The Role of Self-involvement in the History of Caring in Mental Health

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The purpose of this paper is to show that one of the fundamental foundations of current psychotherapy is informed by a strong implicative dimension from the therapist who must be present at the core of the therapeutic moment. This point will be demonstrated using historical examples from French psychiatry and psycho-therapeutic movements, as well as Anglo-Saxon vignettes. Ultimately, this article summarizes three types of moments that are seminal in mental care: (1) the emergence of psychiatric care; (2) the emergence of psychoanalysis; and (3) the emergence of the questioning of the practice of psychological care in its social perspective; it also examines the carer's position and his or her involvement.

On ethical treatment

It is often alleged that Philippe Pinel (1745-1826) was responsible for freeing the lunatics from their chains. For those who still adhere to this myth, there is an alternative story to be told that is perhaps more fascinating and stimulating than the legend itself. In fact, freeing the lunatics was based on a humanitarian project that included aspects of courage and will, and was actually achieved through the efforts of Jean-Baptiste Pussin (1745-1811) and his wife. This movement began at Bicêtre hospital, just inside Paris, then at La Salpétrière. At that time, Jean-Baptiste Pussin was "governor of the lunatics" (the appellation "warden" would only come to be used at the beginning of the French Revolution). Before this, he had been working in the above institutions as an educator for children taken into care – a detail that is significant when one considers the progression from caring for children to caring for the mentally ill.

In those days, there was virtually no medical treatment for mental illnesses. Physicians did little but walk through places of confinement, and the

absence of treatment seems to have been the general rule. However, this changed when one man, Jean-Baptiste Pussin, decided to go a bit further (Jagger, 1990). He was the first man who disavowed the medical *persona* of merely carrying out orders — not only in his manner towards patients but also in his analysis of symptoms — and he therefore served as a model in the early XIXth century for what the ideal lunatic warden should be. However, it is well known that Pinel praised and actively called upon the Ministry of the Interior to appoint him to the Salpétrière. For Pinel, Jean-Baptiste Pussin played an essential role in introducing the treatment of mental illness: "As he elaborated his 'psychologic treatment' for mental patients, Pinel was gratefully aware of his debt to Jean-Baptiste Pussin". (Pinel, 1992: 13, my translation)

The reason is that Jean-Baptiste Pussin was breaking new ground in what was later to be called "moral treatment." What was put forward in this new approach was the respect of "lunatics", the methodical organization of their living conditions, and the personally humane qualities of the person directly in charge, who was not yet considered a full member of the caring professions. These qualities were, in Pinel's own description of Jean-Baptiste Pussin, "humanitarian feelings, the purest philanthropy, an untiring assiduity in his supervising, knowledge gained from thinking about it acquired by pondering experience, an unwavering firmness, a well thought-out courage supported by physical qualities the most appropriate to impose upon patients, a well-proportioned body frame, strength of limbs, thunderous of voice when the going is rough, and the proudest and most dauntless bearing" (Postel, my translation).

Pussin put forward his therapeutic methods that stressed moral treatment of mentally ill patients while acknowledging the reasonable difficulty of working with this patient base. He urged taking care of patients with gentleness, imposing upon them without ill-treating them, winning their trust, trying to address what has disturbed them, and making them contemplate a happier future. All of the above imply adequate supervision and the outright banning of physical abuse of the mentally ill by orderlies, who would be instantly considered as offenders and dismissed. And finally, Pussin argued for a limited use of means of containment and restraint for the raving mad.

It may be gathered from the above that primary importance was placed on establishing a strong relationship in the approach of the person suffering from a mental illness. As described by Pinel, this is precisely what Pussin was involved in during his relationship with his patients. Indeed, Pussin seems to be the first professional who listened to each of his patients and went so far as to ask them their names. Perhaps, as some have suggested, this is because he realized that he could well have been one of them. (Didier, 2007)

The beginning of French psychiatry can be understood as starting with this humanitarian investment. On the other side of the Channel, Francis Willis (1718-1807) was conducting a similar experience. Willis was both a doctor and a clergyman, and one might say, in fact, that he was a perfect combination of Pinel and Pussin. In addition, Pinel knew of Willis's work as did Willis of Pinel. Particularly in his reflection on the concept of “restraint or no restraint,” Willis' humanist point of view can be strongly felt. He was no doubt the first to assess the benefits and risks of what became, thanks to him, a real treatment. Furthermore, he favored his patients' activity and the rehabilitation of their dignity by giving them appropriate clothing. (Willis, 1943)

A counter-example to Willis and Pussin would be John Haslam, who was running the well-known Bethlehem Hospital (Bedlam). Until 1700, it was the only public lunatic asylum in all the British Isles. Even if Haslam appeared to be choosing “moral treatment,” he was hardly defending virtue and kindness in his work, as it was said that: “He considered the insane less than pathetic victims or even people one could pity. He was never prone to consider lunatics as anything else than terrifying, sometimes ridiculous or even laughable.” The treatment of the patients was affected by this attitude, and the administration eventually asked Haslam for explanations (Haslam, 1996: 100). Haslam's attitude and behavior strongly emphasized how much the caring relationship required specific arrangements. Among these arrangements, was a well-known therapy that was contemporary to Pinel and Willis: Animal Magnetism (Postel, 1981: 104-05).

Animal Magnetism

It is now understood that Franz Anton Mesmer, a German physician, did not believe so much in the power of magnetism (whose healing force supposedly was due his magnetic rods) as much as in the therapist's own power (Zweig, 1932). For him, the power of the therapist was couched in his personality, which would transmit his mysterious fluid by the means of passes. Indeed Mesmer's work was based on the idea that recovery occurred in the context of a relationship with someone else, and only in connection with this person. Besides, Mesmer resorted to orderlies known under the name of *valets touchards* – surely not by chance "touching valets" – described as handsome young men who were considered by Frédéric Masseix as the predecessors of male nurses.

According to Mesmer, it was the relationship between therapist and patient that was of the utmost importance. And this is why he wrote that, to begin with, magnetism must be transmitted by feeling. This was confirmed by Puységur, his epigone, who underlined the importance of the physician's will in healing, and established that the welfare of the patient was a necessary precondition for successful treatment. The experiments with mineral magnetism were to pave the way for "animal magnetism" (animal as in *animus*, implying "full of life"). The theoretical basis was that one could influence another individual at a distance without any need to touch or manipulate this person.

In the United Kingdom, James Braid (1795-1860) was first interested in animal magnetism, but eventually turned to hypnosis [1].[2] Braid was a surgeon and he used a first-time hypnosis under anesthesia. He conducted experiments that sometimes involved emotions; however, these experiments had no psycho-therapeutic goals: "I have now entirely separated hypnotic from animal magnetism. I consider it to be merely a simple speedy, and certain mode of throwing the nervous system" (Braid, 1843: 61; 67). Hypnosis continued and became a psycho-therapeutic modality still used today.

[2] The term "hypnosis" was coined by Etienne Felix Cuvillier (1755-1841) a few years earlier.

If we return to the nature of the therapist-patient relationship, the hypnotist, through the power of suggestion, is a therapist who cultivates his influence on his patient. His aim consists in compelling him to act or react, often even against his will (for instance, in the case of hysterical patients). Here, the aim was clearly to cure the patient. To do so, the therapist had to exert an invisible power, but one that threw his own person into relief. The therapist used to stand face-to-face with the patient. He used to speak to him and to give him orders. Sometimes he laid his hands, the very means of the power of suggestion, upon him. Dominique Megglé, when describing hypnosis in brief therapies, made it clear that, above all, it was due to an attitude: the therapist's (Megglé, 2005: 38; 42). The therapeutic experience could only be singular and unique, and he insisted on his personal involvement to such a point that it proved to be exhausting for him.

We might think that Megglé, following the Mesmerian trend, seems to have underlined that there was a correlation between the degree of the patient's satisfaction and the degree of involvement of the therapist. This leads one to think that the therapeutic relationship depends more on affect than on the transmission of fluid or energy and that its role is profound. It is at this historical moment that the whole of the Freudian contribution to patient care emerged.

From hypnosis to psychoanalysis

It is helpful to recall here the names of, on the one hand, Charcot (School of La Salpétrière) and on the other, Berheim (School of Nancy), as both used hypnosis to treat their patients – most notably hysterical ones. Freud was impressed by the use of this technique as well as by the personality of Charcot (Gay, 1998). Back in Vienna, he defended the interests of hypnosis among his colleagues (*Ibid*. 52). Yet, later, Peter Gay, one of Freud's biographers, noted that: “psychoanalysis as Freud developed it in the mid-1890s was an emancipation from hypnosis” (*Ibid.* 51). “Yet Freud, intrigued by Anna O, [was] disappointed by therapeutic effects of hypnotic suggestion” (*Ibid.* 64).

With his friend and mentor Joseph Breuer, he returned the case analysis of Anna O. who was treated by Breuer. At this time, Breuer still used hypnosis, but not always and probably less often because the patient happened to put herself in states of semi-hypnosis. The psycho-therapeutic practice used by Breuer — not yet theorized – consisted of attention, thoughtfulness, listening, and attendance. This new therapeutic device, the "talking cure" (according to Anna O's expression) worked wonderfully (*Ibid.* 78; 79), and contained, according to Breuer himself, "the germ cell of the whole of psychoanalysis" (*Ibid.* 64).

Breuer's involvement in the management of this patient was remarkable. When symptoms became more severe, Breuer came to visit his patient every evening. The proximity was such that Anna O. even developed a phantom pregnancy: "Here comes Dr. B.'s child. Breuer then decided to stop his visits and directed his patient to other colleagues (*Ibid.*). What is noteworthy is that her troubles came to a point when, according to Breuer, "all of her symptoms had been brought under control" (*Ibid.* 67). Breuer and Freud theorized from this event. Faced with the failure of his hypnotic practice, Freud decided to radically alter some of the ways in which the patient was taken charge of – for example by changing the therapist's position. The person who was to become the psychoanalyst, would not stand face-to-face but would deliberately stay away from the patient's visual field. Furthermore he would not suggest, but on the contrary, he would let the patient speak on his or her own volition. At this stage, it is clear that Breuer and Freud had developed a practice that was intended to be wholly different. However, suggestion, which is the core of the hypnotic process, was not left out by the father of psychoanalysis. According to Laplanche and Pontalis, "the insistent suggestion is to search for the pathogen, 'it erased' in favor of a spontaneous expression of the patient. These are the patients themselves who will play a role in this development" (Laplanche & Pontalis, 1981).

Transference and counter-transference

Freud's first definition of counter-transference remains descriptive: it is about "the influence a patient has on the subconscious feelings of his or her

analyst" (Freud, 1904). It is important to note the evolution in Freud's thoughts on counter-transference. In 1912, Freud recommended that analysts use the surgeon as a model during the analytic treatment, as the latter leaves aside an affective reaction and human sympathy; however, in 1913, Freud wrote about *mastering* the counter-transfer and, finally, in 1915, he emphasized the importance of considering counter-transference in order to "understand it better." (Birot, 2006)

Freud's followers – the most well-known including Ferenczi, Winnicott, Racker, Paula Heimann, Margaret Little, etc. – would continue working on the concept of counter-transference, as can be seen in the following examples: Ferenczi brings up the question of the analyst's involvement when it becomes excessive (*Ibid.* 327); as for Winnicott, he talks about hatred in the counter-transference (Winnicott, 1949: 69; 74). For Paula Heimann, "the analyst's emotional response to his patient within the analytic situation represents one of the most important tools for his work."

As one can see, counter-transference is an issue that became very soon – as soon as the rise of Freud – central for psychoanalysts (except for Lacanians). This perspective raises the issue of the – subconscious – involvement of the therapist as a key element for the therapeutic treatment. However, the concept of transference that Freud wanted to promote is not the only way to view the therapeutic relationship. For example, Carl Rogers argued that transference was not a good thing in a therapeutic relationship. For him, empathy and authenticity had more impact in therapeutic process.

Empathy and Authenticity

One cannot talk about involvement in a therapeutic relationship without mentioning Carl Rogers. Rogers did not work in the same theoretical field as Freud. For him, there was no subconscious based on repression; thus, there was no need to go through transference. On the contrary, Rogers' key concepts concerning the attitude of the therapist were about empathy, congruence and authenticity. It is noteworthy that for Rogers as well as for Freud, it was obvious that the therapist's attitudes as well as the "client's" are the core condition of good therapeutic relationship (Brazier, 1993).

Empathy integrates three components: understanding the point of view and the emotions of another, communicating this understanding, and in doing so, still remaining consistent with one's self. Congruence must allow the therapist to seem like a deeply human person in the eyes of his patient: "he does not pretend to be superman and above the possibility of such involvement" (Rogers, 1942: 87). Rogers warned against involving oneself too much: "he will do better to face openly the fact that to some extent he is himself emotionally involved, but that this involvement must be strictly limited for the good of the patient" (*Ibid*. 87). The patient's attitude was also described. The latter must not consider the therapist as someone who will give solutions or consider him as a relative (who has authority over him) or a friend. All these attitudes — the client's as well as the therapist's – aimed at not favoring transference since, according to Rogers, this slowed down the therapeutic work. Such a belief leads us to consider the notion of therapeutic alliance.

Therapeutic alliance

Psychologist Edward S. Bodin was indeed one of the first professionals to suggest that a good working alliance was essential to therapeutic change, no matter what the approach was. He conceptualized it into three components: mutual goals, mutual therapeutic tasks, and the quality of the emotional bond. "In the vision of the future, the psychotherapist will combine the personal qualities that make for a good partner with the accumulated knowledge about the relevance of various therapeutic tasks and the skill to implement these to induce change" (Horvath, 1994).

Nowadays, the notion of therapeutic alliance — which has achieved great success in the somatic care field – is apparently threatened by new practices only based on the treatment of symptoms (as described in *Diagnostic and Statistical Manual of Mental Disorders*, DSM IV) as psychoanalysis and person-centered therapies were before. Thus, new organizations have been created such as the Hearing Voice Movement (INTERVOICE), that bring together not only people who "hear voices" but also psychotherapists and psychiatrists who want to break with the new therapeutic models.

Their goal is to find the "solidarity" and "involvement" that the patients could find in humanistic therapies (Romme, 2009).

The notion of Therapeutic alliance was also adopted by cognitive-behavioral therapy, and it is beneficial to consider whether this therapeutic approach implies the notion of self-involvement.

Cognitive-behavioral therapy

We know that cognitive-behavioral therapy (CBT) was originally intended to include psychology in academic science, as one of the so-called "hard" sciences. To do so, its founders needed to prove its ability to take measures and do experiments in laboratories with a hypothetico-deductive method. Clearly, this *modus operandi* is still ever-present in today's academic milieu, as measuring and evaluating are persistent in CBT.

However, of most interest in this discussion are, on the one hand, the methods used in this therapeutic approach, and, on the other hand, what is described in the general attitude of the therapist. With regards to the methods, one often finds that the notion of *immersion* or *in vivo exposure* of the patient sometimes occurs in the presence of the therapist. In those cases, the therapist supports the patient in confronting the threatening object (such as phobias). The aim is clearly to reassure the patient so that he can overcome his fear. The notion of implication is intrinsic to the method, in the sense that the therapist is sharing an experience with his patient in an environment (the street or an elevator) that was chosen according to the latter's symptom. But it is not just limited to the resolution of a symptom. The attitude of the therapist here cannot be ignored (Fontaine *et al*., 1989: 29). Indeed, some authors talk about assertiveness as one of the conditions necessary to the therapist who also has to be "empathetic," "understanding," and "warm" in addition to being "dynamic." His personality and his influence, or even his charisma cannot be disregarded. The therapeutic relationship is compared with a teacher-student rapport (*Ibid*. 26).

Hence, one can find the notion of the therapist's implication in CBT. However, unlike all the others, it stays focused on a definite goal: the elimination of a symptom. The therapist sets a time-limited therapeutic program

for the patient, who has to submit to it, as his progress will be measured and quantified. If there is any self-involvement, it is reduced and only limited to solving a problem. There is no room for intersubjectivity.

The involvement and the collective

If we turn to institutional catchment area psychotherapy, it becomes clear that involvement may be partly derived from militancy. It is instructive to consider four examples. At first, we can see the Marxist-Freudian approach as a commitment in which there was a will to pave the way for a social dimension. First, Wilhelm Reich (1897-1957), a pupil of Freud, is one of the most famous examples. Indeed, this psychoanalyst, a communist, first created a psychoanalytical health center for the poorest members of society. He then created a research and discussion public center to favor the sexual blooming (self-fulfillment) of popular masses with the “sex-pol” movement (Sharaf, 1994).

Secondly, it is instructive to consider the institutional psychotherapy movement, which was created in France with the collaboration of the Catalan psychiatrist Francescu Tosquelles (1912-1994). For institutional therapists, the institution must also be treated. The institution is a process that emerges from all its components: the nursing team, the patients, the clerks, the employees, the managers, etc. In this movement, it is the involvement of all that is sought. In a different vein, but still evoking the involvement of a collective point of view, we find Michael Balint's project. Balint was a physician who invented speech groups for the caring professions (Balint, 1957). In the beginning, he urged family practitioners to take part in those speech groups during their initial training.

This exercise aimed at borrowing from the psychoanalytic free associations and at giving the opportunity to therapists to talk about their own practice. Spontaneous speech was preferred so that any practitioner could give the truest possible account of the emotional side of the practitioner relationship. For Balint, the school to which one could belong did not matter so much. What was of the utmost importance was that the therapist was humane, which could be more powerful than the drugs he prescribed. Balint

was the first to coin the phrase “drug doctor.” As mentioned above, this is precisely the same conclusion that Pussin had reached in his era. This raises the question of whether there could be the possibility of establishing any caring relationship without involvement? Finally, it is instructive to consider the movement of anti-psychiatry.

Anti-psychiatry

The beginnings of the anti-psychiatry movement date back to 1960 in London. The main anti-psychiatrists of Europe are considered to be: David Cooper, Ronald Laing, and Aaron Esterson and, in the U.S., Thomas S. Szasz. The historical and sociological context that enabled the emergence of this movement is important: the 50-60 years in the West and especially in England after World War II. This era featured the post-war boom, the wars of independence of the former colonies, and the Vietnam War. In the United States, the Black Power movement fighting against racial inequalities was emerging [2].[3] Meanwhile, in the middle of the Cold War, capitalism favored the construction of bedroom communities[4] [3] with workers engaged in repetitive tasks: alienated and dehumanized but gathered in strong union. In addition, from World War II, the increase of the influence of communism in Europe was a factor. A movement of freedom opposed to a capitalist society deemed too oppressing was dawning and eventually led to the uproar of May 68 in France: a movement that started with the young, who refused the conventional society of their parents which they considered alienating.

So where does psychiatry fit into all this? It allied power and authority by the internment and care obligations. The thesis of anti-psychiatry is based on a critique of the capitalist society, perceived as totalitarian and authoritarian, and where any deviance is socially condemned and suppressed by psychiatric detention. The AP movement offered a new approach to psychosis: mental illnesses do not exist. The belief was rather that the individual takes refuge in madness to deal with intolerable social situations. Madness is a reaction to increasingly strong pressure caused by society. Psychosis is an in-

3 Segregation was abolished in 1964 in the USA.

4 Ken Loach’s famous movie, “Family Life,” shows this aspect (1971).

terior journey, a period of depression leading to a reconstruction that ultimately allows better contact with oneself.

AP offers new therapeutic practices, such as the experience in the mode of therapeutic communities. This is to ensure that patients are managing their own communities and that therapeutic measures can be taken. Patients must take responsibility for their care, but carers have an important role to play in support. In 1965, Dr Laing, Cooper and Esterson founded the “Philadelphia Association” to create original safe havens, such as "Kingsley Hall.” The association set itself the goal of changing the way mental health and mental illness were considered. It served as an invitation to change the model of care, because what was at issue was not the illness of one person, but rather a social process. The newly created community center is characterized by its willingness to rid the subject of any framework.

Conclusion

Through this historical recounting, one can clearly see how the involvement of therapeutic relationships has evolved over the centuries, starting with the consideration of the lunatic as a person, discovering the subconsciousness of hysterics, focusing on people and their suffering, and trying together – both the patient and the therapist — to change the social conditions of living. The common theme of all these movements is, in essence, the revelation of the healer involving himself in the therapeutic relationship.

Self-involvement is foremost a particular theory about human nature that I can relate to as therapist. Respecting the patient seems now to be a permanent feature: a precondition that must be addressed for any progress to be made. For isn’t the patient a fellow human being experiencing psychological suffering? The base on which one can start providing help would thus consist of a collection of attitudes and emotions that comprise attention, solidarity, will, availability, acceptance, empathy, humility, the capacity of thinking, and respect.

All the attitudes that we have seen throughout this article have defined the last 200 years. Self-involvement is essentially an extension of the therapist's inner-self that mingles with his medical practice, but that nevertheless

aims at giving others the opportunity to heal and emancipate themselves from their pathologies. In other words, self-involvement is ultimately an act of freedom. It is unfortunate that the emphasis on listening to the patient is now threatened in our society of profitability, which tends to address problems in a standard routinized way, and analyze patients as clusters of symptoms rather than as complex human beings. Self-involvement, whether or not it proves therapeutic for a given patient, is one of the highest achievements of the relation between two people. We must not lose this ethos as the field moves forward in the XXIst century.

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