MEDICAL PRACTICE

Personal Paper

Psychoanalysis, psychotherapy, and health services

M SHEPHERD

British Medical Journal, 1979, 2, 1557-1559

In the late 1950s, at the height of the postwar boom enjoyed by psychoanalysis in the United States, a fatidical observer commented shrewdly that, "Despite pretentious affirmations to the contrary the fact is that psychoanalysis, on which modern psychiatry is largely based, is in a state of virtual collapse and imminent demise."¹ Twenty years later the accuracy of his prediction was publicly underwritten by a cover story in *Time* magazine, pointedly entitled "Psychiatry on the couch."² In efficient, plastic prose psychiatry is presented in the role of patient, with the following clinical formulation:

History: European born. After sickly youth in the US, travelled to Vienna and returned as Dr Freud's Wunderkind. Amazing social success for one so young. Strong influence on such older associates as Education, Government, Child Rearing and the Arts, and a few raffish friends like Advertising and Criminology.

Complaint: Speaks of overwork, loss of confidence and inability to get provable results. Hears conflicting inner voices and insists that former friends are laughing behind his back. . . .

Diagnosis: Standard conflictual anxiety and maturational variations, complicated by acute depression. Identity crisis accompanied by compensatory delusions of grandeur and a declining ability to cope. Patient averse to the therapeutic alliance and shows incipient overreliance on drugs.

Recommended treatment: requires further study.

Prognosis: problematic.

That American psychoanalysts themselves appear to accept this assessment and are much concerned about its implications emerges from Dr Mortimer Ostow's recently published paper,

which was prepared for a project on the future of psychoanalysis being conducted by the Psychoanalytic Research and Development Fund.³ Dr Ostow attributes the declining prestige of his subject in both non-medical and medical circles to several causes: "a climate of opinion which resists counsels of abstinence, competition by other methods of treatment, application of cost-benefit criteria, an apparent diminution in the incidence of classical neurosis, the discouragement of originality in psychoanalytic institutes, and the inclusion of dynamics in residency training." He does not, however, question the value of psychoanalysis as "the best and most comprehensive theory of mental function and mental illness that we have," and his recommendations are, broadly, to batten down the hatches but to navigate in the same general direction.

Influence of psychoanalysis

A less partisan outlook may lead to less questionable conclusions. With hindsight psychoanalysis can be seen to have a manifold appeal, as might be expected from a subject that combines the elements of a theory of human development, a series of technical procedures, a metaphysical system, and a form of treatment.⁴ The evolution of so complex a phenomenon calls for, and has received, a detailed historical analysis,⁵ which underlines not so much its scientific validity as the perceptiveness of Lionel Trilling's reference to the movement as "one of the culminations of the Romanticist literature of the nineteenth century."⁶

The impact of psychoanalysis on medicine, however, has been most closely bound up with its claims to be a form of treatment and, more specifically, through its virtual appropriation of the term "psychotherapy." This has been a relatively recent development. Pierre Janet, in his magisterial survey of psychotherapeutic procedures, included psychoanalysis as no more than one of several methods in current use and graphically categorised it as a form of "mental liquidation."⁷ Much of the

Institute of Psychiatry, Denmark Hill, London SE5 8AF**M SHEPHERD, DM, FRCPsych, professor of epidemiological psychiatry**

subsequent material success enjoyed by psychoanalytical psychotherapy derived from its widespread acceptance in the United States, where, after overcoming some initial resistance, formal psychoanalysis came to assume a highly prestigious and affluent position from the 1940s until the "fat years" of the late 1960s.⁸ Since then it appears to have been consumed by its own progeny. In the language of *Time*, the Freudian movement "set the stage for the narcissistic excesses of today's Me Decade." Dr Stephen Appelbaum, writing as a devout psychoanalyst on the "alternative" therapies of the 1970s, refers to their links with "a set of activities guided by Freud's understanding of personality, the prototypical form of which is psychoanalysis."⁹ For Appelbaum Gestalt therapy, "est," bioenergetics, transcendental meditation, primal screaming, and yoga all constitute elements of the "human potential" movement, which, as he points out, no longer retains any pretence of an affiliation with medicine but is rather to be regarded as a form of secular religion, with hope as its central dogma.

The mainstream of American psychiatry is unlikely to be long diverted by the decline of psychoanalysis. More than 20 years ago I referred to the attempt being made "to ingest the whole system, python-like, into the body of academic opinion" and anticipated a "post-prandial reaction . . . leading towards the elimination of indigestible matter and waste products."¹⁰ The process of excretion is now apparent, accompanied inevitably by eructations and intestinal spasms. The drift is away from the exotic West coast and deep waters of the Californian cults towards the safety of the medical harbour.¹¹ In other countries the fate of psychoanalysis has varied from outright rejection in the USSR¹² to a belated quickening of interest in France¹³ but, significantly, in every case the reaction reflects sociocultural and economic forces rather than medicoscientific considerations.

Psychotherapeutics in Britain

What of the United Kingdom? In Britain, despite the contributions of several prominent British psychoanalysts, both native born and foreign, the influence of psychotherapeutics on psychiatry has been noticeably less than in the United States. The principal reasons for this difference include the long-standing links of British psychiatry with the main body of general medicine (the term "psychological medicine" as a synonym for psychiatry is most unusual elsewhere); the eclectic tradition fostered at the Institute of Psychiatry over the 20 years after the war, which proved to be a crucial period for the academic development of the discipline; and, most important of all, the existence of a health service that determines not only the structure but to some extent the function of the practice of medicine. From the inception of the NHS professional psychotherapy has come traditionally within the private sector, and its place in a national health service raises several stinging administrative, ethical, and scientific questions.

Unexpectedly, but perhaps appropriately, one of the most searching attempts to grasp the nettles has been made by a lawyer, Sir John Foster, in the admirably lucid report of his inquiry into scientology.¹⁴ As the remit was to inquire into the practice and effects of the scientologists' activities, much of the Foster Report concentrates on the implications of that controversial subject. Noting, however, that its founder has claimed that scientology embodies "the first thoroughly validated psychotherapy," Sir John was moved to consider some of the wider issues raised by psychotherapeutic practice and, after a judiciously impartial survey of the situation, went so far as to recommend "that psychotherapy (in the general sense of the treatment, for fee or reward, of illnesses, complaints or problems by psychological means) should be organised as a restricted profession open only to those who undergo an appropriate training and are willing to adhere to a . . . proper code of ethics, and that the necessary legislation should be drafted and presented to Parliament as soon as possible."

Statutory registration

The Foster Report was published in 1971. In 1975, at the suggestion of the Department of Health and Social Security, a joint working party was formed to consider the question of statutory registration. Seven organisations were members of the working party: the Association of Child Psychotherapists, the British Association for Behavioural Psychotherapy, the British Association of Psychotherapists, the British Psychoanalytical Society, the Institute of Group Analysis, the Royal College of Psychiatrists, and the Society of Analytical Psychology. The report of this working party, which appeared three years later,¹⁵ endorses the view that a statute enacted by Parliament is needed to regulate a profession of psychotherapists. It also contains, however, a strongly worded note of dissent provided by the British Association for Behavioural Psychotherapy, a body that does not equate psychological treatment with analytical psychotherapy. This asserts:

There is no general agreement as yet on what constitutes a valid psychotherapeutic training, nor is there good evidence that patients benefit from treatment by most qualified psychotherapists, with a few exceptions. That some professional groups approve training courses is of little help to the public until it has been shown that the psychotherapy which is the subject of such courses in fact benefits patients. . . . However, registration outlined in the main report is suggested on the basis of training which is largely of unproven value at the present time. This is likely to do more harm than good to the public by unnecessary restriction of access to those treatments which are useful, and by retarding innovation in a field which is changing rapidly. The future may well bring ways of sorting out which forms of psychotherapy training produce skills which are and which are not useful for clients, and at that time registration on the basis of such training might be feasible. The interests of the public would then be served by setting up a body composed largely of representatives of research councils which could promote the public benefit by encouraging the adoption of demonstrably beneficial psychotherapeutic approaches and discouraging the use of ineffective ones.

Future of psychotherapeutic practices

The tone and content of this disturbing statement raise some key issues for the future of psychotherapeutic practices in Britain. Hitherto these have been considered chiefly as an expensive amenity of private care, often costing the patient hundreds or thousands of pounds. If, however, they are to justify their advocates' claim to constitute an element of a State-subsidised health service, some form of accountability becomes necessary. Criteria for the effectiveness of treatment now constitute a central feature of the cost-benefit analysis of mental health services,¹⁶ but so far the evidence bearing on the central question of the efficacy of psychotherapy is all too scanty. Animated by the current debate on national health insurance, the issue has assumed some importance in the United States, where it has been well summarised by Dr Morris Parloff of the National Institute of Mental Health.¹⁷ After conceding the rights of society to know the value of any service for which it is being asked to pay, Dr Parloff reviews the evidence on the effectiveness of psychotherapy to conclude "that we can assure the non-researchers that psychotherapy has shown some evidence of potency; however, our research has not yet been designed or conducted in a manner that can provide truly responsive answers to their questions. The best I can say after years of sniffing about in the morass of outcome research literature is that in my optimistic moods I am confident that there's a pony in there somewhere."

Concerned but less optimistic observers than Dr Parloff may be excused for wondering about that pony. They are troubled by the huge investment of time and money over a long period on procedures whose efficacy is still so uncertain. Nor can they have failed to observe the reluctance on the part of professional psychotherapists to have their activities subjected to independent evaluation, as exemplified in Britain some

years ago by an ill-fated Medical Research Council trial.¹⁸ This attitude contrasts sharply with that of modern behaviour therapists, who not only challenge the theoretical basis of psychoanalytical "therapy"¹⁹ but can point to some evidence favouring their own activities.²⁰

In the 1980s the medical profession can no longer afford to adopt a laissez-faire attitude to the unsupported claims of the psychotherapists or be overimpressed by what D H Lawrence once called "the deep damnation of self-righteousness that sticks to every creed." A further psychotherapist, it has been calculated, could be required for every 100 000 members of the population²¹; and some general practitioners, social workers, family therapists, and counsellors of all persuasions continue to press the case for psychotherapeutic services at a less specialised level. The matter is rendered still more important by two major points emphasised in Sir John Foster's report: firstly, that "those who feel they need psychotherapy tend to be the very people who are most easily exploited: the weak, the insecure, the nervous, the lonely, the inadequate, and the depressed, whose desperation so often is such that they are willing to do and pay anything for some improvement of their condition"; and, secondly, that "the possibilities of harm to the patient from the abuse, or the unskilled use, of these techniques are at least as great as the possibilities of good in the right hands."

If the undoubtedly large numbers of the "most easily exploited" are to be offered more than support, humanitarian assistance, and professional friendship, a rigorous examination of the scientific as well as the organisational basis of psychotherapy is needed. This task is not easy and will surely call for a more objective appraisal than can be expected of practitioners with a heavily vested interest in the debate. Perhaps a new decade will usher in a new sense of urgency.

References

- ¹ Mowrer, O H, *Journal of Nervous and Mental Disease*, 1959, **129**, 222.
- ² *Time*, p 74. 2 April 1979.
- ³ Ostow, M, *Bulletin of the New York Academy of Medicine*, 1979, **55**, 477.
- ⁴ Lewis, A, in *The Later Papers of Sir Aubrey Lewis*, p 59. Oxford, Oxford University Press, 1979.
- ⁵ Ellenberger, H F, *The Discovery of the Unconscious*. London, Allen Lane, 1970.
- ⁶ Trilling, L, in *The Liberal Imagination*, p 47. Harmondsworth, Penguin, 1970.
- ⁷ Janet, P, *Psychological Healing*, vol I, p 589. London, George Allen and Unwin, 1925.
- ⁸ Gifford, S, in *Psychoanalysis, Psychotherapy and the New England Medical Scene*, ed G E Gifford Jun, p 325. New York, Science History Publications, 1978.
- ⁹ Appelbaum, S A, *Out in Inner Space: a Psychoanalyst Explores the New Therapies*. New York, Anchor Press/Doubleday, 1979.
- ¹⁰ Shepherd, M, *American Journal of Psychiatry*, 1957, **114**, 417.
- ¹¹ Guze, S B, *Comprehensive Psychiatry*, 1978, **19**, 295.
- ¹² Bassin, F V, in *Neurosis*, ed O Janota and E Wolf. Prague, Státní zdravotnické nakladatelství, 1961.
- ¹³ Turkle, S, *Psychoanalytic Politics*. Thetford, Burnett Books, 1979.
- ¹⁴ Foster, J G, *Enquiry into the Practice and Effects of Scientology*. London, HMSO, 1971.
- ¹⁵ Profession's Joint Working Party on Statutory Registration of Psychotherapists, *Statutory Registration of Psychotherapists: a Report*. London, Tavistock Centre, 1978.
- ¹⁶ WHO Working Group, *Cost/Benefit Analysis in Mental Health Services*. Copenhagen, WHO, 1976.
- ¹⁷ Parloff, M B, *American Psychologist*, 1979, **34**, 296.
- ¹⁸ Candy, J, et al, *Psychological Medicine*, 1972, **2**, 345.
- ¹⁹ Marks, I, *Psychological Medicine*, 1979, **9**, 629.
- ²⁰ Sloane, R B, et al, *Short-term Analytically Oriented Psychotherapy vs Behaviour Therapy*. Cambridge, Mass, Harvard University Press, 1975.
- ²¹ Wing, J K, and Wing, L, *British Journal of Psychiatry*, 1970, **116**, 51.

(Accepted 7 November 1979)

My Student Elective

Babies and bananas: on foot in Rwanda

ROBERT ELSWOOD

British Medical Journal, 1979, **2**, 1559-1561

There are few international airports smaller than Kigali, whose embracing hills force an airliner to descend in a series of alarming turns before hitting the almost-too-short runway with a jolt. On the ground, the profusion of immigration papers supplies in formality what the terminal buildings lack, and beyond the gate the country's only tarmac road leads between the fields and banana patches into Kigali itself. The town is a haphazard, dusty place with shanty-town fringes encroaching on the countryside, and this is the capital of Rwanda.

Rwanda lies in the central highlands of Africa where the equator crosses the Nile-Congo divide. It is a land of beauty and

squalor crowded with four or five million people; it is also inaccessible but welcoming, politically stable (by African standards), and desperately poor. As a former Belgian protectorate it is little known in Britain except among those with an interest in its mountain gorillas, tribal anthropology, or the signal part it has played in the growth and revival of the African church. An elective in 1976 took me there and proved an experience so vivid that two house jobs have not blunted its impact or eclipsed its importance in my outlook on medicine.

Two student colleagues met me in Nairobi and, all of us full of first impressions of Africa, we flew on to Kigali before driving the final dusty leg through the hills to Gahini hospital. The hospital was our base and home for the next 10 weeks, while we did some of the groundwork for starting an under-5s clinic. The aim of our trip was to study the nutrition and health of the local toddlers in order to fit the running of the clinic to their special problems, and to provide a "before" portrait of this unmeasured population against which the benefits of the new work could be assessed. Our part was to organise a survey of all the under-5s in a defined area and to provide the hands and feet to carry out

Department of Obstetrics and Gynaecology, Western General Hospital, Edinburgh EH4 2XU

ROBERT ELSWOOD, MB, CHB, senior house officer