



## **Evolution of Psychotherapy**

### The origins of psychotherapy

By most accounts, Sigmund Freud invented psychotherapy in Vienna in the 1880s. In those days, psychiatrists only treated severely ill patients in hospitals and asylums. People who lived in everyday society sought help for emotional disturbances from neurologists, which is what Freud was: a nerve doctor. That's why we still have terms like “nervous condition” and “nervous breakdown.” Unlike most nerve doctors at the time, Dr. Freud had a new idea about the cause and remedy for these emotional issues.

He believed that anxiety and other symptoms were due to uncomfortable thoughts, feelings, concerns, or wishes that were unconscious — that the person didn't know they had — and that making this material conscious would relieve the symptoms. This process, called psychoanalysis (i.e. analysis of the psyche, or mind), was the first psychotherapy. Sessions were nearly daily, with the patient lying on a couch and speaking as freely as possible. The analyst listened carefully and said very little.

Psychoanalysis soon spread to a small group of doctors in Vienna, and then to the rest of Europe and eventually the world. For a variety of reasons, psychiatry, not neurology, adopted psychoanalysis, leading many psychiatrists out of institutional settings and into office practice. Carl Jung, a Swiss psychiatrist, was a student of Freud who adapted psychoanalysis to include more spiritual and symbolic elements.

In the early decades of the 20th century, psychoanalysts began to more strongly emphasize the healing nature of the relationship between patient and therapist, alongside working to make the unconscious conscious. Meanwhile, psychodynamic psychotherapy, a less formal offshoot of psychoanalysis, gained prominence. This version had both patient and therapist sitting up in chairs and meeting only once or twice a week. While the patient still spoke as freely as possible, the therapist was more actively engaged in the dialogue.

By mid-century, several psychoanalytic theories were in vogue. However, these schools were more alike than they were different. All provided individualized treatment for each patient, and encouraged free exploration of thoughts and feelings. The intimate (but professional) relationship in therapy was considered integral to healing.

The 1950s and 60s also saw the rise of humanistic and existential schools of therapy, which de-emphasized therapeutic technique in favor of “authentic” relating between patient and therapist, with a focus on what the patient finds personally meaningful. These, too, considered the relationship essential to healing.

Here at PsiAN, we refer to all of the above as "therapies of depth, insight, and relationship."

### The impact of academic psychology

World War II led to a shortage of psychiatrists, and the new field of clinical psychology quickly rose to fill the gap. While many psychotherapists continued to practice traditional psychoanalytic/dynamic therapy and others followed the new humanistic/existentialist schools, a third group of clinical psychologists took their cue from academic psychology's emphasis on experimentation and quantitative measurement. Behaviorism and learning theory formed the basis of alternative forms of psychotherapy. These placed less value on the healing relationship, and more on concrete, reproducible interventions aimed to remedy specific emotional symptoms.

For example, psychologist Albert Ellis promoted a confrontational “rational emotive behavior therapy” in the 1950s as an alternative to psychoanalysis. Then, in the early 1960s, the American psychiatrist and psychoanalyst Aaron Beck argued for psychotherapy that aims to change thoughts (cognitions) in order to change feelings caused by those thoughts. Beck called this cognitive therapy. The combination of Beck's cognitive therapy and academic behaviorism led to cognitive behavioral therapy, or “CBT.”

In addition to psychiatrists and psychologists, some social workers also became therapists in the post-war period, leading to the specialty of clinical social work. These clinicians brought social work's emphasis on community, institutions, and social functioning into the field of psychotherapy. For the most part, clinical social workers also conduct therapies of depth, insight, and relationship.

### The rise of “evidence-based” therapy

By 1980, the field of psychotherapy was a hodgepodge of different disciplines, approaches, and theories. The psychoanalytic/dynamic tradition, the grandfather of them all, had overreached in attempting to explain all mental disturbance. And while a number of research studies supported the effectiveness of dynamic and relational therapies for many emotional problems, quantitative experimentation in these therapies was never a high priority; nor was much effort made to publicize the results that were collected. As a result, the general (mis)perception is that there is not an evidence basis for psychoanalytic/psychodynamic therapies. In contrast, CBT borrowed from its academic roots a taste for numerical, objective

results. Many research studies were done. Using concrete, easily measured outcomes, it was relatively easy to show that CBT decreased symptoms in comparison to control groups that received no treatment. It is important to clarify that these studies did not show superiority over other modalities of treatment, but over no treatment at all.

The focus on symptom improvement publicized by CBT researchers meshed well with the framework chosen for the third edition of psychiatry's diagnostic handbook (entitled The Diagnostic and Statistical Manual of Mental Disorders, and commonly referred to by the acronym "DSM.") Unlike prior editions, DSM-III (1980) avoided psychoanalytic language; it based diagnosis on observable signs and symptoms. By decreasing the number of such symptoms, the patient would no longer "meet criteria" for a diagnosis. The treatment would be deemed successful — even if the patient was still suffering.

This scorecard notion of cure formed the basis of evidence for the effectiveness of CBT. And this evidence, in turn, resonated with "evidence based medicine," a movement, starting in 1991, to ground all medical treatment in objective findings and reproducible results — usually by means of group studies called randomized controlled trials. In the eyes of academics and much of the public, such evidence removed psychotherapy from the realm of unquantifiable humanistic undertaking and turned it into a medicalized, scientifically proven treatment.

#### The false promise of "evidence-based" treatment

Unfortunately, quality of life, which is what psychotherapy strives to improve, isn't that simple to measure or assess. For one thing, many people who seek psychotherapy don't have the concrete symptoms studied in CBT trials. They may suffer a pattern of dysfunctional relationships, self-defeating behavior, career stagnation, or dissatisfaction with life, without really knowing why. They may repeatedly argue with authority figures, feel abandoned by others, or feel ashamed and humiliated. They may know their lives don't feel right, but can't be more specific. Therapies of depth, insight and relationship are highly effective in dealing with these kinds of problems, and the evidence supporting therapies of depth, insight, and relationship for these issues is actually greater than the evidence for CBT.

Second, while many studies of CBT show superiority over a control group, i.e., those receiving no treatment at all, the amount of improvement is often very small and often doesn't last very long. These limitations are also in the published literature, but are rarely noted by readers. For example, one large study of CBT found that 75% of patients did not get and stay well, yet the paper is still widely cited in support of CBT.

Third, the so-called gold standard of medical evidence, the randomized controlled trial, only looks at group differences, meaning differences between groups of people. Within any group, individuals have different results. Some improve a lot, some very little. Others may actually do worse. Treating everyone the same may improve the group on average, while not serving some

members well at all. This is particularly true of emotional issues, which differ from person to person more than, say, symptoms of diabetes or high blood pressure. Psychotherapies of depth, insight, and relationship *assume* individual differences, and treat them as the centerpiece of each therapy. The uniqueness of the individual is respected, not dismissed as experimental “error variance.”

For these and other reasons, it is misleading to attach “evidence based” to a particular psychotherapy approach while implying that others lack evidence. A fair-minded person would say that all mainstream approaches have their strengths and weaknesses, and all are based on scientific evidence.

### What “evolution” really means for psychotherapy

In biology, evolution is driven by survival of the fittest, i.e., by what works. Evolution advances only when the new works better than the old. True evolution occurred in the history of psychotherapy when psychoanalysts paid more attention to the therapeutic relationship, when humanists emphasized authenticity and existentialists explored meaning, and when clinical social workers brought social realities into therapy. Modern psychotherapy incorporated these advancements along the way. Today’s psychotherapy is “Freudian” no more than modern philosophers echo Plato, or modern physicians practice 19th century medicine.

In contrast, the recent rise of symptom-focused, formulaic therapy is not an evolutionary advancement. Such approaches do not serve individual sufferers particularly well. Their “fitness” lies in how well they fit a narrow research paradigm and the preferences of third party payers - insurance companies. Theory and research support the idea that the relationship in therapy is inherently healing, and that treating an emotional issue in depth, not just symptomatically, offers more and lasting benefit. It is no advancement to neglect these truths.

PsiAN supports ongoing research into psychotherapy and other mental health care. Evolution still means change. But we believe the phrase “evidence based treatment” is misleading and doesn’t reflect a real evolution in practice. The history of psychotherapy began with intensive effort to understand the uniqueness of an individual in depth. It should not end with an abandonment of that effort.

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