MEDICAL PRACTICE

Contemporary Themes

The Isis Centre: a counselling service within the National Health Service

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British Medical Journal, 1976, 2, 355-357**Summary**

A new centre has been established to provide readily accessible counselling, consultation, and mental health information. People may refer themselves or are recommended to attend by general practitioners or other agencies. The counsellors have varied backgrounds in paramedical or counselling services, and they are supported by psychiatrists. Of a sample of 100 clients, four were referred to one of the team's psychiatrists and 33 visited the centre only once. The centre's staff aim to adopt a flexible approach to the client and his problems, and formal psychiatric categories have not been found useful. Provision is made for people who want to solve their problems by discussion rather than medication and those for whom the existing psychiatric services may have little time to spare. Consequently, the approach adopted by the Isis Centre, whereby many people benefit from psychotherapy yet the psychiatrist deals directly with only a few selected cases, contributes towards meeting the great need for psychiatric services and using the psychiatrist's skills more effectively.

Introduction

Although many people suffer from some form of psychological disturbance and distress,¹ only a few seek help from their doctors, and even fewer are referred for specialist help. Because a general practitioner can devote only a short time to each patient and because very few have been relevantly trained, only a few patients receive specific psychotherapy or counselling.² The only way the general practitioner can respond to the psychotherapeutic needs of his patients is through acquiring some common-sense psychotherapeutic skill, and this skill is all that most general practitioners will offer. Yet the use of empirical methods picked up from everyday life should be looked on with the same suspicion in psychotherapy as it would be in any other sphere of medicine.³

Even if a patient is referred to a psychiatric outpatient department psychotherapy services are few and waiting lists long.⁴ Time seems to be a major factor in limiting the amount of psychotherapeutic treatment offered to patients, and, clearly, there is little point in increasing training in psychotherapy for the psychiatrist unless he has the opportunity to use this skill⁵; the average consultant psychiatrist could devote less than one session a week to psychotherapy.⁶

A recent memorandum on the manpower needs for psychotherapy⁷ has advocated an expansion in the establishment for consultant psychotherapists to the level of one per district general hospital. The report estimated that it might take about 20 years to achieve the target figure of 250 posts but makes it clear that the highly trained psychotherapist may use his skills best if he works in a consultative capacity with other people with different roles. It is also important that help should be available rapidly when any person seeks it, since this is likely to be at a crisis point in his life, when he is most able to benefit from it.⁸⁻¹⁰

We describe here a centre established to supplement existing psychotherapeutic services by providing readily available counselling and consultation.

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The centre

The Isis Centre, situated near the centre of Oxford, was planned as part of the increasing involvement of the psychiatric services at Littlemore Hospital with the community. It was formally opened in October 1970 and is open to the public on weekdays from 9.00 am to 5.30 pm. It is also open in the evenings and at weekends for specific meetings and therapy groups.

The centre primarily provides a counselling service, and people may call informally to seek help for emotional problems. It also provides information and advice on appropriate ways of reaching various mental health services. The premises may be used by other hospital units when an informal atmosphere is needed. The centre does not advertise its services, apart from on its own premises and through informal contacts with other statutory and voluntary agencies. Some of these have used the premises for group meetings, to which the staff of the centre may act as consultants.

Staff

The centre is staffed by people drawn from backgrounds of education, marriage guidance, nursing, occupational therapy, pastoral care training, and social work. There is a full-time co-ordinator, who has both an administrative and counselling role, and a full-time secretary/receptionist; all other staff work on a sessional basis. Some are fully employed at the hospital and spend two sessions a week at the centre; others simply work part-time at the centre. The counselling team at present has six members. Three psychiatrists, a clinical psychologist, and a principal psychiatric social worker are also concerned in the project and between them provide consultation, supervision, and psychiatric assessment, when these are felt to be appropriate.

Although their relevant experience has been taken into account, staff have been selected primarily because they possess a basic understanding of psychodynamic processes and can apply this awareness appropriately in counselling. Those with more experience and training play an important part in increasing the skills of the less experienced.

Staff training is based on supervised practice, and both individual and group supervision are available. Most of the staff make their own arrangements for additional training in various types of psychotherapy, and the team may benefit from their experience. The team meets twice weekly for two hours, which seems enough to establish a team identity. Half this time is devoted to staff training and discussing theory. The remainder is spent in discussing the problems of clients. The evaluating counsellor presents an initial assessment and the team considers possibilities for further intervention. The team meeting helps all staff to share a general outlook that emphasises the psychodynamic factors in emotional distress but allows for different theoretical approaches.

Counselling

The service aims to respond to people's needs when conflicts are at their height, or while a personal crisis still exists.

Self-referral is usual, but people may be recommended to call at the centre by other agencies. The distinction is made between recommendation and formal referral, since the centre regards itself as responsible to the individual only and not necessarily to the source of referral. It differs in this respect from a psychiatric outpatient department. Most people are agreeable to another agency being contacted, if this is relevant, and, similarly, it is usual to ask for permission to contact the general practitioner. Occasionally a counsellor will refer a person to one of the psychiatrists on the team. Only at this stage does the "client" formally become a "patient." This referral is arranged with the prior consent of the general practitioner, who, together with the referring counsellor, will subsequently receive a report of the consultation.

People are seen in a relaxed and informal setting and interviews last up to 50 minutes. Areas of concern are explored by helping the person to follow his own train of thought, rather than by asking direct questions. The counsellor is interested in finding out why he has chosen to come to the Isis Centre and why he has come at that particular time. He is alert to the way in which the person presents himself, and he discovers the ways in which the client experiences stress and his characteristic responses to past crises. He explores with him his assets, his significant relationships, and his plans for the future.

Evaluation may take several sessions. The assessment process itself can be therapeutic,¹¹ enabling a person to clarify the issues that have led him to seek help. Sometimes he can decide on ways in which he

might tackle his difficulties himself. Alternatively, he may wish to continue to work on his problems with the help of his counsellor. For most, counselling tends to be time-limited and focal, with a specific number of weekly sessions planned to work on defined problems, which are agreed to be the area of concern. Group psychotherapy is offered whenever this seems appropriate, and long-term psychotherapy is occasionally made available, when there is evidence of a particular capacity to respond to this form of intervention.

Clients

The number of new clients seen at the centre and the total number of attendances for individual counselling in the five complete years since the centre opened are shown in table I.

TABLE I—Numbers of new clients and total attendances for five years

	1971	1972	1973	1974	1975
Total attendances	898	1237	1078	1221	1582
No of new clients	286	282	218	254	295

Some of the characteristics of users of the centre may be demonstrated by an illustrative sample of 100 of the people who were seen between January and June 1975. Twenty-two were recommended to come to the centre by a medical agency (general practitioners, health visitors, etc); 14 by other statutory agencies (probation officers, social services, etc); seven by the Samaritans; and two by other voluntary agencies. The remaining 55 were self-referred. Thirty-five had had previous psychiatric treatment, and 34 had consulted their general practitioner in relation to their presenting problem.

About a third of the sample came to the centre only once, a third were seen two to four times, and a third were seen more than five times. Ten people were seen more than 10 times, and 20 people were still attending when the assessment was made. Fifteen people were referred for treatment other than with the counsellor first seen: five to another counsellor in the team, four for group therapy at the centre, four for specialist treatment elsewhere in the hospital service, and two to their family doctors. Four were seen by one of the team's psychiatrists for clinical assessment.

The centre is used primarily by young adults: 73 clients were under the age of 35 (table II). Of the sample, 55 were women and 45 men;

TABLE II—Age and sex distributions of 100 people seen at the Isis Centre

Age (years):	<20	20-29	30-39	40-49	>50
Women	8	21	14	9	3
Men	2	23	9	5	6

47 were single, 34 married, 16 divorced or separated, and three widowed. The centre is consulted by a cross-section of society and not just by those who, because of intelligence or education, might be more articulate. Of the sample studied nine were professional people, 18 were manual workers, 17 were in intermediate occupations, 18 were housewives, 23 were students, and 15 were unemployed. Students represented nearly a quarter of the sample, probably reflecting the high proportion of students of all types living in the Oxford area. Only five of the students were undergraduates at the University of Oxford, which has its own counselling service, but six were post-graduate students of the University. Nine attended other colleges and three were still at school. Four of the 18 housewives and only one of the 15 unemployed people had received college education.

Presenting problems seem to fall into the four main categories shown in table III. Many people also complained of depression, anxiety, tension, etc. Such subjective feelings of distress commonly merged with one another, and accurate differentiation was not possible. Similarly, in considering diagnostic categories after assessment, clients could not easily be classified according to conventional psychiatric nomenclature. Most could be said to be suffering from a type of neurosis or personality disorder, but only one person in the sample was obviously psychotic.

The traditional "illness-centred" diagnosis has, however, little practical value. A diagnosis which takes into account the style of

TABLE III—Presenting problems, divided into four main categories, in sample of 100 people seen at Isis Centre

	No of clients		No of clients
<i>Actual behaviour problems:</i>		<i>Other maturational difficulties</i>	24
Work or study difficulties ..	11	Problems of sexual identity ..	9
Antisocial, violent, or criminal behaviour ..	9	<i>Situational problems:</i>	
Sexual problems ..	19	Isolation ..	10
Drug or alcohol abuse ..	12	Economic (poverty, unemployment, housing) ..	15
<i>Fears of possible behaviour:</i>		Physical illness or handicap ..	4
Fear of madness ..	13	Bereavement or specific loss ..	7
Fear of suicide or self-injury ..	11	Marital tensions or other specific relationship ..	38
Fear of injuring others ..	8	tensions ..	18
Fear of other loss of control ..	4	Family tensions ..	18
<i>Development problems:</i>			
Life crises ¹² ..	6		

interpersonal relationships is more appropriate. Clyne¹³ has described the disadvantages of the traditional diagnosis in general practice and describes alternative models developed at general practitioner seminars led by Balint. These have relevance for the Isis Centre. The counsellor's task is to attempt a formulation in psychodynamic terms, which can be communicated to colleagues, recorded, and subsequently researched. In applying this formulation, the counsellor must relate to the client in such a way that the client feels he is understood. The client may then be encouraged to work on the task of understanding himself in relation to his specific problems.

Discussion

The centre aims to offer alternative or additional modes of psychotherapeutic intervention and consultation to meet some of the deficiencies of existing services. It does this by offering a counselling service direct to the community. In this way, it is available when people are encountering crises in their lives. The centre seems to have been used appropriately. Only a third of our sample had had previous psychiatric treatment, and two-thirds had not consulted a doctor about the problems for which they currently sought help. The presenting problems are usually the source of considerable distress or disability, but few clients presented with intractable personal and social problems for which they had already received much help. Most came highly motivated to deal with problems that were appropriate to a counselling approach.

Discovering the extent to which intervention alleviates distress is a major research undertaking, common to all psychotherapeutic endeavours, and at present beyond the resources of the centre. We hope that the approach adopted may have a preventive function, but this, too, requires further investigation. Research currently under way seeks to compare clients of the Isis Centre with users of other mental health agencies. For example, it would be interesting to know whether there are differences between users of emergency, walk-in psychiatric clinics, such as that of the Maudsley¹⁴ and other hospitals, and users of a service such as this, where the observable link with the hospital is minimal. Although we cannot yet evaluate the role of the centre within the wider context of provision of services, several points may be made.

Firstly, the centre is open to anyone and hence does not share the constraints of other counselling services, such as marriage guidance or youth services, which confine themselves to particular types of problems. The flexible definition of problems allows the staff to respond to the unique cluster of troubling factors that characterise a particular person. The centre differs from the multidisciplinary social casework centre described in Edinburgh¹⁵ in that it provides only counselling and consultation, but it also aims to facilitate the appropriate use of other medical or social resources available to the client.

Secondly, the centre seems to offer several advantages to various groups. It provides an alternative resource for the general practitioner who does not want to take on the counselling himself or make a psychiatric referral. By recommending the centre, he leaves the initiative with his patient, who, if he decides to approach the centre, may do so when motivation to work on his problems is high. The centre also offers an alternative approach

to the person who may be reluctant to divulge details of emotional difficulties to his general practitioner. To various community agencies the centre is a resource that they can either approach for consultation or recommend to clients. A service is provided for people who see themselves as being distressed rather than ill. In an outpatient setting their symptoms might result in a diagnosis of illness, but they do not adopt a sick role. These people, by virtue of their motivation, may be more suited to a psychodynamic approach to their problems than those who conceive of themselves as being ill within the traditional medical model.¹⁶ The centre, therefore, provides a service for people who want to solve their problems by discussion, rather than, for example, by taking medication, and who, indeed, may resent an attempt to solve problems which they see as having psychological determinants by physical means.

Finally, this approach provides a means of using the skills of the psychiatrist economically and effectively. This is essential if psychiatry is to devise ways of meeting the need for services that is implied by the high degree of psychiatric morbidity revealed by epidemiological studies. The psychiatrist's role becomes one of providing consultation for front-line staff and seeing patients only when his specific diagnostic skills are required. He is also likely to treat personally a few patients, so that his own skills do not atrophy. With the current shortage of psychiatric manpower, it is inevitable that the hospital and outpatient clinic will continue to make major demands on the psychiatrist's time. The centre appears to offer a coherent model whereby the experience of the psychiatrist with an interest in psychotherapy may be effectively utilised.

We acknowledge with thanks the help given to us by the late Dr L K Elmhirst, of the Dartington Hall Trust, in providing the premises for rental, and the foresight of the Oxford Regional Health Authority in supporting the project. We should also like to thank the staff of the Isis Centre, particularly Mrs S Oldfield and Mrs P Cosin, for their help with the preparation of this paper.

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With disquiet about the carcinogenic risks of hormone treatment, what alternatives are there for the control of menopausal symptoms?

Firstly, physical and emotional causes for such symptoms must be excluded. The management of the menopause requires explanation, advice, and reassurance as well as any drug treatment. For hot flushes and other vasomotor symptoms, clonidine, 25 µg twice a day, has been claimed to give good results.¹

¹ Clayden, J R, *British Medical Journal*, 1974, **1**, 409.