C. KNIGHT ALDRICH

OFFICE PSYCHOTHERAPY FOR THE PRIMARY CARE PHYSICIAN

American Handbook of Psychiatry

Office Psychotherapy For The Primary Care Physician

C. Knight Aldrich

e-Book 2015 International Psychotherapy Institute

From *American Handbook of Psychiatry: Volume 5* edited by Silvano Arieti, Daniel X. Freedman, Jarl E. Dyrud

Table of Contents

Office Psychotherapy for the Primary Care Physician

The Primary Care Physician's Contribution to Mental Health Care

According to the Joint Commission on Mental Illness and Health (1961), three out of ten mentally troubled persons turn first for help to their family doctors. Not everyone has a family doctor, however, and so many people turn instead to internists or pediatricians, or else bring their problems to the hospital emergency room. In this chapter, all these medical sources of help for emotional problems will be identified as "primary care physicians," or PCPs.

The PCP undertakes the treatment of most of these patients in his office, and by doing so relieves a great deal of the pressure on overburdened psychiatrists and other mental health resources. But even if there were no lack of mental health professionals, the PCP would be important in mental health care since he is in a particularly strategic position to treat mild and relatively uncomplicated mental health problems. If he recognizes their early symptoms and institutes appropriate treatment, he may be able to prevent these problems from becoming chronic. For example, if he identifies a patient's anxiety and focusses in his medical care on the anxiety rather than on its symptomatic manifestations, he may forestall the development of an entrenched hypochrondriacal displacement.

The PCP, particularly if he is a family physician, is naturally involved with his patients during normal life developmental crises as well as during crises of separation, mourning, and disability. He is therefore well situated to carry out secondary prevention, and to note the subtle personality changes that often are the first signs of psychiatric illness. He has another advantage in that he usually knows the patient's family background. He is selected by his patient, who thus demonstrates confidence in him, and therefore he does not have to work through resistances to referral. He provides continuity of general medical care, and thus has a natural opportunity for follow-up care after a course of psychiatric treatment has ended. Finally he is usually more accessible than the mental health professional.

All these considerations contribute to making him the key "firing-line professional" (Kiesler, 1965) in the nation's mental health efforts. However, the PCP needs encouragement to carry out this aspect of care and to use his potential more effectively. In the past, psychiatric theory and practice as taught to physicians have tended to discourage them from undertaking such care; psychiatrists have implied, if not actually stated, that the management of mental health problems routinely requires such detailed patient histories and such extensive exploration of unconscious forces that no PCP would have the time or the skill to get involved. Although this viewpoint appeared to limit mental health care to mental health professionals, recent work has indicated that less time-consuming and less intensive exploration carried out early in

the course of emotional disturbance may often be more effective than longer and more intensive treatment undertaken at a later point (Bellak, 1965; Wolberg, 1965). Treatment by the PCP may therefore be the treatment of choice in many cases.

As Zabarenko (1968) reports, most PCPs develop a psychological awareness in managing the psychological aspects of illness, often using it spontaneously without recognizing its nature, value, or implications. In some cases this awareness may be enough for satisfactory care, but more often the PCP needs help in understanding psychiatric principles and practice, how they relate to his patients, and how he can adapt them to his own patient care milieu. Psychiatrists who provide this kind of help are not only applying their skills indirectly to many more patients than they can themselves treat, but also are encouraging the referral of more suitable and better prepared patients.

Epidemiology

How much of the PCP's practice is "psychiatric"? The answer to this question depends on one's criteria for identifying a psychiatric case. Greco (1966), in a careful review of his own family practice, states that the majority of his patients suffered from what Balint (1957) calls "unorganized illness," as contrasted to well-defined, identified illness, with the implication that the

psychiatric component was significant in the majority.

About 5-10 percent of the PCP's practice fits into such standard psychiatric categories as anxiety neurosis, schizophrenia, or phobia. The remaining 90-95 percent may be divided roughly into three groups. The first group consists of patients for whose conditions psychosocial elements represent the major contributing factors. These include, among others, patients with psychophysiological disorders, hypochondriacs, and a number of depressed patients whose depression is masked by physical symptoms. The second group consists of conditions for which psychological factors play definite although secondary contributing roles. An example might be a patient recovering from a coronary thrombosis who is overweight and cannot seem to curb his appetite.

The final group comprises organic conditions which are, nevertheless, of some psychiatric interest because of their psychological impact. Thus an organic illness may be accompanied by irritability in some patients and overly compliant behavior in others. It may produce denial and counterphobic responses in some and exaggeration of symptoms in others. Finally, it may result in depression or in paranoid projections. Any of these emotional concomitants may affect the course of treatment of the organic illness, and so should be recognized and properly managed by the physician.

Although the PCP needs to recognize the psychological factors in most of his patients, he should not feel constrained to undertake formal treatment with all of them. In most cases in which the psychiatric factor is not of major significance, he can incorporate a concern for the psychological component into his conventional medical care.

The emphasis in this chapter will be on the PCP's psychotherapeutic care of relatively acute conditions in which the psychiatric factor is primary, and on the consulting, teaching, and referral relationships between the psychiatrist and the PCP. The care of psychosomatic conditions is discussed in Volume 4 of this *Handbook* and the care of chronic psychiatric conditions is discussed in other chapters of this volume and in Volume 3.

Differences Between the Psychiatrist's and. the PCP's Psychotherapies

The PCP's psychotherapeutic care of patients with relatively short-term psychiatric problems resembles, in many ways, the directive-supportive techniques described in other chapters of this volume. Inevitably, however, there are differences between the psychotherapy carried out by mental health professionals and that carried out by the PCP. Since World War II the type of psychotherapy usually taught and practiced in the United States has had as its stated or unstated goal the uncovering of unconscious processes, with the expectation that once these thoughts and feelings are out in the open

the patient will be able to cope with them in a more realistic way. However, the nature of a primary care physician's practice and the amount of training in psychotherapy which he can be expected to undertake make it impractical, except under unusual circumstances, for him to attempt to undertake uncovering psychotherapeutic procedures. There is also a question whether such an attempt is even desirable, considering his volume of patients and the time required for uncovering. He therefore should concentrate on short-term treatment, emphasizing conscious rather than unconscious processes and aiming at symptomatic relief rather than personality change.

Another difference between the two kinds of practice arises out of the relatively open and busy nature of the PCP's office which may promote an atmosphere which appears incompatible with confidentiality. The PCP needs to counteract this appearance by making it completely clear that what the patient tells him in confidence will be kept in confidence.

Furthermore, there are significant differences between the psychiatrist's and the PCP's clienteles. One consists only of patients with acknowledged psychiatric problems; the other consists of patients with all kinds of medical problems, including some acknowledged and some unacknowledged psychiatric conditions. These differences may lead the PCP to resist the idea of practicing psychotherapy. He cannot afford to antagonize too many of his patients, and he may believe that he should avoid

psychotherapeutic involvement lest his patients be insulted. Such avoidance, however, often reinforces a patient's feeling of shame because of his inability to cope with his problems, and thus increases his resistance to exposing them. Eventually some of those patients must be referred, and they are more likely to perceive such referral as rejection if it comes without warning. On the other hand, routine investigation of emotional as well as organic components during diagnosis sets the stage for the PCP to make the best possible use of himself as a treatment agent, reduces resistance to a possible psychiatric diagnosis, and can facilitate later referral if necessary.

The PCP's Diagnostic Process

The diagnosis of a psychiatric condition or component should not be made solely by exclusion of organic disease. Instead, it should be made, whenever possible, primarily on the basis of its signs and symptoms, as in any other medical condition.

However, diagnosis is often complicated by the simultaneous occurrence of both organic and psychiatric components. For many of the PCP's office patients, moreover, and particularly those with the "unorganized illness" described by Balint (1957), a final diagnosis only emerges gradually and piecemeal, if at all, as treatment proceeds. The model of medical care taught in most medical school and postgraduate training, which emphasizes

hospitalized patients and requires the physician to look for a single cause and to develop a single, clear-cut definitive diagnosis before undertaking treatment, is thus often not adaptable to office patients.

The presence of either an emotional illness or a significant emotional component is usually apparent to the reasonably experienced PCP after the first few minutes of history-taking (Browne, 1967). To diagnose the nature of the emotional component requires, however, a more detailed history and occasionally interviews with family members. To evaluate possible contributing or concurrent organic components requires a physical examination and, perhaps, laboratory tests.

The History

The nature and quality of the psychiatric component should be determined through the history. The history of any illness in which there is a possible psychiatric component should include: (1) an account in the patient's words of the nature of the symptoms; (2) the time of onset of symptoms and a review of the patient's life situation at that time; (3) the course of the illness, including events or changes in the patient's life situation which occurred at the time of or prior to changes in the illness; (4) previous treatment efforts and their effects; and (5) the reason why the patient is seeking help from the PCP at this particular time. The events around the time of onset give the PCP

clues to the *precipitating factors;* the discussion of the course and previous treatment gives the PCP clues both to the *perpetuating factors* of the illness and to his treatment regime; and the immediate reason for seeking help may indicate significant recent changes, usually for the worse, in the patient's symptoms or life situation.

History-taking should be carried out to the extent possible through open-ended interviews, in which the PCP gives the patient the responsibility for continuity (Enelow, 1972). The PCP facilitates communication by nonspecific, catalyzing comments ("yes ... I see . . . mmm . . ."), and encourages the patient to keep on the track by repeating key words or phrases or by open-ended questions ("Would you tell me more about...?"). He defers direct questions as much as possible to the end of the interview, focusing them on essential material that has not emerged spontaneously.

Thus the PCP does most of the listening and the patient does most of the talking as the story gradually unfolds. As Greco says, "Insightful listening time spent on (exploring) the actual reasons for coming results in less time spent in (later) non-productive visits . . . when I am talking, I am not listening, and when I am not listening I don't hear the real reason why the patient is calling for help at this juncture" (Greco, 1966, p. 73).

Throughout the history, the PCP should be alert to the patient's

emotional response to his interest in the psychological side. With some patients, who resist associating psychological factors with their symptoms, the PCP may need to go more slowly in exploring these factors than with other patients.

The past and family histories form the basis for understanding the *predisposing factors* of a psychiatric disorder. The PCP, however, does not need as comprehensive an understanding of these factors as does the psychiatrist, and for the most part can afford to defer collecting the details of the past and family histories until they come up naturally during treatment in a context that has relevance to the patient. There are even some parts of the past history which are initially better not revealed, particularly episodes which the patient may be too ashamed even to tell a trusted PCP until he has tested the response to less disturbing aspects. The PCP should not feel that he must ferret out all the gory details before he can start being helpful, nor should he feel personally affronted if the patient withholds certain information.

The Tentative Diagnostic Statement

Patients often resist acceptance of a psychological basis for symptoms, because of pride, shame, or the need to avoid facing their conflicts, and they may either reject the PCP's arguments and authoritative statements or

simulate acceptance for the sake of keeping the peace. If the possibility has been explored during the history-taking, however, the physician can naturally discuss psychological factors before he undertakes his laboratory workup and perhaps even before he carries out his physical examination. The resistant patient usually believes that the tests will prove the physician wrong, and so he may be less hesitant to discuss a possible psychological factor before the diagnosis has been made than he would be if it were already established and he had no possible escape. If the laboratory reports are negative, they can be presented as confirmatory evidence of the physician's positive diagnosis rather than as the bases for establishing a diagnosis by exclusion. In this way the patient's confidence in the physician, essential for effective treatment, is strengthened by the work-up, and his resistance to discussing psychological factors is reduced (Aldrich, 1966).

For example, a patient with a palpitating heart can usually accept the significance of a normal EKG when it confirms the doctor's earlier statement —the statement that he believes that the tension the patient has discussed is sufficient to account for the palpitation, but that he has ordered an EKG to make doubly sure there is no additional organic factor. The same patient would be harder to convince if the doctor had not discussed the relationship of tension to palpitation until he had the negative EKG to prove that the symptoms must be functional. Thus, by waiting until the physical and laboratory examinations have been completed and then attempting to use

their negative results to persuade the patient that his symptoms are psychological, the PCP relies too much on the laboratory, and dilutes the impact of his own diagnostic skill. In this situation, the patient often simply suggests that more tests should be carried out.

Even if the physical and laboratory examinations result in the diagnosis of an associated organic disease, treatment is made easier by an early diagnosis of an emotional factor. Both factors will require treatment, and the PCP, having made positive diagnoses of both, can engage his patient in the simultaneous treatment of both.

Communication with Family Members

Diagnostic information from external sources may be of considerable help, but the physician should be sure that his patient's confidential communications are respected. Only in emergency situations should he communicate with the relatives against the patient's wish, and under these circumstances he should so inform the patient, indicating that he realizes he is taking matters into his own hands and explaining why he is doing so. There are relatively few occasions when a physician must get information from relatives simply to check on the veracity of his patient's story. Much of the importance of communication with relatives lies in providing the PCP with an opportunity to enlist their help in future treatment, as well as in giving him a

broader view of the setting in which the problem has developed.

Psychotherapeutic Procedures

Introductory Explanation

Once the diagnosis of a psychiatric condition is reasonably clear, the physician and patient should agree on the goals of treatment and plan for their attainment. It is important for the PCP to make a distinction between the illness and the personality; if he sets his sights on personality change, he is undertaking a much more ambitious goal than he will have time or training to accomplish. In the case of a compulsive personality suffering from superimposed depression, for example, his goal should be the relief of the depression, but there should be no explicit or implicit promise that treatment will continue until the compulsivity no longer exists. The psychotherapeutic model is not the infectious disease/antibiotic model in which the goal is the total elimination of illness, but the cardiac decompensation model in which the goal is restoration of function within the limitations of an impaired heart. However, there is an important difference. Psychotherapy which effectively counteracts the episode can leave the patient free to continue his personal development through his life experience, whereas the compensated but damaged heart tends to become more damaged as time goes on. Moreover, psychotherapy for the crisis situation may indirectly result in improvement of

the patient's basic personality problems: the compulsive patient who has overcome his depression may, as a side effect, become less compulsive.

In any event, the patient should know what the PCP hopes to accomplish, and how he plans to accomplish it. Most patients expect that their PCPs will give them advice, medication, and definite answers to their questions. Since the patient's role in psychotherapy requires more activity on his part and less from the PCP, enough time should be spent in an introductory session on explaining the new procedure so that the patient is not confused or disappointed when formal treatment begins.

This explanation is particularly important when the PCP is simultaneously treating psychological and organic components. The depressed cardiac patient may need to play a dual role, namely, to accept advice and medication about his heart but to talk about his depressed feelings, and he should understand when and why a shift in role is required in the course of a visit to his PCP.

Duration of Treatment

Such mundane concerns as duration and frequency of interviews, and their cost, should also be discussed before treatment begins. Psychotherapy conventionally is carried out by mental health professionals in forty-five to fifty-minute sessions, once a week or more often, usually over a period of

months. This pattern is appropriate when personality change rather than symptom relief is the goal of treatment, but it should not be assumed to be appropriate for psychotherapy carried out by the PCP. It encourages the emergence of unconscious material with which he is not prepared to cope, and it requires more time and more predictability of scheduling than he can provide.

Shorter sessions are better adapted both to the PCP's treatment goals and to his schedule. With respect to the length of sessions, Castelnuovo-Tedesco (1965) recommends a "twenty-minute hour," based on observations that the total time spent by the physician in all aspects of an average visit is twenty minutes; others report an average time of fifteen minutes. But whether the physician decides on fifteen, twenty, or thirty minutes, he should stick to his plan and give the patient all of the time he has decided on and all of his attention. The patient feels short-changed if the PCP terminates early, but on the other hand the patient often delays getting down to business if limits are not rather firmly set.

Therefore, sessions should be ended on time, firmly and without apology. Consistency in terminating sessions also lets the patient wait until the end of a session to bring up a subject which he fears may shock or alienate the PCP, secure in the knowledge that he will not have to pursue it past a predetermined point. When he finds that the PCP is neither shocked nor

alienated, he can risk bringing up the uncomfortable subject earlier in a later session. Preplanned termination also provides a structured stopping place for the PCP; in most contacts the PCP terminates with a decision and a prescription, but in psychotherapy there is no analogous point of closure.

Psychotherapeutic efforts are best contained within regular appointments, usually once a week. More frequent sessions risk getting the PCP too deeply involved, and less frequent sessions impair continuity. Additional contacts (office, home visit, or telephone) may be necessary in the course of the doctor's medical care of the patient, but if these contacts include psychotherapy, the patient will be tempted unconsciously to seek more and more of them. Along with his other problems, virtually every patient enters treatment with many unfulfilled dependency needs deeply embedded in his personality structure (Coleman, 1949). If the PCP does not set consistent limits to the amount of time he provides in the context of psychotherapy, the patient's attention can easily be diverted, without his realizing it, from a potentially productive effort to overcome his symptoms to a futile attempt to fulfill his dependency needs. For this reason, psychotherapy is best kept within structured limits. It is also best not undertaken during night calls; although they are usually accompanied by a substantial amount of patient anxiety, and are often useful in diagnosing emotional problems, the psychotherapeutic treatment is best carried out in the office (Clyne, 1963).

The PCP often hesitates to start psychotherapy because he assumes—and often has been taught—that it must go on indefinitely. In recent years, however, many advantages of therapy with termination planned in advance have been recognized, advantages to the doctor and to the patient, who both benefit from knowing more clearly just what they are letting themselves in for (Aldrich, 1968; Frank, 1968). Although once in treatment, patients may unconsciously seek to prolong it to fulfill their dependency needs, they initially tend to fear an indefinitely prolonged period of psychological dependency, and may be more likely to enter treatment if they see a definite end to it (Reid, 1969). There are also more mundane but nevertheless important financial barriers to entering a type of treatment whose total cost cannot be predicted; although the cost of prolonged treatment can be used as psychological resistance to entering treatment, it is more often than not a realistic consideration.

Treatment, therefore, in the PCP's usual case should be set up for a definite number of sessions—perhaps eight or ten for most relatively acute conditions—with a planned recapitulation at the end. For the most part, psychotherapy of the type discussed in this paper will be effective within eight to ten sessions; if it is not, it is doubtful whether it will be effective in a longer period and the PCP should then consider referral for a more intensive or different type of treatment.

Time-limited, regularly scheduled psychotherapy is not the appropriate treatment for all the PCP's psychiatric clientele. He needs to be more flexible with certain patients— chronic ambulatory schizophrenics, for example,— and arrange to see them at variable intervals according to their current needs. There are also dependent personalities with long-standing hypochondriacal symptoms who do best when the PCP does not plan termination in advance, but instead accepts their need for a stable, protective, not too intense relationship. Once these patients find that their PCP is not trying to get rid of them, that he welcomes them for brief—perhaps ten-minute—regular visits even without symptoms as tickets of entry, and that he evidences more interest in their life situations than in their physical complaints, they often begin to show marked improvement.

Scheduling and Privacy

Although the PCP cannot insure the same kind of privacy, confidentiality, and predictable scheduling as the psychiatrist, he can often make enough of an adaptation to approximate the ideal. Some PCPs have found that scheduling their psychotherapeutic work on one afternoon or one morning a week is possible; others schedule these patients at the end of the work day, although there is some question whether fatigue limits their effectiveness at this time. In any case, privacy is essential, and an assurance of confidentiality is particularly important since the PCP usually also cares for

other members of the patient's family as well as for friends and acquaintances.

In other types of medical care, distractions and interruptions, while not welcome, can be tolerated. However, because psychotherapeutic success depends so much on continuity of attention, the physician is best advised to arrange for all interruptions, telephone or otherwise, to be deferred until the session is over, except for extreme emergencies. Interviewing requires not only attention but the appearance of attention to be effective. The PCP who says, "Go ahead, I am listening," while he looks through papers on his desk lets the patient know that he is not receiving full attention.

Basic Principles of Psychotherapy

Psychotherapy is in many ways an extension of history-taking with a slightly different emphasis. Although the PCP takes a history in order to understand the patient and his illness, the patient often finds that he too understands better as he relates his history, and that he can use this understanding to find new and more effective ways of coping with his stresses and conflicts. In the same way, psychotherapeutic interviews often have as a by-product an enrichment of the patient's history with consequent increased understanding by both patient and therapist.

Although some of the technical aspects and goals of the PCP's

psychotherapy differ from those of the mental health professional's, the basic principles are the same. The patient is helped to use the therapist as a sounding board to express thoughts and feelings which have frightened him or confused him or made him feel ashamed or guilty. The therapist listens to these thoughts and feelings empathically and without passing judgment, and through various types of intervention helps the patient sort them out and reevaluate them more realistically. He does not try to superimpose his solutions on the patient, but instead helps the patient develop confidence in his own capacity to cope with the stresses and complexities of his life.

That is about all there is to it, and it sounds deceptively simple. Its success depends, however, not on a learned routine, but on a rather complex and intangible kind of interpersonal communication. This kind of communication differs in many ways from the PCP's usual communication with patients who are having medical problems, and it differs among PCPs, because it depends to a considerable extent on each individual's communication style. Thus the PCP whose style is bluff and hearty will be inclined to intervene more frequently and will have to be more careful about giving too much advice than the PCP whose style is more taciturn. There are, however, some basic requisites for effective psychotherapeutic communication that apply no matter what the individual's communication style.

The PCP's Attitudes

The first requirement for effective psychotherapy is to take the patient seriously. If the PCP considers his nervous patients to be less sick than his other patients, or if he assumes they are imagining or are capable of consciously controlling their symptoms, or if he thinks they are consciously exploiting him by wasting his time, it will be hard for him to communicate the kind of understanding the patient needs to benefit from his treatment.

Failure to take psychiatric patients seriously may be due in part to lack of experience. Most PCPs simply have not had an adequate exposure to this kind of patient during their training. They have not learned how to go about approaching psychiatric problems; they are not sure that any "talking" treatment they provide can be effective; they are not confident of their ability to set limits to the amount of time they spend with such patients; and they question whether they are justified in expecting equivalent compensation for this kind of treatment. Many of them look to psychiatrists for help in managing these problems. Through his participation in continuing education programs, the psychiatrist can provide information which, if tailored realistically to the PCP's needs, will give him the understanding that can overcome many of the barriers to his acceptance and effective treatment of psychiatric patients (Balint, 1966; Becker, 1968; Zabarenko, 1968).

Transference

Some of the barriers stem from the PCP's unfamiliarity with the concept of unconscious transference of emotional attitudes from people in the past to people in the present. The PCP is confronted with transferred feelings to some extent in all aspects of his practice. Transference is usually intensified during times of stress, when the individual tends to regress to a more childlike type of relationship. Most patients regress to some extent during illness, and tend to transfer attitudes characteristic of their childhood relationships with their parents to the medical personnel on whom they are now dependent. The PCP, therefore, is a frequent target for his patients' unprovoked or exaggerated anger, fear, affection, or sexual feelings. Unless the physician recognizes the manifestations of transference, he may be surprised or angered or he may have his feelings hurt by the unjustified anger or distrust expressed by his patients.

Patients with emotional disturbances seem to be more prone than other patients to transfer earlier attitudes to their therapists. Interpretation of transference, while important in deeper types of psychotherapy, is usually not necessary or advisable in therapy carried out by the PCP. On the other hand, awareness and understanding of the patient's transferred feelings can be helpful to the PCP in maintaining his objectivity while encouraging the patient to talk and to express his feelings.

Transference distorts most relationships, especially dependent

relationships, to some extent, and PCPs themselves are not immune. Thus, a PCP without realizing it may carry over some of his own parents' attitudes toward himself and his siblings to his patients, and in that way overreact to his patients' realistic feelings, as well as to their transferred feelings. Even though these countertransference attitudes are usually not conscious, awareness that they may occur can help the physician correct for possible distortions in his response to his patients' transferred attitudes.

The phenomena of transference are more familiar and more acceptable to psychiatrists than they are to other physicians, who may interpret as criticism the intimation by psychiatrists during continuing education courses, for example, that they are not being objective about their patients. Material about transference can be presented tactfully, however, so that it becomes acceptable and helpful to the PCP in his concern for his own or his patients' feelings (Gaskill, 1961).

Empathy

A basic requirement for carrying out effective psychotherapy is *empathy.* In this context, empathy is the capacity to look at a patient's problem from the patient's point of view. Empathy does not mean that the PCP necessarily agrees with that point of view; after all, treatment often involves a change in the patient's outlook, and if the therapist identifies with

his patient so much that he agrees with everything the patient believes or feels, he will find it hard to encourage the patient to change. He also needs to be tolerant and realistically uncritical of the patient, "realistically" in the sense that he cannot very well condone antisocial *behavior,* although he can understand the *feelings,* usually angry or sexual feelings, that make the patient think of or wish to carry out antisocial behavior. Furthermore, since depressions often result from unrealistic self-criticism, the PCP cannot identify to the point of sharing the patient's self-criticism.

Empathy is somewhat different from sympathy, when sympathy implies feeling sorry for the patient and agreeing with the patient's perception of his problems. A sympathetic ear is traditionally helpful to the person in trouble; it is useful when the patient simply wants to share his troubles, and when no change in his way of looking at his troubles is indicated. Too much sympathy, however, may make a later effort at attitude change seem like a betrayal, e.g., if a PCP's sympathy has implied agreement that a woman's troubles are all her husband's fault, she feels betrayed when he tries to help her look at her own role.

Furthermore, too much sympathy with its implied agreement often makes it harder for the patient to reverse himself; if he has persuaded the PCP that he is completely in the right, he hesitates to acknowledge later that he is not really so sure. Finally, it is hard to be angry at a sympathetic listener, and

patients often need to blow off steam at their PCPs.

Listening

A good deal of the PCP's participation in psychotherapy consists of encouraging the patient to talk about whatever is bothering him. But since what is bothering him is often concealed beneath symptoms or other screens, it is often difficult for the PCP to know when to encourage the patient's exploration of a given subject and when to discourage it.

If the PCP gives signals, subtle or otherwise, to the patient which indicate what he does not wish to hear, the patient will tend to respond accordingly. The patient may detect—or assume through past experience—that the PCP is primarily interested in symptoms, and since talking about symptoms serves the double purpose of interesting the PCP and avoiding discussion of painful conflicts, treatment may quickly turn into a fruitless repetition of a catalogue of symptoms. Talking about symptoms is familiar ground to the PCP and he may without realizing it encourage his patients to continue in this vein. Moreover, talking about life problems may make the PCP uncomfortable, if he believes that he is supposed to have answers to all of them. Once he recognizes that he does not have to have the answers, that psychotherapy is a process of sharing problems and a mutual search for ways to resolve them instead of the provision of ready-made solutions, he can be

more comfortable in gently encouraging the patient to talk about his life situation.

Gentle encouragement or discouragement is not so much active as passive; it is usually conveyed by the PCP's show of interest—by nonverbal signs and by requests for further details, etc.—in the subjects he considers significant, and by the absence of such signs and requests in response to a recital of symptoms. The PCP keeps his own participation to a minimum; he keeps the patient talking or communicating feeling by an attitude of interest and concern and by nonspecific comments, or he modifies the direction of the communication by comments that emphasize or focus on one particular aspect.

The PCP finds listening to patients talk about what is important to them less familiar than does the mental health professional. The PCP is accustomed, perhaps more than he should be, to carrying most of the responsibility for the direction of his medical interviews and to being the one who gives information in his treatment. Changing his set to become a receiver of information and to encourage the patient to explore areas whose relevance may not be immediately apparent is difficult and may require a persistent effort as well as a conviction on the PCP's part that the results will be worth the effort.

Intervention

Although the patient does most of the talking and the PCP most of the listening, there are times when it is appropriate for the PCP to intervene. There is no exact formula for deciding on the nature and timing of interventions, and their choice should be determined by the goals of the interview.

Establishing goals for each interview is seldom undertaken when therapy has no planned termination and is expected to require a long period of time. Psychotherapy with a planned termination date, however, usually requires more guidance from the therapist. In order to guide, the therapist must know the destination and the path, both of which should be derived from the diagnostic understanding of the problem (Aldrich, 1966).

This process is illustrated in the following case example. Mrs. C. came to the office of Dr. F., her PCP, complaining of headaches of a few weeks' duration. In the course of his history-taking, he noted that she was mildly but definitely depressed, and he diagnosed the headaches as symptoms of her depression and found no evidence of organic illness. The depression seemed to have been set off, at least in part, during an incident when a neighbor had called in some distress to ask Mrs. C. to stay with her children because she had to take her husband to the hospital. Mrs. C. knew the neighbor very slightly, but was happy to comply; the day passed uneventfully and the

neighbor's husband soon got well. Mrs. C.'s depression seemed out of proportion to the event, but since it was the only out-of-the-ordinary event in her life situation about the time her symptoms began, Dr. F. suspected that it had a special symbolic meaning to her.

In the course of taking the history, Dr. F. found that going to or even talking about hospitals made Mrs. C. uncomfortable, that her father had died —in a hospital—when she was nine, and that she had had to give up some plans for the day she helped out her neighbor. When asked to talk more about these aspects of her history, she protested that no one liked hospitals, that she was too little when her father died to know much about it, and that her plans were really not very important—her neighbor would have done as much for her.

Dr. F. listened noncommittally, but thought to himself that her antipathy to hospitals was more than one might expect, and that she seemed to be protesting a little too much about the inconsequentiality of her abandoned plans. He also kept in mind that children at nine are both aware of death and concerned about it. Recognizing that unresolved grief, shame, guilt, or a combination thereof are usually involved in the causes of depression, he speculated that a delayed reaction to the loss of her father and/or shame at her unwillingness to help her neighbor might be contributing factors. The source of guilt, if any was involved at all, was certainly less evident and

probably would be less accessible to his treatment.

He decided to explore psychotherapeutically the shame and unresolved grief possibilities. He decided to hold off the guilt possibility until he had heard what emerged during the discussion of the first two, and tentatively planned to refer her to a psychiatrist if guilt appeared to be the major factor. He explained the treatment conditions and procedure to Mrs. C., and she agreed to a ten-session course of psychotherapy. He told her that they would be discussing at greater length some of the matters that she had spoken of during the history-taking, and perhaps some other matters; he did not state explicitly the sequence he intended to follow, in part because he thought he might decide to change the sequence, and in part because she had not shown much enthusiasm about either possibility when he had suggested them during history-taking, and he did not want unnecessarily to stir up more resistance to them.

In the course of Mrs. C.'s treatment, Dr. F. interspersed his listening with various types of intervention. Depending on the situation, he made *catalytic* comments to encourage her to proceed, *empathic* comments to communicate his understanding and to elicit expression of feeling, *focusing or directive* comments to start an interview or to keep her on the track, *questioning* comments to elicit more information, *confronting* comments to encourage her to reconsider a position, and *summarizing* comments to terminate a session

or a phase of treatment (Enelow, 1966).

Dr. F. started the first session with a focusing comment: "Mrs. C., I'd like to hear a few more details of that day you were asked to baby-sit with your neighbor's children, about the time your depression began."

Mrs. C. talked for a while, but the details that she produced did not seem significant, even with Dr. F.'s catalytic comments. (Dr. F.'s personal way of encouraging someone to continue talking was to say "Yes" when that person showed signs of slowing down. Most people have their own styles in this kind of catalytic communication, whether in social or professional situations. Dr. F. said "Yes;" another doctor would have said "Unh-hunh," repeated a word or phrase said by the patient, or given whatever other signal he was accustomed to use.)

Dr. F. discerned no evidence of shame or resentment over her baby-sitting task, and so he decided to focus a little more definitely on the loss possibility with a questioning comment. He asked an open-ended question, one that could not easily be answered in a word or two, and that gave Mrs. C. a range of choices for her answer. He asked, "How did the children feel about what had gone on that day?" Mrs. C. gave some details, more about what the children did than how they felt. Dr. F. tried again, gently, to focus: "Yes, but how did they feel?" Mrs. C. claimed that she did not think they seemed

particularly upset. Dr. F., sensing that his rapport with Mrs. C. was good enough so that he could risk a mildly confronting intervention, said, "Even with their father gone to the hospital?" Mrs. C. responded, with some sharpness, "I suppose you are trying to get me to say that all this reminded me of when my father was sick."

Dr. F. at this point momentarily considered an empathic, or mirror intervention, such as "You seem a bit upset by that idea," but hesitated to say it. Later, in reviewing the session, he wasn't sure why he had hesitated—perhaps because it seemed too obvious, or possibly because it might have added unnecessarily to her annoyance. Instead, he said nothing. Silence may seem to be a nonintervention rather than an intervention; paradoxically, however, it has the effect of an intervention when the situation would ordinarily call for a comment. Silence in such situations is not easy to maintain, and often requires a therapist to restrain his tendency to do something to keep the conversation going. Too long a silence, however, may be perceived as anger or boredom. In this case, Mrs. C. soon broke the silence: "Well, all right, I can see how they have something in common, but I don't see what they have to do with what's wrong with me now."

Dr. F.'s next comment was conditioned by the fact that the interview time was up. It was in part summarizing, and in part could be classified as directive, although he carefully phrased it in a nonauthoritarian way: "I'm not

sure what relationship they have, but I think there's enough chance of a connection so that we should talk some more next time about your father's death and your reaction at the time."

Dr. F. opened the second interview with a focusing statement: "We were going to talk this time about your father's death." Mrs. C., helped by some catalytic responses, gave a good many details of the events leading up to her father's death. She told Dr. F. about saying good-bye to him before going to school on the day he went to the hospital. The following is transcribed, with minor editing, from the interview, which was tape recorded with Mrs. C.'s permission.

Dr. F.: "And when you came back . . ." (catalytic)

Mrs. C.: "Well, we went up to see him in a hospital . . . My brother came over . . . we were playing outside . . . the four younger kids with the neighbor kids. We were sort of dirty, didn't look very nice, but he just picked us up off the street and said 'Come on with me.' "

Dr. F.: "Um . . . yes." (catalytic)

Mrs. C.: "And he took us in this building—it was the first time I had ever been in a hospital. Oh, do I have to talk?"

Dr. F.: "It's really upsetting to remember it." (Although this comment did not answer her question directly, it implied that she should continue. It was an empathic intervention, and gave sanction to her expression of emotion. She began to cry, and Dr. F., realizing that it was important for her to express her feelings, did not attempt to console or reassure her. He remained silent; Mrs. C. gradually stopped crying.)

Mrs. C.: "It's silly to be crying now."

Dr. F. might well have responded with another empathic intervention, which probably would have precipitated more tears. He decided instead that she had cried enough, at least for this session, and moved on with a question to encourage her to continue her story. Either response would have sufficed; as in most situations, there is no one correct intervention.

Dr. F.: "Did you cry then?"

Mrs. C.: "No. I was too ... I don't know. I felt bad, but I couldn't cry . . . Everybody else was crying, but I didn't cry. He looked so ... he looked so changed." (pause)

Dr. F.: "Changed?" (catalytic)

Mrs. C. continued to describe these events, with some more tears, while Dr. F. listened empathically. At the end of the session, he summarized: "I know it's been painful to talk about your feelings about your father's death; it sounds, however, as if you've needed to have more of a chance to share them with someone. Next time I think we had better continue on in this direction."

In the next six sessions they continued to discuss the events surrounding her father's death, until Mrs. C. felt sufficiently relieved of her depression and headaches to terminate treatment.

The case excerpt illustrates the use of focusing, catalytic, empathic, directive, confronting, questioning, and summarizing interventions in helping

a patient to express feelings and to maintain progress toward the goal of therapy. Another type of intervention is clarification, which may be used in helping a patient understand attitudes. Thus, when later in the series of interviews Mrs. C. expressed a great deal of anger at her mother's lack of understanding of Mrs. C.'s feelings about her father's death, Dr. F. observed that her mother might have been so preoccupied with her own grief that she had nothing left over to give her children, but that this would have been hard for a nine-year-old to understand. The clarification of feeling—in this case, clarification of the mother's, not the patient's—was made tentatively, not dogmatically, and with care not to make Mrs. C. feel ashamed of not having understood her mother.

Clarification of alternatives is used to help a patient make a decision or take action. In most instances it is better for the therapist to clarify alternatives and help the patient make his own decision than to give advice and, in effect, make the decision for the patient. Clarification does not come naturally to the PCP, whose spontaneous impulse, based on his routine with other types of patients and his concept of a physician's proper role, is to respond to questions or indecision with advice. "The most significant outgrowth of the medical orientation is the inner conviction that unless one gives the patient something (medication, a rest, a diet, an incision, an appliance, advice, or directions), one is not treating him adequately" (Group for the Advancement of Psychiatry, 1964, p. 332).

The trouble with advice that can be followed is that it encourages the patient to rely on the PCP rather than on himself for decision-making and thus reinforces the patient's feeling that he is not competent to make his own decisions. Advice that cannot be followed— "Stop worrying," for example—is useless and indicates a lack of empathy; if the patient could have stopped worrying on his own, he would not be seeking help.

Except when the patient does not have the background to judge, as in medication problems, the PCP can usually be more helpful if instead of giving answers he attempts to clarify the problem. Thus if the patient says, "I feel terribly tired and I am sick of my job. Do you think I should quit?" the PCP should not feel obligated to give advice. On the other hand he should not simply say, "Well, it's your decision," which gives no help at all. Instead he might ask, "What do you think might happen if you changed jobs?" leading to a discussion of the relative merits of the alternatives. In this way the patient can be helped to come to a decision, and while he has received the help of the physician, he also has the satisfaction of having ultimately made his own choice.

Reassurance is a response many PCPs almost automatically make to patients' fears about organic illness. But reassurance is only reassuring when it is based on valid data, and a premature attempt at reassurance which promises relief of symptoms before the PCP knows enough about them is

often perceived as indicating lack of empathy. "How can he be so sure I will be all right when he doesn't really know what is wrong?" thinks the patient, although he may not say so for fear of offending the doctor on whom he is dependent. Reassurance needs to be couched in realistic terms. A comment such as "I suspect you will be able to carry on in spite of your symptoms," appears at first glance to be less reassuring than "Your symptoms will all go away," but if it is based on adequate information it is likely to be borne out by experience and therefore in the long run perceived as evidence of the doctor's understanding and competence.

Reassurance is frequently used prematurely to abort the expression of feeling. But since, as in the case of Mrs. C.'s tears described above, the expression of sadness, anger, discouragement, or other strong feeling more often than not hastens the progress of treatment, it usually should be sanctioned, not restrained, by the therapist. To indicate by quick reassurance that the expression of feeling is unacceptable to the therapist may repeat the sequence of events that caused its expression to be inhibited in the first place, and so perpetuate the problem instead of relieving it. When a patient is experiencing but attempting to conceal strong feeling, an empathic intervention often helps him to acknowledge it, express it, and learn to be less afraid of it.

Modification of the Environment

Modification of the environment can be helpful, but it is generally overused. When the doctor sends the depressed patient on a vacation for a change of scene because he wants to remove environmental irritants, he is also removing the patient from sources of support, including himself. Since most depressions as well as most other psychiatric disorders are primarily related to internal problems, which the patients carry on vacation with them, they may become worse instead of better away from home and doctor.

Another example of overused environmental modification is the case of the adult child who, in response to his doctor's recommendation, prematurely banishes a cranky parent to an institutional setting and then suffers more from guilt at the parent's absence than from annoyance at his presence. This does not mean that elderly relatives should never be institutionalized, but that all factors should be taken into account before the recommendation is made. As in the case of advice, clarification of the alternatives which helps the patient make his own decision is better than prescribed environmental change in most instances.

Medication

In most of his practice, the PCP tends to rely primarily on medication and secondarily on his personal interaction with the patient. He therefore may be inclined to put too much confidence in the use of medication for his

psychiatric patients. He also is often tempted to use medications as placebos for illnesses without organic causes. Indeed, the initial apparent effectiveness of placebos may lead him to have more confidence in them than a longer view justifies (Shapiro, 1959). The problem with placebos is that their duration of effectiveness is usually brief, and if the PCFs contact with his patient is at all prolonged, he will find that the patient will soon look for a more effective drug. The efficacy of the new drug will in turn be short-lived, and the PCP will then find himself in a fruitless search for the ideal placebo, while the patient becomes dissatisfied, overmedicated, addicted, or all three.

The PCP, therefore, should if anything play down the effectiveness of his medication in conditions likely to be of long duration, even though playing it down reduces the component of suggestion and the placebo effect. He should emphasize instead the search for psychological solutions. He may say, "I know you are having a good deal of discomfort (insomnia, etc.) and I want to prescribe this medicine which I believe will relieve your symptoms to some extent. Meanwhile it is important that we get down to business and look for what is causing the symptoms." In this way the patient can judge the effect of the medication more realistically, will not expect too much of it, and will be less inclined to become overly dependent on it.

When medication is definitely indicated, it should be used in adequate quantities rather than in homeopathic doses. It is best in the long run for the

physician to know well the indications, dosages, expected action, and side effects of one or two tranquillizers, one or two antidepressants, and one or two hypnotics rather than to try for a superficial knowledge of all the myriad psychoactive drugs that have been developed. He should substitute new drugs on his list only after a clear superiority in pharmacological action has been demonstrated. If he adopts each new drug that the detail man recommends, he can easily get pharmacological and placebo effects mixed up, and in the long run may substitute less effective for more effective drugs in his armamentarium.

Family Problems and Joint Interviews

Emotional problems tend to cluster in families, and problems in family relationships are often brought to the PCP. Even when the primary complaint may appear at first to be limited to one member of the family, treatment may be facilitated if the marital couple or other members of the family are treated as a unit.

Marital and family therapies are somewhat more complicated than individual therapy, but may still be within the competence of the PCP. As Browne and Freeling observe, "There is no doubt that the joint interview has its pitfalls, and as with all medical techniques, requires experience to obtain the best results, but for the general practitioner it is probably the most

neglected and yet one of the most powerful therapeutic tools at his disposal" (Browne, 1967, p. 3).

In family treatment, it is important for the PCP to avoid taking sides or attempting to act as a referee. His goal instead is to act as a catalyst in improving communication within the family and in helping members of the family to modify their attitudes to one another. Many of the techniques described in Chapter 18 can be effectively used by the PCP.

Psychiatric Consultation and Referral

Not all patients with emotional problems can be effectively treated by the PCP. Suicidal and acute psychotic conditions are among those for which referral is appropriate, although the PCP often has an advantage in the follow-up care of such patients after they have been discharged from psychiatric hospital care. These patients may be less likely to neglect follow-up treatment if they are referred back to a PCP whom they know and whose office is more accessible and more familiar than a follow-up clinic.

In anticipation of his possible follow-up care of any of his patients who have been in a psychiatric hospital, the PCP should maintain communication with the relevant psychiatric services. This type of communication can best be established at the time of referral, or early in the patient's hospital stay if the PCP has not been the original referring agent. Through such

communication, treatment regimens can be coordinated, and the PCP may also act as a bridge between hospital personnel and the patient's family, helping to clarify the patient's clinical condition and his needs to the family, and helping to maintain the family's linkage to the patient.

The decision to refer a patient to a psychiatrist or to a mental health facility depends on the nature, severity, and treatability of the condition. The effectiveness of the referral depends to a considerable extent on the PCP's personality and skill in engineering the transition from his care to psychiatric care. If the patient takes the referral to mean that he is being rejected by the PCP, or that his illness is imaginary or hopeless, he is likely to resist acceptance of the referral or of subsequent psychiatric care. On the other hand, the patient should not be oversold in an effort to persuade him to accept the referral. Overselling that promises a cure within an unrealistically brief period can result in the patient's becoming discouraged when magical results are not forthcoming. The referring PCP also should not be vague or misleading about the nature of the referral; the patient feels betrayed if he is led to believe that he is going to see someone other than a mental health professional. Finally the PCP should be aware of alternative community resources such as family service agencies which may be equally or more appropriate sources of help.

Open lines of communication between the PCP and the psychiatrist are

essential for successful consultation and referral, but require an effort on the part of each participant to understand the other's special circumstances. The PCP is used to receiving a written, definitive diagnosis after a relatively brief period of evaluation from specialists to whom he has referred patients; the psychiatrist's diagnosis tends to develop gradually over a relatively long period of time and to overlap treatment. There is often no clear-cut point, therefore, at which the psychiatrist can give a final summary of his diagnosis and recommendations, and consequently he often delays any communication back to the referral source. Furthermore, psychiatric evaluation tends to be rather long-winded, and it is not always clear how much information the PCP finds useful.

Many psychiatrists and PCPs, therefore, find that telephone communication is more productive. Telephone communication, when scheduled to fit into the idiosyncratic practices of each party, makes it possible for each to answer the other's questions, and to develop the kind of collaboration which is in the best interests of the particular patient or family. With easy access to a psychiatrist's telephone consultation, the PCP can feel secure in undertaking a more substantial share of the mental health problems in his community, and the psychiatrist can expedite appropriate referrals.

The PCP should know his referral psychiatrist well. However, since psychiatrists have particular interests—hospital psychiatry, child psychiatry,

intensive psychotherapy, adolescent psychotherapy, addictions, etc.—it also may be advantageous for the PCP to get to know more than one referral psychiatrist, so that when possible his patient can be directed to someone with a special interest in his particular type of problem.

Even when referral is not indicated, the PCP who has established a relationship with a psychiatrist feels that he has someone to turn to if he needs guidance or reassurance in the management of some of his patients. The kind of consultation Caplan (1970) has called "consultee-oriented," can be useful to the PCP; the patient is not seen by the consultant and the focus is on the PCP's problems in management of the patient rather than directly on the patient's diagnosis and treatment recommendations. The psychiatrist who makes himself available for this kind of consultation as well as the more conventional kind to the PCPs in his community will render service far beyond the limits of his practice. He will thus strengthen the collaboration between PCPs and mental health professionals which is essential for optimal prevention and treatment of the range of psychiatric problems in his community.

Bibliography

Aldrich C. K. *An Introduction to Dynamic Psychiatry*. New York: McGraw-Hill, 1966.

----. "Brief Psychotherapy: A Reappraisal of Some Theoretical Assumptions," *Am. J. Psychiatry*, 125 (1968), 585-592.

Balint, M. *The Doctor, His Patient and the Illness*. London: Pitman Medical, 1957.

Balint, M., E. Balint, R. Gosling et al. *A Study of Doctors*. Philadelphia: Lippincott, 1966.

Becker, A., ed., *The General Practitioner's Role in the Treatment of Emotional Illness*. Springfield, Ill.: Charles C. Thomas, 1968.

Bellak, L. and L. Small. *Emergency Psychotherapy and Brief Psychotherapy.* New York: Grune & Stratton, 1965.

Browne, K. and P. Freeling. *The Doctor-Patient Relationship*. London: Livingstone, 1967.

Caplan, G. *Theory and Practice of Mental Health Consultation*. New York: Basic Books, 1970.

Castelnuovo-Tedesco, P. *The Twenty-Minute Hour*. Boston: Little, Brown, 1965.

Clyne, M. B. *Night Calls*. London: Tavistock, 1963.

Coleman, J. V. "The Initial Phase of Psychotherapy," *Bull. Menninger Clin.*, 13 (1949), 189-197.

Enelow, A. J. and S. N. Swisher. *Interviewing and Patient Care*. New York: Oxford University Press, 1972.

Enelow, A. J. and M. Wexler. *Psychiatry in the Practice of Medicine*. New York: Oxford University Press, 1966.

Frank, J. D. "The Role of Hope in Psychotherapy," *Int. J. Psychiatry*, 5 (1968), 383-395.

Gaskill, H. S. "The Physician-Patient Relationship," *J. Med. Educ*. 36, II (1961), 133-140.

Greco, R. S. and R. A. Pittenger. *One Mans Practice*. New York: Lippincott, 1966.

Group for the Advancement of Psychiatry. *Medical Practice and Psychiatry: The Impact of Changing Demands*, p. 332. New York: Group for the Advancement of Psychiatry, 1964.

Joint Commission on Mental Illness and Health. *Action for Mental Health*, p. 148. New York: Basic Books, 1961.

Kiesler, F. "Is This Psychiatry?" in S. E. Goldstein, ed., *Concepts of Community Psychiatry*, pp. 147-157. Bethesda: National Institutes of Health, 1965.

Reid, W. J. and A. W. Shyne. *Brief and Extended Casework*. New York: Columbia University Press, 1969.

Shapiro, A. K. "The Placebo Effect in the History of Medical Treatment (Implications for Psychiatry)," *Am. J. Psychiatry*, 116 (1959). 298-304.

Wolberg, L. R., ed., *Short-Term Psychotherapy*. New York: Grune & Stratton, 1965.

Zabarenko, L., R. A. Pittenger, and R. N. Zabarenko. *Primary Medical Practice: A Psychiatric Evaluation*. St. Louis: Warren Green, 1968.