

Psychotherapy in General Practice

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SUMMARY

A psychiatrist can accomplish psychotherapy with re-constructive goals successfully within 3 to 5 years.

A general practitioner should be able to observe and modify a very small segment of a disturbed personality during consultations lasting 8 to 10 minutes.

An attempt is made to describe how this can be achieved by complete identification with the patient and his problem; the discovery of a basic defect in his personality; attempting to bring this to his understanding and by teaching him to improve his behaviour.

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Psychotherapy is the treatment of emotional problems when a trained person satisfactorily establishes a controlled professional relationship with his patient. The object is to solve, remove, modify or retard existing symptoms of disturbed patterns of thought, feeling, attitude, or behaviour, and to promote positive personality and development.¹

This is achieved by the systematic application of certain psychological techniques. In general practice modification is essential to fit this form of therapy into the pattern of daily routine, where patients can only be granted a limited period of time. The following aspects are the highlights in the classical setup of the therapeutic process:

- the doctor (general practitioner);
- the patient;
- his illness;
- the doctor-patient relationship;
- and general practice psychotherapy.²

THE GENERAL PRACTITIONER

Psychotherapy starts when the patient hears good reports about the doctor. That he is human, informal and easy to approach, with a kindly disposition and capable of coping with different situations.³ That he practises medicine as a calling, a sort of religion, a real profession, and never a business, and makes available his heart as well as his head. That he has character, intensity of feeling, is concerned with his patient's problem, willing to listen and not hurried.

The doctor needs, in addition to his training and experience in this particular field, personal attitudes

and characteristics which appeal to this type of patient, such as sensitivity to the feelings of others, the ability to be objective about problems, flexibility of interpretation and feeling, and freedom from serious emotional problems himself. Then he is likely to be warm and responsive, intelligently alert, and with intuitive understanding of his own limitations as well as those of his patients. The doctor must be able to integrate and manage differing and even contradictory attitudes; he must be dignified and restrained but still approachable.

The best compliment a doctor can receive is—'You know, you are a real human being. I can talk to you so easily'. He must be able to listen and to communicate clearly, be tolerant and receptive, yet able to limit the patient's behaviour when necessary. He must be able to assume the role of parent substitute, yet be able to free the patient from this need. He must be cultured and knowledgeable, but must not allow his patient to feel this to disadvantage. In many ways the doctor is a living paradox.⁴ This may answer questions like 'Why do my patients leave me?'⁵ and answer the Editorial 'My huisarts en my ginekoloog'.⁶

The general practitioner must never forget that he is a family doctor and not a psychiatrist. The average patient gets 8,3 minutes from his doctor per consultation—it follows that in 8,3 minutes meaningful contact must be made with the patient to attain an acceptable mutual understanding that can be utilised therapeutically; the aim being to find which stones must be turned to reveal the necessary clues. The doctor must be able to 'tune in' to his patient and to suddenly understand his patient better. Usually this communication is highly charged with emotion—a true transference manifestation.

The general practitioner's task is primarily to observe *how* the patient talks, thinks and behaves. What causes him pain and what he, in an obscure and confused way, seeks from his doctor.

This ability can best be acquired under skilled supervision and by the use of various audiovisual technical aids.⁷ Unfortunately only 20-30% of general practitioners are thus properly motivated. Professor A. J. Ryle⁸ writes, 'There is a saying that the chief clinical advantage of the consultant over the general practitioner lies in his more frequent appreciation of the necessity for a rectal examination.'⁹

THE PATIENT

The general practitioner has the best chance of therapeutic success with mild to moderately severe mental disturbances like (i) stress adjustment problems; (ii) personality disorders of fairly recent onset; and (iii) many neurotic reactions, which all seem to benefit from short-term psychotherapy.

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All symptoms must, however, be carefully attended to, since all may have an important bearing on the illness. Some patients may wish to keep their symptoms because of some secondary gain after the cause has become organised. Forces deep within the personality may resist a change, and there is a struggle against giving up symptoms, no matter how distressing they appear to be.

There are various problems for which reality often has no better solution than a neurosis. Poor intelligence, advanced age coupled with lack of flexibility, may seriously affect treatment. A basic fault in the biological structure of an individual, involving both his mind and body in varying degrees, forms the basis of nervous disturbances. This defect is usually the result of a considerable discrepancy between the needs of the individual during his early formative years and the nursing care available at that time. This creates a deficiency state, the consequences of which are only partly reversible. Vestiges remain contributing to what is called constitution, individuality, or character, both in the psychological and biological sense. According to Sir William Osler, 'The contractor put in poor materials'.²⁰ The basic cause of this early discrepancy may be congenital or environmental—insufficient, careless, haphazard, over-anxious, over-protective, or only non-understanding care.

Crises later in life, internal or external, psychological or biological, elicit symptoms or exacerbations of these vestigial responses. Disturbances of behaviour follow, and the personality may eventually become disturbed. For example: (a) trait and pattern disturbances, schizoid, cyclothymic with widely fluctuating moods, paranoid, immature, emotionally unstable and compulsive personalities; (b) sociopathic personalities, with a tendency to act out behaviour, rather than mental or emotional symptoms, including antisocial or dyssocial reactions, sexual perversions and addictions, who lack internal control and do not learn from experience; and (c) psychosomatic symptoms, free from the stigma of mental illness, are responsible for behavioural patterns causing mental conflict when they clash with reality. The patient then develops feelings of anxiety and guilt which are unpleasant and he puts up flight or defence mechanisms repressing the conscious impulses into the unconscious.

Substitution of alternate goals and gratifications are found, including:

Rationalisation: an excuse for a behavioural pattern.

Projection: someone else is blamed.

Regression: earlier and easier levels of adjustment are resorted to.

Sublimation: a change to socially acceptable activities.

The most important conflicts centre around sexuality, aggressive urges, and the need for status.

When the defence structure of the individual remains intact and works efficiently, he is considered to be well adjusted. Emotional disturbances result when the defences become exaggerated or distorted.

Excellent opportunities, unfortunately too often missed, to practise preventive psychotherapy can arise from the 'no-illness' situation when a patient comes for a check-up. There is also the constant challenge to the practitioner to organise a doctor/patient relationship around a chronic

illness. This should be avoided and specialist consultation rather be recommended.

THE ILLNESS

Psychoneurotic disorders are relatively mild disturbances of personality and often respond favourably to psychotherapy by a general practitioner.

Ten per cent of all people have some such disturbance, and a third of the patients who consult general practitioners suffer from neuroses, especially female patients.

Most psychoneurotic disorders can be treated on an outpatient basis. They are earmarked by anxiety, expressed either directly or indirectly as the patient responds to internal and external threats by means of an over-active autonomic nervous system.¹¹

The physical symptoms include a more rapid heart rate, breathing difficulties, gastro-intestinal upsets, excessive perspiring, and similar bodily changes. The psychological symptoms range from vague uneasiness to apprehension and dread.

In psychoneurotic disorders other than the anxiety reactions, the underlying fear is changed into some other symptom. The phobia is the most common—a pathological fear in which anxiety becomes focused on a specific object, person, or situation. Closed areas, open spaces, pointed objects and heights are common causes of such phobias.¹²

Anxiety is handled differently in the obsessive-compulsive reaction. Unwelcome recurring ideas and repetitive acts are linked, and the reactions include excessive orderliness, cleanliness and compulsive doubting. Pathological preoccupation with physiological symptoms and functions causes hypochondriasis, which is so common in general practice.

The conversion reaction is a neurotic disorder in which the anxiety is converted into a physical disability, e.g. abnormal visual, auditory and tactile sensations and motor disturbances in the form of tics, tremors, contractions, paralyses, and convulsions.

In the dissociation reaction the patient unconsciously controls his anxiety by splitting one part of his personality from the self. This relatively independent personality is then responsible for amnesia, automatic actions, sleep-walking, and a multiple personality.

The neurotic depression reaction is one in which anxiety is expressed in hopelessness and dejection, and usually has a favourable prognosis.

The external forms of psychoneurotic disorders vary considerably, but the underlying purpose is an attempt by the patient to deal with an overwhelming anxiety. Constitutionally the neurotic has a low tolerance for, and an ineffective technique in dealing with, anxiety, or a neurosis-precipitating experience of a traumatic or threatening nature. These include unhappy marriages and love affairs, stressful situations at work, tension, lack of scope for self-realisation or creative ability, parent-child problems, and the need for status.

If the symptoms are expressed through the central nervous system, the condition is diagnosed as a conversion reaction. When underlying emotional difficulties are ex-

pressed through body systems innervated by the autonomic nervous system, the resulting condition is called a psychosomatic disorder—the inner conflicts and anxieties are transformed into physical symptoms expressed through the autonomic nervous system.

The most common psychosomatic disorders are cardiovascular, gastro-intestinal, respiratory, genito-urinary and dermal reactions; also endocrinal and musculoskeletal phenomena and special sense disturbances. This includes headache in all its forms, and perhaps even carcinoma.

General practitioners doing major surgery should read literature pertaining to this subject.^{3,12,13} One may then question the wisdom of subjecting a patient to an operation except for very cogent reasons, especially if she is under 40 years of age, has a history of pre-operative depression, or has no demonstrable disease. Surgery is *not* a vehicle for psychotherapy.

Less amenable conditions, which can be given more effective support as regards psychological and physical symptoms, include the psychoses—the schizoid, paranoid and chronic depressive patients.

DOCTOR/PATIENT RELATIONSHIP

The doctor must establish a sound personal relationship with his neurotic patient during psychological examination, thus permitting frank discussion in such a way that friction, unhappiness and suffering are prevented. The essence of a general practitioner/patient relationship is its continuity, and any treatment, particularly a successful one, should represent an increase in intensity of this fruitful co-operation.¹⁴

On a basis of mutual satisfaction and frustration a unique relationship is established. The patient learns what help he can expect from his doctor and, on the other hand, how much anxiety and suffering he has to bear on his own. The intensity of the interaction is determined by the patient's needs, and the doctor must be prepared to endure an emotional impact of a very high intensity, which may even over-tax his resources. Only thus can vital dynamic experience be made available in a professional setting.

The patient can then, on the basis of a new understanding of himself, make some conscious effort to correct some of his otherwise automatic ways of behaviour and thought. A part of the patient's life which felt unreal and unimportant, may become real and important as he recognises something new in himself, and this recognition is shared by another.

Ideas and emotions previously suppressed or repressed because of shame and guilt, may no longer appear queer, unrealistic, or even mad. These, when acknowledged, make it possible for him to experience more in his relationship with other people.

The general practitioner learns how often and with what type of complaint the patient comes to him, how he behaves under stress, or when something unexpected happens, e.g. when a member of his family falls seriously ill. Respect for the patient's intimate life makes it imperative for the doctor to acquire the necessary skill to examine a patient without causing embarrassment.

In the search for pathology in the whole person, and to reach a comprehensive diagnosis, physical symptoms and signs must all receive attention. In addition, neurotic symptoms must be properly evaluated.

The general practitioner sees his patient under all sorts of circumstances, in different settings, also socially, and sometimes intimately, as during an internal examination. Such contacts have highly important psychological implications and therapeutic potentialities.¹⁵

The doctor has an intimate relationship with the patient's relatives, friends and neighbours, and he should employ these sources of information fruitfully for the benefit of his patient. He must be available—on tap—whenever the patient wants to vent deep and intense emotions. The patient must, however, feel that the doctor will tolerate his unconventional behaviour before he feels free to thus vent his inner feelings.

Coincidentally put, the practitioner must be able to apply intelligently the knowledge he gains of a patient's life pattern to the latter's home-life, his work and the world around him.

Interplay of emotions between doctor and patient plays a crucial part in psychotherapy. The doctor must recognise and control them, instead of acting upon them. He must examine his own feelings while treating his patient, since these may explain some important symptoms of the illness. Do other people feel the same? Such feelings may even bring about a change in the doctor's own personality.¹⁶

The member of a family group who first comes to ask for help is usually the least ill, and therefore has the better prognosis. It is never advisable to treat the absent patient.¹⁷

Psychotherapy is similar to pruning a tree—prune the symptoms to get the illness into shape, and then aim for radical cure and not only the relief of symptoms.

Identification forms the basis of emotional understanding as if he himself were the patient, but he must be aware of his role and of his emotions—the borderline between intellectual and emotional understanding. No matter what the setting is, consulting room, bedroom, or hospital ward, this relationship must always be professional and dedicated. The duration of the relationship is determined by the interaction between patient and doctor, and influences the quality of the interview. Success or failure of this relationship is determined by (a) mutual understanding; (b) knowledgeable interpretation; (c) the sense it makes to the patient; (d) insight; and (e) integration of insight into personality.

GENERAL PRACTICE PSYCHOTHERAPY

The therapeutic process consists of four essential parts.¹⁸ Firstly, a good working relationship with the patient is necessary. Secondly, investigation of the source of the problem—current situations and past experiences, the significance of the message the patient is trying to convey, and transference manifestations which the patient exhibits in his relationship with his doctor. Thirdly, translating insight and understanding into action, and lastly, termination of the treatment process and the handling of dependencies that exist.

General practice psychotherapy has as its keystone a thorough physical examination, including a complete neurological examination.^{19,20} Difficulties in therapy may arise during the progressive stages from the conducting of the initial interview, where patient and doctor must find each other before a diagnosis can be made, through any of the following stages: the use of interviewing techniques in a process of primary airing of emotions; an understanding of the psychodynamics responsible for the psychological disturbance; the detection and handling of transference; the awareness and mastery of counter-transference; the dealing with resistance; the use of the 'flash' phenomenon when possible; the use of interpretations—the growth of insight and constructive action to integrate progress; and the termination of therapy.

These steps must develop normally and be handled adequately. In an aura of security, stability and complete freedom from interruption, a pleasant warm environment must be established, with the doctor radiating benevolence, interest and confidence. He must accept what the patient offers, encouraging him to talk, and help him to overcome shyness and embarrassment. Once a clear idea of the patient's problem is attained, the doctor can point out the purpose and goals of the interview and the limitations of the therapeutic effort. This will help the patient to understand what is expected of him and what he can expect from the doctor. The doctor gets an idea of the degree of insight the patient has, the relative strength of his defences, and the flexibility of his personality. The patient is allowed to talk without fear of punishment, censure or judgement, and an occasional interruption from the doctor is only to help him express himself more clearly.

Transference occurs when the patient divulges his secret fears, anxieties, problems, hopes and ambitions. Gradually the doctor assumes a more important role as the patient finds someone who will listen. This positive transference of love and affection for the doctor has as its alternative counter-transference, when the doctor becomes bored, disinterested, annoyed, and antagonistic towards the patient. This must be recognised in time and controlled before harm is done. These feelings may correspond to what the patient experiences in his life, and must be carefully analysed as part of his trouble. Similarly, anxiety and guilt-laden experiences must be seen in the same light and so scrutinised.

This probing may cause resistance to bringing new material into the open, and the behaviour of the patient may undergo a radical change resulting in aggressiveness and resentment. This calls for tactful handling to change the approach from both sides.

Emotionally charged thoughts (from deeper levels) are discharged and eventually significant feelings expressed. This may be revealed in various ways, and is only likely to happen if the tension of the interview is continually maintained. Careful observation and patience will reap the reward. The patient usually falters, hesitates, stammers, drops his eyelids, weeps or tries to control his tears, becomes agitated, blushes, grins or laughs; or suddenly there is a complete, uncomfortable silence.²¹ A sore spot has been touched and both patient and doctor know

that a vital aspect in their relationship has been reached. The patient is then permitted to take the initiative since further probing may only cause an emotional storm.

Should the patient become unco-operative it is best to terminate the interview and wait for a more opportune future moment to stress this particular aspect. Future interviews may also be sterile, but occasionally something may click which has never made sense before, and there is a sudden better understanding—a clear formulation which must be shared by both doctor and patient—a flash of understanding with a sudden deepening of relationship. This may happen during an uneasy stage of the interview when both doctor and patient drop their defences, and a word, a phrase, or a sudden significant movement betrays the patient.²² Silent reflection is bound to follow when the basic truth has emerged—the actual answer to what is bothering the patient.

The doctor should respect the patient's right to hide further secrets, but a more intense and intimate contact has been made. The doctor is now in control and with time further developments can be expected.

Sooner or later, generally too soon, the patient will ask for an interpretation of his symptoms. The time may not be appropriate since insight may not have been attained. Interpretations must only be given when they can be fully appreciated, or two or three feasible explanations be given for the patient to think over, allowing him to suggest which one he feels most appropriate.

Weaning is helpful, the patient being seen less often, observing whether any therapeutic gain is maintained, and finally a complete break takes place without relapse.

The ultimate goal of therapy is an improvement in the basic fault which is causing a pattern of behaviour; and the patient is enabled to understand himself and to find a better solution for his problem thus achieving the integration as yet not developed, or which has broken down because of a disturbed relationship between him and his environment.

CONCLUSION

It should now be quite clear that for successful results with general practice psychotherapy, a close interaction between doctor and patient is most important. For reorientation to occur, the doctor must treat the whole person. The patient demands the attention of the doctor and will never be satisfied with just an operation, an injection, or a capsule.^{23,24}

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