Psychotherapy is the art of relieving psychiatric problems by psychological means. Which problems are psychiatric and which means of treatment are psychological could be debated at length. The boundaries of psychotherapy impinge on many areas—faith-healing, religious counselling, the many caring professions, psychopharmacology and neurophysiology. Numerous ideas and methods are subsumed under the term psychotherapy. Some psychotherapists confine their view of psychotherapy to a limited theory and technique, while others are more comprehensive in their practice and encompass a variety of viewpoints. In the past many different schools of thought proliferated, each claiming the superiority of its own methods and its theory, while being neglectful of other techniques and ideas. New ideas would often be treated as heresy, while pragmatism would be regarded with suspicion.

Today the number of psychotherapies, or of techniques which are called psychotherapy, is growing rapidly. Interactional varieties of psychotherapy are multiplying, both in individual and especially in group contexts. Many kinds of groups now flourish in America. These often overlap considerably, and some are probably different more in name than in method. Behavioural psychotherapy or behaviour modification is a misnomer for an ever wider range of psychotherapeutic techniques. The term 'behaviour therapy' has lost much of its meaning since it has come to denote so many disparate techniques most of which have little in common with one another beyond a common lip-service to debatable theoretical antecedents. Desensitization, assertion, aversion, operant conditioning, modelling, covert sensitization, feedback control, and negative practice are more notable for their differences than their similarities. Flooding or implosion is now said to be a behaviour therapy, though one of its originators, Stampfl, conceived it in psycho-dynamic terms, while the allied technique of paradoxical intention is said to be a form of existentialist psychotherapy (Frankl, 1960). Methods of psychotherapy are being and will continue to be diversified. The best of this wealth of new ideas will survive the test of experience, and will pass into regular clinical practice.

There are also trends towards unification. Opposing schools are becoming more moderate in their claims and more sober in their assessments. Their adherents are growing less reluctant to adopt methods with pedigrees outside their own theoretical systems. We are beginning to realize that so-called behaviour therapy and the more interactional (dynamic) therapies have much in common, and indeed often need to be welded together into a single repertoire for the treatment of a given patient. From a variety of standpoints, Weitzman (1967, psychoanalytic), Truax and Carkhuff (1967, client centred), Lazarus (1967, behaviourist) and Brady (1968, behaviourist) have called for the combined use of desensitization, of empathy and warmth, and of interpretations and traditional procedures. Bergin (1968), who is uncommitted, combined warmth and empathy in a desensitization technique in treating a homosexual. He pointed out the need for more empiricism. He thought that 'the efficacious therapies of the future are unlikely to be behavioural therapies, but rather something built upon them and something far broader and more potent in relation to the full scope of human phenomena'.

Rivalries are being resolved in the growing trend to integration. Although past behaviourists divorced their treatments from older forms of
psychotherapy, sophisticated workers now align such techniques under the general rubric of psychotherapy (Kanfer and Saalow, 1969; Heller and Marlatt, 1969; Cautela, 1969; Strupp and Bergin, 1969; Brady, 1968). A further impetus to unity now comes from an unexpected quarter. Techniques of meditation have had little influence on western practice till now, though they are commonplace in Japan (e.g. Morita psychotherapy, Kora, 1968). Similar E.E.G. changes occur in different forms of meditation, be they Zen, yoga, mantra or Catholic mystic meditation (Kasamatsu and Hirai, 1969; Fenwick and Hebden, 1968; Tart, 1969). Of much the same quality is the state of well-being that follows. These similarities are usually obscured by esoteric terminologies. Moreover, feedback control of the alpha rhythm has been reported to produce mental states akin to those of meditation (Kamiya, 1969). A new conjunction is thus occurring between mysticism, neurophysiology and psychotherapy. Possibly these techniques are more helpful to the well than the ill. It is a field we have only begun to explore.

There is also self-control of autonomic responses. Patients can learn to control their own heart rate with the aid of an external feedback system (Lang, 1969). It is possible that patients could learn to control their own autonomic responses which reinforce anxiety. This would have obvious psychotherapeutic potential.

These feedback systems have been provided by computers, with time saved for the experimenter. Machines can take some of the drudgery out of the simpler treatments such as desensitization and aversion; but in this field we are feeling our way.

A more practical way to save precious time would be by using less highly trained personnel. Many caring professions in effect are giving psychotherapy—social workers, probation officers, marriage guidance counsellors, clergymen and nurses. There is no reason why simpler techniques like desensitization, operant program and some counselling should not be carried out by auxiliaries under supervision. Future psychotherapists might employ teams of such personnel. The relations between auxiliaries and the psychotherapist could be like that, say, of physiotherapists to a physician. What the team-leader practised himself would depend on his time, inclination and skills. He might specialize, or he might practise a diversity of methods. But he would not recommend just one technique to all his patients. He would, rather, assess the patient's problems, direct him to this one or that among his aids, to this treatment or that, together or in series; and he would make sure that the patient's needs as a whole person are met.

Will such psychotherapists need to be medically qualified? Much treatment is already being given by the non-medical, including an increasing number of clinical psychologists. The value of a medical psychotherapist will depend upon the population being treated. The team-leader will need to be a doctor for patients in hospital who require physical investigation and treatment, and when drugs are being used. But when medical problems are minimal, the team could well be headed by a clinical psychologist. However, all personnel in the caring professions should be trained to spot the signals calling for medical intervention. Of course the line between medical and non-medical problems will always be a blurred one, and will shift as knowledge grows. The point is to maintain therapeutic standards, while avoiding unnecessary restrictive practices.

The cost-effectiveness of psychotherapy is a grave problem. If all the misery which could be treated was treated then half our population might end up spending most of their time treating the other half. The use of machines and the training of special therapists are only likely to make a small dent in the demand for psychotherapy in the foreseeable future. How much a society is willing to pay for psychotherapy is a political question which society as a whole will have to resolve. Practical economics will determine what level of distress or problems a given society can afford to remedy.

The broadening of techniques of psychotherapy has had an interesting consequence. Past psychotherapeutic methods were largely applied indiscriminately to all forms of neurotic disorder. Today awareness is growing that any particular technique can only help certain kinds
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of patients or problems (Strupp and Bergin, 1969). This idea is implicit in the concept of focused psychotherapy expoused by Frank in Baltimore and Malan at the Tavistock Clinic. It is now increasingly recognized that indications for any one technique are limited. It is unrealistic to expect dynamic group psychotherapy to be the treatment of choice for a patient who has a specific phobia of birds but is otherwise functioning well socially, sexually and interpersonally. For such a patient, desensitization, flooding or modelling are more economical techniques. It is equally unrealistic to think that desensitization would be the treatment of choice for a depressed patient who is locked in an ambivalent struggle with her mother for domination. In such a case more realistic treatment would be individual interactional psychotherapy. In an isolated homosexual patient one may need to combine aversion to diminish homosexual drive with desensitization to reduce heterosexual fears, plus dynamic group psychotherapy to help the patient overcome his deficits in social learning.

As techniques are applied more specifically to selected problems more powerful questions can be asked and answered. A generation ago a typical study of the outcome of psychotherapy might look at a heterogeneous group of patients treated by, say, psychoanalytic methods. More recently a control group of patients might have been added. Usually no definite answers emerged from such studies because the questions were too global and the methods too soft. In the last few years much narrower questions have been asked, in highly selected groups of patients so that definitive answers have been easier to get. This trend is accelerating.

Instead of asking 'is psychotherapy (or behaviour therapy) useful?' one now asks 'useful for what purpose?' and strictly defines the kind of psychotherapy one has in mind... e.g. 'which kind of problem can we expect desensitization (or group-analytic psychotherapy or flooding or psychodrama) to be helpful for?' Asking limited questions of this kind has enabled us to define the value of techniques such as desensitizations quite closely in controlled studies. We can now say fairly confidently that desensitization is useful in reducing anxiety from focal sources such as those of specific phobias (Marks, 1969) or certain forms of asthma (Moore, 1965), but that it is not very helpful for the relief of obsessive-compulsive disorders or anxious agoraphobics. Similarly electric aversion is now known to reduce fetishistic desires, but it is of little benefit for a transsexual patient who wants a sex change operation. This approach could be applied to other techniques e.g. 'which forms of depression might be expected to respond to individual interactional psychotherapy, which should be referred for group-analytic work, and which should have tricyclic drugs or ECT?'

The advantages of asking specific questions can be seen even in diffuse problems like assessment of the psychotherapy of African tribal doctors. Turner (1964) has traced out in elegant detail the active ingredients of treatment by a traditional healer in northern Zambia. This study is a model case history of psychotherapy in a primitive tribal context. The patient had palpitations, somatic pains, fatigue and social withdrawal. During treatment the various causes of ill feeling by members of the tribe against the patient, and his own hostility towards them, were brought out into the open. Then, through traditional rituals which included bloodletting, confessions, purifications, prayers to the dead, tooth-drawing, and arousal of expectations, the ill-feeling was transformed into well-wishing. Emotion was roused and then stripped of its illicit and antisocial quality. The patient was thus reintegrated into his group as step by step its members were reconciled with one another in emotionally charged circumstances. The main endeavour of the doctor was to see that individuals were capable of playing their social roles successfully in a traditional structure of social position.

Specific studies help to identify the active ingredients of psychotherapeutic techniques, which then allow one to refine their applications. Over the past decade systematic investigations of the therapeutic components of desensitization have separated essential from unnecessary aspects in the technique. Desensitization has turned out to be an assembly of several useful procedures which act together to produce therapeutic change. Such investigations make
a 'fractional distillation' of different therapeutic ingredients. We can expect this process to extend in future to most forms of psychotherapy.

Three related trends have been described so far. First, different psychotherapeutic techniques are being applied to selected kinds of problems rather than to all psychiatric patients. Second, research questions about these techniques are becoming less global and more specific. Third, more attention is being paid to the active therapeutic ingredients of each technique. A fourth development might grow out of these—the shift from single general theories about psychiatric disorder to multiple lower order ones. Past theories have been characterized by a tendency to over-generalize about all mental disorder e.g. psychoanalytic theories emphasized the role of unconscious conflicts in generating all neurotic symptoms, while learning theories stressed how all such symptoms are learned. As it is realized that different rules may govern the acquisition and disappearance of different neurotic syndromes, so more limited theories may be formulated to explain each of these syndromes. These theories might be more limited in scope but closer to the facts, more testable, and therefore of greater predictive value. For example, a patient may have had a phobia of cats since childhood together with a grief reaction after recent loss of her mother. The temptation in the past has been automatically to assume that both the phobia and the depression were related to the same underlying phenomena. But evidence now shows that focal phobias run a predictable course regardless of the presence of other pathology, and that their response to treatment can be largely independent of the course of coexisting depression or other symptoms. Each set of events requires its own explanation. In the same way agoraphobia, obsessive-compulsive neurosis, conversion symptoms and personality disorders might each be maintained by wholly different mechanisms which have little to do with one another. A few features of psychiatric disorders reflect built-in characteristics of the human nervous system, others are the product of early learning, some of later learning, yet others may ensue from intra-psychic conflict, while some will be explicable in biochemical or neurophysiological terms. Only when the geography of mental disturbance has been mapped out in much more exact detail can a Darwin-like synthesis be evolved out of the disparate facts.

What recommendations can be made for the teaching of psychotherapy in the light of these trends? The most urgent need is for teaching of psychotherapy to become more efficient, broadly based, and integrated. Past training of psychotherapists has been laborious and expensive because of emphasis on trainees having personal and training analyses. The training value of these analyses has not been adequately shown. It is possible that these analyses could be shortened or even eliminated without detriment to the effectiveness of psychotherapists. It goes without saying that self-understanding and compassion are important assets to psychotherapists, but better means could be explored to foster these qualities e.g. intense brief training in sensitivity type groups.

A broadly based training will cultivate an open and flexible mind in trainee psychotherapists. A trainee needs more than a working knowledge of the psychiatric syndromes and the theory and practice of the school he happens to have selected, be it psychoanalytic, Adlerian, behaviourist or any other. An educated psychotherapist in the future will need to know about allied disciplines like ethology and clinical psychology. He will need to be familiar with all the many techniques now subsumed under the psychotherapies, even though there may only be time for him to become expert in a few of these. A psychotherapist who is sophisticated would know about individual and group interactional psychotherapy, about conjoint marital therapy, about crisis coping, meditational techniques, the concept of feedback control, desensitization, flooding, aversion and the methods of operant shaping. Although there are moves in this direction, such training is hard to obtain at the moment. Its organization would be a major task, but an eminently rewarding one which would hasten the advance of psychotherapy towards an integrated and systematic discipline.
REFERENCES


