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Psychotherapy within general psychiatry*

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This paper focuses on issues relating to the place of psychotherapy within general psychiatry rather than describing details of psychotherapeutic methods and their range of application in psychiatric practice.

Over the past two decades a change has taken place in the operational base of psychotherapy within psychiatry. In the past the analytically trained psychiatrist constituted the foundation stone of this base. His clinical commitments were for the most part similar to those of his psychiatric colleagues and included the care of long-stay patients suffering from psychosis and organic mental states. Patient management and treatment, decisions about discharge and follow-up procedures were a matter for him alone. His presence in the hospital encouraged discussion of analytic theories and practice with junior and senior colleagues. In turn he was exposed to the views of those whose preferences were for an organic orientation in psychiatry.

Today the analytic psychiatrist has been largely replaced by the consultant psychotherapist. He functions in quite a different way from his predecessor. Rather than having direct responsibility for the whole range of mental disorders, the consultant psychotherapist's field is confined almost entirely to non-psychotic mental illnesses. His time is spent with cases of neurosis, adjustment reaction and personality disorder. His patients are referred to him by psychiatrists and general practitioners. He assesses their suitability for psychotherapy and undertakes this himself or more often refers them to junior psychiatrists as part of their training in psychotherapy. Most of his time may be taken up supervising the psychotherapeutic work of others. Supervised work is often his only contact with the more severe types of mental illness. This lack of direct contact must reduce the range of his clinical experience and deprive him of a common experience with the general psychiatrist.

What has brought about this change? There are several causes among which are the following. There is the belief that clinical responsibility should not be borne by the person undertaking a patient's psychotherapeutic treatment. It is feared that if both responsibilities are shouldered by the same psychiatrist, the evolution of the transference is disturbed because the requirements of management places him in an authoritarian role. However, such a separation of functions can have other consequences equally damaging to the treatment. It may lead to an idealisation of the psychotherapist and a hatred of the clinical administrator. This difficulty cannot always be resolved.

Secondly, psychotherapeutically minded psychiatrists have always been concerned about the practicability of individual treatment in a health service setting. The introduction of analytic group psychotherapy was in part a response to this concern. This method came to be employed for educational purposes initially at the Tavistock Clinic in London. General practitioners, psychiatrists, social workers and psychologists joined in these groups to improve their psychotherapeutic skills and to enlarge their knowledge of explanatory psychopathology. Those conducting the groups hoped to maximise the effect of their clinical experience and therapeutic potential by transmitting it to others who could then treat and manage patients who would otherwise be deprived of help. This is the aim of the consultant psychotherapist. He hopes to pass on his knowledge and skills to psychiatrists, nurses and social workers. It is a practice based on idealism in that it aspires to do the greatest good to the greatest number. It is often forgotten that the result of these educational activities falls short of what is actually wished for. All too often there is a misunderstanding of the technical and theoretical concepts. Sometimes the group participants – psychiatrists, social workers and nurses – are left with an unrealistic view of the indications for the different kinds of psychotherapy and what psychotherapy can actually achieve.

A further cause of the change springs from the belief that psychoses are brain diseases whereas neuroses are psychical reactions arising in abnormal personalities. Therefore psychoses are the realm of the psychopharmacological and biological psychiatrist. The neuroses and kindred states are the province of the psychotherapist. This dichotomy results from the rejection of the psychobiological approach in psychiatry. An instance of this is the concept of the delusion proper. This concept is based on the observation that schizophrenic and paranoid patients experience certain mental events as ego-alien and unlike any previous mode of thinking, feeling or perceiving. This disruption in the continuity and quality of mental life is believed to indicate that delusions proper do not have psychological

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antecedents. They are psychologically irreducible. However, psychoanalytic investigation has shown that the delusions which appear, for example, at the onset of psychoses are giving representation to the unconscious and preconscious wishes and fears which troubled the patient prior to the break with reality.

A fourth cause is the lack of interest shown by many psychoanalysts in general psychiatry (Lucas, 1985). They prefer to work with patients suffering from symptom and character neuroses. It is impossible to legislate for work preferences but there are other considerations to be taken into account. One is that many psychoanalysts believe that participation in general psychiatry can be harmful to their work as analysts by adversely influencing their technique and general approach to patients.

The introduction of individual and group analytic methods to the psychiatric hospital evokes reactions among the nursing staff, and psychiatrists are no less affected. These reactions are often disruptive of relationships between patients and staff and between staff members. Reactions of this kind on the part of hospital staff should not be a surprise. Even with the changes brought about by personal analysis, the impact of patients' behaviour and emotions can evoke responses on the analyst's part which are patently damaging to the treatment. In psychotherapeutic work with established cases of schizophrenia and with chronic depressions, the patients' lack of emotional involvement, their self preoccupation, the paucity of productive responses to interventions is disappointing, discouraging and frustrating (Muller, 1972). A sense of anger and irritation with the patient's unwillingness or inability to join in is frequent enough. There are psychoanalysts who believe that these conscious counter-reactions are unconsciously induced by the patient and represent an important element of his psychotherapy.

These counter-reactions are not necessarily best dealt with by encouraging their expression in unstructured discussion groups of staff members. The ventilation of anger, dissatisfaction and discontent does not necessarily lead to tranquillity and to a positive attitude to the patient. This is especially so when the anger is acting as a screen against anxiety and guilt. There are dangers in automatically applying techniques designed for individual and group analytic therapy to those who are not bound by the restraints of a therapeutic alliance. These adverse reactions to patients and to psychotherapeutic treatments require discussion, but this is most safely undertaken by a structured educational programme.

Today nurses, like doctors, are rotated from ward to ward and from department to department. This may be appropriate for general hospitals but it is damaging to psychiatric patients and disheartening to nurses and psychiatrists. Time and continuity are the levers which transform a casual contact between patient and doctor or nurse into a psychotherapeutic relationship. This spontaneous development is disrupted when the doctor or nurse is suddenly removed from the ward because his or her time there has come to an end.

The changes which have taken place in the psychiatric scene in the United Kingdom over the past 25 years are in part due to the increase in the number of patients suffering from neurotic symptom complexes referred to hospital and out-patient departments. Cases of this type were always to be found in admission wards of mental hospitals, but not in such numbers as today.

The introduction of the first minor tranquillisers led to therapeutic optimism. It appeared as if these drugs would be as symptomatically effective for patients suffering from neurotic symptom complexes as chlorpromazine was for the symptoms of schizophrenic and paranoid psychoses. Psychotherapy seemed to be redundant in the face of the immediate improvements brought about by the new medication. Then came the anti-depressants. It soon became obvious that these drugs were not stemming the flow of patients into hospitals or psychiatric clinics. Indiscriminate use over years has aggravated the therapeutic task by creating dependency. Patients are reluctant to give up the drug treatment even when their symptoms are in no way improved. A somewhat similar situation is to be found with patients suffering from schizophrenia and paranoid psychoses. As patients are frequently on long-acting medications it is impossible to identify the spontaneously remitting cases. Once discharged from hospital, patients are fearful of discontinuing medication even when it is no longer playing any part in the remission.

Rehabilitation programmes have led to numbers of chronically ill patients being discharged from hospital now that the more alarming clinical manifestations of their disorders are contained by long-acting pharmacotherapy. There is reason to believe that, in the case of the non-remitting schizophrenias, the disinterest, apathy and withdrawal are aggravated by this treatment and promote the self-neglect which is a feature of the chronic state. There is now a very large contingent of both psychotic and non-psychotic patients for whom physical measures of treatment are largely ineffective. This is probably a cause of the current resurgence of interest in psychotherapy and other psychological treatments.

Psychotherapy may contribute to the resolution of clinical problems by encouraging the tendency, inherent in most mental disorders, for remission if undisturbed by excessive pharmacotherapy. To be successful this requires a familiarity with the nosography of mental disorders and their psychological structure. Neurotic symptom complexes and the schizophrenias may be taken as examples.

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Neurotic symptom complexes comprise anxiety and hysterical symptoms, inappropriate depression of mood, phobias and obsessions. They fall roughly into two groups. There are the symptom complexes which fluctuate in intensity. These fluctuations occur in relationship to alterations in life circumstances. Their onset is associated with marital dysharmony, illness of a family member, disappointment in love or a professional or business disaster. In the other group of neurotic symptom complexes the symptoms remain constant and are uninfluenced by changes in external circumstances. They are the true neuroses.

Different kinds of psychotherapy are called for in the two categories. Analytical treatment is of little help in states where the symptoms are bound to contemporary life events. Analytic treatment is appropriate when the symptoms proceed from an unconscious mental conflict that has been brought to life by some current frustration, disappointment or challenge. It is the reactive case which remits when admitted to hospital or by a favourable change in life circumstances. These patients respond to a psychotherapy which is directive and supportive. Difficulties arise when the symptom complex becomes entrenched because it has proved impossible to remove the current stress situation.

In the schizophrenias, using the Bleulerian criteria for diagnosis (Bleuler, 1978) not less than 40% of cases proceed to a remission. In the remainder the course of illness is to a mild, moderate or severe "end state" (Bleuler, 1978). In modest doses chemotherapy enables the psychiatrist, in first admissions, to discern the wishes and fears which have played a part in the initiation of the illness. When the course is to remission a psychotherapeutic tie has been formed between patient and psychiatrist. This permits a gradual reduction of medication before discharge from hospital. If there is a relapse, as in cases which follow a cyclical course without deterioration, the patient can look to a familiar figure to support and understand him through the acute attack. In long-standing cases ("end states") the psychotherapeutic strategy is to encourage the growth of the healthy residue of mental life. An analytical approach is impeded by the patient's autism. Much can be achieved by respecting his delusional world which affords him relief from the sense of helplessness and vulnerability. Regular meetings in hospital or in the community may lead to a lesser need for medications and a reduction in apathy and self-neglect.

The psychiatrist who hopes to make psychotherapy a central feature of his practice requires a period of personal analysis in order to master psychotherapeutic techniques. In the course of analysis he has the opportunity to experience transference and resistance. Neither reading nor supervised psychotherapeutic work can achieve this end. The automatic tendency to repeat the past as transferences does not require the formal setting of a psychotherapeutic situation. It may arise in the most casual contacts between patient and doctor or nurse. These repetitions find expression in patients suffering from psychoses just as they do in cases of neurosis. Recognition of these transferences can often forestall reactions which may be damaging to the treatment procedure whatever its nature.

Prior to 1939, psychiatric practice was mostly confined to mental hospitals. Those who suffered from symptom and character neuroses attended physicians, neurologists, medical psychologists (an extinct breed) and psychoanalysts. The 1939–45 war changed that. Psychiatrists in the Armed Forces were confronted by the whole range of mental disorders. These experiences led psychiatrists to psychotherapy. After 1945 psychiatrists increasingly took over the psychotherapeutic role of the physician and neurologist as far as non-psychotic mental disorders were concerned. Established clinics like the Tavistock in London and the Lansdowne in Glasgow were expanded.

Times have changed. In a recent editorial in the *British Medical Journal* entitled "I don't want you to see a psychiatrist", the author (Wilkinson, 1988) claims that 95% of psychiatric patients are now treated by general practitioners or by "non-medical providers of mental health care". General practitioners have turned to psychologists, social workers, community nurses and counsellors rather than to psychiatrists to obtain help for their patients. These professional workers have taken the place of the physicians and neurologists of the pre-1939 area. Much of the responsibility for this development can be attributed to the organicism of academic psychiatry and its preoccupation with physical methods of treatment and natural science methodology. The clinical tradition of Bleuler and Adolf Meyer has been allowed to languish and with it systematic psychotherapy. The "non-medical providers of mental health care" have been encouraged to fill the gap which was being gradually bridged by psychiatrists. The public, lacking confidence in psychiatrists, has once again come to identify them as doctors who treat the mentally deranged. They are no doubt relieved when told by their general practitioner "I don't want you to see a psychiatrist". This is sad for those psychiatrists who hoped that with strengthening of the psychotherapeutic approach the practice of psychiatry would increasingly embrace the totality of mental illnesses. Instead the psychotherapeutic tradition has been weakened and the analytical psychiatrist despatched to the periphery of psychiatric practice. This can only lead to the detriment of psychiatric practice and education of psychiatrists of the future.

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Staffing a district psychotherapy service

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In 1975 the DHSS made psychotherapy one of the five psychiatric specialities. Since then, any comprehensive District mental health service has had to include a psychotherapy department.

The types of disorder that benefit from dynamic psychotherapy, for example neuroses and personality disorder, are well documented (Malan, 1979). Many of the patients with such conditions demand a lot of attention from primary care services, community services and general psychiatric teams. A District can reduce the strain on these services, and its need for day hospital places and hospital beds in the management of these patients, by establishing an out-patient psychotherapy department.

One of the main reasons why Districts have been slow to develop psychotherapy is that they have faced problems about what kind of staff they can safely employ.

The problems of staffing

The only formal career post in the NHS is that of consultant psychotherapist. A District could, therefore, proceed by establishing a department staffed only by consultant psychotherapists. In practice, this option is both unrealistic and undesirable. It is unrealistic because Districts have neither the will nor the finances to appoint a sufficient number of consultants to provide anything approaching a service. It is undesirable because non-medical psychotherapists, who are cheaper to employ, would be precluded from a career in the NHS, resulting in a waste of talent.

In practice then, Districts will want to appoint non-medical staff in addition to consultants. Unfortunately, the employment of non-medical psychotherapists in the NHS is problematic. There is no single profession of psychotherapy. There is no register of psychotherapists. There is no central council of psychotherapy regulating either training or standards of clinical practice. It is even debatable whether such structures are desirable. Instead, there is a mass of separate organisations offering various trainings, courses, degrees and diplomas. These problems are compounded when it is realised that many of the training organisations in the private sector are unfamiliar with the range and complexity of the work in the NHS, offer only a limited range of clinical experience to their trainees, and have little experience of the serious psychiatric disorders. Districts providing a psychotherapy service, therefore, face major problems. The first is what kind of staff they can safely employ in addition to consultant psychotherapists. The second is how to ensure quality control over their clinical practice.