments of the human mind, along with the evolution of family and group therapies have made it obvious that seeing "the individual as a dynamic system each part of which affects the other parts . . . " is correct, but needs an important modification involving an extension of the meaning of the word "individual". In a psychological sense, an individual is never an individual. He develops concurrent and interchangeable concepts of himself and his world. The baby's and mother's (and later society's) parts are projected and introjected primarily in illusory ways, only later tempered to variable degrees with reality and rationality. Each individual carries an image of his society within him and has a dyadic projective and introjective relationship with it and with the outside society. Bonds

may be formed between individuals who have similar projective and introjective systems based on similar aspects of the real world. These group identifications, projections and introjections may vary from being nearly real and rational to being quite illusory and psychotic. Indeed many "normal" group phenomena can only be explained through knowledge of individual psychotic processes.

Thus the same psychic mechanisms exist within individuals, whether in a dyadic mother-child or therapist-patient setting, in groups, families and societies. Similar psychic mechanisms exist in individuals' interactions with their individual societies, as between human groups in international affairs. The structure housing the emotions may vary in different circumstances, and convention of communications may vary, but man does not mutate into a higher being in a group, and his relationship to it is like the earlier models which he carries in his mind.

Clinically, then, it *may* be valid to look at aspects of society with some of the viewpoints pertaining to patients; that is to see "the individual, individuals and society as a dynamic system each part of which affects other parts. Many of these parts are unconscious, but this can be modified by insight and understanding."

It is a comfortable illusion to consider that what is dealt with in psychotherapy is the irrational aspects of life, and that daily living is rational. The opposite may be just as true. In fact, it may be that the consulting room is simply a relatively secure and rational environment in which to observe certain types of irrational processes. These same irrational unconscious processes may hold greater sway in individuals who do not present for psychotherapy, and even more so in aspects of society as a whole. Where a psychotherapist uses his skills to help uncover unconscious processes which lead to individual or social malaise may depend more on his own training, taste, fears, defences and resistances, than on the need for his skills in certain areas, or the overall pay-off for his interventions. Lifton (4), who is perhaps the only person who made a study of the psychological after-effects of the Hiroshima bomb stated facetiously that psychiatrists (and other mental health workers), and indeed mankind, pay attention to matters in inverse proportion to their importance.

There are various ways in which the understanding of unconscious parts of society can be achieved; for instance, by feedback of results of

psychodynamic exploration, dispersion of the body of theoretical knowledge as known at any particular time, or through more "therapeutic" techniques. The feedback will have to reach an emotional core in a part of the community to have an effect. Similarly, the therapeutic stance in the dynamically oriented participator, will need to include understanding of the emotional underpinnings of certain actions, and how he himself feels in relation to the emotional meaning of the situation. For instance, why might the psychotherapist along with others, deny the effects of Hiroshima, or other proclivities around us which may lead to self-destruction? Hence transference and counter-transference attitudes modified for the situations in question need to be used.

Finally, if the definition of psychotherapy *is* to have a broader validity, we must return to the question of techniques used in contractual situations with individuals being used on a wider non-contractual basis. It may be answered that if a person falls over, one may help him up without first entering into a contract.

There is an implicit contract in society that people help each other. If a psychotherapeutic stance is able to help society learn something which it otherwise could not learn, then surely it is ethical, or even one's duty, to allow society to take advantage of such available knowledge. Because much dis-ease in society is due to unconscious forces, and not many disciplines are skilled in discerning unconscious forces, perhaps it is the business of those who deal with such forces in a scientific way in their everyday work, to study unconscious processes in society and let society have the benefit of such studies.

Freud's hope of changing child rearing practices through psychoanalytic knowledge has been justified to some degree. The perception of the child has changed in society. He is no longer seen as a small replica of an adult, or a tabula rasa on which to imprint adult impressions. On a practical level we have seen the growth of the child guildance movement, improvements in kindergartens, awareness of the needs of children separated from parents, and in the treatment of antisocial children.

In the adult world particularly in the United States, there are some areas of notable psychodynamic influence, for instance in the current sway of the biopsychosocial view of disease. But overall the influence has been more subtle, as it is in psychotherapy altogether. We do not revolutionize the aspects of our patients through psychotherapy; rather

we allow freedom for the growth of varied attitudes and for increased options. Psychoanalysis has contributed to society's greater awareness of its own complexities. This is reflected in popular art forms like films and television, where great psychological depth may be portrayed in characters presented, contrasting markedly with the stylised portrayals of past decades.

We shall now examine the reasons often given as to why psychotherapeutic techniques and knowledge should be restricted to the clinical setting.

Reasons advanced for limiting psychotherapy to the clinical setting

1. *Lack of knowledge.* It is true that one should have knowledge in the field in which one comments, and that many of us are not trained in sociological observations. Yet not many disciplines are trained in observing unconscious aspects in society. For example, the question of nuclear powered ships visiting Australia was not discussed in terms of community anxiety about becoming potential targets for future nuclear attack. Rather the anxiety was defused and effectively stopped from reaching public consciousness by a displacement of the argument to the State-Federal political level. Another example is that through fear, society at times dissociates itself from, denies, and even blames the less fortunate in the community, as for instance the psychiatrically ill or the unemployed. Such observations may rightly be fed back to the community. Lack of sociological knowledge if present, should be rectified, so that one talks in an informed manner about such problems.

2. *Too much use of knowledge.* On the other pole of the argument, those credited with knowledge of unconscious processes are seen like mental equivalents of champion boxers for whom it is in poor taste to practise their prowess outside strictly limited settings. Ministers of religion, policemen and doctors, like psychotherapists, should not give gratuitous advice in social situations.

So should these professionals forsake their professional identities and skills outside their strict work settings? Perhaps it is not so much their skills which are perceived as a source of danger, but the untactful use of these skills to expose others' vulnerabilities against their will. Once the professional is trusted as a constructive ally, his skills are appreciated with gratitude. In fact, there would be disillusionment, say with a professional friend who did not lead one (albeit as kindly as

possible) to the conscious knowledge that one's wart was a cancer when the professional friend knew that it was. It may be that the interpersonal fabric of trust, tact, and use of professional skills for the benefit of the receipient are more important than the presence of the classical clinical setting.

It is important to clarify that we are not talking here of self-styled "do-gooders" or "wild" therapists who use half-baked interpretations to make a social point for themselves at the expense of others. They are a menace and lack ethics in the clinical as well as in the wider social setting.

3. *Breaking the rules of communication.* It may seen unfair to consciously use skills to understand non-verbal messages, the emotional stance of the speaker and one's emotional reactions to him in order to understand the total communication. What right does one have to analyse what is beyond the conscious conventional communication in words? Of course conventionally, there is no unconscious communication, and non-verbal communication. Actually everyone takes in unconscious communications, but the psychotherapeutic technique does so consciously.

The problem is not in the conscious use of the psychotherapeutic technique, but with the person communicating disparate messages on two levels. When communication is congruent on the conscious and unconscious levels, people do not mind analysis of their messages. They are usually even gratified when for instance, their tears and their expressions of sadness are fully noted. They may resent, however, having pointed out inconsistencies between sad verbalizations and a concurrent smile.

Yet people want to communicate both sides of inconsistent messages, with the proviso that those aspects, which they are not conscious of themselves (for reasons of fear, guilt, or shame) also stay unconscious in the recipient. Because of the nature of communication of unconscious messages, this often happens. Also the psychotherapist likes to obey the rules of communication, for fear that he too would feel exposed and vulnerable if his unconscious became fair game for observation.

Consider observing the double messages of a friend who is denying grief, yet who constantly talks of other people's grief. A conscious

appreciation that the friend would like to talk about his own grief but is afraid to do so, can help provide a meaningful response to the friend. However, before one can respond to a friend's unconscious messages appropriately, one may have to fend off the friend's infectious sense of anxiety relating to his grief, and one's own reluctance to confront grief. Thus to reach the conscious appreciation that the friend is afraid, but would like to talk about his own grief, may require a conscious psychotherapeutic-like stance. The only reason why it is not actually "psychotherapeutic" is because we are not treating our friend in a clinical setting.

4. *The argument against introspection, and for feeling.* There is an argument against constant psychological awareness, i.e. too much thinking and analysing, for it is contended, this stops one's natural "living" and "being".

This is certainly so when introspection and intellectualization substitute for feeling. Yet our discipline is based on the knowledge that understanding, while experiencing, gives freedom and expansion of feeling, not to its obliteration. The therapist who analyses his patient's, his society's and his own feelings does not negate meaningful experiences, but rather is able to respond with greater sensitivity of feeling and facilitates greater poignancy and understanding in and around himself.

There are few things as satisfying as the harmonious interaction of intellect and emotion in experience. Both are necessary for the full sense of being in the experience.

Real reasons for not extending the psychotherapeutic stance

Even if it be accepted that a psychotherapeutic stance is valid and ethical outside clinical psychotherapy, its use or non-use will still be determined by unconscious emotional reasons. Such reasons may themselves be usefully understood through psychotherapeutic techniques.

It is hard enough to confront feelings in the strictly regulated clinical setting, where there is control of the overall situation. But outside of this setting one is at once more involved and less in control. Thus one may be more socially challenged and feel more vulnerable outside the consulting room.

We should remember that no matter how well analysed we are, in

everyday life there is much scope for unpleasant affects and defences against them. A great emotional effort is needed to take a therapeutic stance, especially when not pressed to do so. Thus, when we tell ourselves that we have not time or business to be involved with this or that group or issue, we may be joining with the rest of the community in avoiding unpleasant feelings. We need not search out every challenge. But we should know what we are doing and why. Otherwise being "off work" is not a recuperative process in the sense of a holiday, but flight from work, in the sense of flight from the ego, which always carries costs.

Definition of the psychotherapeutic stance

The psychotherapeutic stance implies the exploration of unconscious processes in human and societal interactions. It explores the feelings motivating such processes and utilizes the techniques of clinical psychotherapy. These include the knowledge of psycho-dynamics and transference and counter-transference processes. Feedback of the understanding gained also uses principles and ethics of psychotherapy. The understanding is fed back to individuals or groups in order for them to utilise it for further exploration. The psychotherapeutic stance may be used to expand one's own self-understanding.

Applications of the psychotherapeutic stance

1. *Self.* Therapy has much relevance to our relationship with the world. It facilitates self-observation in the world and observation of the world. When personal therapy is finished, the process of self-observation may continue fruitfully. In this context alone psychotherapy is more than an episode.

In therapy, there are temptations to not look at aspects of ourselves in relation to actual dangers in the world. It appears that some psychotherapists, including those who treat future therapists, do not allow their clients to face the threats in society because they themselves feel too threatened. Such avoidance may mean that analysts and psychotherapists as a group do not handle outside catastrophes, political events, or even internal politics any better than other sections of the community.

2. *Family and friends.* During therapy we are encouraged to have a

psychotherapeutic stance vis-a-vis those close to us, and our relationships with family and friends may improve markedly. Conflicts may suddenly become understandable. By viewing oneself one sees others more realistically too. Again there is no reason why this need stop after therapy ceases.

3. *Non-psychotherapy patients.* Observing doctors and patients in physical medicine, one may appreciate the urgent need of a psychotherapeutic stance. Any contact (even if only mental) between doctor and patient, arouses intense, largely unconscious feelings, which determine what sort of treatment the patient receives. Such transference and counter-transference-like reactions if not understood and tackled appropriately, may lead to tragic therapeutic mistakes. Patients may be ignored, over-treated, under-treated, or operated on because of inappropriate anxiety, anger, guilt, and so on. One cannot afford to ignore unconscious communications here.

Consider a schizophrenic who cut his wrists and told the doctor he now felt well. The doctor colluded with the dissociated part of the patient and avoided with him his inner chaos; after suturing his wrist, he sent him home.

Another patient presented with recurrent dyspepsia. Picking up the cues sympathetically, the doctor could relate it to stressful family visits and could then discuss options for handling such visits.

In medical settings, one sees traumata in vivo which patients relive and elaborate, and psychotherapists may spend much time untangling later on. Great opportunities exist for psychotherapists to use their knowledge of psychopathology in order to make effective interventions early "on the ground floor". Examples of types of individuals who may be helped are those (especially children) who are assaulted, are in accidents, are bereaved, etc. Another group needing much help are the dying or the seriously ill. The caretakers of such groups need help too.

Not having the time to provide for these patients, having so many others who need help, not knowing what to do, are reactions well worth considering with a psychotherapeutic stance. In the caretakers also there may be denials and rationalizations. Maybe psychotherapists are also frightened by such acute problems and prefer the well-controlled, not so ill, interesting patients who do not stress them too much.

4. *Distressed groups.* Though it is acknowledged that psychological wounds must be treated as much as physical ones, psychotherapists are conspicuous by their absence in populations who suffer such wounds and who could be given mass preventive "ground floor" treatment. Examples are survivors of disasters, bereaved groups, army veterans, migrants and refugees, the unemployed, institutionalized children and so on.

One cannot treat all these people individually, but the psychotherapeutic stance could feed into helping systems dealing with them. Hoppe (5) described the intensely difficult counter-transference problem when treating concentration camp survivors. How many Robertson film "John"s can we cope with during a working day? Barnett and Bain (6) described the difficulties in researching and accepting the heartbreaks in an ordinary British day nursery. One should not underestimate the emotional difficulties in approaching distressed groups. One should also not underestimate the political resistances that groups evolve to protect themselves from having to acknowledge unpleasant feelings, which they may be asked to share with these distressed groups.

And yet conscious awareness of the problems and evoked feelings may allow psychotherapists to approach, research, treat, and institute prophylactic measures for these populations.

All these features were exemplified in the recent experiences with bush fire victims. Pamphlets were distributed to the bulk of the population describing their own and their children's feelings and reactions and the reasons for these feelings. This information provided much relief and had a steadying effect for many of them. They were reassured that their extreme feelings were normal, and that they were not going mad. Individual contacts were intense and exhausting, especially because of counter-transference-like feelings. Yet one could see before one's eyes unconscious blocks and conflicts which could potentially lead to neuroses, resolve with therapeutic intervention. For instance, a child's behaviour problem was due to his inability to express his anxiety related to his fire experiences, because his father would block any beginnings of this expression. Once the father's guilt of allowing his son to experience terror and nearly die in the fire was brought into the open and discussed, both father and son were able to go over their mutual experiences with much feeling, and their grieving processes could continue normally.

5. *Society.* On a smaller scale, a psychotherapeutic stance may help resolve a stalemate in committee meetings. On a larger scale, I have already alluded to the psychotherapeutic stance being valid as a way of looking at society. I have mentioned the example of the nuclear-powered warship issue. The question of war itself is too little addressed by those aware of unconscious forces. Yet wars are fuelled by unconscious forces. Where are the psychodynamic explanations of the Falklands War, or the Iran-Iraq war? Or a potential World War? Are we too overwhelmed by the enormity of the dangers to address ourselves to these questions?

Recently I attended a university meeting where Russian and American representatives spoke about disarmament, accusing each other of unfair motivations. An elite panel questioned both speakers about numbers of missiles, as if numbers was the most important issue. They were easier to deal with than fear and mistrust to which a psychotherapeutic way of approach could redirect the discussion. A journalist present at the meeting was outraged at the opportunity lost to discuss the substantive emotional issues. His feelings were confirmed as valid by the psychotherapist. He then proceeded to deal with the substantive issues in his own creative professional way. So in bigger or smaller ways we can draw society's attention to the underpinnings of its taboos and prejudices.

In the past, social psychoanalysts may have been too sweeping, too pessimistic (7) or too messianic with their interpretations of the unconscious causes of war and its prevention through mass psychoanalysis (8-9). In other words they lacked an overall psychotherapeutic stance, and they left their listeners resentful or despairing.

Conclusions

I have noted a semantic difficulty in the word psychotherapy, which is absent in its parent, psychoanalysis. Psychotherapy implies therapy in a clinical setting only. Yet just like psychoanalysis can apply itself to wider issues, so can psychotherapy. To this wider application of psychotherapy I gave the name psychotherapeutic stance.

Psychotherapy as a clinical experience has to be an episode. When talking about psychotherapy as a way of life, I am really talking about application of the therapeutic stance as a way of life. To what extent

should this be a way of life for the psychotherapist?

In a way this is a rhetorical question because each psychotherapist has his limits, determined by unconscious forces, as to how much he can maintain a psychotherapeutic stance, even if consciously he thought it desirable. Some people may have the external psychotherapist so well assimilated in their personalities that they observe with the therapeutic stance without effort. For others this may be a task of considerable arduousness.

It is as well to have some perspective on the nature of clinical psychotherapy. It is a tough science, carried out in a certain setting meant to eliminate intruding factors which make the process even tougher. Yet as such, it can only be applied to a few selected individuals. These individuals represent the tip of the iceberg of many not dissimilar individuals in the community. The few who obtain psychotherapy satisfy the physical, psychological and social factors which enable them to have treatment. Many of these factors are chance ones and do not necessarily reflect therapeutic cost-effectiveness. For instance the patient's ability to attend at certain times may be associated with a chronic gelling of his symptoms. Greater therapeutic pay-off may have been obtained years earlier when he presented in an acute form, at a hospital casualty department.

Furthermore, he may be part of a similarly affected group, for which earlier group intervention may have been helpful. At times then, individual psychotherapy may seem like treating a malaria victim while ignoring the malarial swamps which are the sources of infection.

It is hoped that this paper indicates that the psychotherapeutic stance outside the episode of personal clinical psychotherapy may have useful applications.

It must be stressed that one is not advocating the proselytization of a rigid *Weltanschauung*, the dangers of which Mr Rodriguez pointed out. But the scientific discipline of psychotherapy, which helps to uncover truth and dispel illusion (10), may be applied wherever the human unconscious holds sway.

The sort of psychotherapeutic awareness we are talking about requires constant effort, attention to truth, including inner truth, which often hurts. It requires facing conflicts and enmities. We suspect that most psychotherapists have chosen this way of life, but that it is a constant struggle which decides how much of a way of life it is. Against the difficulties involved, there is the awareness of greater fullness and meaningfulness of such a way of life.

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