PSYCHOTHERAPY AND THE GENERAL PRACTITIONER—I*

BY

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I wish to start with the fact that I have to talk to general practitioners about things that each of them does every day practically with every one of his patients; I who am not a general practitioner have, in fact, done very little general practice, and for a short time only, and—I think it is better to admit in advance—not even very well. I have therefore to discuss topics about which I know very little, with people who know them intimately from first-hand experience. And on top of this I intend to tell them, not that they should do their everyday work differently—that would be really foolhardy and impertinent—but that they should do it *with a difference*.

What I mean is this: what the general practitioner does, the act itself, should remain outwardly the same: talking patiently with the patients, listening to their complaints, using his well-proved diagnostic skill to find out what they really need from their doctor, and giving them something as near as possible to what they really need. The difference I have in mind should be an internal affair; it concerns what the general practitioner thinks and feels while he is doing his work.

To begin, I wish to prove that hospital medicine and general practice are not identical—in fact, they are greatly different. Still—I repeat here only common knowledge—what the future general practitioner is taught is exclusively hospital medicine, and only after he has started his practice has he any opportunity to learn, at his own peril and at that of his patients, what general practice really is. Thus it happens that in some way he is always rather ashamed of what he is doing; he feels that his real duty is to be a minor, or even a full-grown, hospital scientist, and consequently considers his own work as a general practitioner a kind of second best, which could and even should be done better—that is, according to the standards of hospital medicine—if only there were more time and more facilities available. And lastly, because of this general atmosphere he hardly ever dares draw upon his own experiences and state confidently what he really knows, for in his mind his knowledge is neither as valuable nor as reliable as that of the hospital scientists.

Certainly you will ask now, where have I got this knowledge? The answer is that for the last six years or so we in the Tavistock Clinic have organized research seminars in which general practitioners and psychiatrists discuss as equals psychological problems arising in general practice. All the material used in this address stems from this source.

The Real Field of Study

We have only time to discuss one patient. This will be a chronic case—the real field of study for the general practitioner. It is fair to say that if the time of observation is comparatively short—from a few weeks to a few months—the findings of scientific or hospital medicine are

valid and relevant; but if the time of observation is extended to several years, new factors emerge which profoundly change the picture. Whereas hospital medicine only rarely finds opportunity and musters staff and facilities for this long period of observation, this is part and parcel of the daily work of a well-established general practitioner. Our case will clearly show this difference. I quote this case as it was presented by Dr. B. at one of our recent seminars: the shorthand record has had to be abridged for publication, but is otherwise unchanged.

An Illustrative Case

"Mrs. D., aged 42, married. One daughter of 20. She was seen in April for the first time in our practice by Partner No. 1, who made a note that she had had an operation for twisted bowel five years ago and she had had constipation and pains for 20 years; he gave her 'normacol' and liquid paraffin. Then she saw Assistant, who added that Mrs. D was 'highly strung; severe emotional overlay,' and gave her 'drinamyl.' She saw the same doctor nine days later, and he wrote, 'Much improved. Continue treatment.' A month later she saw Partner No. 2 and told him that a fortune-teller predicted that she would have a long life but her husband a short life. She had been weeping ever since. He put down, 'Anxiety state.' She saw him again three days later. She felt faint in the morning, legs were weak; he continued drinamyl.

"About a week or 10 days ago she was brought into the surgery as she had collapsed near by. Partner No. 1 saw her, dialled 999, and sent her off to hospital with diagnosis '? overdose.' She was discharged from hospital about an hour later.

"I saw her first in mid-June. She is small, slight, has very grey hair, rather pale complexion, a lot of lipstick, and she smokes excessively. Was very retarded, moved slowly, took a long time to say anything, and was on the verge of tears all the time. She told me she had had a very hard life, looking after her mother, her daughter, and always going out to work. Though she didn't mind going out to work she really didn't think her husband appreciated how hard she had worked all these years.

"During the air-raids a bomb fell very near and she was badly shaken. Her husband sent her with the daughter to the country. Mother went somewhere else—to another relative probably. When evacuated she met an American soldier aged 24 (she was 26). She had intercourse with him once; she did not want to, but he persuaded her; she did not think there was anything wrong in it at the time.

"There are no hospital letters to support what follows, but she tells me that soon after she had trouble with her periods. She went to the local hospital and was told she was pregnant. A few months later she was told she was not pregnant but had an ovarian cyst, and this was removed. Meanwhile she had told her husband she was pregnant by this American soldier. Her husband was very shocked, was almost in a state of collapse at hearing the news; but they made it up, and she thinks they have been happier since.

"Between 12 and 20 she went to different fortune-tellers three times. Each one told her there would be a death in the family, and there followed a death in the family . . . the husbands of two of her sisters and her stepfather died. The fortune-teller she saw recently told her that her husband would live another two years, or would die within two years. She is quite convinced that this is going to happen.

"I saw her again this morning. She was worse, more retarded, more hopeless. One gets the feeling that she believes it is because she went to the fortune-teller that caused the chain of events. She also feels responsible for the death of the people in the family when she was young, though she does not actually put it into words.

"To-day the notes arrived from her previous doctor. There are a lot of consultants' reports. While attending an out-patient department for her bowel complaint she had a cold axillary abscess in *January, 1948*, which was successfully treated; chest x-ray normal. *October, 1948*: She was having difficulty with defaecation; nothing abnormal found and she was being treated with confection of senna. *February, 1950*: 'She must, I think, be suffering from spastic colon. I could find no abnormality clinically or on proctoscopy. Arranging barium enema, x-ray, and blood count. . . .'
March, 1950: 'Barium enema—no abnormality; blood count: 85% haemoglobin and 4,300,000 red cells; sigmoidoscopy—no abnormality. Symptoms must be largely

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functional. . . ' April, 1951: 'She was found to have second-degree piles, and these have been injected. She was given a sheet of instructions on bowel function, and some normacol. . . ' July, 1951: 'Has signs suggestive of supraspinatus tendinitis. She has been put on treatment in the physiotherapy department. . . ' October, 1951: 'This patient was admitted with incomplete intestinal obstruction. She had had a number of similar but less severe attacks. Laparotomy was performed and revealed the obstruction in the ileum. It was adherent to her previous scarring. The adhesions were divided and she made an uneventful recovery.' June, 1952: 'She gave a history of chronic constipation. Abdominal and rectal examination failed to reveal any abnormality. She was reassured about her condition and liquid paraffin was prescribed.' August, 1955: 'I was unable to find any haemorrhoids in this patient and although she tells me she is constipated she only has soft faeces in her rectum. Perhaps her previous history is significant in her acquisition of an exaggerated bowel awareness. She also says she feels blown up towards the end of each day, and I am wondering whether there is some stricture formation at the site where the adhesions were divided. I have arranged a barium meal and follow-through for this. She also complains of feeling depressed and requested a consultation with a psychiatrist. I am arranging this. . . ' November, 1955—from the psychiatrist: 'The above-named patient of yours was referred to my out-patient department from the surgical department, where she was regarded as being over-preoccupied with her alimentary tract for no adequate physical reason. This is indeed so, but on further inquiry I find she is suffering from a moderate degree of depression, with the usual accompanying anergia, lack of concentration, excessive guilt, and irritability. She herself tends to blame her housing conditions for this, but as she has been there for 20 years this, I feel, can only be of partial aetiological significance. With your agreement I would like to see her further in out-patients in the hope of improving her general depressive condition.'

"She was seen then by the psychiatrist four or five times. There is no further letter, and I could not get much out of her about what sort of treatment she got from him."

Dr. B. then added that he thought there was no time to lose, and so he made an appointment with a psychiatrist, who was well known to him, to give the patient E.C.T. without any delay.

Points from the Case

There are a great number of important issues in this case, all well worth discussing. I shall pick out only a few. The first is diagnosis. Everybody will agree with the psychiatrist that the woman is suffering from depression. What the psychiatrist did not say in his letter is that the depression has been going on for many years. When it started it is difficult to say, but the case history suggests that its first symptoms may go back to puberty or early adolescence—when she first went and consulted fortune-tellers. Even the basis on which the depression had arisen can be approximately surmised; it must have something to do with her bad wishes towards her near male relatives, first stepfather and brothers-in-law, and recently her own husband. The fortune-teller, obviously, is only a mouthpiece of her own repressed desires. The little that we know about her does not allow us to go further and speculate why originally these desires had arisen in her and why recently they had developed to such intensity that she broke down. Remarkably, the psychiatrist's report did not even mention these problems.

Then there is another highly important aspect. When a patient presents symptoms strongly suggestive of psychological problems doctors in general feel uneasy and sooner or later—as did Dr. B.'s partners—resort to two kinds of wholesale medication. One kind is well-meant common-sense reassurance, and the other is prescribing some tonic or stimulant if the patient is depressed, or some sedative or—to use its recent fashionable name—tranquillizer if the patient is not. Drinamyl, being a combination of stimulant and sedative, is a happy solution of the doctor's dilemma.

This automatic prescribing of tonics and tranquillizers in cases suggestive of psychological problems has an unintended but highly important side-effect. When a patient comes to his doctor complaining—I leave the verb intentionally without an object—his attitude towards illness is

still "unorganized." What will happen in the future is determined partly by the nature of the illness, but partly—and especially so in chronic conditions—also by the doctor. I do not mean here faulty diagnoses or therapeutic errors, but the effects of clinically correct diagnoses and rationally correct therapy. What usually happens may be described as follows: the patient offers various symptoms to his doctor; the doctor, on the basis of his knowledge, experience, and diagnostic skill, decides which of the symptoms should be taken seriously and be treated, and which not. The "illness" to which the patient and the doctor settle down is thus a compromise, acceptable to both.

This agreement between patient and doctor about what to consider as the true "illness" can be described from another angle as the doctor helping the patient to organize an "illness" around certain symptoms. The present state of medicine, with its emphasis on organic diagnosis and the corresponding neglect of psychological factors, prompts the doctor to organize illnesses around anatomical or at least physiological—that is, around some concrete—pathology; in our case around intestinal functions, resulting in Mrs. D.'s "exaggerated bowel awareness," so poignantly described by one of the consultants. The awkward question arises, how much of this "exaggerated awareness" is due to her intrinsic illness or constitution and how much to her doctors' efforts. Our whole training is an incessant cautioning against the dangers of missing some organic sign. Although this is a well-founded attitude, I think doctors—particularly general practitioners—should be equally strongly warned against finding an irrelevant organic sign and concentrating their own and the patient's efforts towards treating it, while not paying due attention to the glaring psychological symptoms.

Although everybody hearing Mrs. D.'s whole history will agree that her psychological problems have been the most important "illness" offered by her, her doctors responded exclusively to other "illnesses" offered, and treated only those. Thus we hear of an ovarian cyst removed; from more recent years we have evidence that she was considered to be suffering from life-long constipation, a cold axillary abscess, spastic colon, piles, tendinitis, incomplete intestinal obstruction due to adhesions which were accordingly divided, a possible stricture due to further adhesions, etc.

Hospital surgeons performed four operations on Mrs. D.—all successfully—and so they closed her case, proudly improving their statistics. But what about the general practitioners? They had to go on attending Mrs. D., still suffering from exactly the same complaints as before or between the operations.

Collating the Evidence

Does this mean that the operations were not necessary? Or that treating her constipation was incorrect? Emphatically not. The four operations, as well as the treatment prescribed for her constipation, were rational therapy. It will be remembered that in the beginning of my address I said that I do not propose that doctors should do their work differently, merely that they should do what they are doing *with a difference*. Everything done in this case was correctly done; but now, looking back on the whole medical history, it appears as if the overall problem had persistently eluded the doctors. Instead of tackling the real problem, all doctors in unison joined hands with the patient to concentrate all attention on the function of her bowels.

Although the psychological problems—or, as Assistant noted on the patient's card, "the severe emotional overlay"—were glaring, no doctor, *not even the psychiatrist*, tried to piece the evidence together. For the whole duration of her "illness"—that is, at least since her ovarian cyst—Mrs. D. was described by all her many doctors as suffering from some entirely organic disease, and it was only in November, 1955, that a psychiatrist was consulted. All the records in the various hospitals or in the files of her

general practitioners list her under the various organic "illnesses" proposed by her and accepted by the doctors. Is this sensible "medicine" or only a matter of convenience, a kind of short-term, and perhaps short-sighted, thinking? And how many cases diagnosed and listed in our statistics as organic, might turn out—if properly examined—to belong to this category?

All these aspects of the case were thoroughly thrashed out in a long discussion at our seminar. The following week we learnt from Dr. B. that when he saw the patient on the day after the seminar her depression seemed more tolerable—perhaps *it* was better, or maybe *the doctor* was better. To cut a long story short, patient and doctor could talk to each other; a good deal more of her previous history was revealed which threw new light on the possible causes of the something "bad" collecting in her. In the end the emergency appointment with the psychiatrist for E.C.T. was cancelled, as neither patient nor doctor felt any urgent need of it. Let me add, drinamyl was neither prescribed nor asked for, but a psychotherapeutic relationship was started—it is true, somewhat late in the day, and so with only a very guarded though not absolutely bad prognosis.

The real change achieved at this point was that the doctor approached the patient in a different mood, in a different spirit; instead of trying to find some not quite relevant—or even irrelevant—organic change, he established a psychotherapeutic relationship with the patient, which may grow into something. Whether he himself will be able to continue the treatment or will have to refer the patient to a specialist is a matter of policy, not of principle. In other words, a tactical step, not a strategic decision. The strategic decision was taken when he sat down with his patient and listened to her. This kind of listening is an art, at least as difficult and subtle as using a stethoscope. Skill, training for this kind of listening is not yet included in the medical curriculum. Maybe it will be in the future.

As you see, here is a vast field of research accessible, above all, to the general practitioner. It is he who knows intimately the patient's previous history, and it is he to whom the patient first turns with his fears, pains, or worries—with all that medicine calls complaints, symptoms, or signs. It is the general practitioner—of all doctors—who can most easily get hold of and piece together the various bits of information about a patient, so that the picture should make sense. Moreover, his relationship with the patient is, as a rule, lasting, not ephemeral like that of a specialist. Thus he can conduct long-term observations extending over many years and can collect sufficient well-authenticated material on the basis of which the short-term achievements of hospital medicine can be more accurately assessed. Obviously this cannot be done so long as general practitioners are overawed by the unquestionably great successes of hospital science and cannot consider their own observations valid and reliable.

Help for the G.P.

Here we—psychologically minded psychiatrists—can be of considerable help. It will be remembered that Dr. B., after the second interview, found Mrs. D.'s depression so severe that he arranged for an immediate E.C.T. I do not wish to raise here the much-discussed problem of shock therapy; for our case this is a side issue. What is important, however, is that Dr. B. could not bear the woman's depression; it was too much for him. The more our experiences in our seminars grow, the more we become impressed by the amount of therapy prescribed—*sit venia verbo*—to help the doctor. Whether this kind of prescription helps the patient is another matter. The chief assistance that we psychiatrists can offer a general practitioner is to enable him to become aware of his own involvement in his patients and so help him to respond better, more freely, and more accurately to their needs, while being less encumbered by his own emotions.

This is by no means an easy task, and I am rather doubtful how far an individual general practitioner can achieve it on his own. One promising method for acquiring this self-awareness and with it a modicum of psychotherapeutic skill is participation in our research-cum-training seminars. I know that one case is not sufficient proof for such a peremptory announcement, but it was impossible to quote more here.

Conclusion

So may I sum up: The most important aspect of the problem "general practitioner and psychotherapy" is to understand the presenting complaints as symptoms of the patient's whole life history. In order to achieve this the general practitioner must become less dependent on—that is, more critical of—hospital medicine and with it more confident about his own observations. Further, an equally important condition, he must become aware of his own involvement in his patients' problems in order to control his responses more accurately. Whether this latter can be achieved without outside help must remain for the time being undecided.

PSYCHOTHERAPY AND THE GENERAL PRACTITIONER—II*

BY

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I shall deal with only a few of the aspects of psychiatry as related to general practice, and it would perhaps be of most interest if I concentrate mainly on the influence which the research seminars at the Tavistock Clinic had on my work as a general practitioner and give some general idea of the nature of our group and its atmosphere.

Problems of the G.P.

It soon became apparent that the problems of general practitioners were different from those of the psychiatrists, in so far as we have large numbers of patients who have to be dealt with on the spot, so to speak. We cannot pick and choose; we cannot put them off; we cannot tell them to go elsewhere because we are too busy. They have to be dealt with there and then, and it becomes obvious that we must necessarily evolve different techniques to treat them. As, in the normal course of events, psychiatry in general practice does not exist at all, we had to work it out for ourselves over a period of a few years, and it is really the purpose of this contribution to demonstrate how valuable and rewarding was the time spent at the seminars, and how much it has helped me in my everyday work.

It must be remembered that we have originally been trained to think in terms of pathological processes and have in our minds a list of drugs which will alleviate these conditions. When I was a student it was a very small list, but it is much larger now; in fact, the advent of the antibiotics has enabled us to really cure people of certain inflammatory diseases. But in my early training disease of the mind (other than frank lunacy) was relegated to the diagnosis of patients after full investigation had revealed no organic cause. At that stage we produced a medical sneer, our attitude changed to one of contempt, and we labelled the patient "a neurotic"—a dreadful slur. We sometimes let the patient down more lightly by calling his condition "functional." We felt we had done a jolly good job at this stage

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