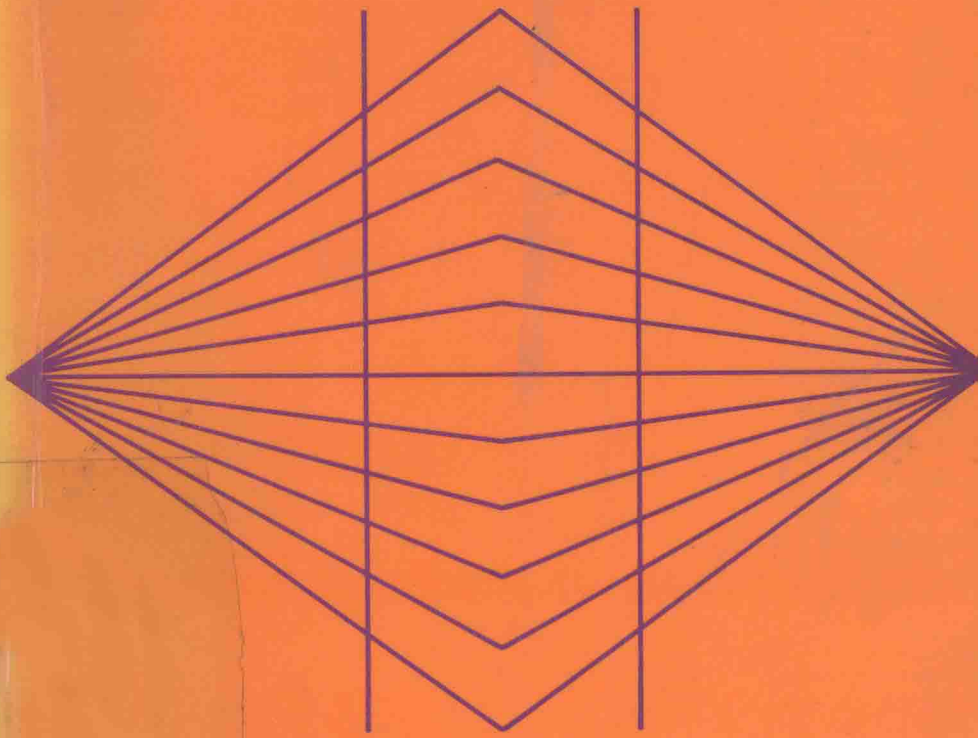
Basic Psychotherapy

Second Edition

Richard Parry



Churchill Livingstone

Basic Psychotherapy

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SECOND EDITION

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Preface to Second Edition

'Lord Emsworth . . . was wondering, like all authors who have sent their stuff off, if it could not have been polished a bit and given those last little touches which make all the difference. However, again like all authors, he knew that what he had written, even without a final brush-up, was simply terrific . . .'*

We first-time authors know exactly how he felt. 'What purity of thought,' we say, 'What elegance of expression!' However, there is a second phase, when the warts become apparent, and I was very relieved to have the opportunity of preparing a second edition.

The title has been changed, the text rewritten, and new material added. In response to several requests, one (one!) new chapter, on 'Schools of medical psychology' has been included, and a short list of suggestions for further reading has been added.

I am very grateful to everyone who made comments and criticisms of the first edition. One wrote that I had obviously enjoyed writing it. I hope it will be equally obvious that I have enjoyed rewriting it.

Edinburgh, 1983 R.A.P.

* Wodehouse P G 1974 Pigs have wings. Barrie & Jenkins, London

Preface to First Edition

My undergraduate interest in psychiatry evaporated during my clinical years, as it does for many medical students, when I encountered psychiatrists and psychiatric patients. It was re-awakened during six years of general practice during which I had the opportunity of attending one of the seminars for general practitioners organised by the late Dr Michael Balint and his colleagues at the Tavistock Clinic.

This had the unexpected but not absolutely unique consequence of leading me to suppose that I was a better psychiatrist than the psychiatrists, and I decided to specialise. Perhaps psychiatry's loss has been general practice's gain. In consequence I have fallen into many of the pitfalls of psychotherapy and have sometimes seen others fall in after me. I decided, therefore, to introduce some order into my own practice, partly in the hope that others as well as myself might learn something from my mistakes.

This book is, therefore, really an account of some of the guidelines used by one man in his psychotherapeutic work. They are certainly not the only guidelines, neither are they necessarily the best ones. It is not easy always to adhere to them, and it may be a comfort to the reader, as it is to the author, to know that in their time, some of the greatest therapists have strayed from the ideal.

It is hoped that the book may be of value to the medical student, particularly during his clinical years. It would best be studied during his course on psychiatry, as a supplement to his standard textbook, for at this stage, he may be interested in acquiring some psychotherapeutic skills. Perhaps too it will be of value to other doctors, especially to general practitioners, to psychiatrists at the beginning of their training, and to members of other professions which run parallel to medicine and especially psychiatry: nurses, social workers, occupational therapists and clinical psychologists.

I have another important group in mind. This comprises the increasing number of people who offer some sort of counselling, either as part of their own profession (clergymen, welfare officers, etc.) or

in a voluntary capacity (Marriage Guidance Counsellors, Samaritans, etc.). These people often use skills which are similar to those employed by the psychotherapist, just as physiotherapists and osteopaths may use techniques which were developed by specialists in physical medicine.

It may be surprising to learn that the book has no clearly stated theoretical basis. I have in fact used only those concepts which are acceptable to most theoretical schools. I assume the existence of unconscious mechanisms, that there is a part of the personality which is called the conscience, and that some people may have incestuous thoughts and feelings.

Only very limited use has been made of case histories, and these are fictional or apocryphal. I have not used the experience of specific patients known to me, but because patients may have rather similar experiences, some may think that they recognise themselves or others. The only non-fictional character is the author himself, and he has been considerably romanticised.

It must be conceded that psychotherapy is not in the high regard of many psychiatrists at the present time — indeed, many take a great deal of trouble to demonstrate that, not only is it of no value, but that in some cases it may actually be harmful. These criticisms must be taken very seriously, but unfortunately, it is not always clear what is meant by the word 'psychotherapy'. Until the subject can be defined more precisely, the criticisms can neither be confirmed nor corrected. I hope that this book may add one small straw to the wind of definition.

Many people have helped me in the preparation of this work — albeit unknowingly. They include my friends, my foes, my family; my professors, my pupils, my patients and my publishers. They are really so numerous that it would be invidious to pick out a few in particular. They all have my sincere thanks.

Edinburgh, 1975 R.A.P.

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Introduction

'Psychotherapy is, above all, not theoretical knowledge, but a personal skill,' Michael Balint. *The doctor, his patient and the illness.*

The high ambition of this book is to teach the student nothing that he does not already know. This became the author's intention when, at the end of the course on which it is based, a member of the class said 'You have not told me anything new, but you have made me think about it'.

'Thinking about it' is the first stage of the 'limited but considerable change in the doctor's personality' which Balint considered to be an essential in the acquisition of psychotherapeutic skill. The development of the skill requires practice, and whilst a book can offer some guidelines and indicate the pitfalls, it cannot replace actual experience. In his 'Introductory lectures on psycho-analysis' Freud reminded his audience that by listening to him they would not learn 'how to set about a psycho-analytic investigation or how to carry the treatment through'. Operative surgery provides a suitable parallel. No book can teach the surgeon how to proceed in an individual case, but it may supplement his own experience and the examples of his teachers.

The medical student's first contact with patients occurs when he learns to take a case history. It is then that he begins to observe the patient — and to be aware of the patient's observation of him. The art of careful history taking is without doubt a matter of prime importance. There are few diseases in which a careful history does not reveal the diagnosis. It is confirmed subsequently by physical examination. Symptoms are seldom preceded by physical signs. As a result of history taking, the student will, for example, learn to differentiate between organic heart disease and a neurotic preoccupation with cardiac function. It is a matter of regret that history taking frequently ceases at this point. Many investigations might be avoided and much anxiety alleviated if, as the result of a few more

questions, the reasons for the neurotic preoccupation could be elicited.

The influence of a doctor upon his patient is tolerated in these days of scientific medicine as an inevitable but regrettable distraction. Ingenious methods are devised in an attempt to eliminate it from therapeutic trials or at least to neutralise it. Doctors often feel slightly dishonest when they use their relationship with him for the benefit of the patient and prefer to ascribe the credit to a placebo reaction. But the influence of the 'bedside manner' cannot be denied.

Balint formulated the useful proposition that the doctor himself could be thought of as a potent drug which may be used for good or ill. He emphasised the care with which the doctor must be 'dispensed'. The aim of this book is partly to help the reader define the nature of this 'drug' and to use it in a way which will be helpful to himself and beneficial to his patients. There is no wish to define it for him.

So far, we have spoken about the relationship between a doctor and his patient, but others also relate to patients. Furthermore, not everyone who needs the assistance of a helpful relationship is a patient. Nurses, social workers, occupational therapists, clinical psychologists and other members of the para-medical professions may exert a powerful influence on their patients and they must learn to employ this influence to its maximum effect. Other people, too sometimes counsel: they may be church workers, welfare officers or members of one of the voluntary organisations such as the Marriage Counselling Service or the Samaritans. It is hoped that the methods described here may be of value to them also.

Lest it should be questioned that a book designed primarily for doctors should be offered also to non-medical workers, it may be pleaded that treatment is not the exclusive prerogative of doctors. The same general methods may be used by workers in other fields as well as the medical one. For example, simple therapy for colds, coughs and constipation may be suggested by pharmacists and herbalists as well as by doctors. It is, however, hoped that if the non-medical or voluntary worker finds that he has undertaken something which appears to be beyond his capacity, he will seek the help of a professional adviser.

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'The talking cure'

CARDINAL PRINCIPLE: There is nothing so obvious that it can be accepted without question.

If you agree with everything you read in this book, it will have failed in its purpose. For it is not a dissertation. It is an account of some of the techniques which have been evolved to cope with the problems which arise in medical (not exclusively in psychiatric) practice. Some have been adopted by the author because they suit his personality, his way of working, his profession and his speciality. He sometimes finds it is necessary to modify them.

He does not suppose that his approach will suit everyone who reads about it. However, he hopes that others, whether psychiatrists, general practitioners, specialists in other branches of medicine or members of allied professions, will be encouraged to compare their own techniques, to criticise, modify or adopt, those which may be useful, and to think carefully about those they reject. At the same time, the reader who is learning his craft should take the opportunity of observing his colleagues and teachers, criticising, modifying and, where appropriate, adapting the techniques used by them. He should also watch and compare the techniques used by all those who interview others, particularly on the radio and television. The intention is to help him to develop the most appropriate approach for his professional needs.

Although written primarily for doctors and nurses, many of the problems to be discussed here will be familiar to others who are concerned with helping people. It is possible that they too will find something of value.

Talking with patients is not concerned merely with gathering information about them. If this were so, doctors could one day be replaced by computers. Talking is also the means by which a diagnosis is achieved, a course of treatment planned, and a prognosis assessed. It has a further function. We will try to show that whatever the disorder, whether psychological or organic, there is something

about talking with patients which is itself therapeutic. The matter is, therefore, of the greatest clinical importance.

Some of the problems we will discuss are very complicated. Let us begin with one which appears to be simple. By what name should one address a patient?

In the 1940s and 1950s, male patients were often called simply by their surname. The nurse would say, 'Here are your tablets, Smith.' In still earlier times, patients were often called by the number of the bed which they occupied. The doctor might ask, 'Let me see your tongue, Number 22.' What is appropriate to the 1980s?

It is acceptable to call children by their first names, but at what point does a child become an adult? Adolescents, in their struggle towards maturity, sometimes resent being called by their first names. They feel that people who do so are treating them like children. At the other extreme, some adults plead to be called by their first names. It is as though they still yearn to be treated as children. Which is correct?

In some centres, the problem is solved by calling every patient, whatever his age, by his first name. This is a simple solution, and may seem suitable to the times. Elsewhere, some patients are called by their first names and others by their surnames. Unfortunately, the therapist sometimes forgets who is called which. When he discovers that he is called John on one occasion and Mr Smith on the next, the patient may wonder what has happened: and whether he has offended. Such inconsistency is clearly undesirable.

Some therapists choose age as the criterion. They call patients who are younger than themselves by their first names, and older patients by their surnames. This solution may be satisfactory when the therapist is in his 20s. But the years pass by quickly, and if he sticks to his principle, he will soon find himself calling people in their 50s by their first names, by which time, it may be less appropriate.

Other therapists deal with the problem by presenting it to the patient. They ask him to choose how he wishes to be addressed. Usually the patient asks the therapist to call him by his first name. It sounds more friendly. In turn, and for the same reason, the patient may ask the therapist for permission to call him by his first name. It sounds more friendly. This raises a fresh problem. What is the nature of the relationship between the patient and his therapist? Is it one of friendship? In the view of the author, a relationship of friendship is not appropriate in psychotherapy. The relationship is a professional one, of great complexity. In friendship, confidences are exchanged, favours granted and pleasures shared. Such things

never happen in psychotherapy. The relationship can be a kindly one, without being friendly.

Thus, we find that the problem is not simple, after all. There is neither a right nor a wrong answer. Each raises problems of its own. None is too trivial to be dismissed. The reader may, and should, make his own decision.

It is the author's practice to call all his patients by their appropriate title — Mr, Mrs, Miss, Doctor, Professor, Ayatollah, Your Majesty, and so on. He expects his patients to address him by his formal title. He tries to be consistent, and adopts the same approach, even with young people. Many of his colleagues disagree with him.

Problems in medicine may arise out of things which appear to be very simple, from the moment of the first contact between doctor and patient. In fact, there is little that is simple.

Now we will describe a common but rather surprising phenomenon. We will use as an illustration, an experience which recurred frequently in the author's early years in medicine, which were spent in general practice.

Appointments systems were then unusual. Provided that the patient came during advertised hours and was prepared to wait long enough, he would eventually be seen. The doctor saw everyone — however many there were. This was often an arduous task, but he tried to perform it as skilfully and as speedily as possible.

Sometimes the patient — more often a woman than a man — came with a rather vague complaint, and whilst the doctor was gathering his thoughts, she offered her own explanation. It usually involved her husband, her children, her parents, her brothers and sisters, her in-laws, her friends, her neighbours, her husbands' colleagues, other doctors, shopkeepers, the clergy, the Government, the Opposition, the Communists, the Trade Unions and the Russians. The interminable story was interpersed by a variety of emotions. Sometimes the patient was angry, sometimes she laughed, sometimes she cried, sometimes she looked embarrassed, sometimes she shouted, sometimes she whispered.

The doctor tried to listen attentively to this torrent of words, but to tell the truth, he was completely bewildered. To add to his problems, he could hear more and more patients coming into the waiting room. Eventually the patient stopped for breath, and the doctor did the thing which, as a medical student, he had been taught never to do. He prescribed a hurried tonic and told the patient to return in a week.

She usually did so, and her opening words were nearly always the same. She said, 'Doctor, I want to thank you for all the advice you gave me last week. I did exactly as you suggested and my symptoms have completely disappeared.' Then she would add, 'I didn't need your prescription', and give it back. The doctor was always very puzzled. He could not remember giving any advice. He could remember only his increasing impatience with her garrulity, and his inability to understand what she was talking about. Yet now she was reporting that she was cured.

This sequence of events recurred many times, but the doctor remained perplexed. What was happening? If the patient had *taken* the tonic, he would have ascribed her recovery to its placebo effect. He would have concluded that an inert but rather disagreeable medicine had been invested with magical powers and that her recovery was due to simple faith. But she had not taken it. Anyway, what is a 'placebo effect'? Is it real or imaginary, good or bad? If it makes the patient better, we should surely pay more attention to it.

And how can one explain her recovery when she did *not* take the tonic? Was it because the doctor had a 'placebo effect'? Did the patient look upon him as a witch doctor, with magical powers of cure? If this were so, we are still no further forward. In fact, she herself would have rejected the idea as nonsense. She would have insisted that she merely did as the doctor advised. She disagreed that the doctor had given her no advice.

As time went by, the author was to discover that experiences such as these were very common. Many of the doctors who worked with Balint (1961) encountered similar phenomena.

A century previously, a Viennese neurologist, Josef Breuer, who is still remembered for his work in respiratory physiology and particularly for his part in the description of the Hering-Breuer reflex, had a similar experience.

He was responsible for the treatment of a young and attractive patient named Bertha Pappenheim. Fraulein Pappenheim complained of a variety of physical symptoms. Excluding only her left arm, she had lost the power of all her limbs. She was unable to speak her own language, although she could communicate in English. She had alternating states of consciousness, tunnel vision, and sometimes suffered from terrifying visual hallucinations. There was no organic cause for any of her symptoms, and nowadays a diagnosis of conversion hysteria would probably have been made.

Breuer discovered that if the patient could remember the circumstances which existed when the symptoms started, they disappeared.

Unfortunately, however, she was seldom able to recall the circumstances. Breuer therefore adopted a technique which had been employed by Charcot in Paris in the course of his investigations into post-hypnotic suggestion. Charcot had observed that patients could often remember things that they had 'completely forgotten' whilst under the influence of an hypnotic trance. This observation played an important part in the renewal of interest in the 'unconscious'. Fraulein Pappenheim was a good subject for hypnosis, and Breuer used the technique to help her recall the origin of her symptoms. When he did so, she was freed of them.

He quotes several examples. In the heat of the Viennese summer, and although she suffered greatly from thirst, the patient was unable to drink any fluid for about six weeks. Under hypnosis, she recalled that this symptom had originated when she walked unexpectedly into a room used by her companion — an English girl whom she disliked. There she found her companion's dog lapping from a glass. The patient was angry and very disgusted, but she had been carefully brought up to believe that it is not ladylike to express vulgar emotions. She concealed her revulsion and left the room without speaking.

When, under hypnosis, she recalled the incident, the patient gave vent to her disgust, asked for a glass of water, immediately drank a large quantity, and wakened with the glass at her lips. The symptoms never returned. Fraulein Pappenheim herself nicknamed the process, 'The talking cure'.

Nowadays, such extreme cases of conversion hysteria are rare. Nevertheless, we are still taught that it is not always polite to express our feelings. The events which puzzled the author when he was in general practice occurred when his patients gave vent to their true feelings. Although he neither used, nor thought of using, hypnosis in order to obtain their 'confessions', he had, without realising it, been using a technique which was very similar to that of Breuer. Frequently, it resulted in recovery.

'Just talking'

When someone is overwhelmed by a psychological problem, his friends often ask, derisively, how 'just talking' can be of help. We have made a first attempt to answer this question. There is something about 'just talking' that encourages us to remove the pejorative word 'just'. Whatever the disorder, psychological or organic, talking seems to help patients.

Our intention, therefore, is to help the reader to develop his technique in interviewing: to assist him in helping his patients to 'talk'

in the way which is most beneficial. We do so in the belief that *talking* is helpful to them. It is not our intention to demonstrate how the reader can amaze his friends, psychoanalyse his enemies, and discover the hidden weaknesses of his seniors.

A patient

When a patient asks for help, she does so with the natural expectation that her problems will be solved.

Here is such a patient. She is a good looking woman in her early 30s, with long, straight hair, very dark, with a few streaks of grey. Her figure is trim and she dresses well. She has arrived 30 minutes early. The previous patient has cancelled his appointment, and consequently she is seen immediately. She appears slightly disconcerted when she is ushered straight into the consulting room, and enquires, with a hint of anxiety, 'I'm not late, am I? My appointment was for 3 o'clock! The doctor explains what has happened and shows her to a chair. The reader will notice that he does not leave the choice to her. When both are seated, he says, 'Tell me what problem is.' The exact form of his opening question is still evolving.

The patient speaks in a pleasant and well-modulated voice. She tells her story very concisely and it sounds as though she has rehearsed it carefully. Briefly, it is this. Her husband, who, is an executive a little older than herself, has started to drink heavily. She fears that he is becoming an alcoholic. She says that she cannot stand it any longer. Unless he does something she will leave him. He does nothing. What should she do?

Well, what should she do? Here are some of the suggestions made to the many patients of whom she is compounded:

Get a job.
Find a hobby.
Do voluntary work.
Flirt with other men to make him jealous.
Ask your doctor for a tranquilliser.
Start drinking with him.
Make sure that he is never alone.
Ask a friend to speak to him.
Remember that many husbands who drink have lost their job, and he still has his.
Buy some provocative underwear.
Think positively.
Think of all the good things.
Think of all the people who are worse off than you.
Pull yourself together.

Make yourself attractive.
Wait until he gets worse.
Wait for him to do something for himself.
Be thankful for small mercies.
You have to expect that sort of thing when they get to the male menopause.

The reader is invited to comment on each of these suggestions.

The patient's question was a simple one. What should she do? As she told her story, she herself provided a *logical* solution. She said, 'Unless he does something, I will leave him.' The *logical* answer is that she should leave him.

However, when this is pointed out to her, she bursts into tears. She says, 'I can't possibly do that. I love him. Besides, there are the children. Can't you do something?' The *logical* solution has been of no help.

It is improbable that the reader will find words to solve the problems of his patients in a book. Emotional problems are not solved by words, however elegant, well-intentioned, passionate or eloquent they may be. Neither are they solved by logic.

One well-meaning person suggested that our patient should think of all the people who are worse off than she. The reader should reflect upon this fatuous but common cliché. If I have toothache, it is not alleviated by the contemplation of someone else's toothache. Pain is not relieved by thinking about the pain from which others are suffering. Patients are not cured by being told to think of something else, to find a hobby, to snap out of it or to appreciate that 'You have to accept that sort of thing at your age.' Clichés have no part to play in psychotherapy.

There is no 'technique' by which a husband can be prevented from drinking. No therapist would expect a loving wife to accept her drunken husband without complaint. However, the therapist can — and will — ask, 'How has this situation come about? Why has it persisted? Why has it not been possible to find a solution? What avenues must be explored if we are to make progress?' Some of the questions to be asked may seem trivial to the point of insult. However, there may be great difficulty in obtaining the answers, even to the most simple.

An obvious question is, *why* does the husband drink? Is he someone who cannot cope with the demands that are made upon him? Perhaps drinking is part of his job. There may be many matters of which we know nothing. Does he have a troubled conscience? Does he dislike the atmosphere at home? Is he trying to get rid of his