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Comments regarding the article "What psychotherapy is and is not: an essay on redefining of the term" by Jerzy W. Aleksandrowicz (Archives of Psychiatry and Psychotherapy, 2003; 5 [1]: 59–68)

COMMENT I

On the essence of psychotherapy: A reply to Jerzy W. Aleksandrowicz

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In Professor Jerzy Aleksandrowicz's article in the March 2003 edition of *Archives in Psychiatry and Psychotherapy,* the issue of the putative definition of the term psychotherapy once again takes center stage. In this instance, the author proposes that the term, "psychosocial help," would, in fact, be more reflective of what actually occurs during the course of treatment. In his view, the concept of psychotherapy needs to be redefined, because what is often called "psychotherapy" today involves the use of an array of procedures to help individuals navigate various psychosocial stressors rather than psychological disorders. Dealing with psychosocial stressors may require attention to such elements as emotional support, multiple aspects of personal development, and the improvement of social skills, but these aspects do not demand medical, psychopathological perspective and the consequent knowledge of medical treatment. However, the author also explains that some cases treated in psychotherapy require that the therapist has sound medical knowledge due to the etiology of the specific illness. Therefore, sufficient medical education and training are warranted. Aleksandrowicz suggests that such important differentiations between paradigms can be – and should be – made discrete by using appropriate terms depending on what is in play.

Early in his article, Prof. Aleksandrowicz admits that past efforts to define what psychotherapy is and is not, have not been particularly successful. It becomes evident by the end of the article that Prof. Aleksandrowicz has discovered for himself why. The fact of the matter is that to try to tease out the elements that constitute psychotherapy is a challenge on a number of levels. As the author states, "There exists a gap between disorders requiring medical treatment, psychotherapy, and those cases of general dissatisfaction or unhappiness requiring non-medical treatment" (p. 61) and this is probably why certain qualifiers have been added in recent decades to the term psychotherapy. Whether we refer to "medical psychotherapy," or to "clinical psycho-

therapy," for example, it is clear that the struggle to better define psychotherapy is ongoing and will likely continue to be debated for a long time.

In considering this author's argument, it is essential to consider several issues

First, there is the matter pertaining to psychotherapy requiring medical education and training. Should practitioners of psychotherapy have medical training and education? The discussion is complex. One of the earliest and best known discussions of this issue relates to lay analysts who conduct psychoanalysis. In 1927, Sigmund Freud wrote that he had long been of the opinion that a medical degree was not essential for a practitioner of psychoanalysis, but that certain non-medical qualifications were [2]. At the time of this debate, the American Psychoanalytic Association did not admit non-physicians to active membership of the association, whereas the British Psychoanalytic Society allowed them admission provided that these members worked under the supervision of a physician. These decisions stemmed from an incident that occurred in Vienna, Austria, in which an individual, who was a non-medical member of the society, was charged with "quackery."[1]

In the postscript of his1927 work on "the question of lay analysis" [2], Freud writes, "*A scheme of training for analysts has still to be created. It must include elements from the mental sciences, from psychology, the history of civilization and sociology, as well as from anatomy, biology, and the study of evolution."* (p. 103). Freud further stated, *"I have assumed, that is to say, that psychoanalysis is not a specialized branch of medicine. Psychoanalysis is a part of psychology; not of medical psychology in the old sense, not of the psychology of morbid processes, but simply of psychology. The possibility of its applications to medical purposes must not lead us astray."* (p. 103).

It was Freud's opinion that, in many respects, medical knowledge actually interfered with the ability of one to perform effective psychoanalysis. In fact, Freud takes the idea a step further by stating, *"To say medical knowledge is necessary for psychoanalysis is more an artifact of physicians' thinking than it is anything else."* He elaborates:

"Some time ago, I analyzed a colleague who gave evidence of a particularly strong dislike of the idea of anyone being allowed to engage in a medical activity who was not himself a medical man. I was in a position to say to him, 'We have now been working for more than three months. At what point in our analysis have I had occasion to make use of my medical knowledge?' He admitted that I had had no such occasion."

"*Again, I attach no great importance to the argument that a lay analyst (non-medical trained analyst) must be prepared to consult a doctor, or have no authority in the eyes of his patients, and will be treated with no more respect than such people as bone setters or masseurs. Once again, the analogy is an imperfect one quite apart from the fact that what governs patients in their recognition of authority is usually their emotional transference and that the possession of a medical diploma does not impress them nearly so much as doctors believe. A professional lay analyst will have no difficulty in winning as much respect as is due to a secular pastoral worker"* (p. 107–108).

It appears that Freud was alluding to the notion that the individual relationship has more to do with the effectiveness of treatment than whether or not someone is medi-

[1] The term "quackery" is defined by Webster's Ninth Collegiate Dictionary (1991) as pretending to cure diseases.

cally trained. This could easily apply to the concept of psychotherapy as well. The issue has been the focus of much of the contemporary research that has appeared in the professional literature regarding therapeutic effectiveness. A recent article by veteran psychologist Jay Efran [3] makes the point by relating the story of a conversation that he had with a former patient:

"Several years ago, a young man called to thank me for 'being there' when his life was falling apart. He was distraught over a relationship breakup, he had stopped going to his college classes, and was alternating between grand suicidal gestures and bouts of marijuana-assisted self-pity. I saw him off and on for several years after that, and he had done exceptionally well – changing academic majors despite family reservations, completing his degree, and launching a career as a film maker. When he called, he was about to marry the woman he was living with. As we reminisced, I asked him which aspects of our work had seemed significant – hoping, of course, to hear about some brilliant interpretation, piece of sage advice, clever homework assignment, or poignant moment the two of us had shared. He drew a blank. I reminded him of a couple of sessions I thought might have been pivotal. He paused, and then said with a note of finality, 'Nope. I guess it all just boils down to you having been you!'"

"I was flattered, but disappointed. Here was my chance at a first-hand report about what actually works in therapy. 'You having been you' was not particularly enlightening: it was nothing I could bottle and use with other clients. After our conversation, I was as perplexed as ever about the nature of the therapeutic process" (p. 31).

Decades ago, Frank [4] stated that the active ingredient in psychotherapy lies in the generation of hope and positive expectancy, rather than in the impact of any specific therapeutic techniques or training. More recently, research has indicated that the power of placebo is equally important, citing evidence that much of the change that occurs in psychotherapy can be traced to general factors, whereas the specific impact of therapeutic techniques accounts for only a small part of the outcome [5]. In fact, there is no research literature to support the need for one to possess medical training in order to conduct psychotherapy effectively.

However, researchers have identified other pertinent factors common to the therapist, client, and therapeutic process [6]. They found that there were sub-factors in each of these entities that affect outcome, such as supportiveness, therapeutic alliance, catharsis, and therapist warmth; learning factors, including corrective emotional experiences, insight, and feedback; and that action factors, which include cognitive mastery, modeling, and behavioral regulation also had a part. The researchers identified these variables as influencing outcomes independent of particular therapeutic techniques or medical or psychological training.

Following an extensive review of the research literature, Lambert and Bergin suggest that approximately 30% of the psychotherapy outcome variance is attributable to therapists' variables affecting the relationship with the patient, such as empathy, warmth, and acceptance of the patient [7]. Other researchers have concluded that the therapeutic alliance is the most important factor in determining positive therapeutic outcomes over and above therapists' training and credentials [8, 9, 10].

A comprehensive review of the published research on psychotherapeutic processes and the elements that contribute to successful outcomes is provided by Nathan, Stuart,

and Dolan [11]. The educational training of the psychotherapist is not mentioned as one of the components that contribute to success.

In a consumer report survey - the largest to date on psychotherapy and other mental health treatments - conducted in the United States in 1994 [12], respondents were asked a series of questions about their experiences with mental health professionals, physicians, medications, and self-help groups. Of the more than 7,000 readers who responded with detailed information about the person from whom they sought help, approximately 3,000 reported having talked only to friends, family, or clergy, whereas approximately 4,100 said they had contacted mental health professionals, family doctors, and/or self-help groups. Thirty-seven percent of those who consulted a mental health professional spoke with a psychologist, 22% with a psychiatrist, 14% with a social worker, and 9% with a marriage counselor. Of these respondents, 43% admitted that they were in a "very poor" or "fairly poor" emotional state when they were looking for help. The results of the survey indicated that those who sought therapy from a family doctor reported doing well, but those who saw a mental health professional for more than six months reported doing much better. What is more, the level of satisfaction with the psychotherapy was equivalent whether the respondent saw a social worker, psychologist, or psychiatrist. Those who saw a marriage counselor were somewhat less likely to report having benefited from therapy. Again, possessing a medical degree or medical training appeared to have little or no significance with respect to the outcome of treatment.

Prof. Aleksandrowicz's article does raise a cogent point regarding cases that do require a medical perspective. The following two case vignettes involving patients who suffered from a diagnosis of panic disorder may shed light on how medical training may be beneficial in treatment for one circumstance, yet hinder treatment in another.

In the first case, the individual had a medical disorder underlying the panic symptoms. The disorder had gone undiagnosed by both the primary care physician and the clinical psychologist. The second vignette involves an individual who suffered from panic disorder, was assessed by a psychiatrist, and placed on medication; unfortunately, because the disorder was approached from a purely medical perspective, the underlying dynamics were not addressed until the individual was treated by a clinical psychologist.

Case Vignette No. 1

Jane, a 44-year-old elementary school teacher, was referred by her family physician for symptoms of panic disorder. She was prescribed Alprazolam (0.5 mg.) on an as needed basis. Jane was administered a number of questionnaires, including the Structured Clinical Interview Schedule (SCID-IV) for DSM-IV, along with the Body Sensations Questionnaire (BSQ), the Beck Depression Inventory (BDI), the Panic Attack Symptom Questionnaire (PASQ), and the Mobility Inventory (MI). She also provided a full history, which, for the most part, was unremarkable and devoid of any medical complications or major mental illness. Jane informed the clinical psychologist that she had undergone an extensive medical evaluation by the family physician, which included an electrocardiogram, an electroencephalogram, and "a full blood profile."

She further stated that they all reported negative results. Her symptoms included palpitations, sweating, nervousness, nausea, and syncope. Jane met all the criteria for DSM-IV panic disorder.

As this was the first incident of panic symptoms and Jane reported no prior history of symptoms or limited symptom attacks, she was treated with cognitive-behavior therapy, encompassing symptom induction, de-escalation, as well as breathing retraining [13, 14].

Within several months, Jane's symptoms failed to abate with cognitive-behavior therapy or with the later added use of anxiolytic medication. After numerous conversations between the clinical psychologist and the general physician, Jane was referred for a consultation with a psychiatrist, who also happened to be board certified in internal medicine. After reviewing her symptoms, as well as her medical history, the psychiatrist decided to conduct a 24-hour urine-free catecholamine level analysis and to measure blood cortisol levels. He also ordered a magnetic resonance imagery (MRI), which revealed a 2.5 cm mass in the adrenal gland. This adrenaline-secreting tumor produced symptoms that were very similar to panic disorder owing to paroxysm, the excess secretion of catecholamine in the system. This was the contributor to the palpitations, sweating, and syncope. A urine screen analysis determined excess levels of catecholamines and their metabolites, which confirmed the diagnosis of pheochromocytoma. In this case, the medical evaluation uncovered a serious endocrine illness, the symptoms of which matched a classic case of panic disorder. The clinical psychologist had insufficient medical training to even question the etiology of Jane's symptoms. The psychotherapeutic process was thwarted by the lack of medical knowledge, not only on the part of the clinical psychologist, but the general physician as well. This patient may have been in danger because of their ignorance, which caused a delay in proper treatment. Jane eventually underwent surgery to remove the mass, and her panic symptoms subsequently abated.

Case Vignette No. 2[2]

Clayton, a 64-year-old, married male, consulted his family physician for the treatment of panic attacks. This was the first episode of panic that Clayton reported experiencing, although he did admit having intermittent periods of anxiety throughout his life. Clayton, who was retired, was home alone reading one summer afternoon, when he felt autonomic symptoms - lightheadedness, some dizziness, and an increased heart rate and respiration rate, that led to a fear of loss of control. His symptoms were so disabling that he thought that he was having a heart attack and called a friend who took him to the emergency room of a nearby hospital. Clayton's wife was at work at the time of the incident.

After a thorough medical examination, the emergency room physician administered an injection of protriptyline (20 cc) and referred him back to his family physician. Clayton's physician conducted a thorough examination, including a full blood profile and an electrocardiogram, switched his medication to Alprazolam, (0.5 mg, 1 tab. p.r.n.)

[2] This case has been reprinted in part from its original, which initially appeared in Dattilio, F. M. and Salas-Auvert, J. P. A. (2000). Panic disorder: Assessment in treatment through a wide-angle lens. Phoenix, AZ: Zeig, Tucker & Co., Inc. (pp. 139–142).

and scheduled another appointment for the following week. Two days later, Clayton experienced another panic attack, and was referred to a psychiatrist.

The psychiatrist conducted a standard mental status evaluation, including a clinical history, and explored some of the circumstances and feelings surrounding the panic onset. It was at this point that Clayton said that the initial attack had occurred while he was sitting at home reading a magazine during a summer rainstorm. He recalled being distracted by the sound of the rain on the roof, and then suddenly feeling lightheaded. At first, he thought that he just was having a dizzy spell or had not eaten enough for lunch. However, his heart rate quickly increased, along with his respiration, and a sudden feeling of terror and anticipation of loss of control overwhelmed him. The only emotion that he was able to express was fear, which seemed unrelated to the article that he had been reading. The psychiatrist was not so much interested in hearing Clayton's life story, but felt instead that he had a chemical imbalance. He advised him to remain on the Alprazolam and discussed the idea of trying him on a monamine oxidase inhibitor (MAOI).

It was after visiting the psychiatrist that Clayton decided to speak with a clinical social worker because he realized he wanted to talk more about his fears and the psychiatrist was not available for "talk therapy." During the course of their therapy sessions, the social worker suspected that Clayton may have been abused as a child. He encouraged Clayton to think about any frightening dreams he may have had. Clayton recalled a dream in which his house was flooded in a torrential rainstorm and his wife was drowned. He remembered feeling powerless to help her and overwhelmed by guilt. This created anxiety for Clayton, which sparked panic attacks the following day. During his next therapy session, Clayton described the dream to his therapist, who then helped him to interpret it.

In further exploration of significant incidents in his life, Clayton reported that his father had died of a heart attack when Clayton was approximately 10 years of age. The youngest of three children, with two sisters, five and eight years his senior, Clayton reported an uneventful life, although he recalled tough times during the difficult post-depression era.

The therapy continued to explore Clayton's dream content and any notion of separation anxiety, as well as repressed anger. It was during the course of this exploration that the following information was uncovered.

Clayton was raised in a small town in a mountainous area in the Northeast section of the United States. When his father died, his mother tried her best to provide for the family and take care of her children. But employment was not easy to obtain for a woman in the 1930's and Clayton recalled the family's struggle to make ends meet.

It seems that a prominent businessman in town had been helpful to Clayton's mother and to the family by providing money from time to time and doing them special favors. Clayton later divulged that the man had taken sexual advantage of Clayton's mother, as well as of his two sisters, who were young teenagers at the time. Clayton became aware of this activity because the man would frequently visit his mother in her room with the door closed, as he also occasionally did with Clayton's sisters. Not surpris-

ing, this was an issue that was never openly discussed among the family members. Apparently, it was something that Clayton had blocked out and uncovered only during the course of treatment. Clayton recalled that the man generally visited on rainy days, when Clayton's mother usually was sent home early from her job at the Garden Mart. Clayton also remembered that many times his sisters would lock themselves in their rooms and cry themselves to sleep.

Further exploration uncovered the fact that Clayton felt powerless in the face of what was taking place, knowing that his mother and sisters endured the sexual abuse because they needed the money the man gave them in return. Moreover, the businessman was a powerful figure of great influence in the community and the family was afraid of antagonizing him. The unspoken agreement in the house was never to discuss the issue, and Clayton had been harboring this secret all of his life.

Apparently, the summer rainstorm had reignited feelings of powerlessness and loss of control. The fact that Clayton had been alone, while his wife, whom he depended on, was out of the house at work, was a contributing factor. The following night's dream of a rain-induced flood in his home was symbolic of the intrusion of the man who had sexually abused Clayton's mother and sisters. The water had a sexual connotation, provoking an anger reaction coupled with fear of loss of control. This led to the physiological display of symptoms.

Once this aspect was revealed, therapy focused on working through some of the issues of guilt and feelings of loss of control and powerlessness. Transferential issues also focused on the social worker, who was an older male, eliciting anger reactions from Clayton during the treatment. A heavy use of dream content enabled the therapist to establish the framework for Clayton to divulge his tightly held secret. As the process of working through continued, Clayton reported a reduction in anxiety and the absence of any panic attacks. His medication was used sparingly during treatment, titrated to a sub-clinical dose, and eventually discontinued.

Conclusion

The two case vignettes above provide examples of the same disorder under two different scenarios, one of which suggests that medical training is necessary, whereas the other requires no further medical training or education subsequent to the initial referral by a family physician. In fact, in the second vignette, medication may have actually hindered a full recovery in the patient. When working with disorders that overlap medical illness, special training is necessary; however, this does not always mean that it is a medical background that is required.

Overall, it is my view that while Prof. Aleksandrowicz's point is well taken, the caveat I would offer is that, in some cases, psychotherapy requires medical knowledge and medical training, thus it might be best termed "medical psychotherapy." In other cases, certain types of psychotherapy may be used that do not require medical knowledge. The term "psychosocial support" introduced in his article, is reflective of a service that might be conducted at a very basic or superficial level. The answer may lie in training individuals who provide such psychosocial support to understand when more in-depth treatment is appropriate, when it is necessary to turn to someone qualified as a psychotherapist.

In looking again at the question of what psychotherapy is and is not, Prof. Aleksandrowicz renews an important dialogue about our role as mental health professionals.

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COMMENT II

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In these days of "evidence-based", scientifically-orientated medicine the question of "what is psychotherapy?" is well taken. In most branches of medicine the border between "conventional" (i.e. rational) and "alternative" medicine is fairly well delineated. "Alternative" medicine is often helpful, at times perhaps more effective than "conventional" medicine, but it is not grounded in empirical science. Most of it is "derived from philosophical (sometimes pseudo-philosophical) systems of belief about health and disease. Can a similar separation of psychotherapy based on medical science be achieved?

Prof. Aleksandrowicz attempts to do precisely that in his position paper. There are many ways to help a person in distress and not all of them should be considered therapy. Likewise, there are therapeutic modalities that seem to be very helpful in selected cases, like therapeutic horse-riding, though they can hardly claim to be psychotherapy. His claim that psychotherapy needs to be based on a firm psychiatric diagnosis and rooted in an understanding of psychopathology can hardly be disputed.

Unfortunately, however, the delineation of what is a psychological disease or disorder is much more difficult that a definition of physical illness. When are poor social skills a "problem of living" and when are they a symptom of personality disorder? Is lack of assertiveness a symptom? If they are, than an intervention aimed specifically at those problems should be considered therapy, albeit symptomatic therapy, as long as it is grounded in a rational theory of psychopathology, e.g. self-psychology.

In spite of such "grey areas" the fundamental issue is valid and so is the separation of **psychotherapy,** i.e. psychological **treatment** from what Prof. Aleksandrowicz calls "psycho-social" help and from philosophical, spiritual or mystic means of psychic relief of suffering.