ASCAP November 1996, 8-13

CHANGE IN THE PSYCHOTHERAPY SYSTEM?

I would like to support our Editor's suggestion of a link between ASCAP and the Psychotherapy Section of the World Psychiatric Association. I think this could be achieved without any loss of our usual eclecticism, or our interest in sociophysiology, or our recognition of the importance of a bottom up, as well as a top down, approach to psychopathology. Three out of six of the board members of the Section are already ASCAP members, and the two others that I met in Madrid are sympathetic to our approach. What is so immensely refreshing is that the Section is free of the sectarianism which plagues so much of the psychotherapy world. It is ready to look at psychotherapy from the perspective of evolutionary biology. This seems to me to be a most unusual and promising trend, and one that deserves to be supported.

This development is largely due to the outgoing Section Chairman, Ferdo Knobloch. Ferdo is Emeritus Professor of Psychiatry at UBC in Vancouver, Canada. He is well known for his "Integrated Psychotherapy" published by Jason Aronson in 1979 and since translated into a number of languages (1). He is a contributor to ASCAP and has developed the promising concept of metaselection (ASCAP, June, 1996) to describe the influence of group processes on sexual selection. Ferdo, who alas will not see 80 again, was interned in Auschwitz during the War for marrying his Jewish girl-friend to protect her from the Nazis. Somehow, Ferdo managed to survive, but she did not. Then, when the Soviets came to threaten their freedom again, he emigrated to Canada. At the time of writing he is back in the Czech republic where a conference is being held in his honour. And, to continue the process, we are hoping to arrange a joint meeting in Kromeriz (in Moravia in the Czech Republic) for 1998.

Here are a few quotations to give the flavour of the Knobloch's book, which is beautifully written, lucid and logical:

P. xvi "Experimenting with therapeutic communities of a special kind, at first in a residential setting and later a day centre, we were persuaded that the mutual influence of patients can become the most powerful therapeutic factor known so far."

P. 18 "It is sometimes easier and more economical to achieve changes in patients in an artificial group of patients, rather than with their families. This makes the following work with the families easier. For example, in the therapeutic community of the Day House, a young female patient shows the same rebellious attitude toward the female therapist as toward her mother, and the same jealousy toward a female patient as toward her sister. This may change during therapy, and when her mother and sister arrive to attend a mixed group of patients and relatives, the other patients double for them and speed up the change in the family system."

P. 96 "By corrective experience<u> understand partial reexposure to situations which the person was not able to master in the past, but reexposure under more favourable circumstances, so that successful mastery is achieved</u>."

P. 101 "Since we regard it as an integral part of efficient psychotherapy, this is one of the reasons why we avoid talking about family therapy."

P. 101 "In a well-functioning therapeutic community, the avoidance of appropriate action is a much more frequent problem than acting out."

The treasurer of the Psychotherapy Section is Marco Bacciagaluppi of Milan, who spoke in Madrid on the contrasting child care practices of hunter/gatherer bands and sedentary agricultural communities, and the effect of these differences on factors such as Mark Erickson's familial bonding and incest prohibition (2). As treasurer of a Section which has no funds he is not overworked at the moment, but we have plans for finding him something to do. The other Italian on the Board is Piero De Giacomo who is Professor of Psychiatry in Bari. Piero leads one of the well-known Italian schools of family therapy, and I strongly recommend his book (3) which rivals the innovative capacity and logical basis of the Milan school.

There is also a Japanese member of the Board, but unfortunately he was not able to be in Madrid.

Evolutionary causes of psychopathology

There are several conceptually different but overlapping possible evolutionary causes of

psychopathology, whether one defines that term as social malfunction, reduction of reproductive success or something that the individual complains about.

1. Mismatch of the present environment and the ancestral environment, or, if one prefers the somewhat clumsy term, the environment of evolutionary adaptedness (adaptiveness) or EEA. We were evolved to live in a rural band, but find ourselves living in megalopolis, and so we get sick. A lot has been written about this.

2. People at the tail ends of a normal distribution get sick. For instance, it might take an average amount of social anxiety to produce good adjustment. Those who have too much suffer from anxiety neurosis, those who have too little suffer from antisocial personality disorder.

If there is a reduction of fitness at the tail ends of he distribution, we would expect the variance in the trait to get less over evolutionary time. Therefore we are interested in those forces which maintain trait variation in the population. Some of these are:

a) Heterozygote advantage, as with sickle cell trait. Even if the homozygotes are completely sterile, they are generated again in each generation in the Hardy-Weinberg distribution.

b) Negative frequency dependent selection. If a trait becomes more advantageous as it becomes rarer, variation will be maintained.

c) Temporal, spatial or sexual counter-selection. If introversion is favoured in sparse habitats and extraversion in crowded habitats, variation along the introversion/extraversion dimension will be maintained. The same applies if one end of a distribution is favoured in males and the other end in females.

d) Mutation.

e) The breakup of balanced combinations. Crossing over during meiosis may generate variation by separating closely linked genes which cancel each other out. Balanced combinations do not actually maintain genetic variation, but store it and protect it from the action of selection.

3. Interpersonal trade offs. "Where there is conflict there is casualty". Men compete with men, women with women, wives with husbands, siblings with siblings, parents with children. If there is not a shortage of real resources, there is always a shortage of symbolic resources (power) to fight over. Not everyone can win, and the losers suffer. This is where Mike Waller's comparator mechanism fits in.

4. Intrapersonal trade offs. People have more than one objective in life, and the more vigorous pursuit of one objective may jeopardise another objective, such as staying well. This is most clear with people who take physical risks to achieve their aims, but it also applies to psychological risks. For instance, so much may be invested in a relationship that one is vulnerable when that relationship ends.

5. The function of a seemingly maladaptive behaviour is not apparent. For instance, someone observing a hibernating animal who did not know about seasonal variation in food and water supply might think that the hibernation was maladaptive.

6. Physical and statistical constraints. For instance, in a society in which good mental health depends upon satisfactory pair-bonding, some people will not find partners, if for no other reason than the sex ratio may not approach unity.

I hope that a classification of causes like the above will clarify thinking. Hopefully, other contributors will add causes I have not thought of, or perhaps reduce the above causes to a smaller number of basic causes.

Some thoughts about psychotherapy

Everyone would agree that the world of psychotherapy needs to change. It is difficult to promote change, but at least it does no harm to speculate on the kinds of change one thinks are desirable. I will outline some changes at which I think it would be worth aiming. These are presented for comment and criticism.

1. Specialist psychotherapists de-skill general psychiatrists

I think all psychiatrists should be psychotherapists. Those doctors who practice intensive, long term psychotherapy, seeing patients more than once a week for a year or more, should be called "specialist psychotherapists" to recognise that they are attempting a task (radical personality change) which the average psychotherapist does not aspire to. Therefore, for instance, what is now called the Psychotherapy Section of the Royal College

of Psychiatrists should be called the Specialist Psychotherapy Section. And we should rejoice in our title of Psychotherapy Section of the WPA which indicates that it is concerned with the broad range of eclectic and relatively brief psychotherapies which all psychiatrists should practice.

It is becoming recognised, as Freud recognised, that public psychotherapy must be shorter than private analytic treatment, but along with this view goes the idea that shorter treatment is second best. A recent paper contrasted "analytically based psychotherapy" with the "medico-pharmacological model".(4)

But for many patients shorter treatment is not second best, and there is a multiplicity of models other than the psychoanalytic for conceptualising the problems of these patients.

Since retiring from full time practice, I have done locums in at least 12 settings, and it is depressing to see a patient referred to the Mental Health Team and allocated to the psychiatrist for drug monitoring and to a psychologist or nurse for psychotherapy. And our new management structure and the market economy are aggravating this tendency, as the vital statistic has become "consultant-patient contact" regardless of the length of each session or the number of sessions. It is not surprising that managers are coming to believe that psychiatrists are too expensive to practice psychotherapy! One partial solution would be an increased use of family therapy interventions by the psychiatrist, and I hope to return to this theme later.

You could take a more extreme view and suggest that all doctors should be psychotherapists. At least they should formulate the patient's problem from the perspective of the patient, and take this into account when planning treatment. If they did this, less people would feel inclined to turn to complementary medicine.

2. Evaluation

Our failure to evaluate the various psychotherapeutic procedures is a downright scandal. It shares its scandalousness with our failure to evaluate psychosurgery, and other "important" treatments. In my view the evaluation of a treatment cannot be left to those who practice it, or even those who refer patients for it, because their ethical responsibility is to the individual patient which takes precedence over the more general responsibility to evaluate treatment for the benefit of those patients yet to come. No-one who practices psychotherapy is likely to advise a patient to run the risk of being allocated to a control group which does not receive psychotherapy, and therefore if it is humanly possible for them to do so, referred patients will evade the trial procedure. Our normal practice of evaluation fudges over this issue, which leads to the paradox that "the more important a treatment is, and therefore the more important it is to know whether or not it works, the less it is likely to have been properly evaluated". I once wrote about this in relation to psychosurgery (5), but the principle applies equally to psychotherapy, and indeed to lot of other major treatments in medicine and surgery. This is another theme to return to.

3. Couple therapy

I think that, as a general rule, when one of a married couple needs psychotherapy, they should both have it together. If you are not part of the solution, you are part of the problem. Moreover, I have seen individual psychotherapy ruin marriages. There is resentment in the other partner at the expenditure of time and money, and at the development of an intimate relationship outside the marriage. I have seen group therapy destroy a marriage as the development of strong within-group cohesion, associated with special knowledge and jargon, led the wife to despise her husband who was outside all this development. Of course, there are exceptions to this principle, such as when a married person is not keen to stay in the marriage. At least there is a case for a randomised trial between individual and couple therapy for married patients.

4. Selection for specialist psychotherapy

Concerning selection for specialist psychotherapy, I have come to use a "rule of thumb" although where I got it from I could not say. Patients who need specialist psychotherapy have usually been damaged in childhood, and have failed to develop the normal confidence in themselves and basic trust in others that we associate with adult mental health. In my experience, this damage can occur at one of two main stages of development, and the difference has a bearing on choice of treatment. Some people do not feel loved and valued by their parents in early childhood, or are actually abused by them. These patients do not develop a basic self-confidence in themselves or a basic trust in others; they need a "re-run" of the parent/child relationship, and therefore need long-term individual psychotherapy so they can learn from the therapist the lessons they failed to learn from their parents (what if they are married, you will say - well, that is a problem). They

need what the Knoblochs call a "corrective experience" in the transference situation.

Other patients had satisfactory relations with their parents but did not establish membership of their peer group in adolescence. These patients need a "corrective experience" of the peer group relationship and therefore need group therapy, so that they can learn from their fellow group members the lessons of acceptance and belonging which they failed to learn in adolescence.

This rule of thumb, which seems so obvious to me, does not seem to be accepted by specialist psychotherapists, and I would be grateful for any comments, and for references to such a practice in the literature.

I note that in Integrated Psychotherapy the Knoblochs describe in detail the case of David, one of whose problems was a disturbed relationship with his father, and this problem was dealt with during a six week course of treatment in the day hospital. This might suggest that even for parental problems brief psychotherapy should be adequate. However, in the case of David the paternal relationship was satisfactory up to the age of nine, by which time basic trust is thought to have formed, and also in the case of David his father was able to join personally in the group treatment to good effect. It is an empirical matter as to whether patients damaged by their parents before the age of nine can benefit from short term group therapy, or whether they require longer term one-to-one treatment. At the moment the practice in the UK is for these patients to be referred for specialist individual dynamic psychotherapy. (6)

5. Symmetrical relationships

A fundamental problem for many people is that they cannot form equal, symmetrical, reciprocal relationships. They either crawl or boss. This is not surprising if we accept that the egalitarian hunter/gatherer band (if it ever existed) lasted a much shorter time in our evolution than the group based on a dominance hierarchy. The equal relationship which is possible between same-sexed adults (and between opposite sexed adults) is a pinnacle of social evolution and is not achieved by everyone. A major factor in preventing such relationships is bullying in schools, so that children learn the lesson "get on top of him before he gets on top of you"; another factor is the general acceptance of the pernicious "Peter Principle" (7) which states that "he who is not one up is one down." This is another problem which can be addressed by group therapy, as it was in the case of two patients whose treatment is described in detail in “Integrative Psychotherapy”, Anne (pages 148-161) and David (pages 231-273). This inability to form equal relationships has been called "the authoritarian personality".

6. Co-counselling.

In co-counselling, two people meet regularly and counsel each other. They take it in turns to counsel and be counselled, dividing the time equally between the two roles. They may meet a teacher or facilitator every so often, either as a couple, or, more usually, in a group of about five co-counselling couples. This method should be investigated thoroughly in various cultural groups. It is clearly an inexpensive form of psychotherapy. Also, it is a way of combining group and individual therapy. Also, it helps to address problems of symmetry in relationships, and it avoids the dependence which may be created by traditional psychotherapy. Describing the method in her book The Barefoot Psychoanalyst, Rosemary Randall emphasises that the counsellor should not adopt a superior attitude to the counsellee.

7. The shivering model.

ASCAP readers will be familiar with this model which sees an episode of depression as a de-escalating strategy operating at MacLean's reptilian brain level. Using the analogy of shivering in response to cold, we say to patients that, if we were treating shivering, we would not start massaging the muscles and injecting them with muscle relaxants - rather, we would be asking questions such as, "Why haven't you turned on the central heating?" Likewise, in treating the depressive response to social adversity or failure to achieve goals, we say, "Why haven't you dealt with this problem at the higher level, either carrying out a successful escalation in spite of your depression, or de-escalating by backing off or getting the Hell out of the situation or relationship?" Russell Gardner, who, like me, has used this to effect in psychotherapy, has a concept of ATP in which the patient is advised to recruit Allies, to Think, and to Plan.(8) To plan a strategy in the presence of friends and family is a powerful antidote to the spontaneous operation of the reptilian brain. I would like to see this technique applied to a series of depressed patients to determine the causes of "not switching on the central heating."

In the October issue, the Editor pointed out that the shivering model often requires the patient to give up something, and in this it is similar to David Rosen's concept of

"egocide". Here is discussion of the need to give things up by another exponent of integrative psychotherapy: (9)

"Another aspect of schema change during psychotherapy is a process much like mourning. Very often a resolution of conflict has been derailed because the person cannot tolerate states of mind that have to do with giving up something he or she desired, or from which he or she benefitted in the past. By entry into the usually warded-off state in a safe situation of therapy, the person may rerail a process that was derailed. As the process continues, the person may experience useful mourning. The person gives up an old attachment and may give up an old way of being, and with that relinquishing may gradually form a new self-schema, more supraordinate self schemas leading to better self-organisation, and also the ability to enter into new relationships that will, with repetition, lead to schematic change in such inferred structures as role-relationship models."

8. Self-help groups

Self-help and other community groups are important. It would be useful to have "action research" into how the general psychotherapist can facilitate such groups and offer himself as a consultant in case they get into difficulties.

9. Community groups

A major problem in our society is the decline in church membership. People get a lot of both tangible and intangible benefits from being members of a church congregation, and at the moment those who are unable to accept such membership lose out on these benefits. I realise that Julian Huxley tried hard to establish a humanist "religion" and totally failed, and it is possible that it is necessary to accept and share apparently irrational beliefs in order to make such membership worthwhile. Nevertheless, the problems of loneliness and alienation which non church members suffer would indicate to me that further attempts to offer a secular alternative to religion should be made.

Having written the above, I read that Carl Jung made this point in a letter to Freud in 1910. (10)

10. Therapeutic communities

We need to know a lot more about the dynamics and effectiveness of treatment in both residential communities and the sort of day hospital described by the Knoblochs. Needless to say, no-one has carried out a randomised trial of either of our national NHS therapeutic communities (The Henderson Hospital and The Cassell Hospital). Regional therapeutic communities have risen and fallen in this country, usually established on egalitarian principles by charismatic figures like Maxwell Jones, only to collapse when their less charismatic successors are outwitted by the "group seducer". (1) In the private sector, residential communities based on the "Minnesota Method" for the treatment of chemical dependency (and more recently also for eating disorders and "co-dependency") have mushroomed and appear to have great success, not only in helping people to give up drugs and alcohol, but also in general personality development. This kind of treatment is not available on the NHS, and we have a problem with people who want it but cannot afford it, and want the NHS to fund it.

11. Believers in the schizophrenic patient's delusions

Finally, a pet scheme which is based on our group-splitting evolutionary hypothesis of schizophrenia (10,11). Looking at the schizophrenic patient as a failed cult leader, it might be possible to replace the real cult with the virtual reality of computer-generated cult followers. It is possible that the negative features of schizophrenia are due to the failure to get the boosting and validation which the cult leader gets from his adherents, and if we could replace this process, we might be left with functioning patients with bizarre beliefs, but no more bizarre perhaps than the shared beliefs of the majority.

Afterword

This is not a manifesto of the Psychotherapy Section of the WPA. They are my personal views and aspirations. I offer them for debate, in the hope that an evolutionary psychiatry based on evolutionary psychology might be able to effect some change in what looks to me like a very change-resistant system. The time seems right.

1. Knobloch, F. and Knobloch, J. (1979) Integrated Psychotherapy. New York: J. Aronson.

2. Erickson, M.T. (1993) Rethinking Oedipus: an evolutionary perspective of incest avoidance. American Journal of Psychiatry, 150, 411-416.
3. De Giacomo P. Finite Systems and Infinite Interactions: The Logic of Human Interaction and its Application to Psychotherapy. Norfolk CT: Bramble Books, 1993.
4. Maloney, C. (1996) Setting up stall in the market place: psychotherapy in a state health service. Psychiatric Bulletin, 20, 277-281.
5. Price JS. A paradox of psychosurgical evaluation. In Hitchcock ER, Ballantine HT, Meyerson BA, eds. Modern Concepts in Psychiatric Surgery. Amsterdam: Elsevier/North Holland Biomedical Press, 1979:337-348.
6. Whyte, C. (1996) The need for dynamic psychotherapy. Psychiatric Bulletin, 20, 541-542.
7. Peter, L.J. & Hull, R. (1969) The Peter Principle: Why Things Always Go Wrong. London: Souvenir Press.
8. Gardner, R. & Price, J. (in press) Sociophysiology and depression. In: Recent Advances in Interpersonal Approaches to Depression, ed. T. Joiner & J.D. Coyne. Washington DC: American Psychological Association.
9. Horowitz MJ (1994) States, schemas and control: general theories for psychotherapy integration. Clinical Psychology and Psychotherapy, 1, 143-152.
10. Storr, A. Feet of Clay: A Study of Gurus. London, HarperCollins, 1996).
11. Price, J.S. and Stevens, A. (in press) The group-splitting hypothesis of schizophrenia. In The Evolution of the Psyche (ed. D.Rosen, R.Gardner & M.Luebbert). Westport, CT: Greenwood Publishing Group.
12. Stevens, A. & Price, J. (1996) Evolutionary Psychiatry: A New Beginning. London: Routledge.