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Review Article

Psychotherapy and General Practice

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The authors review the development of liaison psychotherapy in general practice, and argue that a 'skill-sharing' approach, where the general practitioner retains the treatment role, is a more efficient model than a 'consultation' approach. Skill-sharing models are reviewed, and the need for psychiatrists and psychotherapists to be more directly involved in teaching basic psychotherapeutic skills to general practitioners is emphasised.

As part of the general trend towards liaison between psychiatrists and primary-care teams in the UK (Strathdee & Williams, 1983), psychotherapists are increasingly finding themselves being asked to provide a service in a wider range of settings than before (Wilson & Wilson, 1985). Part of the pressure for this development stems from the increasing recognition that psychotherapy in the National Health Service has a much wider definition and range of application than psychoanalysis or the services offered by specialist psychotherapy units (McGrath & Lowson, 1987). This recognition is accompanied by the realisation of the potential value of the skill and expertise of the psychotherapist working in general practice, using the term 'psychotherapist' in a broad sense to describe professionals from any discipline who employ psychological and psychodynamic treatments for a range of social and psychological problems. In this review we survey the last 30 years, starting with the work of Michael Balint. We argue that psychotherapy has an important role to play in general practice, but that effective models must be tailored to the special needs of professionals and patients in primary care.

Psychiatrists in general practice

Strathdee & Williams (1983) estimated that almost one in five general adult psychiatrists spent some clinical time in general practice, and one reviewer (Mitchell, 1985) commented that "the momentum continues unabated". The move out of hospitals into general practice clinics has been paralleled in clinical psychology (Kincey, 1974), social work (Carney, 1980) and counselling (Irving & Heath, 1985; Hurd & Rowland, 1985).

Strathdee & Williams identified three distinguishable patterns of working styles adopted by psychiatrists (Strathdee, 1987): the 'consultation', the 'shifted outpatient', and the 'liaison attachment' patterns. This classification contains much overlap between categories, and it seems more economical to talk of 'consultation' approaches, in which the burden of treatment is taken by the psychiatrist, and 'liaison' or 'skill-sharing' approaches, where the aim is to keep the majority of treatment with the primary-care workers.

According to Strathdee & Williams' (1983) data, the large majority of psychiatrists still see and treat the patients themselves. There is no element of skill-sharing or improving the general practitioners' skills for dealing with the 95% of psychiatric morbidity for which the general practitioner (GP) is the main treatment provider (Goldberg & Huxley, 1980). The total number of psychiatrists providing any kind of liaison service is small (154, compared with 29 650 GPs in practice in England and Wales in 1982 (Fry *et al*, 1984)), and in all less than 20 are running Balint groups (see below) or working in such a way that the GP is seen as providing the major part of treatment.

The influence of Michael Balint

The history of the liaison between psychotherapists and general practitioners begins with the seminal work of Michael Balint whose book *The Doctor, His Patient and the Illness* (Balint, 1964) revolutionised general practice, and 30 years later remains controversial. At the Tavistock Clinic, Balint ran weekly seminars for groups of GPs, over two or three years. The findings that emerged from these groups can be crudely summarised as follows.

(a) Many presenting complaints were shown to have a psychological basis.
(b) As a consequence, the primary importance of physical diagnosis, with psychological diagnoses being arrived at by exclusion, was challenged.
(c) The potentially potent influence of the doctor's *behaviour* was emphasised; the metaphor Balint used was of the drug 'doctor', which can have both positive and negative effects.

(d) The doctor's "Apostolic function" was clarified. Balint defines this as "the urge to prove to the patient, to the whole world and above all to himself that he is good, kind, knowledgeable and helpful".
(e) The "collusion of anonymity", in which no one doctor was found to be taking responsibility for difficult patients, was revealed and criticised. This had an important influence on the development of thinking about personal care and personal lists in general practice (Pereira Gray, 1979).

These findings are still relevant today, and several of these conclusions are equally relevant for other health-care professionals. Some of Balint's ideas remain highly controversial, however.

Balint saw much of the morbidity presenting to GPs as being of psychological origin, and taught that GPs should aim for a 'deeper' level of diagnosis, understanding the psychodynamic significance of individual symptoms. This led to an emphasis on the key role of psychoanalytical theory, which has been criticised (Sowerby, 1977; Madden, 1979).

The system of training the Balint group developed from this work has been very influential. In such groups, GPs meet weekly for one and a half to two hours, over a period of two or more years. Balint (1964) (p. 303) talks of the considerable change in the doctor's personality that occurs as a result of the group process, and the exploration of the doctor's countertransference with the rest of the group. Perhaps as a consequence of this, the drop-out rate from Balint's early groups was high (60%), although later this decreased to 25–30%.

A key concept in *The Doctor, His Patient and the Illness* is that of 'listening', although this is imprecisely defined, and described in somewhat mystical language:

> "our aim is to help doctors become more sensitive to what is going on, consciously or unconsciously, in the patient's mind when doctor and patient are together. . . . The events we are concerned with are highly subjective and personal, often hardly conscious, or even wholly beyond conscious control; also *as often as not there exists no unequivocal way of describing them in words*." (p. 302, our italics)

It is part of our thesis that these concepts can, to some extent, be defined and that the objectively observed *behaviour* of both GP and patient can be reflected upon and developed to improve 'listening' skills.

Balint actively encouraged GPs to attempt psychotherapy with patients, and provides some guidance in his book. He recognised the large number of patients seen and supported by GPs for whom formal psychiatric referral had little to offer, but he does not describe clear limits to psychotherapeutic endeavour, or offer clear practical guidelines, and what he suggests is probably more than most GPs would wish to attempt. Nevertheless, his suggestion that many patients benefit from at least one "long interview" has become accepted practice.

In recent years there has been considerable critical backlash against Balint's ideas, and much has been written both criticising and defending his approach. The criticism is on four major counts.

(a) It is suggested that Balint trained doctors to focus too much on psychological factors in their patients, replacing caring with psychological curiosity. Zigmond (1978), in a powerful paper entitled "When Balinting is mind rape", uses the verb 'to Balint', meaning compulsively to offer interpretations to patients who have not asked for them.
(b) From a theoretical standpoint, the central importance of psychoanalytic theory to the exclusion of other aetiological models has been questioned (Sowerby, 1977; Madden, 1979).
(c) Allied to this is concern over whether GPs need to have formal training in psychotherapy. Madden (1979) dismisses this outright, feeling that the case for the importance of psychotherapy to the GP is not made.
(d) It is argued that the system of training in Balint groups requires the demonstration of verbal skills at a level of sophistication that many doctors feel they cannot achieve (Sowerby, 1977).

It remains arguable whether those entering general practice training should be required to have good verbal skills, but Sowerby (1977) suggests that those who have found Balint training unacceptable are viewed as somehow deficient. Madden (1979) seems to assume that psychoanalytical psychotherapy is the only possible form of psychotherapy practised by GPs, and in so doing ignores the considerable range of psychotherapeutic skills employed by many workers in primary care. Balint himself was aware of the need to pitch training at a level that would meet the differing needs and demands of participants, and this remains an important issue. Pietroni (1986) defends Balint as a mentor of the holistic medicine movement, and both he and Williamson (1979) argue Balint's fundamental area of concern was the interactive nature of the consultation, paving the way for the sociopsychological approach to consultation (see below).

Liaison between GPs and psychotherapists

Following Balint, the development of more direct liaison with GPs by psychotherapists began in the late 1960s in the UK, with Brook (1978). In the model he describes, the psychotherapist becomes a part-time member of the GP's team; as a result of frequent contact, the team can consider together how best to pool their respective skills, and to support one another on the basis of increased understanding of one another's problems. In the 1970s, Brook established a scheme whereby staff (psychiatrists, social workers or psychologists) of the adult department at the Tavistock Clinic were attached to group practices as 'consultants'. As well as seeing referred patients, they carried out joint interviews with GPs, were available to discuss GPs' patients, and attended a weekly meeting at the Tavistock Clinic, which was attended by a member of each practice team. Brook & Temperley (1976) suggested that this approach enabled patients to obtain help earlier than they would otherwise have done, and that a key factor was helping the primary-care team to change their attitudes to patients. Unfortunately, it is unclear from the illustrative case history Brook & Temperley (1976) give, what part the patient's interview with the consultant might have played. Malan *et al* (1975) suggested that under some circumstances a single assessment interview can promote considerable change in a patient, and in view of this and the lack of more objective evidence, Brook's enthusiasm for the therapeutic effect of a change in GPs' skills is difficult to support.

This model, combining elements of both the consultation and liaison models, is important because it emphasises the holistic approach to understanding patients in general practice, does not have analytic theory as a crucial element, emphasises the training of GPs in new ways, particularly using group methods, and finally models skills at a level that is appropriate to the needs of the GPs involved. All these elements are of central importance to any attempt to improve the psychological skills of GPs. Unfortunately, such experiments have so far been mostly confined to the London area. Brook's model has, however, been influential in the development of a more direct liaison between psychotherapists in specialist settings and GPs.

Wilson & Wilson (1985) have described their experiences of liaison with GPs, and discuss with some candour the difficulties that can arise, especially those related to slow development of communication and consequent misunderstandings. Wilson & Wilson suggest that these occur because GPs and psychotherapists have different expectations, both of each other and of the patients. Their examples compassionately and humorously demonstrate the degree of professional tolerance and understanding that is necessary for the success of any liaison.

In the UK, psychotherapists work to a large extent using the liaison approach, but other therapists using psychological treatments, such as psychiatrists, social workers, counsellors, community psychiatric nurses, and psychologists, work primarily within the consultation model, seeing patients referred to them by the GP. Reported studies of interventions by psychologists have largely described behaviourally oriented treatments rather than dynamic psychotherapy (e.g. Earl & Kincey, 1982; Robson *et al*. 1984), although cognitive therapy has also been offered by some (e.g. Ross & Scott, 1985) and, in one study (Blackburn *et al*, 1981), albeit with methodological problems (Goldberg, 1982; Teasdale *et al*, 1984), has been demonstrated to be a superior treatment to antidepressant medication in general practice. Counsellors have offered a wide range of approaches to treatment, the predominant mode being non-directive psychotherapy (Hurd & Rowland, 1985). There are many organisational difficulties in arranging for counsellors to be paid for their work (Rowland & Irving, 1984), and a number work voluntarily. Some practices have established links with organisations such as the Marriage Guidance Council (Martin & Martin, 1985).

There is a considerable need for more evaluation of the effectiveness of such services (Kamerow & Burns, 1987). Early reports, mostly of uncontrolled studies by counsellors (e.g. Anderson & Hasler, 1979) and psychologists (e.g. Ives, 1979; Koch, 1979; Jannoun *et al*, 1981) were enthusiastic in their reports of decreased frequency of consultation and decreased prescribing of psychotropic medication following intervention. Later, controlled studies are more equivocal: Robson *et al* (1984) and Blakey (1986) both report fewer consultations and reduced prescribing following intervention, but Earl & Kincey (1982) found no significant effect on either. Ashurst's (1982) controlled study of the effects of counselling demonstrated benefits in the withdrawal of patients from minor tranquillisers. Carney (1984) examined the effectiveness of social workers attached to GPs in the management of depressed women, and found no significant differences between subjects and controls, although a group of women with acute exacerbations of chronic depression did show some significant improvement. Ginsberg *et al* (1984) and Marks (1985) both report significant clinical and cost–benefit advantages in the attachment of nurse therapists to primary care. In Mark's study patients treated were primarily those with obsessive–compulsive

and phobic illnesses, who would otherwise have been referred to a hospital out-patient department.

The attachment of dynamically orientated psychotherapists to primary care has received comparatively little attention. In a prospective, controlled trial of brief psychotherapy in a family practice, Brodaty & Andrews (1983) demonstrated no difference in outcome between patients receiving brief problem-orientated dynamic psychotherapy and groups receiving either therapy from their family practitioner or no treatment. In Norway, a problem-orientated brief psychotherapy service, accepting direct referrals in primary care, produced a significant reduction in admissions to mental hospital (Hansen, 1987). This is one of the only studies describing the outcome of pure consultation model psychotherapy intervention in general practice, and the patients chosen (chronic neurotics) are a notoriously difficult group to treat.

Thus any benefit to patients from direct intervention by mental health professionals in general practice is as yet unproven (Mitchell, 1983). Moreover, the effects of providing a consultation service on either the treatment of patients *not* seen by the liaison consultant, or on doctor–patient relationships in general practice consultations, remain to be demonstrated. Both Brook (1979) and Mitchell (1983) claim that GPs can learn new skills as a result of such attachment, and in Strathdee's (1987) survey of GPs' views of consultation attachments, GPs reported an increase in their knowledge of psychiatric disorders and their treatment. Such claims require objective validation, and so far any changes in attitudes, knowledge or skills of GPs who have collaborated in GP attachment schemes have not been formally evaluated. Some psychologists (Spector, 1984; Salmon, 1984) and psychiatrists (Goldberg, 1986) who are sceptical about the effectiveness of such attachment in improving the psychological care of the majority of patients in general practice advocate a broader educational and skill-sharing role for the mental health professional in primary care.

There are unanswered questions about psychotherapy in general practice. What is meant by psychotherapy in general practice? What are the differences, if any, between psychotherapy skills and consultation skills? What is the point of teaching psychotherapy skills to GPs? To approach these difficult questions, it is necessary to review another area of research into the GP consultation.

Detection and treatment of psychological illness in general practice

That GPs have a considerable role in the management of psychiatric illness has become apparent over the last 20 years (Goldberg & Huxley, 1980; Shepherd *et al*, 1981), but despite this increasing awareness, Blacker & Clare (1987) comment in their review that much depressive illness in general practice remains undiagnosed and/or untreated, and the problem remains of how to ensure that this morbidity is treated adequately. The basic psychotherapy skills of empathy, sensitivity to emotional cues, clarification, and ventilation of emotion may well increase the accuracy of detection and change this pattern. Understanding the process of the consultation becomes of great importance. There are considerable methodological difficulties involved in studying general practice consultations (Cartwright *et al*, 1976), which have made progress in this area difficult to achieve. Recent technological advances have made recording consultations on audio- and videotape relatively simple, leading to considerable progress in the study of process and outcome of individual consultations. The first analysis of taped interviews between British GPs and patients was provided by Byrne & Long (1976), who draw the distinction between 'doctor-centred' encounters, in which the doctor has a fixed agenda and interrogates the patient along predetermined lines, and 'patient-centred' encounters, where the doctor accurately clarifies the patient's problems and agenda. We would argue that it is possible to teach GPs the skills involved in the latter style of working.

Analysis of verbal interchanges has varied in complexity, from relatively simple models (Byrne & Long, 1976; Marks *et al*, 1979; Gask *et al*, 1987*a*,b), which consider only the form of the doctor's communication (whether open or closed questions are used, whether the doctor used facilitation, reassurance, etc.), to more complex models, designed to classify all communications from doctor and patient by both form and content. The best such model is Stiles' Verbal Response Modes, which has been widely used in both general practice and psychotherapy research (Stiles, 1979). These moves towards observation and definition of behaviour in consultations may ultimately make it more possible to teach and share such skills.

Researchers employing techniques of consultation analysis have explored several lines of inquiry. Raynes (1980) has examined the decision-making process and has demonstrated that GPs tend to adhere to familiar and trusted, but rigid, routines when embarking on investigation and management. Tuckett *et al* (1985) have shown that the 'framework of knowledge' that patients bring to consultations is rarely explored by doctors, and that doctors rarely know whether their patients have understood what they have told them. A large body of literature,

reviewed by Pendleton (1983), now links studies of doctor–patient communication with outcome criteria, such as patient satisfaction, compliance and health status.

The related problem of why GPs vary so widely in their ability to detect psychological problems has exercised a number of researchers. Marks *et al* (1979) demonstrated the central role of both the interviewing style of the GP and his/her personality. Goldberg *et al* (1980) found a significant relationship between accuracy of assessment and GP behaviour, including the ability to make good eye contact at the beginning of the interview, clarify the present complaint, ask open questions, deal successfully with talkativeness, and demonstrate empathy. Failure to identify psychiatric problems was associated with missing cues, both verbal and non-verbal, reading notes while patients talked, and focusing questions on the past history. Davenport *et al* (1987) suggest that such behaviour by the GP discourages the patient from revealing symptoms of psychological distress, either by the words used or tone of voice.

The need for psychotherapy skills in general practice

The fact that important relationships exist between the behaviour of the doctor and the patient in an interview implies that the possession by the GP of basic psychotherapeutic skills may materially improve detection of problems. Psychotherapy in this context is taken to mean the use of specifically psychological skills to detect and treat patients with psychological problems. Our argument is that these are more than just good interviewing skills, as this term is generally understood.

Goldberg & Huxley (1980) relate GPs' behaviour to their accuracy in detecting psychological illness in consultations. Such behaviour included making eye contact at the outset of the interview, clarifying presenting complaints, asking direct questions about physical complaints, being sensitive to verbal and non-verbal cues, and dealing with overtalkativeness. All such behaviour can be defined and readily modified by training. These behaviours are similar to the skills described by Lesser (1985, see his Table 2) in his Problem-Based Interviewing model. GPs can be trained in this model relatively easily (Gask *et al*, 1987*a*,*b*, 1988) and use of these skills improves both detection of psychological problems (Gask *et al*, 1987*b*) and their management in terms of improved outcome (Gask, in preparation).

Training in psychotherapy skills in general practice

Training GPs in psychotherapy skills thus becomes an important issue. In parallel with the increased recognition of the need for better interview skills training in medical schools (Sanson-Fisher & Maguire, 1980), GP training has moved towards a greater consideration of the psychosocial aspects of the consultation (Freeling & Harris, 1984), and providing more courses on communication skills for trainees (Schofield, 1983). The effectiveness of audio- or videotaped feedback of the doctors' own interviews has been clearly established as the best form of such teaching (Maguire *et al*, 1978). In general practice, peer-group review of audio-taped consultations has been shown to be effective in improving the general interviewing skills of experienced GPs (Verby *et al*, 1979), as well as trainees (Davis *et al*, 1980). Models for such teaching, developed out of research done on the doctor–patient relationship, have been particularly influential in GP teaching. Pendleton *et al* (1984) have developed a method for reviewing tapes, and 'Pendleton's rules' for giving effective feedback (the doctor concerned comments first, the teacher then comments first on strengths, achievements and effective skills, and only later on weaknesses and ways to improve skills) are well known. This model of analysis does not, however, incorporate any method for acquiring or practising new skills during feedback, nor has it been evaluated. Similarly, Tuckett's research (see Tuckett *et al*, 1985), which has led to a model of training that aims to teach doctors to involve their patients to a greater degree in consultations and to improve the educational outcome of the consultation (Boulton *et al*, 1984), has not been evaluated. Perhaps most importantly, none of these models attempts to teach psychotherapy skills as defined earlier. In a review of mental health training in primary care, Burns *et al* (1983) comment that although interview skills training is widely available to trainees, few schemes attempt to teach more specific psychological skills, or formally to evaluate such teaching.

Counselling models have also been influential in GP training, but although most GP trainees are exposed to counselling skills during vocational training schemes (*Journal of the Royal College of General Practitioners*, 1980; Murgatroyd, 1983), the Rogerian non-directive model does not lead to more effective assessment of patients by GPs (Bensing & Sluijs, 1983), and may be more appropriate to the long interview, where a clear counselling agenda is set, than the short interview, where detection and assessment of problems is the prime task.

Training in more formal psychotherapy skills in general practice is available in the UK, and continues to be focused in Balint-group training (Balint, 1979). Many GPs who have a special interest in individual

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psychodynamic psychotherapy have links with specialist psychotherapy units for training and supervision. Special training for those with an interest in family therapy (Neighbour, 1982), marital therapy, sex therapy (Courtney, 1981), and group therapy is also available, on a somewhat patchy basis, throughout the UK. For many GPs, however, these are special interests that demand a great commitment in time and effort, or provide inappropriate training (Cawley, 1977).

Goldberg *et al* (1980) have demonstrated that such skills can be taught to GP trainees using one-to-one video feedback, and recently Gask *et al* (1987*a*,*b*, 1988) have shown that such training is also effective in a group setting with both trainees and more experienced GPs. These studies taught the problem-based model of both assessing and treating psychosocial problems developed by Lesser (1985), which would seem more appropriate to the general practice consultation than the non-directive approach. This model shares some of the features of Egan's (1982) approach, but is more specifically tailored to medical assessment, and includes specific teaching on management as well as detection. It seems probable that such a model, once taught to experienced GPs, could be taught by them to their trainees, thus obviating the need for specialist teachers and permitting such teaching to be disseminated widely beyond hospital-based teaching settings. We are currently evaluating this teaching model. A number of psychologists who liaise with GPs have now broadened their role to incorporate an important skill-sharing component, as this may prove to be a more effective use of manpower in primary care, and help to meet otherwise unmet clinical needs (Weinman & Medlick, 1985; Cormack & Forrest, 1985). In the Manchester area, a special-interest group of psychologists and GPs has been set up to consider training issues and the role of psychologists in helping GPs to deal more effectively with such issues as benzodiazepine dependence (Cormack, personal communication). This kind of approach has been investigated systematically by Catalan *et al* (1984), who showed that teaching GPs simple counselling skills had measurable benefits in reducing the prescription of minor tranquillisers, without any increase in overall consultation time. This work would be more useful if it had included a clear description of the training offered – in fact there is a general need for studies to include such descriptions.

In both psychotherapy and general practice, outcome research has been slow to develop and is fraught with methodological problems (Wilkins, 1984, unpublished; Freeling, 1985). Yet, if liaison between general practice and other specialties is to be properly evaluated, adequate measures of outcome are essential. The relation between psychotherapy and general practice should be broadly based and educative, rather than the narrow liaison–consultation approach which is common at present, and evaluation will also have to be broadly based, assessing both changes in GP behaviour and skill, and changes in patient outcome following changes in GP behaviour. Assessing behaviour requires techniques for analysing consultations, and the work of Gask *et al* (1987, 1988) demonstrates that this is indeed possible, challenging Balint's (1964) view, apparently shared by many researchers, that "there is no unequivocal way of describing [events in the consultation] in words". Effects of intervention on outcome must be described using such measures as symptom relief, compliance, patient satisfaction and overall cost of treatment. The studies of Catalan *et al* (1984) and Gask (in preparation) have demonstrated clear positive effects of psychological intervention in patients with mixed anxiety and depression, a group which typically receives poor treatment in general medical settings. A broader review of the assessment of teaching in liaison settings is provided by Cohen-Cole (1980), who recommends that the efficacy of teaching be measured using adequately controlled studies, and who offers methodological criteria by which such studies can be designed and judged.

Providing a range of options

A study of the relationship between GPs and the specialist psychotherapy services in Manchester may provide an important clue to how the relationship between GPs and psychotherapists could develop (Reilly, 1987). 'Many' GPs wanted more information on the services available, 'some' wanted further training and supervision in order to manage more of their patients, while only one GP expressed a strong interest in having a practising psychotherapist. There is no evidence that this model of liaison is either cost-effective or an effective way of improving the psychotherapeutic skills of GPs in general. Nevertheless, within the limitations of staff availability, some departments may choose to work in this way.

General practitioners who are interested in the management of the majority of psychosocial problems seen in primary care, but do not wish to devote a considerable amount of time to formal psychotherapy training, may well benefit from one of the broader-based approaches aimed at teaching basic skills in psychological assessment and management such as the Problem-Based interviewing model (Lesser, 1985). This includes teaching skills in

individual, family and marital assessment, and straightforward management strategies with a behavioural bias, and emphasises the GPs' need to understand what other services are available, and which patients can be treated using such models and which need to be referred.

Specific themes and packages of skills can often be taught rapidly, and one-day courses in such areas as interview skills training, psychological approaches to management of patients with AIDS, or helping patients with early alcohol dependence recognise their problems and accept treatment, involve psychological strategies that can truly be regarded as psychotherapies (using our broad definition). These do not necessarily need to be taught by specialist psychotherapists, but could be facilitated by interested psychiatrists or other mental health specialists. For those GPs who wish to develop fairly extensive skills in psychotherapy, and can make a commitment to training, the Balint-type group may be appropriate, but ideally this should offer a clear model of the psychotherapy skills to be taught, and use effective teaching skills, such as audio- and videotape feedback in supervision sessions (Maguire *et al*, 1978). An alternative model has been described by Andrews & Brodaty (1980), in which GPs are offered an extended training of some 26 sessions, including behaviour therapies, marital and sexual counselling, and brief psychotherapy with supervision. We acknowledge that such a course cannot aim to make participants into competent therapists and is no substitute for intensive training.

Despite the range of courses and training opportunities available, many GPs do not wish to be exposed to such teaching. Balint recognised this, and his solution was to provide teaching only for those who would attend. This may not be the most desirable attitude to adopt when the aim of dissemination of such skills must be to improve care of psychological problems in the community as a whole. Possibly the only way to achieve this in the long term is to change attitudes. Closer links with mental health professionals in primary care may help in this task, but in the long run it will best be achieved by proving the effectiveness and the benefits to be gained by careful evaluation of teaching programmes, both in terms of the skills transmitted and their relevance to patient outcome.

Conclusion

Psychotherapy in general practice settings is now nearly 40 years old, but in many ways the real needs of GPs have not been addressed. Despite the enthusiasm for consultation approaches in the move to more community-orientated care for psychological disorders in general practice, such approaches are severely limited in the extent to which they can help GPs deal with the wealth of psychosocial morbidity presenting to them. More effective strategies involve broadening the definition of psychotherapy, and recognising that every doctor–patient interaction involves emotional communication and requires skills that are psychotherapeutic. Skill-sharing approaches to disseminating these skills among primary-care workers hold the best chance of effective management reaching the appropriate patients, but to do this, primary-care workers need to be taught such basic skills, and a range of options needs to be available, so that teaching can be geared to individual needs. In the short term, this can be done by interested psychiatrists and psychologists, as well as psychotherapists, but in the long term, the most effective way of disseminating such skills might be to teach trainers and supervisors in primary care, who can then pass them on to increasing numbers of their trainees. In addition, the teaching and the effects on patients of any new skills learned must be carefully evaluated.

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