PSYCHOTHERAPY, THE PSYCHOTHERAPIST AND THE PATIENT*

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I ask you to regard psychotherapy as the application of psychological principles to the adjustment problems of human beings. The therapy is not a treatment imposed from without as in clinical medicine, but is more akin to education, or a process of re-education designed to elicit a change of behaviour. The behaviour pattern may be changed by changing the environment as in admission to hospital, by changing the attitude of the people in the immediate environment as in child guidance work, by changing the attitude of the patient towards these people and towards himself through a greater insight into his concept of himself. The increased insight leads to a closer integration of the personality, which results in a dynamic equilibrium personally and socially. In short, it leads to health.

The mechanistic idea of disease leaves no room for the concept of health, but nowadays the art of medicine, which is a special kind of relationship between doctor and patient, needs to be scientifically informed if we are to participate effectively in the adjustments of scientifically informed men and women. Hence the need for collaboration of knowledge, biological, psychological and social. The past is in mesh with the future, and I firmly believe that evolution will proceed psycho-socially.

In a company of engineers you meet draughtsmen, pattern-makers, moulders, blacksmiths, tool-makers, machinists, turners and fitters. In a company of doctors you meet as many diversities. In both instances they are all men. I deprecate the assumption of inferior-superior roles, especially when applied to general practitioner and specialist, and to patient and doctor. The converse is equally to be deprecated, namely the practitioner saying, " I *use* so-and-so for my surgical cases." Four years ago the doctors in this area elected a general practitioner to be the president of the British Medical Association. Does one feel superior or inferior when the

*A paper read at the Conference on Psychotherapy held at The Lady Chichester Hospital, Hove, in October 1959.

J. COLL. GEN. PRACT., 1960, 3, 154

patient is a princess, an ambassador, a judge, a colleague, or a labourer's wife with one child who disturbs her twice weekly with nocturnal asthma, and another with enuresis, but yet manages to keep her house, her family and herself clean on an income of £8 per week without incurring debts? I think it is a mistake for a doctor to tell his patient he is calling in a specialist; better to say he is seeking another opinion, a more experienced one maybe, and preferably that of a friend. The patient at a domiciliary visit is not then in awe of the oracle; time is not spent on thawing an artificial barrier. Even if I cannot accept it, the offer of a cup of tea afterwards indicates that a friendly relationship has been established. I remember in my student days the patient's sister offered to darn a hole in my sock while I was waiting to deliver the baby. Mutual help and co-operation was the valuable factor in the relationship that night, and that is exactly what I hope for to-day. "The rank is but the guinea stamp." The psychotherapist must be a physician, sensitive, intuitive, learned, decisive, wise, with an ethos of integrity and humility.

I have no intention of enumerating the psychological principles I mentioned at the beginning, but I would define them as dynamic. It is the application of these principles which concern us particularly to-day, and when we do that we should expect the unexpected. Appearance is never the reality, and reality seldom puts in an appearance, unless we are constantly on the alert for unwitting irrelevancies. Every symptom expresses a duality, positive and negative factors operating simultaneously although not in equal proportions. The symptom is an expression of the opposites, but not a solution.

This statement is seen very clearly in the application of psychological principles to certain skin conditions, when we learn that they are skin reactions rather than skin diseases, that is reactions of the patient by way of his skin. Mrs. C, aged 40, was a widow with a patch of eczema at the back of her head. She was the vivacious mother of two children, divorced from her ex-teacher, ex-parson husband because of his penchant for old women with wealth, and penniless nursemaids. After the divorce she lived impulsively on her energies as a shop-keeper with the financial help of her brother in Australia. By the time he died and his help ceased she had learned to live on her charm. She also retained a conscience, but the two never functioned concurrently. During a more prolonged attack of the latter than usual she defied her conscience and managed to be admitted to the Roman Catholic Church. Then suddenly it dawned on her that she could never marry again. The Church satisfied her conscience; a married Canadian was satisfying her instinct, but neither would recognize the other. When I met her she was in the process of relieving herself of an early pregnancy. When

asked how she squared that circle, she naively replied that she just put it at the back of her head. I couldn't help complimenting her on how obviously successful she had been. The law of opposites is inherent in Nature and must be accepted. The synthesis of the opposites in a healthy fashion is our function whether the symptom is dermatological, pulmonary, cardio-vascular, gastric, intestinal, genito-urinary, muscular or articular. We could all quote examples.

Years ago I entered a practice which had been in existence nearly one hundred years, a third of that time by my predecessor. It was a real family practice. The older people were his contemporaries; the younger ones he had brought into the world and I was seeing the third generation being born. Being a compact, conservative community one soon learned that Mrs A. and Mrs B. were sisters, and that the two Mrs D's were married to brothers. The scope ranged from geriatrics to obstetrics and included infant welfare, child guidance, educational guidance, vocational guidance and marriage guidance.

Such a practice taught one to see stereoscopically, and like one drop in the ocean of medicine it reflected the whole span of life. In the conduct of general practice we make a voluntary contribution to the evolutionary scheme, and cannot help but build up for ourselves out of our experience an ethical standard. It is the wise use of the authority which patients put in our keeping which is the basis of the public's respect for our profession.

A consultant colleague and friend once said to me, " Half my patients come to me because they are married, the other half because they are not." The proportions in general practice may be different, but the problem presents itself in both types of practice. My favourite question is " Why did you marry?" or " What did you hope for in marriage?" The answers are so revealing that they provide the clues to the appropriate re-education or education. Under the heading of marital maladjustments we meet such problems as disparity in the ages, racial and religious beliefs of the partners, insanity, epilepsy, alcoholism, transvestism, sexual perversions, impotence, preference for masturbation, vaginismus, dyspareunia, frigidity and sterility. It is the strength of the bonds to the parents which makes for harmony or disharmony in marriage, the negative bond usually being projected on to the mother-in-law when not on the partner's alleged short-comings. When the young couple grow up free from dependency on their parents, and are capable of accepting frustrations as an unavoidable part of life, the young wife accepts marriage with poise and enthusiasm. She ceases to exercise a jealous monopoly over her husband, but regards him as a giver of love and the progenitor of children who are regarded as replicas of

a desirable personality. The young husband looks at his wife, not as the personification of his phantasies but as an individual in her own right with a personality of her own, and as a woman whose physical and mental equipment arouses his desire for the achievement of mutual ends.

If that is an idealized picture too seldom encountered, in psychotherapeutic practice anyhow, I know we are all too familiar with the clinical syndrome of cruelty in the home. What a paradox it is! Cruelty is the antithesis of kindness, and the disposition to inflict unnecessary pain. Humiliation of the ego is the equivalent to injury of the body and results in a dissolution of the parts. The threat of it is the origin of an anxiety neurosis. The result is a degradation of the civilizing process based on the natural law of development, the fragmentation of the ego, leading to a schizoid personality or to delinquency. In any discussion on cruelty in the home one cannot omit at least a passing reference to sadism, the chief characteristic of which is the absence of any tender emotion linked to sex. Aggression, by means of flagellation for example, has to be introduced to procure orgasm. It is the link between mental and bodily cruelty. Maladjustment and cruelty in the home give rise to maladjustment and crime in society. The married masturbator and the married homosexual inflict a greater devaluation of the partner's body and ego, more cruel than ordinary adultery.

Many of my colleagues fight shy of forensic psychiatry, but I regard it as part of social medicine, the study of healthy individuals in a healthy community. The anti-social element in suicide is recognised by the fact that is an act of revenge against society as well as a retreat from it. Schizophrenics commit the most violent acts to which they respond as if nothing had happened. Paranoiacs commit crimes against people to publicize their grievances. Alongside these aggressive acts is the lack of guilt-feeling, and the craving for innocence which is so regressive towards immaturity. Displacement of responsibility is an insidious malaise from which we are not entirely immune. Balint refers to it in his " collusion of anonymity ", which he traces to the perpetuation of the teacher-pupil relationship, a relationship which again could be reduced to the parent-child relationship and the age of irresponsibility if not of innocence. But blame is the expedient of impotence. If we condemn we cannot treat; if we condone we cannot educate. What we aim at is to release patients from unconscious compulsions towards conscious aims, from fear towards security, from aggression towards tolerance, from infantile dependence towards adult co-operation, from inhibitory conformity towards spontaneity, from prejudice towards rational judgment, from guilt-feelings towards the volitional

acceptance of personal responsibility and consequences. In short, we aim at re-education.

Success in psychotherapy as in the other half of medicine depends on several factors, one of which is correct diagnosis. It cannot succeed when the symptoms are an expression of a basic biological defect as in one homosexual whom I met whose androgens were as much below normal as his oestrogens were above. The analysis of an oedipal situation does not remove a cerebral tumour; nor does a course of ECT. A young policeman with sciatica was referred because of agitated depression, but he had sarcoma of the vertebrae. Another policeman was referred because of psychasthenia. I could elicit no positive psychological findings and advised further investigation which resulted in a diagnosis of Addison's disease. One of our surgeons wrote, " Please advise if further investigation necessary." Again I found no adequate psychological cause, and said so, much to the surprise of the surgical mess. Carcinoma of the thyroid was the result of the further investigations.

This is the convenient moment to say a word about malignancy, with which you are more familiar than I am, so I know I am deliberately treading on debatable ground. Denial is a universal reaction to cancer, and may even take the form of hypomania. The surgeon who refuses to tell and rationalizes his reluctance as being for the good of the patient is usually one whose own ego is on the defensive against reality and whose life probably lacks deep, meaningful, emotional relationships. There is something wrong with an ethical code which permits a deliberate lie on such an occasion. A mature physician chooses his time for imparting the truth, and is willing to devote the time for the subsequent discussion, relying on his own psychic energy and strength to enter into an honest, frank, patient-doctor relationship without being emotionally threatened. A person who is afraid of life or death and whose vital energy is used up in the defence of an insecure ego has a hard time in the fight against cancer. The disease is rapidly fatal in the over-anxious and the tensely inhibited. Ego defensiveness and loyalty to reality can both be tested by the Rorschach technique.

Lack of success in psychotherapy also depends on several factors, among which one would mention the counter-transference, or in less technical terms strong aggressive drives on the part of the patient—in short, his capacity to hate. Depression is obvious to any layman, but is it the underlying hate which the intuitive physician senses and which can make him unreasonably uncomfortable, so that when he learns that the disposal of hate is the great problem of the depressive he is inclined to give instantaneous assent. It is this hatred of the aggressive feelings towards the self and others which culminates in

the act of suicide, infanticide, or homicide. It is hate which the obsessional is preoccupied with. The hysteric's intense love-relationships are an over-compensation for rejection. The paranoid hates blatantly. The schizoid loves to hate. It is this capacity to hate and the patient's techniques for dealing with it which can arouse strong irrational feelings in our colleagues, but to us provide a challenge to our understanding and our competence to cope. Freudian analysts know that it is the negative transference which calls for all their skill, experience and patience. I fully agree, because unconscious, uncontrolled hate is the retarding factor in the process of civilization, which is the evolution of consciousness.

The value of psychotherapy lies in the dividends which it pays to our patients and to ourselves. I have mentioned them earlier, so I will refrain from repetition, but I will conclude by saying it is a thrilling experience to participate in the change from nature to culture, from instinct to a spirit as dynamic and urgent as any instinct, from the physical to the psycho-social.

The Pattern of Domiciliary and Institutional Confinements in Ealing. 1958. G. MARGARET MCDONALD M.B., B.S. *The Medical Officer* (30th October 1959) **102**, 225.

An increase in the demand for domiciliary midwives in Ealing led Dr McDonald to make this inquiry. Over the last six years there had been a steady increase in the number of home confinements, whilst the number of hospital births had remained steady. Eight hundred and eighty-nine women who had been confined in 1958 were interviewed and a questionnaire completed by health visitors. The questions were designed to find out the preference amongst the mothers for hospital or home confinements. Six hundred and seven chose to have a hospital confinement but seventy-three of these had to have a home confinement, and two hundred and fourteen were confined at home by choice. Sixty-eight were confined at home but not by choice. Of the seventy-three who were confined at home against their wishes ten were primigravidae and all ten decided, on retrospect, that they really preferred to stay at home. Thirty-eight of the sixty-three multigravidae expressed a similar satisfaction with their home confinements.