# Clinical Topics

## Referral of patients for psychotherapy

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It is generally agreed that some 15% of the family practitioner's list of patients has an obvious psychiatric disorder,[1] and another 10% a hidden one.[2] But only a small proportion, varying from one in 10 to one in 20, of these are referred to psychiatrists. Those who are admitted to psychiatric units tend to be acutely and severely disturbed, even psychotic, unlike the bulk who are referred to the psychiatric services as outpatients and those who remain under the care of their general practitioner. These are suffering from either acute or chronic stress, and varying degrees of neurotic disability, personality problems, or psychosomatic disorder. They are the patients for whom the temporary provision of a holding hospital environment and the suppression of acute symptoms with medication may be unnecessary or insufficient, perhaps even contraindicated as long-term solutions to the underlying problems. Psychotherapy at some level is often indicated.

### Range of psychotherapeutic techniques

The range of psychotherapeutic techniques is now very great —indeed, even bewildering: individual, group, family and marital, social therapy, behavioural psychotherapy, and a host of new "fringe" therapies.[3] We here attempt to offer some conceptual guidelines to both general practitioners and psychiatrists in considering what established forms of psychotherapy would be appropriate for particular patients.

We first considered presenting our ideas historically, beginning with the development of psychoanalysis at the turn of the century, the emergence of individual analytically based psychotherapy after the first world war, and then of group psychotherapy and of therapeutic community ideas (social therapy), particularly after the second world war, and, finally, family and marital therapy in the past two or three decades, during which time behavioural psychotherapy has also developed.

Finally we chose to turn history on its head in presenting the concept of a series of sieves, or screens, ranging from coarse to fine. This entails examining the patient's problem as part of the disturbance in his living context, firstly, in his marriage or family, then in his general pattern of relationships with others, and, finally, within his internal world.

Psychotherapy in the general sense is part of all medicine (or any well-conducted profession). This requires respectful interest in the patient, and recognition of his need for support by a helper who is concerned yet sufficiently detached to be objective. Cawley,[4] in describing four different *levels* of psychotherapy, has called this general approach *psychotherapy 1*. It is synonymous with the art of medicine—what a good doctor does—and includes the ability to communicate with people with all sorts of background and problems. It is the level too of support and counselling (see below). *Psychotherapy 2*—what a good psychiatrist does—goes further and includes an ability to communicate with people in all sorts of mental distress and disturbance. It draws on understanding the role in the patient's problems of his development and patterns of personal relationships, and how these influence his presentation and way of seeking help. A repetition of past, often problematic, relationships within the doctor-patient relationship becomes a source of information, particularly in a more ill and disturbed patient, when it tends to reflect child-parent relationships (transference). Such transference is not deliberately fostered and explored as it is in psychotherapy 3, but rather monitored to keep it mildly and appropriately positive. A doctor's feelings (counter-transference) may be used at this level also as a source of important information in general practice, as the Balint group has shown so well.[5-7] *Psychotherapy 3* is the level of formal, dynamic psychotherapy stemming from the work of Freud, and deliberately explores unconscious conflicts and processes, such as transference, within a regular relationship of increasing intimacy and trust. This may be relatively short term, as in brief or focal psychotherapy, weekly for 10 to 40 sessions,[8-10] or long-term psychoanalysis several times a week over many years. Analytic group psychotherapy usually entails one or two sessions a week over two to three years. Family and marital therapy may be successfully achieved in a few sessions but may require a year or two to achieve maximum benefit. *Psychotherapy 4* in Cawley's terms is behavioural psychotherapy, stemming from the work of Pavlov and learning theory. It has been developed particularly by clinical psychologists who use a wide range of techniques for modifying behaviour, typically choosing circumscribed areas of behaviour on which to concentrate.[11]

In this paper we deal chiefly with psychotherapies 3 and 4—that is, psychotherapy conducted in the main by specialists to whom general practitioners and psychiatrists will refer those patients they consider need it. But the first task of these referrers is to exclude organic disorder. Having done so, or in the course of doing so, most doctors will offer a measure of psychological support and counselling (psychotherapy 1), which is best provided by the general practitioner, general psychiatrist, or social worker. Short term it is particularly appropriate for people suffering from a reaction to an acute crisis, such as bereavement, unemployment, or retirement, or long term for sufferers of chronic disability caused by psychosis or severe personality disorder in a person not amenable to more radical forms of psychotherapy.[12] The aims of such treatment are restoration of the "status quo ante" or the prevention or minimisation of deterioration. (Some patients wanting help with particular problems—for instance, adolescent, unwanted pregnancy, or marital problems—go to specialised counselling agencies.) Some general practitioners will go beyond these measures and aim to make a more dynamic intervention. Some will seek and share an understanding of the problem, even in a brief contact (psychotherapy 2). And others with a particular

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interest and training in psychotherapy may arrange one or several longer sessions for more detailed exploration (psychotherapy 3). Patients will usually present to general practitioners as individuals, except in the case of children; and psychotherapy, whether brief or extended, is likely to be one-to-one. Neither the "artificial" or "stranger" group, nor the family in a formal gathering, will be much used, though the latter may be particularly valuable in general practice.[13] In what follows we assume that the referring physician has taken the matter as far as his time and experience permit, and has come to the point of decision: to which form of expert psychotherapy should this patient be referred?

### ASSESSMENT INTERVIEWS

The assessment interview(s) whether with the individual alone or plus the whole family group, and whether conducted by the general practitioner or specialist, is one of the most important moments in therapy. It allows not only the taking of a history of the patient and his problem, but also permits observation of his behaviour under stress, and provides the basis for the therapeutic alliance. Both parties can see how they enter into the doctor-patient relationship and their respective attitudes to the problems presented by the patient. In particular the assessing doctor/therapist will want to determine to what extent these problems can be understood in psychological terms, and how much the patient is willing and able to see them in these terms.

## Treating the couple, family, or wider social systems

In assessing the alternatives, one or more interviews with the patient and his or her family of origin (or, if married, the spouse and then perhaps the family of procreation) should be considered first for the following reasons.

(1) A diagnostic session with the family group (or couple) provides important information that would otherwise take a long time to obtain, and some which could not be obtained at all by separate interviews with the designated patient or other family. One common and important finding is that the designated patient is not the sickest member of the family but is protecting more vulnerable members, or the stability of the marriage, by "volunteering" to be the symptom carrier, scapegoat, or rescuer.

(2) Family interviews have not been found to do harm, despite careful follow-up of doubtful cases. This is not to say that some members may not get upset or angry, which is often necessary if change is to occur.

(3) Family therapy is the "broadest spectrum" psychotherapy. Though the extent of change may be limited as compared with other approaches (since it must necessarily include a compromise between the different aspirations of all the family members) the range of disorders in which it can bring modest but worthwhile improvement is vastly greater than that of any other approach. Indeed, if the social system beyond the family can be involved, when relevant, it is rare for useful changes not to occur, even with "end-of-the-line," "uncooperative" cases with which all other methods have failed. (For example, even children showing severe problems at school, whose parents are unconcerned and resistant to attending a clinic, can change if the therapist offers to meet the child, parents, head, and class-teacher at the school. The principle is the simple and obvious one that the person with the complaint—in this case the teacher, not the child or family—must be present if progress is to be possible.)

(4) It can be an extremely potent modality, sometimes effecting enduring change within a single one-hour session, and usually taking under six sessions. It has also been noted independently by workers in different countries,[14-16] that spacing sessions a month apart, instead of at weekly intervals, actually increases the rate of change. This makes such methods highly economic. Though in Britain the family therapy approach developed more in child psychiatry, a two (or three) generation framework can be fruitful even when the "patient" is adult; and bringing the "well" spouse into the examination and treatment of a disturbed adult can often show the true nature of their disturbance, or increase the therapeutic potential of the marriage, or both. People can help each other in a family or marriage as well as make each other suffer.

We believe it is sensible to consider this approach first and to pass on to others if: (*a*) it proves insufficiently effective; (*b*) it is contraindicated by a history of severe depression or early parental deprivation, or current incapacity of the family to meet developmental needs; or (*c*) it is impracticable because the person wants treatment in his or her own right or the family live far away, refuse to come, or are mostly dead. Separate therapy has its main value for adults who have left, or established themselves an appropriate distance from their families of origin, but who have not yet married and begun to establish families of their own.[17]

## Therapy separate from the family: advantages of groups

If separate therapy for the designated patient is indicated by one of the above criteria, when is individual (one-to-one) work preferable, and when is a stranger-group more helpful? Again, the patient's own wishes may decide this irrespective of what the doctor might recommend, but if a choice is possible the group has great advantage with certain types of problem.

(1) It often facilitates more rapid and deep change than individual therapy in those patients who have little self-understanding or desire for it, and who therefore tend to see their problems as the fault of others. Such "egosyntonic" personality disorders are notoriously slow to change in individual therapy, where the therapist faces the dilemma that confrontation sufficiently forceful to penetrate the patient's defensive armour may be experienced as so critical and wounding that rapport and trust is lost. In a well-conducted group other members not only provide far more forceful confrontation than the therapist may dare attempt, but some patients will also simultaneously take a supportive role, which enables the criticism to be tolerated without excessive loss of self-esteem. Meanwhile, the therapist can preserve a trusted, neutral "referee" position.

(2) For similar reasons a group is often more useful for highly dependent patients who seek to put all responsibility for change in their condition on to others, particularly patients who deny any meaning to their symptoms, offer nothing spontaneously, and wait passively to be asked questions or be given advice.

(3) Patients—many with psychosomatic presentations—who cannot fantasise and are out of touch with their inner worlds, or who exercise a tight control of their emotions so that they give an impression of lack of life and absence of feeling, often "resonate" to the powerful emotional forces that group interaction generates and begin to experience feelings more vividly themselves, becoming aware spontaneously of previously dissociated aspects of their personalities without any conscious attempt to bring this about.

(4) A group is also particularly valuable for those whose sense of identity, including gender identity, is vague and confused, since it not only helps them to find their boundaries by the feedback they receive, but also provides a variety of different behavioural models from both sexes.

(5) Patients with difficulties in coping with groups in life, where the fundamental issues are more to do with early problems in coping with siblings or peers than with parental figures, may also be more suitable for this mode of treatment. In such cases a well-constituted group can give a second chance of growing up in a context containing the rich variety of experiences

normally provided by a healthy family. This is so whether the group is supportive or analytic.

As compared with individual psychotherapy, group therapy has a rather broader spectrum (though there is a wide overlap and each can deal with a range of problems unsuitable for the other). On this ground as well as on the obvious ground of economy (which means wider availability, more intensive provision, shorter waiting lists, or some part of all three) we suggest it should be considered after family therapy, and, when long-term intervention is needed, before individual therapy.

### COUPLES AND MULTI-FAMILY GROUPS

Couples groups, where three or four couples meet together weekly to monthly, and multi-family groups where several families are seen together, combine several therapeutic advantages of both "stranger" and "natural" groups. Though the use of such groups is limited at present, they have been found effective by one of us[18] in cases resistant to conventional treatment through individual, group, or even ordinary marital or family therapy. Because these groups combine some advantages of both family and group therapy, patients attending them show more rapid change than in stranger-groups, but they usually need to come for a year or more. This being so, it is best to attempt a short-term intervention first with the couple or family, to make sure that a more economical solution is not possible, and to consider this option later.

## When is individual (one-to-one) therapy required?

### FLEXIBILITY

One-to-one therapy is much more *flexible* than group therapy, so that the frequency and number of sessions, the level of regression and dependency, the depth and intensity of emotions elicited, the balance struck between reassurance and motivating anxiety, and the degree of focus on a particular task, can all be varied as necessary—that is, it can range from psychotherapy 1 to 3, from support to exploration at depth. Even when therapy aims at change in the structure of the personality, it can vary between a brief intervention focused on a clearly defined and limited problem[8-10 19] and an open-ended psychoanalysis that may last several years, aiming, like group-analytic psychotherapy, towards the more general maturation of the personality.

We might need to limit depth or duration of therapy, as well as who is involved. Many patients do not need or want to explore themselves and their relationships, others do not have the necessary capacities, or are likely to be made worse by having their defences challenged and regressive fantasies stirred up. Even when an exploratory approach is sought and not contraindicated, short-term psychotherapy might be necessitated by the limited availability of both patient and therapist—for instance, when the patient has to travel a long distance. One or two consultations can, in some cases, provide a lot of benefit, and this often takes place with only the designated patient, especially when the natural group, such as the family, cannot be mustered together. Similarly, counselling of people who have suffered a bereavement or who are in trouble because of specific problems, such as an unwanted pregnancy or difficulties in studying, may sometimes be best limited to that person and also kept at a relatively superficial level without exploring deeper unconscious conflicts. One-to-one treatment is particularly called for where the individual's needs are for short-term or concentrated work that would conflict with the needs of the group process which takes time to develop; analytic group psychotherapy is rarely considered if the patient cannot commit himself or herself to at least a year of weekly sessions. Patients with unresolved grief reactions may need a lot of individual help to contact and ventilate stifled grief, and to explore related conflicts and defences.

### UNDIVIDED ATTENTION

Though individual therapy can be used valuably in most conditions and situations, if others in the patient's family are not blocking progress, it seems to be most specifically indicated for those severely deprived personalities stunted or distorted by severe failures in the "facilitating environment" of early months and years.[20] This is particularly so for individuals who lost or never had the experience of "good enough" parents or parental substitutes. Mild deficiencies of this type may be remedied in groups, where profound regression of one or more members can elicit remarkable care and nurturance. Similarly, in the course of marital or family therapy, family members can be helped to recognise and respond more constructively to regressive needs in day-to-day living at home. Although this may suffice to tip the balance in milder cases, there are clearly limits beyond which it would be unreasonable to expect even the most considerate and patient individual to go in meeting the infantile demands of a spouse or child. Then, the undivided attention of individual therapy, at least as a preliminary or concurrent mode, might offer more realistic hope.

Such undivided attention may be essentially supportive in aim, as in casework by social workers maintaining severely damaged people over periods of years; sometimes this alone can lead to slow growth in patients' capacities to trust and grow in confidence. But it is also the basis for individual analytic psychotherapy. This promotes exploration of experiences and fantasies at all levels of development, from the most primitive fusion and separation of the infant self in relation to maternal images.[21] The needs, feelings, and fantasies of the individual can be attended to without interference by those of others. Only this may permit the tentative unfolding of a self that is stunted, distorted, and barely held together.

### NEED FOR PROLONGED PREPARATION

A third indication for individual work is where patients need prolonged preparation for psychotherapy of a more dynamic and exploratory type. Some patients need a lot of help in beginning to think about relationships and feelings, and to adjust to the idea of becoming more open with others, whether one-to-one or in a group. Ideally such preparation begins with the general practitioner.

## "Dynamic" or "behavioural"?

A further choice has to be made between a more dynamic, exploratory, analytic approach aiming at the development of insight or self-understanding, with the hope that this will lead to conflict-resolution, change in the balance of motivation, and alleviation of the complaint; or alternatively the more behavioural, directive approach (psychotherapy 4). This emphasises the development of skills the patient has not learnt or the changing of previous maladaptive learning through behavioural psychotherapy.

In family and marital work less difficulty arises, since most family therapists, whatever their original training, tend to draw freely on behavioural systems or psychoanalytic concepts and methods and to combine these as necessary. In the treatment of sexual dysfunction, for example, the combination of the behavioural approach[22] with a psychoanalytic exploration of the resistances thereby elicited, appears more powerful than either mode used by itself.[23]

In individual and stranger-group work, however, practitioners have tended to remain polarised as adherents of either the psychoanalytic or the behavioural paradigm. The type of treatment that patients receive therefore depends more on the door they happen to enter and the philosophy and personality of those behind it than on what might help them most, so that

the choice of the most appropriate door will often lie with the referring practitioner.

In general, patients whose problems stem from simple deficiencies in experience, or whose training has been inappropriate—so that they are aware of their handicap and the need is more for education or re-education—are helped most effectively and economically by a behavioural approach, either individually or in groups—for example, social skills training for those who have little social experience or sexual attitude restructuring for those who have grown up in prudish families.

If the patient has the wish and capacity, an analytic approach is indicated where a direct approach to re-learning by exposure to new situations is made difficult through the development of complicated defensive systems that obstruct the patient's conscious awareness of the problem and so also limit the therapist's ability to perceive it and to change it directly. For example, forbidden sexual impulses may be disguised as hostility and suffering, as in sadomasochistic behaviour, or complaints of obsessional hostile thoughts may be a way of avoiding taking responsibility for actual, appropriate anger towards others. Where such protective layers have developed to disguise and insulate the original difficulty, the exploratory analytic approach comes into its own. Once the patient is reconnected with the basic problem—becomes conscious of it—he has the possibility of exposing himself to beneficial experience which could help him and which he has hitherto avoided. But if this does not occur spontaneously, a behavioural approach may then be appropriate, as Freud himself noted.

## Combinations and sequences of the different modes

We have found that all these different modes can, if necessary, be fruitfully combined, though a different order may be appropriate in different cases. Conjoint family sessions may help parents accept the independence of an adolescent who is expressing their own fears of separation as well as his own, after which separate individual or group therapy for the youngster may provide a "halfway house" between the family and the outside world. The parents, left alone, may then have to face the marital problem from which their concern over the child distracted them, and this may need therapy as a couple or in a couples-group. Specific sexual difficulties that are next disclosed may be resolved most quickly by "active sex therapy" using a behavioural approach.

While some problems can be equally effectively treated by different methods, benefit may be partial. Then a change of therapy may unblock progress—for example, patients who have undergone psychoanalysis without learning to apply their insights in outside relationships may benefit from group therapy. After one of the briefer forms of individual therapy or family or marital therapy, some patients may benefit from long-term analytic psychotherapy, individual or (most commonly in the NHS) group.

A flexible response requires that all psychotherapists should acquire some knowledge of and preferably some basic skill in the individual, stranger-group, and family and marital psychotherapies, employing both dynamic and behavioural principles. Though each individual will probably wish to concentrate on one or other of these different approaches, we believe that some acquaintance with them all is an essential part of the training, not only of every psychotherapist but of all psychiatrists.

## Long-term, intensive, dynamic psychotherapy

Although it may seem that we have neglected the value of long-term analytic psychotherapy in promoting the quality of life and personal fulfilment, in reality we do not, and believe that some people can benefit only from such long-term intensive work. But more people can be helped by less ambitious and costly treatment, and the NHS cannot afford to neglect those who can be helped by other forms of therapy discussed here. Private psychotherapy exists for individuals who wish to make sacrifices for this personal benefit.

It must be recognised, however, that most of the briefer therapies have been made possible by the detailed knowledge and self-knowledge acquired through the practice and experience of psychoanalytic and group-analytic therapy. Furthermore, as in organic medicine, short-cuts are best taken by those who know their subject thoroughly and are aware of the inherent risks. For both these reasons we believe there is every justification for psychotherapists to spend a proportion of their time training in and practising long-term work, even in the NHS.

Requests for reprints to DGB.

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*What are the indications for a pacemaker?*

In the absence of disqualifying features cardiac pacing is indicated for acquired complete heart block (except nodal), Mobitz II block, and bifascicular block where occasional failure of conduction has been shown or syncopal attacks make it very likely that this is occurring. Pacing is also the treatment of choice where bradycardia or "pauses" (not due to drugs or tractable primary disease) are responsible for symptoms. Determining such an association usually means ambulatory rhythm monitoring. The successful management of the tachycardia/bradycardia syndromes may require pacing as the first step. It may also be indicated for preventing syncope due to carotid sinus hypersensitivity and—using an advanced pacemaker—for the control of some resistant forms of paroxysmal tachycardia.