

Correspondence

Psychoanalysis and analytical psychotherapy in the NHS

SIR

Dr Wilkinson uses 'Dare's sympathetic description of psychoanalytic practice' to describe only the behavioural transactions in the therapy (1). He then promptly throws the baby out with the bath-water and sees its conception as unethical.

When discussing psychoanalytic and psychodynamic practice, a formulation of the theoretical model of therapy is as essential as in any other transaction for theory and practice need to complement each other.

The medical model of psychiatric treatment is based on causality theory. Doctors study symptoms, note changes in mental and physical functions, and make diagnoses based on their findings. Treatment will be based on the search for the causal agent or process, and its appropriate counteraction through the prescription of drugs, ECT or at times surgical intervention. Such a model is based on classical Newtonian physics and confirms psychiatry as a branch of medicine with a research model based on that of classical scientific research. This frequently involves an experimental group of patients with like symptoms who are treated by the same agent and its outcome compared with a matched group of sufferers, a control group, without such treatment.

In the psychodynamic and analytic model of the mind, there is the concept of a process whereby feelings which are threateningly painful at a conscious level are pushed below to an unconscious level. There they have a valency of their own concealed by this safety mechanism, but over time the pressure may mount and translate into symptoms of physical pain, anxiety,

depression or fears for which no known 'cause' can be found. The psychoanalytic model postulates that the painful unconscious 'forgotten' feelings reflect childhood-and-after recurrent failures of idealised parent/child and child/sibling relationships. The therapy model is that of Einstein rather than Newton, as quoted by Kurt Lewin (2); 'It is not the charges nor the particles but the space between the charges and the particles which is essential for the description of physical phenomena'. So too in psychoanalytic therapy the space between patient and therapist is the field where the analyst facilitates the psychic phenomena necessary for the re-experiencing of the painful failed attachments and losses of childhood and the ensuing experience of real here-and-now attachment relationships based on the inevitability and acceptance of loss.

Research into outcome and evaluation of therapy is as important for analysts and psychodynamic therapists as in any field of treatment. It can however never be based on the classical scientific model for the modality is different. A group of patients with the same symptoms is the equivalent of a group of persons speaking with different tongues. In particle physics it is possible to predict the spin of a group of protons but not that of one individual proton. Again for the psychoanalyst the symptoms represent bearers of communication between the unconscious and the conscious mind and therefore there is no attempt to tranquillise them. It is because they start from different premises that 'prominent medical journals' criticise research evidence and its lack in dynamic psychotherapy. Nevertheless research and evaluation is done but it is not always confidently valued by those who do it for always the shadow of the 'scientific' model falls upon it. We have been trained to work that way. Dr David Malan (3) illustrates this

ambivalence in that his own published work speaks loudly to the effectiveness of individual analytic therapy, although he is quoted by Dr Wilkinson as questioning its value in outcome research on the medical model.

The reality of the National Health Service (NHS) psychodynamic psychiatrist is that he must work in the setting of his own department of psychiatry. I, for many years, offered patients half-hour appointments fortnightly for six months and evaluation was made then in conjunction with the patients. I am certain that the cost of this was infinitely less than that of the treatment of medical-model psychiatrist colleagues and their use of expensive drugs. Analysts believe there is potency in the therapy and inevitably it may be potent for ill as well as good. How true this is of medical-model psychiatry and with all powerful interactions.

In the NHS I worked with a multi-disciplinary staff of therapists in a group psychotherapy unit. We asked two questions at the start of this unit and we attempted to answer them through an evaluation study. The two questions were the same as Dr Wilkinson's: Does it work? What is the cost? The answers were that it did work for appropriately selected neurotic patients in that it saved substantially in in-patient days and out-patient appointments when the numbers were compared for the year before group psychotherapy and the mirror-image year for the year following therapy.

As to the comparative cost-effectiveness of this considerable decrease in use of the psychiatric services, the logistics of this has proved too daunting, as indeed it does in so many other medical fields.

References

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Informed dissent

SIR:

Alison Davis's principle concern is with the Right to Life; mine, is with the Duty to Care (1). I am quite prepared, for the purpose of this debate, to accept that all people have an equal right to life. But, if some require 24-hour care in perpetuity in order to exercise this right, the brutal practical question arises as to who is going to undertake this task? After all, carers too have a right to life, and a lifetime of compulsory caring effectively deprives many of them of the right to a life worth living, as my own and several other recent studies have suggested.

Until recently, the answer was obvious. Of course, the parents had a duty to care. In practice, of course, parents nearly always means mothers. Now we may be witnessing the start of the 'Revolt of the Mothers'. Some, at least, have decided that a lifetime of caring is intolerable.

Society's response has been to offer a fair amount of assistance while their severely mentally handicapped children are of compulsory school age, but very little help thereafter. A few outings to the 'club', occasional respite-care booked weeks ahead, if they are lucky, and so on. None of this frees them to live an independent life. All it does is give them an occasional break in order to prepare them for the next round of caring.

If they can no longer cope, then according to Alison Davis, they have the option of adoption. This, unfortunately is not so. Although it is

possible for some moderately handicapped and younger children to find adoptive parents, hardly any very severely mentally handicapped children do so, least of all the older ones. Most languish in institutions if their parents cannot keep them. The reputation of many of the large mental handicap hospitals leaves something to be desired, and scandals about the treatment of patients in them are a subject of recurrent public and parliamentary concern. On June 10 1986, to take but the most recent example, Mr Dennis Canavan MP opened a debate in the House of Commons on Mental Handicap (Hospital Conditions) (2) in the course of which he referred to:

'... the filthy conditions, the dilapidated buildings, the overcrowding, the lack of basic amenities and the severe staff shortages in institutions which are supposed to care for some of the most deserving people in our society . . .'.

Most parents know all this only too well and understand that effectively they have no choice but to 'care' because they are not being offered any civilised or acceptable alternative.

The Government's determination to control public spending means that this situation will deteriorate rather than improve. And it must be said in all honesty, that if there were indeed more public money available many would prefer to spend this on making hip operations more accessible, or on other good causes.

In this connection I note with wry amusement the Delphic utterance of your contributors J K Mason and D W Meyers in the same issue of your journal also writing about deformed newborns:

'The burden on the family is not a matter that physicians should be compelled to evaluate or act upon. The allocation of scarce treatment resources in such cases is a real limiting factor but is one which is imposed by factors beyond the control of physicians or parents – as well as being beyond the scope of this article' (3).

The purpose of my article was to suggest that this tunnel vision really won't do any longer, and when the 'carers' ie the mothers, finally demand their own right to life, the physicians will finally have to make contact with the real world that exists out there, beyond the pages of the journals, philosophical and medical.

References

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Mental Health and Human Conscience, the True and the False Self (Gower 1984)

SIR

Dr Stephen Little's review of my book in the June 1986 issue of the journal, pages 97–98, misinterprets my views in two vital respects:

(1) I am not 'much influenced by Romantic notions of the true self', but I consider the recognition of the true and the false self as manifestations of a person's conscience. This (non-theistic) interpretation of conscience is to me the most powerful antidote to today's malaise of cynicism and despair.

(2) I am not 'content to categorise as "illness" what cannot be appealed to'. Rather is 'a person suffering from a psychotic illness treated existentially [with an appeal to his conscience and freedom] to the extent to which his illness makes such treatment possible', page 147. The 'boundaries of and rationale for this division' [into those with and those without freedom] are explored in the section entitled 'existential assessment', pages 147–149, and are illustrated by the case of 'Anna', pages 122–125. Therefore this 'central issue' is not avoided and 'the applicability of [the] entire theoretical stance' is not threatened.

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