Cognitive-Behavioural Therapy and Existential Analysis

Reflections on Current Psychiatric Training and Practice in the United States

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The Debate on Mental Illness

On October 30, 1977, Thomas Szasz, MD and Albert Ellis, PhD, debated Szasz's notion that mental illness is a myth. Viewing the encounter more than thirty years after it was videotaped remains an exciting experience for clinicians, especially those who share Szasz's concern about involuntary treatment of deviant behavior by physicians and have seen cognitive-behavioral therapy (CBT) become the default treatment modality for both inpatient and outpatient psychiatric services. Revisiting the debate serves as the occasion for some reflections on the ubiquity of CBT as the treatment modality of choice by psychiatrists in the United States.

Rational-Emotive Behaviour Therapy (REBT), the term chosen by Ellis to represent his version of what is now generally called CBT, is the currently the only psychotherapeutic treatment modality taught as part of the regular curriculum residents experience in psychiatry training programmes in the United States sanctioned by the American Psychiatric Association (APA). About ten years ago, however, following a renewed interest in the psychodynamic approach, the APA began to review its preparation of psychiatrists. Evidence-based research was not showing that CBT produced notable improvement in patients. Moreover, there was fresh interest in the psychodynamic perspective thanks to the work of scholars such as Mark Solms (2002), a British psychoanalyst who has published research on correlations between the findings of neuroscience and those of psychoanalytic investigations conducted in the clinical setting. In the wake of these two sorts of research findings, the APA began to mandate the directors of hospital training programmes to include seminars on psychodynamic principles of diagnosis and treatment in their curricula as well as training in CBT. Before sitting for boards in psychiatry, residents are being tested on their knowledge of psychodynamic principles. The instrument in use is still under development. Interest in the work of neuropsychologists was accompanied by the appearance of the *Psychodynamic Diagnostic* Manual (PDM) (2006), which is both a supplement and challenge to the *Diagnostic and Statistical* Manual (DSM-TR) (2000), which clinicians have used in labeling patters of psychological disturbance as psychological disorders since 1952. DSM coding is based

on the identification of signs of certain behaviours and reports by patients of subjective distress. The diagnostic code (or codes) determines a patient's treatment plan, and the extent of insurance coverage of inpatient and outpatient care, which is extremely costly, is sensitive to these codes. This plays out in terms of the time allotted a patient for expert care (days of inpatient care, number of sessions of counselling, medication compliance visits).

Three years ago, I was invited by the director of the residency programme in psychiatry at a large private urban hospital to lecture and give seminars and clinical demonstrations on **psychodynamic principles** to about a dozen residents in one of their four post-graduate years (PGY) of psychiatric residency. During that time I was able to learn about the extent to which CBT is used in such settings.

During my orientation meeting, senior staff reported that some third- and fourth-year PGY residents had experienced a six-week training programme in CBT provided by an outside consultant. This was their only preparation for "doing psychotherapy" with patients. The bulk of their training consisted of learning methods of intake interviewing, assessing signs and symptoms of emergent psychological disorders, making diagnoses based on DSM-IV principles, and arranging treatment plans: hospitalization if deemed necessary, the prescription of psychotropic medications, and the use of CBT when residents went on to see patients in follow-up sessions after being discharged from the hospital.

For a year, I presented weekly three hour-long lectures and seminars on psychodynamic psychiatry. These hours included clinical demonstrations with inpatients to acquaint residents with the application of these principles, but also those of my existential approach to working with individuals. The basic text was Glen Gabbard's *Psychodynamic Psychiatry in Clinical Practice* (2005), which I supplemented with four volumes of selected papers on classical psychoanalysis, object relations theory and self psychology.

With few exceptions, psychodynamic theory was for the most part completely new territory for the residents. Some had not even had an introductory psychology course as undergraduates. One, who had majored in psychology before going to medical school, had been taught that psychology is the study of human behaviour (not experience) and that psychodynamic considerations were pretty much passé. The residents were not pleased that my lectures had been added to their otherwise extremely busy schedules and, as I learned through the year, their supervisors were unconvinced of the value of the new APA initiative. As I learned, they expected more of what they had heard about CBT.

If they had attended the six-week training programme in CBT and used it with patients, they were skeptical about its usefulness, both on the ward and in private outpatient sessions. They noted that since their inpatients

were often unclear about their thoughts (a situation which was usually exacerbated by the effects of the medications they were taking), asking patients to rethink the logic of their behaviour fell on deaf ears. CBT with outpatients was confined to persuading them to take their medications.

At first, they found the existential approach I brought to the seminar table in principle superfluous, since as psychiatrists, they believed, the only effective treatment modalities were "milieu therapy" and psychopharmacological interventions. Psychotherapy of any kind was the province of social workers, clinical psychologists and counselors.

Clinical Psychiatry and CBT

How did CBT make its way into psychiatry? At the time of their debate, Ellis's methods were already widely used by psychiatrists. Psychoanalytic psychotherapy had become cost prohibitive for most patients. Changes in managed health protocols that were put in place in the decade following the debate made long-term psychodynamic psychotherapy unfeasible. CBT had gained its caché on the grounds that it could be effective over the course of only a handful of sessions.

At the time of the debate, Ellis was well known for REBT, which he had first written about in 1959 as "rational psychotherapy." Szasz, whose landmark paper "The Myth of Mental Illness" had been published in 1960 in *American Psychologist*, was seven years Ellis's junior. Both had trained as psychoanalysts and both had abandoned the movement. Ellis dismissed psychoanalysis as having failed to understand how and why individuals persist in believing in what they had assumed to be the case as children. As adults, Ellis held, they should know better, think logically about their condition in life and, in effect, "grow up." Szasz had become a stern critic of psychoanalysis in series of publications on theoretical difficulties with psychoanalytic theory.

Formal and eloquent, Szasz presented his by then well-known view that mental illness is an ailment only in a metaphoric sense and that, in treating such ailments, psychiatrists are only physicians in a metaphoric sense. While recognizing the reality of neurological pathology and advocating whatever care was available to those afflicted with diseases of the brain and nervous system, Szasz denied the meaningfulness of psychopathology and, hence, psychotherapy. Direct and authoritative, Ellis defended the usefulness of the system of psychopathology enshrined in the DSM.

Both were very much aware of their audience. Since the content of the debate is so well known, it remains to summarize the interlocutors' conclusions. For Ellis, psychiatric or psychotherapeutic treatment was necessary to provide for the safety of the community. For Sazsz, the sovereignty of the individual must always trump what Szasz considered to be the intrusion of the medical establishment into the lives of independent,

self-responsible citizens whose autonomy should be honored above all else. If an individual's behaviour had become dangerous to others, it should be controlled, not by physicians but by authorities of civil order. Szasz's views have become aligned with the "libertarian" political stance. Ellis's concerns remained those of the clinical psychologist, understood as a professional mental health care provider committed to providing expert treatment of individuals whose psychological suffering had rendered them incapable of functioning optimally in their everyday lives.

Szasz's critique had always been directed against the management of an individual's life without the latter's consent, whether it be by labeling (psychiatric diagnosis), enforced confinement (hospitalization), or the chemical control of behaviour with medications. Ellis admitted that individuals are sometimes unable or unwilling to admit that they wish to have their behaviour modified. In that case, REBT had to convince them of their psychopathology and go about eliminating it.

Both Ellis and Szasz had seen the advent of psychotropic medications in the 1960s. At the time of the debate, perhaps neither might have predicted the increasingly widespread use of medications in lieu of psychotherapy or as an adjunct to psychotherapy and hospitalization. While Ellis believed that psychotropic medications had their place in the treatment of mental illnesses, only Szasz had the power of the prescription pad, which evidently he has used only sparingly, if at all, through the years.

While they fundamentally disagreed about how to conceptualize aberrant or deviant behaviour, both held that talking with an individual could have a beneficial effect. Szasz has written of his willingness to talk with individuals who consult him about their ways of coping with the inevitable stressors of everyday life. For Ellis, however, part of the therapeutic rationale of REBT is to convince the mentally ill person that he is not well and needs to become better. A certain way of talking with those who consulted him was also required. Oddly enough, in the end Ellis and Szaszs may be said to agree about the efficacy of talk and its possible influence on another person's life. But what sort of talk and to what end? In the end, of course, for Szasz discussion of the use of CBT in treating mentally ill persons simply does not make sense, except insofar as it is yet one more illustration of, at best, a basic misunderstanding (that there is such a thing as mental illness) and, more ominously, the abuse of power by medical doctors.

The Szasz-Ellis debate goes on with out them. Ellis died in 2007 in the midst of rancorous disputes about the management of his institute. Szasz, who is 90, continues to publish. More than thirty years later, Ellis may be said to have lost the battle but won the war, however, insofar as mental illness is taken ever more seriously in psychiatry and clinical psychology and by the public. Moreover, REBT and other forms of CBT are the psychotherapeutic treatment modality of choice by psychiatrists.

Here we will leave behind Szasz's campaign against the imposition of "care" on unwilling individuals and focus on the ubiquity of CBT in psychiatric practice. Like both Ellis and Szasz, I have not abandoned the notion that a certain kind of verbal encounter between individuals can be therapeutic, but everything depends on what is meant by therapeutic. I will argue that the interventional stance of CBT in principle cannot be therapeutic, but that an existential approach can provide individuals with an experience that not only preserves their freedom (which would satisfy Szasz) but even enhances it. On the other hand, CBT, which now dominates psychiatry when psychotherapy is used, robs the individual of his freedom. While there are differences in textbooks of counselling between CBT and REBT, for the purposes of this discussion I will treat them as equivalent and use Ellis's model as exemplary of the cognitive-behavioural modality.

Rational Therapy

A brief look at one of Ellis's first papers is an illuminating starting point for the discussion of CBT since it contains all of the elements of what became known as REBT. Since it is the text of an address, it also gives us an idea of the personality of the founder of REBT.

Soon to be famous for his use of four-letter words in the austere setting of meetings of the American Psychological Association (APsA), Ellis (1959) gave his seminal paper at a meeting of the APsA on August 31, 1956. All of the basic elements of REBT are articulated in it. For Ellis:

(1) "A large part of what we call emotion... is nothing more or less than a certain kind... of thinking," and "in certain (though hardy all) respects [emotion and thinking] are essentially the *same thing*, so that one's thinking *becomes* one's emotion and emoting *becomes* one's thought" (36).

(2) Thinking as emoting or emoting as thinking "tend to take the form of self-talk or internalized sentences," and "for all practical purposes, the sentences that human beings keep telling themselves *are* or *become* their thoughts and emotions" (36).

(3) Emotion thoughts (my phrase) tend to be equivalent to one or the other of the following evaluation sentences: "This is good!" or "This is bad" (37).

(4) "That neurotic or emotionally disturbed behaviour is illogical and irrational would seem to be almost definitional." "Neurosis... consists of stupid behaviour by a non-stupid person" (38).

(5) The treatment of "emotionally disturbed behaviour" or neurotic behaviour consists in "teaching… clients to organize and discipline their thinking" (35). It focuses on re-educating patients who persist in believing what they *know* to be "nonsense" (42). REBT is the treatment of a "secondary neurosis," the pathology of which consists in persisting in

"incompetent and ineffectual behaviour" (38) that was first practiced by a person in his childhood and led to the formation of his "primary neurosis," but can be abandoned by the logical, rational adult he has become.

Inpatient Treatment, Psychotherapy and CBT

Much as the use of psychotropic medications has become part of the life of the "mental patient," so has the use of CBT in counselling such and individual. It remains to look at the reasons for its popularity and, until psychodynamic principles perhaps once again come to inform practice, its hegemony in psychiatry. I will limit my comments to work with inpatients, since this groups of individuals most concern Szasz, and my recent experiences with residents in psychiatry may shed some light on why CBT is employed (albeit grudgingly and, it would seem, halfheartedly) by psychiatrists with their inpatients. I will also note the response of young psychiatrists to ideas based on existential analysis.

To begin with, my young psychiatrists were not convinced that there is any place for psychotherapy of any stripe in psychiatric treatment. Meetings with patients in the emergency ward consist of assessing the prospective patient's danger to himself or others. If this cannot be established, the patient will not be admitted for observation and treatment unless he asks for it. If malingering is suspected, the patient may be discharged. If intoxicated, he may be urged to voluntarily enter another facility in the hospital for medical treatment (detoxification therapy). If he is actively hallucinating, he may be medicated in the emergency room and observed for a period of time before the decision is made where to admit him. Many patients are returning visits to the emergency room. The emergency room staff recognize these patients who may be diagnosed with a chronic factitious disorder (a DSM classification). Many chronic patients are known to be looking for "three hots and a cot" (practitioners' jargon for hospitalization for a period of time during which the patient is fed and has a safe place to sleep). This seemingly cynical appraisal of the person whose identity is chiefly as a "patient" must be considered in view of the psychiatrist's first duty as a physician, which is to care for others. There is little opportunity for psychiatrists to establish a profile of the first-time psychiatric emergency room patient. After the "intake" protocol (a series of standard questions) has been satisfied, if there has been talk of suicide or violence against others, the psychiatrist is obliged to see to the legal requirements of admitting the person for observation and treatment. As noted, some patients are quite willing to be admitted, for the reasons given. Others are strongly opposed and resistant ("negativism"). Treatment will consist of the prescription of one or more psychotropic medications. If threats of self-harm have been strident, nursing staff on the ward will keep a "suicide watch" near the door of the patient's room. Often heavily

medicated, inpatients gradually resume routine activities. Concurrent medical conditions are identified and treated. After the prescribed period of hospitalization has passed a decision is made by senior staff as to whether the individual may be discharged. Most patients are then prescribed medications to be used on an outpatient basis and a follow-up compliance appointment is scheduled.

Residents report that noncompliance with taking prescribed medications is the most common issue of follow-up visits. Apart from arranging for the provision of services by social workers and institutions known to the hospital where patients may live if they cannot return home or are homeless, the psychiatrist's other subsequent contacts with the patient may include a limited number of CBT sessions. The number of sessions is determined by the insurance coverage carried by the patient. Individuals receiving public assistance are allotted a limited number of visits. A fresh episode of illness is required to renew the cycle of covered care.

While teaching the residents, I asked to sit in on psychotherapy sessions with inpatients. I learned that none ever took place. Such sessions were to scheduled only for the patient after his discharge. All the same, several residents claimed they had informally carried out CBT with inpatients, usually in a commons room or, rarely, in the patient's room. Two conference rooms were available on the ward I visited, but these were used for staff meetings or, on certain occasions, to interview a patient's family members or reunite the patient with his family.

In conformity with the principles of REBT, the residents reported, they sometimes spoke with a patient about certain misconceptions the patient might have. As Ellis recommended, they acted as educators, "teaching these clients to organize and discipline their thinking" (1959, 35). Much the same approach was taken by PGY 3 and 4 residents in sessions with patients who had been discharged. I sat in on a number of these sessions. Using principles of CBT, the psychiatrist usually urged the patient to "rethink" his noncompliance with taking prescribed medications and to understand that this was the rational thing to do, since taking the tablets would make the patient "feel better" over time. The success rate of using REBT with outpatients to reach this goal (compliance with taking medications) was reported by residents and senior staff as extremely low. Chaotic home environments, residence in housing designated for "mental patients," homelessness, mild to moderate mental retardation, chronic organic illness, unemployment, poverty, lack of social skills, long-term abuse of alcohol and "street" drugs (crack cocaine, methamphetamines, narcotics), involvement with the criminal justice system, and use of the inpatient system as a safety net and temporary refuge from dismal life circumstances had rendered the patients unable to assess their situation and deal with the challenges of their distress.

Ellis's view that otherwise "unstupid" people tend to act stupidly clearly does not apply to this group of patients. On the other hand, having been taught that the principles of REBT are applicable, psychiatrists are enjoined to treat their patients as Ellis recommended: to get them to "think straight." For this to happen, said Ellis, it is necessary "to make a forthright, unequivocal *attack* on the client's general and specific ideas and to try to *induce* him to adopt more rational ideas in their place" (1959, 44). The psychiatrist employing "rational therapy" "serves as a frank counter-propagandist who directly contradicts and denies the self-defeating propaganda which the client has originally learned." He "encourages, persuades, cajoles, and at times commands the client to partake of some kind of activity which itself will act as a forceful counter-propagandist agency against the nonsense he believes" (1959, 44-45). The goal is for the patient to "internalize a rational philosophy of living just as he originally learned and internalized the illogical propaganda and superstitions of his parents and hi culture" (1959, 45).

As the close of his address, Ellis made the following observation, which makes it clear why REBT is not the "therapy" of choice with patients of the kind I have described and who constitute the greater population of clients seen by psychiatrists in the inpatient setting:

> *Can therapy be effectively done, then with* all *clients mainly through logical analysis and reconstruction? Alas, no. For one thing, many clients are not bright enough to follow a rigorously rational analysis. For another thing, some individuals are so emotionally aberrated [sic] by the time they come for help that they are, at least temporarily, in no position to comprehend and follow logical procedures. Still other clients are too old and inflexible; too young and impressionable; too philosophically prejudiced against logic and reason; too organically or biophysically deficient; or too something else to accept, at least at the start of therapy, rational analysis*
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> (1959, 49).

It is easy to understand why the residents and their seniors are reluctant to employ REBT. It does not apply to their patients. For Ellis, REBT was appropriate for "neurotics" (a term that is no longer to be found in the DSM), yet the sort of person Ellis rejects as being able to make use of REBT constitutes the bulk of individuals seen by psychiatrists in the inpatient setting. When their clients become outpatients, however, REBT is applicable, but there the psychiatrist "encourages, persuades, cajoles, and at times commands the client to partake of some kind of activity [taking his medications] which itself will act as a forceful counter-propagandist agency against the nonsense he believes" (1959, 49).

Existential Approaches

Given their experience of REBT as the only authorized form of psychotherapy, it is not surprising that the residents were unconvinced that psychotherapy had any place in their work, including the sort based on psychodynamic principles. Trained as physicians to write "orders" for patient care, the use of REBT was something these psychiatrists could appreciate, but found that its use primarily in the service of forcing compliance with a prescribed regimen of psychotropic medications was rarely effective. The general confusion and collusion with the system of psychiatric care with which many of their patients were familiar made the goals of REBT unfeasible. A noticeable change in outlook occurred, however, after I had demonstrated psychotherapy with inpatients.

I did not make it clear that what I had done was based on psychodynamic principles, but I believe that was the assumption the residents had made since I made references to how patients often make use of hospital personnel, including their psychiatrist, as embodiments of internal object representations. But I also spoke about the psychiatrist's understanding of what he meant to his patient. Here I introduced concepts from existential analysis. Trained as physicians, the residents were accustomed to maintain the distance necessary to effectively treat individuals in distress without becoming personally involved in their plight. It slowly became clear to them that, as psychiatrists, they were in the paradoxical position of being called upon to both maintain a certain necessary indifference to their patient's life and at the same time to draw near to his existence. This tension is the source of psychiatry's problematic position in the world of caring for the well-being of others. While REBT seems to be a solution to the tension, it is not, however, because it depends entirely on the authoritarian position of the physician. A genuinely therapeutic relation, as I explained, requires something more: a mutual experience of relation between one human being and another, physician and patient.

Exhorting the patient to think differently and to change habits of living (diet, exercise, rehabilitation) seem to be equivalent. They are not. While the latter are orders based on an understanding of physiological processes, the former can never be more than admonishments, based as Ellis claimed on the assumption that the "neurotic" patient is a sort of failure, someone who fails to apply the rules of logic when he is capable of doing so. Ellis's exhortations are ultimately moral, we recall, since they are correctives to a person's self-spoken sentences that are reducible to judgments of the sort "this is good" and "this is bad." Following Ellis, no matter how benevolent the psychiatrist may be in the way he "commands" his patients to think differently, in the end when he does so, he infantilizes his adult patients. While this is acceptable in the practice of the other branches of medicine,

in which the patient agrees to obey his physicians orders in the interest of regaining physical health, in psychiatry it amounts to “relieving” the patient of his freedom. I was suggesting, however, that psychotherapy can be therapeutic only when its goal is restoring a person’s freedom, when it has been limited by life circumstances.

Concluding Thoughts

Psychiatry in the United States is dominated by one of the traditional treatment modalities: milieu therapy (hospitalization), medication with so-called psychotropic agents, ECT (electroconvulsive therapy), and a form of psychotherapy known as cognitive-behavioural psychotherapy. Physicians specializing in psychiatry are trained primarily in the use of the first two. The use of CBT, especially in its best-known form (REBT), fails to be therapeutic, however. Along with hospitalization and medication, it conforms to the medical model of treatment (diagnosis followed by treatment), but in this case, with the exception of genuine brain or neurological pathology, there is no disease entity to be diagnosed. There are no laboratory tests for any mental illnesses, as the DSM states explicitly. In line with medical practice - for example, internal medicine - psychiatrists *order* treatments, but the difference is that in the treatment of an organic disorder the patient is always free to refuse the treatment ordered. He may decline to take a course of antibiotics even though he has a life-threatening infection. For the psychiatrist, however, compliance is required, or the patient is considered to be yet more ill than he was originally thought to be. Having been diagnosed with a form of schizophrenia, the patient who refuses medications or wishes to leave the inpatient ward during the period he has been prescribed to stay is implicitly diagnosed with a further disorder. Oddly enough, though, it does not have a name. It merely confirms the presenting psychopathology.

Here we return to the debate between Szasz and Ellis, which continues. Those of us who practice a form of existential analysis offer a solution to the debate, a way of ending it. That is to recognize that certain forms of human interaction can be psychotherapeutic *without having recourse to the notion of psychopathology*. We will agree with Szasz that everyday problems of living should not be pathologized. They are no more pathological than the pain in my finger when I close a cupboard door on it or the ache in a joint as my overworked or failing body temporarily fails. We will disagree with Szasz, however, if he says that there can be no psychotherapy for the distress people feel, for example, in relationships that are failing. A certain kind of encounter which is *noninterventional* can work, much as friendships do, to make way for a person find possibilities he had not realized were there for him. This is liberating and works with the tendency people have to be free. (It does not deny that there may be

opposing tendencies in people to be dependent or gain a sense of comfort by choosing to remain in bondage to the facts of life or even an outlook into which they have been indoctrinated.) Such an encounter is quite different from a form of "psychotherapy" that badgers or threatens or more subtly persuades a person to conform to certain way of thinking and behaving, which are the stated means and goals of REBT. In principle, an encounter that is interventional cannot be psychotherapeutic, and that is the rationale and *modus operandi* of REBT.

Existential analysis has the capacity to restore a genuinely psychotherapeutic encounter to psychiatry. Psychotherapy on psychodynamic principles practiced by psychiatrists occupies a position intermediate between current psychiatric practice (control of behaviour by means of enforced hospitalization or the use of psychotropic medications). Perhaps both Ellis and Szasz were right in abandoning psychodynamics. On the other hand, the imposition of authority in the use of REBT, while clearly less harmful because it cannot be forced on the patient, is in the tradition of relieving patients of their freedom, rather than enhancing the possibility of their recovering it which existential analysis affords.

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