The current status of psychotherapy

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Summary

Psychotherapy has a long history but its practice has always been strewn with controversy. In this review, the current status of psychotherapy is examined by setting its development in historical perspective. While previous practice was often based on the pronouncements of "masters", current approaches are almost always embedded in both rigorous theoretical formulations and frequently also in empirically derived data on efficacy. A fundamental understanding about the mechanisms of action of psychotherapy is a promising new development that is emanating from modern techniques of neurosciences and neuroimaging. Whether such understanding will lead to a renaissance in the clinical utility of psychotherapy is still early to say. However, there is little doubt that the provision of a holistic care for patients with psychological and mental disorders in particular, and most physical conditions in general, should be informed by an appreciation of the bi-directional nature of the relationship between the mind and the body and should therefore include the provision of appropriate psychotherapeutic interventions.

Keywords: ***Psychotherapy, History, Practice, Evidence, Future***

Résumé

Il y a une histoire longue en matière de la psychothérapie mais dans la pratique, elle est toujours sujet à controverse. Dans cette étude de revision, le statut actuel de la psychothérapie est étudié tout en considérant son développement dans une optique historique tandis que la pratique précédent était souvent basée sur la déclaration des "masters", des méthodes actuelles sont Presque souvent ancrées dans les formulations théoriques et également sur les données empiriques sur l'efficacité. Une compréhension fondamentale sur les mécanismes d'action de la psychothérapie est un nouveau développement qui est train d'emasser des techniques modernes de neurosciences et neuroimageries. Peut être qu'une telle compréhension pourrait mener à une renaissance en matiére d'utilité clinique de la psychothérapie est encore trés tôt à dire. Toutefois, il y a un peu de doute que la provisions des soins holistiques pour des patients atteints des troubles psychologiques et mentaux en particulier, et des conditions physiques en général, devrait être informé par une appreciation de la nature bi-directionelle d'un rapport entre l'esprit et le corps et devrait donc comprendre la provision et l'intervention psychothérapeutique approprié.

Introduction

Psychotherapy means different things to different people. However, most conceptualizations of psychotherapy do not deviate significantly from the classic definition provided by Jerome Frank[1] who defined psychotherapy as the process by which one person attempts to relieve another person's psychological distress and disability by psychological means. Such psychological means is typically by words or other communicative or symbolic behaviors or gestures. The practitioner has received some form of special training and bases his or her practice on some form of theory about personal distress and ways of alleviating it.

Historical overview

Psychotherapy has had a checkered history. From the giddy days of Freudian and neo-Freudian traditions to the depressing decade of biological reductionism, psychotherapy has been at the centre of clinical controversy. A time there was when psychotherapy was touted as the panacea for all mental ailments and for all objectionable behaviors. Mostly because such exaggerated promise could not be fulfilled, a period soon came when those outside the mental health care profession as well as some within that profession subjected the practice of psychotherapy to derision. Psychotherapy is just beginning to come to its own in terms of scientific credibility. Less than a decade ago, several influential commentators concluded that most of psychotherapy is unscientific and not significantly different from placebo and espoused biological reductionism[2]. It is unlikely such a view would be accorded much credibility today as the scientific renaissance of psychotherapy is very well on its way[3].

But how did it all start? It is important to recognize the two major strands of psychotherapy in order to appreciate its history. While the empirical-scientific form has a more recent history probably dating back to not longer than the mid-eighteenth century, the religio-magical form is as old as human culture[1]. However, the latter is now largely outside of mainstream orthodox public health service in most countries, and is not the focus of this paper. When psychotherapy is practiced within the orthodox medical service, it is almost always the empirical-scientific form of it. However, it is important to note that, given that a large proportion of the health service in many develop-

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ing countries is provided outside of orthodox care delivery system, the religio-magical form of psychotherapy is probably more practiced in such countries than the empirical-scientific form[4]. It is also worth noting that, irrespective of what practitioners of the empirical-scientific form of psychotherapy may claim, they share some similarities with the practitioners of the religio-magical form.

The empirical-scientific form of psychotherapy, even though diverse in its theoretical underpinnings, can be said to have three major roots: Psychoanalysis, behavioural therapy, and cognitive therapy.

Foreshadowed in the form of hypnosis by the charismatic physician, Anton Mesmer, modern psychotherapy has its origin in psychoanalysis, a form of treatment designed by Sigmund Freud[5,6]. Freud expounded the psychoanalytic theory which is based on the notion that early childhood experiences are internalized in the unconscious. He postulated that the unconscious influences behavior, thoughts, and feelings. The early fundamentals of psychoanalysis consist of the technique of free association conducted in the well-known setting of the patient reclining on a couch and the therapist sitting behind the couch, with no face-to-face contact. Its basic concepts included those of the sexual etiology of the neuroses, of ego psychology, transference, and of defense mechanisms. These early fundamentals and basic concepts were soon revised and amended by Freud himself and, even more drastically, by neo-Freudians and non-Freudians as well. Examples include Horney's rejection of Freud's theory of the neurosis and his discarding of Free Association and the couch; Harry Stack Sullivan extended the use of psychoanalysis to psychotic patients and developed the face-to-face psychiatric interview; Anna Freud emphasized the adaptive function of defense mechanisms; Klein brought the British concept of object relations to psychoanalytic theory and thus redefined the analyst's role as one involving participation in the process; in the 70s and 80s, Davanloo, Malan, Hoffman, and Chessick introduced brief psychoanalytic psychotherapy, supportive psychotherapy, social constructivism, and the integration of psychoanalytic techniques with existential philosophy. In the main, psychoanalytic psychotherapy has evolved to three main types as a result of these influences: psychoanalysis, expressive psychotherapy, and supportive psychotherapy[5]. While the first two involve the analyzing of transference and defenses and uncovering unconscious material, the third targets the suppression of unconscious conflicts and strengthening defenses.

Behavior(al) therapy, developed by the South African psychiatrist Joseph Wolpe, is based on the principles of behaviorism as expounded by J B Watson. The animal learning experiments of B. F. Skinner and Ivan Pavlov provide its main empirical roots [7]. In behavior therapy, the therapist attempts to change what patients do, to improve their health. Behavior therapy includes a methodology, referred to as behavior analysis, for the strategic selection of behaviors to change and a technology to bring about behavior change, such as modifying antecedents or consequences or giving instructions. Today, behavior therapy has not only pervaded mental health care but under the rubric of behavioral medicine, it has also made inroads into other medical specialties.

It has been suggested that the evolution of Behavior Psychology was a reaction to the abstract and introspective nature of psychoanalytic thinking[7]. Believing that mental content is not directly observable and is therefore not amenable to rigorous scientific inquiry, behaviorists focus on verifiable and overt behavior. Behavioral views thus differ from cognitive views in holding that physical rather than mental events control behavior.

On the other hand, cognitive therapy, developed in Philadelphia by the psychiatrist Aaron Beck, has a broader theoretical root. Cognitive therapeutic principles and techniques are based on concepts from cognitive and social psychology, information-processing, and psychoanalytic theory[8]. Cognitive therapists believe that the way individuals interpret experience determines how they feel and behave. For example, if persons view situations as dangerous, they experience anxiety and want to escape. The four basic emotions of sadness, elation, anxiety, and anger, respectively, are evoked by perceptions of loss, gain, danger, and wrongdoing by others. Incorrect evaluations of life situations as hostile or dangerous may derive from biased information processing which may in turn lead to distorted interpretations in the form of verbal or pictorial cognitions. In depression, for example, patients see themselves, their experiences, and their futures in negatively biased ways, which in turn sustains or magnifies depressive symptomatology[8]. The goal of cognitive therapy is to correct these habitual thinking errors found in different psychopathological states. Verbal interventions and restructuring of cognitive processes are employed. The aim is to help patients identify their dysfunctional cognitions and correct distorted beliefs that underlie them. A wide range of therapeutic techniques consistent with the cognitive model of psychopathology may be used. The therapy itself is active, structured, time limited, and focused on current problems. As patients begin to think and act more realistically, their symptoms and behavior improve.

Coming from radically different theoretical frameworks, one can see why the practitioners of psychoanalytic psychotherapy, behavior therapy, or of cognitive therapy claimed the superiority of their respective practice over the practice of others. It is also understandable that each would feel offended to be grouped with the others. Thus, psychoanalytic psychotherapist treated the others with some disdain, saying that they were dealing with the surface rather than the substance of patients' problems. They suggested that the apparent benefit patients might derive from the other approaches was ephemeral as the phenomenon of symptom substitution would lead to the replacement of one set of problems with an-

other. Of course, behavior therapists and cognitive therapists thought the often protracted therapy that psychoanalytic psychotherapy prescribed was a time-wasting and expensive exercise and that what was worth attending to was the "here and now" problem of a patient rather than some abstract notion of repressed early experience. To complicate matters, even within the broad spectrum of psychoanalytic psychotherapy, some purists believed that any deviation from some perceived core concepts of Freudian psychoanalysis was a farce. Indeed, supportive psychotherapy, even though psychoanalytically based, was derided as an inferior form of therapy to, for example, expressive psychotherapy.

Current practices

The current practice of psychotherapy is eclectic. The time of single ideology-driven practice is gone. Even though therapists still tend to specialize in one major area, clinicians tend to draw on multiple theoretical backgrounds in their practice. Indeed, some of the more recent psychotherapeutic methods and techniques are grounded on multiple theoretical antecedents. An example of a recent treatment modality with this sort of background is Interpersonal Psychotherapy[9, 10].

Developed by Gerald Klerman and Myrna Weissman, and based on the ideas of Harry Stack Sullivan and the interpersonal school, the theoretical foundation of Interpersonal Psychotherapy draws on the writings of Sigmund Freud on grief and mourning and on the attachment theory of John Bowlby. In spite of this strong psychoanalytic background, Interpersonal psychotherapy makes no etiological assumptions and focuses on current rather than past interpersonal relationships. In its formulation, one can certainly see strong influences from the cognitive and the behavioral schools[11].

Eclecticism has been encouraged by a number of factors. First, patients rarely present with neatly defined etiological factors. The reality of psychological problems is that, while they may have their roots in early experience, current learning and cognitive processes are important in their precipitation and persistence. Second, while unearthing repressed memories may be important, the process is usually long and challenging. Most patients want quick relief from at least some of the more pressing components of their presenting problems and most modern health systems require immediate value for money. In this regard, a clinician may choose to offer an essentially cognitive approach to achieve early remission and then provide an expressive psychoanalytic treatment to sustain the remission. Third, overall, many types of psychotherapy have now been shown to be efficacious provided the therapist is sufficiently skilled to deliver the specific type of treatment and the patients are appropriately selected[3,12,13]. While there may be indication for one type of psychotherapy or the other for a particular patient, no one particular method is good for every case requiring psychotherapeutic intervention. Also, various forms have been adapted and used in the context of individuals, families, or groups.

Indications for psychotherapy

In clinical practice, patients who are referred to psychotherapists often have multiple problems. A typical referral to a psychotherapist would suggest that the patient has not responded to medications, an indication that the patient's problems are diverse, complex, and probably also chronic. That is the clinical reality. However, in recent years, task forces, especially the American Psychological Association Task Force on Psychological Intervention Guidelines[12] and the Task Force on Promotion and Dissemination of Psychological Procedures[13] have drawn up lists of therapies which have been shown to be of proven efficacy in relation to individual DSM diagnoses. These task forces have of course based their recommendations on "empirically validated" psychotherapies, that is those forms of psychotherapy for which there are research findings to support their efficacy.

These current indications therefore include:

Schizoprenia: for which psychosocial family education has been shown to reduce the risk for relapse in patients receiving medication[14]. A program of cognitive-behavioral technique to help patients understand and cope better with their symptoms have also been shown to be helpful to patients with schizophrenia who remained on medication [15].

Mood disorders: It is now generally accepted that a combination of psychotherapy and pharmacotherapy is more efficacious than pharmacotherapy alone[16]. In certain cases, pharmacotherapy may be the treatment of choice for many individuals with depression because of lack of side effects and because it may more directly address some of the social issues associated with the onset and persistence or relapse of depression. A recent randomized trial demonstrated the efficacy of adjunctive psychoeducation in reducing relapse rates in patients with bipolar disorders[17].

Anxiety disorders: social phobia, generalized anxiety disorder, obsessive-compulsive disorder, specific phobia, and posttraumatic stress disorder are firmly established indications for psychotherapy. Exposure procedures are the treatment of choice for panic while approaches combining cognitive-behavioral techniques with interpersonal and dynamic methods are used for other anxiety disorders.

Somatoform disorders: Somatization, hypochondriasis, and pain disorders are also now commonly treated with methods with strong cognitive component[18].

Substance abuse and dependence: Given the diverse problems presented by people with substance abuse or dependence, multiple pscyhotherapeutic methods are often indicated and used. Patients with opioid dependence on

methadone maintenance are often treated with supportive-expressive psychotherapy. Family therapy has been used for adolescent substance abusers. Relapse prevention, a cognitive-behavioural approach developed by Marlatt and Gordon[19] is often indicated in the maintenance treatment of those with addiction problems.

Personality disorders: The psychotherapeutic treatment of individuals with personality disorders remains challenging and complex because of the heterogeneity and the variable severity of these disorders, and the observation that personality traits and their corresponding disorders are resistant to change and very difficult to modify. Even with this caveat, there is some evidence for positive benefits for patients with personality disorder who receive long-term cognitive-behavioral or psychodynamic-based interventions[20].

Physical disorders: The evidence is very tentative, but suggestive, that psychotherapy may also work in physical conditions. Reports are beginning to emerge that psychotherapy may improve survival of patients with breast cancer[21,22] and may reduce mortality and prolong remissions in patients with malignant melanoma[23,24]. The course and progression of many physical disorders are strongly influenced by emotional factors, thus making psychotherapy a useful adjunctive treatment in their management. For examples, the progression of HIV infection is influenced by life stress[25] and survival following myocardial infarction is partly determined by co-morbid depression[26].

As earlier indicated, this list deals with problems for which empirical evidence of efficacy of psychotherapeutic intervention exists. There are of course many other problems, some which do not constitute a disorder as defined by the DSM or ICD-10 for which clinicians use psychotherapy. This difference between research findings and clinical reality is a reflection of the current state of psychotherapy research, to which this article now turns.

The current state of psychotherapy research

Given the nature of psychotherapy, dealing as it does with rather intangible interactions between the therapist and the patient, it is not surprising that research in this area has been fraught with difficulty. It was indeed thought in the past that psychotherapy and its outcomes were unmeasurable. However, that has now all changed. The earlier major attempts employed the use of meta-analysis (an assessment of treatment effectiveness through averaging and combining results across studies). A landmark and first of such analysis was conducted by Smith et al[27]. They showed that psychotherapy was very effective by demonstrating a mean effect size for psychotherapy of 0.85 (that is, a change in a clinical condition that could be ascribed 85% to psychotherapeutic intervention). Subsequent to this paper and this period in psychotherapy research, there is now an abundance of studies aiming to improve the practice of psychotherapy, inform public policies regarding psychotherapy, and streamline the provision of mental health care.

In spite of many good studies addressing these various aspects of the practice of psychotherapy, many therapies still lack the empirical evidence that methodologically robust studies such as randomized controlled trials (RCTs) can provide [28]. Even though the RCT paradigm has its own shortcomings [29,30], it remains the gold standard when support is sought for evidence-based clinical practice. A few therapies are however now supported by state-of-the-art RCTs. Such therapies are often based on explicit manuals and conducted on patients meeting explicit diagnostic categories defined in ICD-10 or DSM-IV.

Given the nature of real-life patients seen in therapy, where most often present with multiple problems which may not be classifiable into pure syndromes[31], a number of writers have wondered whether RCTs are indeed appropriate to psychotherapy. A distinction has therefore been made between the provision of evidence for efficacy, which is what RCTs do, and the need for data on effectiveness which aims at generalisability of research findings to situations beyond the confines of experimental research criteria. Also, there has been a suggestion that a research paradigm for psychotherapy must aim not just at providing data for evidence based practice but may also need to be guided by practice-based evidence, which involves the gathering of good quality data from routine clinical practice[30].

Whatever approach is used, the problems confronting current psychotherapy research remain essentially the diversity of the variables investigated, the varying methods of appraisal, the heterogeneity of the patients studied, the differences in therapist training and skill, and the variations in clinical settings.

Current knowledge about how psychotherapy works

One of the most exciting new frontiers of research is the investigation of the neurobiology of the brain processes involved when psychotherapy works. The last decade or so has seen an exponential increase in our understanding of the neurobiological basis of psychiatry. Today, we can claim, as does Eisenberg[32] that psychotherapy that makes a difference changes brain function. Research has demonstrated that measurable changes take place in the brain during psychotherapy and that these changes are the routes by which psychotherapy brings about improvement in patients' conditions. For example, we know that patients with obsessive-compulsive disorder have measurable abnormalities in cerebral metabolism in the basal ganglia, the limbic system, and the cortical projections. Recent neuroimaging studies of the brain show that patients who improve following cognitive-behavior therapy have these abnormalities reversed in a manner similar to those of patients who improve with medication[33]. Also, researchers have demonstrated that psychodynamic therapy may work by bringing about normal-

ization in serotonin metabolism [34].

It probably should not be surprising that psychotherapy may prove beneficial to patients with physical disorders, including cancers. The role of emotion in the causation and progression of physical disorders [35] has been demonstrated through the link between, for example, hostility and early death in men and the positive effect of optimism on recovery from heart attack. For example, a recent report showed that, among young adults, time urgency/impatience and hostility were associated with a dose-response increase in the long-term risk of hypertension [36] Our understanding that there are biological pathways linking the mind, emotions, and body derives from evidence showing that emotions have powerful effects on the autonomic system and has led to a burgeoning new area of science, psychoneuroimmunology [37].

Given what we currently know therefore, the notion that drugs affect the brain and psychotherapy affects the mind is simplistic and erroneous, as we now know that such Cartesian dualism is faulty. Current knowledge suggests that there is a complex interaction between genetic/biological vulnerabilities and the environment with bi-directionality being the pattern of interaction. Now, we know that "medications have a 'psychological' effect in addition to their impact on the brain, and psychotherapeutic interventions affect the brain in addition to their 'psychological' impact" [38]. In short, that the rigid distinction between the mind and brain is no longer valid.

The future of psychotherapy

There is a paradox in the current practice of psychotherapy that may tell us something about its future. We now know that psychosocial factors are instrumental in bringing about the onset of not only mental disorders but also physical disorders. In the past 40 years, new and effective psychotherapeutic interventions have been designed for various psychiatric disorders, including depression, anxiety disorders, even schizophrenia. In more recent times, our understanding of the biological processes underlying mental illness is undergoing a revolution. This revolution is driven by findings in neurosciences, imaging techniques, and in molecular genetics. We now have some insight into the biological process underlying the effectiveness of psychotherapy. Indeed, this past decade was described as the "decade of the brain" [39]. We can say that we are now close to having sufficient knowledge for "fitting the biopsychosocial jigsaw together" [3]. Unfortunately, this knowledge is not widely reflected in the current services to patients. In psychiatry, specialization in psychotherapy is dwindling everywhere. In West Africa, as an example, the scope for the effective training in and practice of psychotherapeutic skills is limited by pressure on clinicians to see large number of patients. In spite of early promise [40-42] good research on psychotherapy has barely begun, even though there is a pressing need to examine the appropriateness of some of psychoanalytic psychotherapy's theoretical foundations to our culture [40, 41,43,44]. Training in psychiatry is deficient in good interviewing skills and in psychotherapy, not just in less resourced centres but also in places such as the US where biological aspects are now emphasized to the neglect of psychological factors. Rather, trainees merely acquire the skill to make DSM 45 and ICD-10[46] diagnosis and prescribe medication. While it is arguable that formal psychotherapy needs to be conducted by psychiatrists rather than by non-medically trained clinicians like social workers and clinical psychologists, it is nevertheless true that many patients benefit from psychotherapy and that their doctors should have the skills to provide some of it. Indeed, our increasing knowledge of the influence of psychological factors on the development and outcome of physical disorders makes it important that every clinician has some understanding of the importance of psychotherapy (in its broadest meaning) and is able to deliver some form of it.

So what is the future of psychotherapy? It is likely that more effective therapies will be designed and that our understanding of how they work will improve. Indeed, in the era of evidence-based medicine, more questions will be asked about the utility and cost-effectiveness of psychotherapy [47]. It is clear that more remarkable advances will also be made in the fields of psychopharmacology, especially with regard to the possibility of targeted medical interventions that are informed by individual's genetic makeup. Given those great possibilities, the future of psychotherapy will depend on our ability and willingness to see our patients as a whole and discard the discredited notion of the separation of the mind and the brain or of a rigidly dualistic notion of psychological and biological aspects of illness.

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