Reuben Bitensky

TUMULT IN THERAPYLAND

There is no profession where social change receives more approbation and less application than psychiatry. It is considered salubrious for patients and clinicians alike. This zeal for the innovative has produced an amazing proliferation of therapies. Beyond this psychiatry even preempts a trailblazing role among the behavioral sciences for its evolutionary approach. Freud's social side has been resurrected and now it is acknowledged that the founding father devoted considerable attention to the social aspects of psychoanalysis.[1] That this tendency is alive and prospering is inferred from the emergence of psychohistory, which may even replace community psychiatry—whose lustre has faded —as an example. However, before the profession is crowned with laurel, it might be well to determine whether this appraisal is apparent or real. A more critical analysis seems to indicate that psychiatry has incorporated social influences—up to a point. At first the social component was given consideration. But, unfortunately, this tendency lost its momentum by the end of the first quarter of the twentieth century when it was assumed that the ideal society had been attained. It was irrelevant, therefore, to be concerned with social conditions that had little or no influence on the patients. As a consequence short shrift was given

[1] There is some justification for this assertion when writings such as the following by Freud are considered: *Civilization and Its Discontents,* New York, W. W. Norton, 1962; *The Future of an Illusion,* New York, Anchor Books 1964; *Moses and Monotheism,* New York, Vintage, 1955; *Totem and Taboo,* New York, Vintage 1975.

to the revolution in technology and the dehumanizing aspects of man's displacement by the machine, to the exacerbation in social problems and the enervating feeling that nothing could be done about them, and to the rampant confusion and hopelessness of a community bereft of an ethos. As was inevitable this professional euphoria resulted in the neglect of the behavioral and psychic implications of these technological and institutional developments. Instead an intriguing anomaly occurred wherein society was perceived as being static and therapy dynamic. There was no reason for methodology to concern itself with the impact of changing values, attitudes, and commitments of patients arising from an evolving society. Modifications in theory seemed possible independently of the environment—at least for the forseeable future. It is not surprising that this formulation fostered the notion that the psychiatrist's roseate view of the world and the patient's were identical. There was no inkling that an ambient mistrust might create doubt whether the practitioner's allegiance was pledged to the patient or the establishment. The din about the upsurge in alienation tended to be regarded as an idiosyncratic academic preoccupation having only minimal implications for treatment. Similarly there was almost no recognition that the much heralded search for identity had been superseded by the pursuit of nonentity, thus everting one of the major problems of psychiatry. And, how could it be otherwise when conformity had become a necessity for survival in a society where to be unique was to be vulnerable? Similar indifference was exhibited in regard to some major impediments to accepted goals of therapy. Wasn't love an almost impossible objective in a competitive society where property relations took precedence over human relations? Wasn't self-fulfillment destined to frustration and creativity doomed to cynicism as these goals became unattainable? This discrepancy between illusory treatment objectives and the limitations of everyday living shows that therapists and patients inhabited different planets. They had in common only the belief that the miracle of the monetary transaction would assure a cure even in the absence of means of communication and empathy. Ludicrous as these expectations were, it was the therapist rather than the patient who was susceptible to the self-delusion that a bygone historical era might illuminate current practice.

The reason that psychiatry has been able to sustain this antiquated concept of the patient's life-style is by the arbitrary separation of psychotherapy from social influences. In fact, some therapists even go as far asserting that treatment is impossible without the extirpation of reality. Thus, the biographer of R.D. Laing states:

> To embark on such a journey—to go mad, in Laing's sense—is to give up all certainty, to lose all distinctions one has ever made between real and not real, good and bad, here and there, now and then, you and not-you. *Clinging to these profoundly uncertain certainties may be at the root of all our madness, schizophrenics and normals alike.* (my emphasis).[2]

While most therapists will not subscribe to such extremes, nevertheless, their antipathy to reality is demonstrated when past and present therapeutic orientations are compared. The basic premise of traditional psychotherapies was that while the patient's adjustment might be deteriorating, nevertheless, his world was intact. Thus, the therapist could confidently suppose that if the patient could be mobilized to reorganize his inner world, his efforts would be reinforced by the outer one. There was nothing contradictory about the therapist being considered as a representative of society. The patient could use him as a model for rejoining the so-called normal majority. While the patient still was beset by some nagging doubts and ambiguities, it was an ideal situation for the therapist. His clientele continued to multiply in the expectation of finding inner solace and outward poise. Therapy and reality were reconciled since both seemed to promote mutual goals for the patient.

However, in the past two decades both therapist and patient are confronting a process of social disintegration of such proportions that it can no longer be ignored. It has contaminated the therapeutic relationship so as to threaten its viability. The patient does not come to the counselor for cure but in flight from a chaotic world and seeking sanctuary in mental

[2] Richard I. Evans and R. D. Laing: *The Man & His, Ideas,* New York, Dutton. 1975. Quoted by Anataole Broyard in "Books of the Times," *N.Y. Times,* Nov. 19, 1975.

illness and therapy. The implications of this are most starkly revealed in considering the reversal in the therapist's attitude toward the patient. As has been mentioned in less troubled times the therapist benignly, if paternally, excused the patient's deviance since the patient admitted his aberration and aspired to normality as defined by the psychiatrist. However, as the social scene deteriorated, a change took place in the therapist's attitude toward the patient—one in which the patient was transformed from the praiseworthy seeker for mental stability into the recalcitrant therapeutic ingrate. This occurred because of the increasing disregard of the erosion in the patient's daily life to the extent that the patient became the realist and the therapist the escapist. This reversal of roles was reflected not only in the nature of the therapeutic relationship but, also, in the theory undergirding it. For as the social milieu exerted more and more pressures on the patient, neglect of the social variables made it almost impossible to understand the immediate impact of social forces on the patient's psychological condition. Such disregard partialized perception of the patient since cumulative social experiences form an integral part of the total psyche and are significant determinants in molding personality. And as this fragmentation of the patient inevitably contributed to therapeutic incompleteness and inadequacy, it is understandable that the path of least resistance was to foist systemic failures on the shoulders of the patient by conceptual and attitudinal means. If society offers myriad opportunities for personal development, then who is at fault but the patient? This contention was reinforced as traditional therapy continued to blur the interconnection between treatment and the outside world. In fact, the patient was expected to eschew the intrusion of his practical problems into the therapeutic session. The hidden message conveyed to the patient was that if he wished to maximize his treatment it would be best to concentrate on instinctual drives and leave the actualities of life in the anteroom. As this effacement of the abrasive social environment gained momentum, it promoted a subtle and yet pervasive pattern of theoreticians unwittingly and yet on seemingly scientific grounds apologizing for the system. This occurred through the strategy of muting social dysfunction while overemphasizing therapeutic capacity to transform personality and behavior. Finally the problem was resolved when social dysfunc-

tion was transmuted into personal malfunction. This trend assumed varying forms for different psychological orientations, but, nevertheless, the basic impetus of professional—and concomitantly—systemic protection was dominant.

This process may be traced in different psychological approaches. Analysis of Freudian psychology demonstrates that originally it contained some critique of society. It was based on the premise that pathology is caused by social constraints on libidinal drives, antagonism between man and society being the *deus ex machina.* However, as Freudianism developed, it devoted less attention to attenuating social inhibitions and, willy-nilly, improvement became a purely personal responsibility under the omniscient tutelage of the therapist. This process was furthered as psychoanalysis divorced practice from the real world and its disciples became unable to differentiate between conceptual replicas and living people. As the theoretical apparitions multiplied, the real people decreased. And, of course, as treatment focused ever more on ghosts fewer benefits accrued to patients. The extant therapeutic model, the neurotic of Freud's Vienna, had little in common with the bureaucracy-ridden, technologically bedeviled, expendable individuals of our time. But as psychiatry clung to its conceptual framework, it was logical that man should appear more and more irrational in a beneficient society. The obvious conclusion was that mankind rather than the organizational arrangements required revamping.

A similar syndrome emerged in ego and existential psychology. In this instance there was a different psychological topography, nevertheless, their therapists, also, were seduced into scapegoating the patients. In contrast to the orthodox Freudians they proposed that pathology was a consequence of malfunction in the individual's problem-solving capacity. Also, as ego psychology had been unable to fulfill its high expectations it became much easier to blame people rather than reflect on professional deficiencies. Certainly it was much more comfortable and less guilt-provoking than exploring whether patients might do better in therapy—or perhaps dispense with it altogether—if problems were manageable. As could be expected these therapists devoted themselves increasingly to building ego strength with little or no consideration of the comparative resolvability of problems at given stages of social development. To further complicate matters the therapist

was confronted by the secondary problems arising from distortions in the patient's personality as he was overwhelmed by impossible tasks. It became a gargantuan task to disentangle the original dysfunction that brought patient to doctor from the iatrogenic complications. In the same manner existential psychiatrists altered the formula but not the result. For them the individual was troubled because of inability to live in the present. Did they consider whether the past equipped the individual to cope with the present; whether the present was livable; and whether the future was promising enough to warrant anticipation?

The same pattern emerged in behavior modification. Normal behavior was to be promoted by more adequate responses to stimuli and by reinforcing these responses. Pathology supposedly arose from inappropriate response patterns. Their simplistic notion of human behavior was supportable not only because they dealt only with manageable individual stimuli but also because they assumed that individual stimuli could be separated from a welter of complex social stimuli. Given this basis it was natural to arrive at the conclusion that individual behavior and attitudes may be modified regardless of changes in the social milieu. They forgot Hegel's famous dictum that whatever is real is rational and that, therefore, it behooved the social scientist to explain how a rational society could elicit irrational responses unless it, too, was irrational. Like their brethren the behavior modifiers are liable to the accusation of putting the burden of responsibility on the individual, absolving society, and by so doing justifying the status quo. Of course, these considerations are not pondered by most therapists. They accept the airy hopes of the social engineers about the functional society that will usher in a new era without asking for whom. It may be noted that behavior modification does not require even therapeutic failure as a motivation for impugning the patient. First, because as a psychological retread it is still riding the crest of acclaim accompanying most new therapies. Secondly, behavior modification assumes that what makes behavior normal is the fact that it is traditional. Once social control is axiomatically accepted as a therapeutic objective, success is guaranteed when patient activity responds accordingly. Of course, this explains why among the therapies behavior modification is the fairest of them all.

As is obvious the systemic malfunction of our time is creating as many problems for the therapist as the patient. For while it is still possible—and most therapists are still so engaged—to exonerate the system, it is becoming a more and more hazardous undertaking. For therapy becomes increasingly unproductive, if not irrelevant, if the destructive effects of society intrude upon the therapist/patient relationship. The victimization of the patient by the therapist fosters a guilty conscience in the therapist, makes the patient distrust his motives, and casts a pall of misunderstanding and suspicion over the helping process. Nevertheless, as long as vested interest encourages professional credulity, the practitioner finds it increasingly difficult to exculpate society. The relationship with the patient is weakened. Public esteem for the practitioner's expertise is undermined. The psychiatric community then has to respond to this crisis in confidence. The most obvious reaction is to deplore past failures and inflate present and future expectations. Therapy envisions triumphs in personality reorganization that will enable the patient to cope with whatever stresses arise—be they internal or external. As an example, in bio-feedback the patient is supposed to induce the appropriate brainwaves so that he can face life with equanimity rather than anxiety. Or twenty minutes of meditation on the subway will permit him to handle the stresses of the job successfully—nay, it will even go so far as enabling him to dismiss these pressures as insignificant. Even in the face of death therapy assures profound therapeutic benefit, if not immortality.[3] Or else therapy is supposed to provide the instrumentality by which society will cure its ills. Thus, the proponents of Transcendental Meditation assert that when a certain minimum level of meditating populace is attained it brings about a drop not only in the blood pressure but, also, in the crime rate. Similarly, the behavior modifiers assert that their therapy represents a form of social engineering whereby utopia will arrive.[4]

The second way to deal with the psychiatrist's ambiguous role is to deny that mental illness exists. (As is evident, this is

[3] Kubler-Ross, Elizabeth. *Questions and Answers on Death and Dying,* New York, McMillan, 1974.

[4] Skinner, B. F. *Beyond Freedom and Dignity,* New York, Bantam/Vintage, 1972.

the other side of Laing's formulation that reality ought not to exist. However, it is much more tenable because less extreme.) While this formulation promotes an aura of humanism since it seems virtuous to annihilate pathology by such creative nihilism, actually, its basic stance is reactionary. It is plain as day that mental illness is a major problem of our society and no amount of semantic subtlety can belie the multitudes that flock to clinics, private therapists, social agencies, and mental institutions. Why, then, this medical shell game in which pathology appears and disappears? It may be that the real purpose is not to disprove mental illness, but to hide the bankruptcy of therapy; not to protect the patient from labelling or loss of civil rights, but to protect the therapist from criticism for outmoded, unproductive practice that is threatened by social realities. If mental illness is a chimera, it is no longer necessary to evaluate the expertise of the professional. But the abolition of mental illness had not led to the end of treatment. Instead there has been a phenomenal burgeoning of therapies. And with all this richesse who is to say what works? Before the public can express its disenchantment with the latest mental health fad a new nostrum is introduced to guide the perplexed. In contrast to most scientific endeavors where progress poses new problems, psychiatry has been treating us to new psychotherapies to divert attention from the latest fiasco. Psychiatry may well have achieved the acme of disingenuousness by professing to cure non-patients of imaginary maladies.

The objective scientific observer as well as the layman might well wonder why psychiatry spends so much time and effort in mass producing ineffectual therapies. For this activity is akin to being on a therapeutic treadmill where the faster the discipline goes the more it stands still. But could it be otherwise when a profession is beset by the contradiction of insisting on personal change while condoning system inertia? As long as this double standard is maintained it is dubious whether further advance in psychotherapy is possible. As long as modern practitioners refuse to admit that both individual and society are in flux so long will they be reduced to generating one-sided, ill-considered therapies based on flimsy, inconsistent conceptualizations. As a consequence they will be unable to assess realistically either the potentials of psychotherapy or its limitations.

Continuation on the present course may not only lose respect for the profession but, also, undermine its scientific foundations. As is known from anthropology when rational scientific explanations are avoided there is recourse to the supernatural. Thus, as could be expected there has been an emergence of mystical therapies such as Transcendental Meditation, Zen, Yoga, confessional therapies, and similar analeptics. For there is ample incentive for the therapist to disavow his scientific legacy and adopt faith healing. Aside from the fact that his scientific approach has not worked, there is a real temptation to turn to the occult rather than considering all the empirical data by including the social variables. The attraction of mystical therapy is that it offers a spurious solution to the problem of man versus society, relieving the therapist of the hazard of being critical of society. For mysticism is not only supposed to effect drastic changes in individuals but purports to have the power to humanize society within the existing social structure. This offers the best of all possible worlds for our harassed therapist. No longer can he be accused of neglecting the social aspects of therapy at the expense of the individual. He has discovered the ultimate therapeutic prescription for remolding the individual within existing society and at the same time improving society. How better to help the client and protect his professional interest! Practice becomes perfect through inspirational therapy which influences social organization by means of the cumulative effects of individual treatment and without altering society. Of course, this causes little concern in the corridors of power since the millennium is being postponed until a sufficient number of people have been regenerated. There is not even the remote danger of the assemblage of patients that might stimulate some rash ideas through their mutual interaction. Propriety and order is assured as the individual is either reprogrammed in the sanctified environment of the clinician's office or in the controlled atmosphere of encounter groups.

But the conversion to mystical therapy brings with it a dilemma of its own. The psychiatrist's adoption of the shaman's role is done at the sacrifice of his role as the scientist and professional. For scientific investigation is negated when therapy is based on belief rather than facts and experience, and the professional status is endangered since no credentials are required for faith

healing. Thus, mystical therapy is as ineffectual in resolving psychiatry's dilemma as was the attempt to nullify pathology. Followed to its logical conclusion it can only result in psychiatry becoming an amalgam of cults vying for popular favor on the basis of esoteric rituals rather than scientific expertise. The resort to such a spurious solution is explainable, if not excusable, by the fear of failure of treating people in a society that dehumanizes them and an unwillingness to criticize society for giving it the task of Sisyphus. Already the mental health professionals have had sufficient humiliations from disregarding the conflict between the dehumanizing aspects of the social system and the psychological needs of the individual to warrant some soul-searching. They only have to consider what has happened to the bright promise of community mental health programs which degenerated from enthusiasm for community involvement in the rehabilitation of the mentally ill to the self-deception involved in dumping their patients upon unprepared, unreceptive localities. The so-called deinstitutionalization policies evolved into cynical revolving-door programs where tranquilized patients, more traumatized than ever, were shunted back to the hospitals by the community. However, it is rather easy to discern the social aspects of this situation. What is more subtle and complex for the therapists to perceive is how professional territorialism results in reluctance to evaluate critically the efficacy of their programs and practice. By accommodating themselves to the existing institutional arrangements and ingratiating themselves with the power brokers within their own profession and in society at large they have impaired their ability to evaluate objectively and critically their own activity. As a result not only their own attitudes and values but their theoretical constructs and practice have been contaminated by extraneous considerations of vested interest.

A forthright approach to this crisis seems to suggest acknowledging dehumanizing forces in society and establishing criteria for professional practice. As a preliminary step this means a comprehensive approach to the role of the individual in society where the interconnections between the social and individual are considered. It signifies understanding that personality dynamics are themselves molded and determined by a broad range of social as well as individual and familial experiences with conse-

quent effects on social dynamics. While much attention has already been devoted to the subjective aspects and while this should continue, it should not be to the exclusion of the social component. Therapists ought to be asking themselves the psychic implications of the kind of world the patient inhabits; the organizations that impinge on his daily life; the psychological effects of his work; the contributions of his neighborhood; the psychological derivatives of his class position, to mention but a few. For as two pioneers in this area have put it:

> ...the socialization process not only enriches the knowledge and skills of the child; it precipitates essential changes in various psychic processes and engenders a genuine development of the child's psyche as well.[6]

As one considers the foregoing, it is evident that the development of psychiatry requires a broader, more interdisciplinary, and more scientific perspective. If the socialization process of the individual emanates from and is influenced by a chaotic society, his individual development has elements of the purposeless and uncontrollable and evokes an effort to contend with this disorder. If this is the case, is therapy possible unless therapist and patient engage in the process of considering how the social and individual dynamics intertwine in contributing to the individual's development? Can the therapist disregard the fact that the patient considers himself the plaything of social currents and that his uniqueness can only be forged by his activity in harnessing and guiding these forces? These issues have profound implications for the role of the therapist. In the most comprehensive sense it means that psychiatry has to grapple with the fact that it is society rather than the patient that is culpable—with the inevitable consequences for theory and practice.

[5] Szasz, Thomas. *The Myth of Mental Illness,* New York, Hoeber-Harper, 1961.

[6] A. V. Zaporozhets, and D. B. Elkonin. *The Psychology of Preschool Children,* Cambridge Mass., M.I.T. Press, p. XVIII.