# OUT-PATIENT PSYCHOTHERAPY UNDER THE NATIONAL HEALTH SERVICE

By

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WITH the coming of the National Health Service, there seemed a real chance of establishing fuller psychotherapy in Out Patients. This is not to imply that psychotherapy was not given before; but in most hospitals it was necessarilly limited except in special cases, and there was a tendency to leave it a good deal to junior staff who had the time and wanted the experience.

Theoretically, at least, now there was nothing which might not be attempted. In fact, there was still a limited, but now defined number of hours and a rising case load. This paper describes one attempt to use these improved conditions. Results and methods of treatment are not claimed to be exceptional in any way, but with the continued introduction of new methods, where of necessity the patient's individuality is less considered, it is salutary to reconsider the results of more personal methods, particularly as it continues sometimes to be said that psychotherapy is basically vague and wasteful of time, and vaguer still in results.

There is little difficulty in assessing practical results as far as the patient's subsequent outward behaviour is concerned, and this is after all what chiefly matters to the patient and people round him. What is much more controversial is to make a satisfactory assessment of deep changes in the personality, as re-examinations of sufficient penetration to be convincing are too lengthy to be accumulated in any number, except as a separate research project. There is a further practical difficulty in the follow-up of patients. A certain number move away, and it is not always the unsuccessful case which for emotional reasons does not want the past re-opened.

Psychotherapy is a subject with many approaches, so that the very moderate allowances of time here discussed may seem quite inadequate to some, and even excessive to others. To the referrer, the recommendation "for psychotherapy" may seem perfectly conclusive, though from that point several courses diverge. The approach here has been basically analytic, as whatever the controversy of the schools, it is difficult to think in coherent terms of psychopathology without it. On the other hand, some uneasiness has been felt in trusting to theory in the face of obscurities; nor can apparently lasting recoveries reached by other means be overlooked. The approach to each new case has been therefore somewhat undogmatic. Further, psychotherapy remains a very individual affair, not only in that therapists may be temperamentally better suited to one or other approach, but also because similar treatments are not necessarily suited to patients with the same general diagnosis. Admittedly this is partly the fault of the simple descriptive nomenclature. Nevertheless the personal factor, which it is so often the aim of the statistical method to exclude, remains part

of the total reaction to be coped with and utilized in the cure—not that the utmost scrutiny of results is any less necessary.

The question of time is almost as important as approach, as it limits the scope of treatment and sets the claims of the many against the more intensive and rewarding investigation of the few. The treatment here is confined within three half days a week, one of which is chiefly taken up with seeing new referrals, which are not necessarily suitable for psychotherapy. The practical time used, therefore, is about seven hours weekly.

The sources of referral are mixed. There are a certain number of cases from colleagues in the department, for deeper psychotherapy, chiefly character disturbances, long term neuroses in tolerable personalities and sexual difficulties and perversions. But by far the larger proportion (78 per cent.) were seen as ordinary referrals for psychiatric opinion, largely from outside the hospital. A point is made of this double origin, as although there is some increase in long term cases, the series largely represents a cross section of psychiatric out patients.

When one comes to consider what psychotherapy can be given in something over two half days a week, it will be seen that if analysis in the full sense were attempted, one might be limited to as little as two or three new cases a year, after the first batch had been taken on. Not all cases referred for psychotherapy are suitable for deep analysis, but sufficient cases are referred to make a very long waiting list at this rate. Full analysis is not therefore practical, and unless it could be concealed within a mass of short treatments as compensation, it is improbable that the N.H.S. would sanction the outlay. It is of course also true that apart from the fairly exacting criteria of personality, not many patients are so placed that they can face the concentrated treatment, which may involve much dislocation of their routine, together with the difficulty of finding or keeping a job which will allow all this.

Evening sessions were not possible in this series. In practice the maximum time was two half hour sessions a week, though longer sessions were occasionally given. If deeper psychotherapy is to be talked of, one cannot go below a certain concentration of treatment, which allows sufficient time for detailed insight to be acquired by the therapist, and either a sufficient insight to be given to the patient in terms of his inner conflicts and the real situation, or at least, for the transference and real situation to be manipulated so that maturation can take place in the patient, rather than just persuasion. Indeed, it is only a proportion of the cases later called "Medium" and "Long" that one could say that analytical treatment of a kind had been approached.

A total of 140 patients seen over 27 months from February, 1949 are reviewed, of which 110 (78 per cent.) were referred from outside the department; 67, nearly half, were taken on for psychotherapy. An indication that the majority were not a specially selected sample for psychotherapy is that the remaining 73 included 16 mainly organic cases, admittedly some within the psychiatric sphere such as Pick's disease, senile dementia, and toxic confusional state, and others with indistinct symptoms often masked by an overlay. One case also of enuresis in a heavy sleeper successfully treated by dextroamphetamine on a purely functional basis, showed inconclusive evidence of being psychogenic.

There were also 9 cases of functional psychosis and 5 of varying degrees of mental defect.

This leaves 42 cases, 33 of neurosis, and 6 of psychopathic personality, including mild addiction, and 3 of minor depressive illness. These were all cases where psychotherapy in Out Patients was not considered indicated or was

refused, except one referred to a colleague for support. Some refusals are bound to occur, and it was thought fair to extend this classification up to the third interview, unless the patient has definitely co-operated.

The disposal of these cases is classified below, and this by exclusion gives some indication of the spread of psychotherapy undertaken. The figures in brackets are for cases which were referred after some psychotherapy.

| | Acute and Subacute Anxiety States | Chronic Anxiety States | Hysteria | Obsessional Neurosis | Psychopathic Personality | Minor Depression |
|---|---|---|---|---|---|---|
| Total for psychotherapy and other disposals .. | 20 | 38 | 22 | 13 | 9 | 7 |
| OTHER DISPOSALS: | | | | | | |
| Refusals .. .. | 2 10% | 6 15% | 5 23% | (1) | | |
| In-patient treatment | 2 (1) | 3 (5) | 1 | (2) | 4 (2) | 1 (1) |
| Long term analysis .. | | 2 (1) | | | | |
| $CO_2$ inhalation .. | 1 (1) | 2 | 1 | | | 1 (1) |
| To G.P. for treatment | 1 | | 1 | | | 1 |
| To G.P. for support only—too chronic | | 1 | 4 18% | | 2 | |
| Group treatment .. | | 1 | | | | |
| Total including bracketed figures .. | 8 40% | 21 54% | 12 55% | 3 23% | 8 89% | 5 |

Although this paper is devoted to psychotherapy, the treatment of the patient must inevitably be considered on a wider basis, and there has been no hesitation in referring cases for other treatments or combining them with psychotherapy, if there seemed an advantage, though this is less suited for delimiting the effectiveness of psychotherapy. Thus three cases which had made fair progress were referred for admission, mainly for the convalescent effect, and are not recorded among the psychotherapy cases, while five others on a safe assessment might have been admitted earlier, if it had not been felt there was some chance of maintaining them out of hospital. The bracketed figures for admission do not then consist completely of failed psychotherapy cases; though here and elsewhere brackets indicate the preferred line of treatment.

The combined treatments where psychotherapy was preponderant, are not included here. This applies to three cases which had $CO_2$, and two treated in a group by the writer as a continuation of their individual treatment.

In the table it is significant that the hysterics have the largest proportion of cases refusing or considered too chronic, whereas a much larger proportion of the chronic anxiety states are suitable for various active treatments.

The figures for the obsessionals cannot be taken as entirely typical, as certainly they were less rigid than the average. It is possible that the effects of small numbers and special referrals have combined here. Their absence from under the heading of "long term analysis" is also partly artefact, as only special circumstances make this treatment available.

Six cases were referred for treatment with 30 per cent. $CO_2$ inhalation in 70 per cent. oxygen, in the hope of abreacting tensions which could not other-

wise be reached. Five other cases had this treatment in conjunction with psychotherapy, one with lasting success, to which it is unlikely that the psychotherapy contributed.

Ten cases were referred back to their doctors, including three for treatment beyond support and drugs.

Barring the obsessionals, the total percentages for other disposals correspond roughly with the difficulties to be encountered, as might be expected, with chronic anxiety and hysteria together high, and psychopathy at the extreme; but it will be seen later that the follow-up on chronic cases is not discouraging.

The diagnostic classification of cases in the table is the common descriptive one, except that Anxiety Hysteria is combined with the Acute and Subacute Anxiety States, as for practical purposes in therapy one merges into the other. It is felt that in a short paper too much elaboration would follow if divisions were also made in terms of psychopathological theory. Nevertheless the classification tends to produce unnatural simplification, and does not distinguish the overt neurotic reaction from the personality disorder, though the latter's chronicity may be indicated by its inclusion among the chronic neuroses. An attempt to bring out the issue of personality more clearly is made in a second table later, but some special kinds of disorder remain submerged. This applies particularly to sexual cases.

In so far as these are classifiable under anxiety neurosis, hysteria and obsessional neurosis, they have a similar prognosis, though they may tend to be monosymptomatic superficially, and factors of personality are more predominant. Their inclusion in the table above boosts the "Refusal" and "Too chronic" rates. Two of the six chronic anxiety states, and two of the five hysterias breaking off treatment were sexual cases, as were the one chronic anxiety state and two of the four hysterias labelled "too chronic". The delay before seeking advice was anything up to sixteen years.

At least an equal number of sexual disturbances occurring as part of a general neurosis, are not complained of in the first instance, and sexual disability is frequently discovered in the other partner, often apparently taken for granted. This opens up possibilities in treatment which are quite beyond the available resources, and only a proportion of these partners were taken on.

Homosexuality, cases of which are now coming up much more frequently, belongs in so far as it is psychogenic, to the deeper personality disorders, and is therefore even more uneasily accommodated in the classification, and this also applies to the other perversions.

## Treatment

The treatment given in this series has been put in three categories:

*Short* (S)—Discussion, reassurance and guidance, fortified by mild medication, i.e. light sedation or stimulation by day and sufficient sedative at night to give sleep, if necessary. The therapist aimed at being a well disposed third party outside the conflict, but willing to listen and advise, and if necessary persuade. Sessions averaging ten minutes every two to four weeks.

*Medium* (M)—Deeper discussion, with more attempt to obtain insight in the patient, and to talk out attitudes and past experiences. Some use of free association; occasionally of abreaction and examination under drugs; occasionally some persuasion. Medication if necessary, as above. Sessions averaging 30 minutes, sometimes more, once a week, but in distinction from the long cases not persisted in regularly.

(M and S)—After a period, usually a third to a half of the whole duration, treatment may be carried on as in a short case.

*Long* (L)—Analytic approach, with free association and some interpretation of transference and resistance. Present situation treated in terms of past patterns and personality. Medication little used, as confusing to the transference, and less necessary due to frequency of visits. Sessions 30 minutes, usually twice weekly. As may be seen, even this frequency would mean that seven long cases would absorb all the time available, for as long as they were being treated.

### Rating of Results

I++ Symptom-free or very much improved, i.e. recovered for practical purposes.

I+ Much improved, but not excluding minor symptoms, not impairing the general effectiveness.

I Improved. Some more serious symptoms present, particularly with stress, but the patient has made definite improvement and copes with his environment.

I? In some cases this doubtful assessment has been added, meaning that there is an improvement, but of uncertain value, or the time has been too short to test the result.

I.S.Q. Unchanged.

Worse.

All these ratings are made on the psychiatrist's assessment of the patient, checked against his largely ascertainable achievement and social behaviour. Investigation has not gone deep enough in most cases to show what kind of change, if any, in psychodynamics has taken place, and a radical change could not be expected in most cases, though one hesitates to make this the monopoly of long term analytic treatment. Something in the nature of analysis would indeed be necessary to demonstrate the changed reactions, and again on follow-up, assisted by a battery of personality tests. Short of this, practical results checked against findings at interview are a reasonable criterion, as far as they go, though the more complex the undertaking, i.e. where longer analytic treatment has been given, the less sensitive and satisfactory the method appears. At least it escapes some of the difficulties of more theoretical judgments.

The follow-up was made at approximately eighteen months and is rated in the same way. Patients were seen if possible, but alternatively they could write replies to questions on the presence or absence of any symptoms, their general health, their reactions to work and people, and make any other comments on their state.

Of the 67 patients treated:

| | |
|---|---|
| 42 were interviewed | 62 per cent. |
| 12 replied by letter only | 18 per cent. |
| | — |
| | 80 per cent. |

13 did not reply.

Of these at least

7 had moved away.

As has been said, apart from the failure to reach the patient it is not always certain that no reply is unfavourable. Also, though a relapse is accepted at face value, they are not all of bad import. There was one case who only relapsed under extreme strain and made a fair recovery, and another, followed up over three years, whose relapse was temporary and followed by solid progress.

RESULTS OF PSYCHOTHERAPY

*Anxiety States* (*Acute and Subacute*—including Anxiety Hysteria)—12 cases:

| | On Discharge | On Follow-up after 18 months |
|---|---|---|
| Very much improved .. | 6 | 4 |
| Much improved .. .. | 4 | 4 |
| Improved .. .. .. | 2 | 3 |
| | | 1 did not reply |

That is all were discharged improved, 83 per cent. much improved or better. On the follow-up all replying remained improved, 73 per cent. much improved.

There were no Long treatments:

Average time for Medium treatments $3\frac{3}{4}$ hours over 6 months.
Average time for Short treatments $1\frac{1}{2}$ hours over 4 months.

*Hysteria*—10 cases:

| | On Discharge | On Follow-up after 18 months |
|---|---|---|
| Very much improved .. | 2 | 1 |
| Much improved .. .. | 2 | 3 |
| Improved .. .. .. | 3 | 2 |
| Doubtfully improved (involutional) .. .. | 2 | – |
| | | 1 relapsed after 15 months improvement. |
| Treatment broken off early | 1 | |
| | | 1 did not reply. |

That is 70 per cent. were discharged improved, 40 per cent. much improved or better.

On follow-up 40 per cent. were still much improved or better, though with some slight falling off.

No Long treatments:

Average time for Medium treatments $3\frac{1}{2}$ hours over 7 months.

This average time is lessened by the inclusion of four M and S cases.

Time for Short treatment 1 hour over 6 weeks.

*Obsessional Neurosis*—10 cases:

| | On Discharge | On Follow-up after 18 months |
|---|---|---|
| Very much improved .. | 2 | 1 |
| Much improved .. .. | 2 | 1 |
| Improved .. .. .. | 4 | 3 |
| I.S.Q. .. .. .. | 1 | 1 |
| Improved? .. .. | 1 (returned to medical treatment) | |
| | | 2 cases gone away including one I++ |
| | | 1 case no reply. |

That is 80 per cent. were discharged improved, 40 per cent. much improved or better.

The small numbers and the proportion of no replies lessens the value of the follow-up. If the untraced I++ case had maintained his progress the percentages would have been about the same.

| | |
|---|---|
| Average time for Long treatments | 48 hours over 16 months. |
| Average time for Medium treatments | 7½ hours over 8 months. |
| Average time for Short treatments | 4½ hours over 15 months. |

One of the follow-up results included a temporary moderate relapse. This case improved with four more sessions two years after discharge, and a year later, i.e. three years after discharge, he is very well. He showed some depressive features, but largely reactive to the neurotic pattern. The previous progress he had made appeared to make it much more easy for him to cope on the second occasion.

The case rated I? was one of ulcerative colitis, and will be mentioned later. The improvement, such as it was, was independently assessed, but is hardly significant in this illness.

*Chronic Anxiety Neurosis*—17 cases:

| | On Discharge | On Follow-up after 18 months |
|---|---|---|
| Very much improved .. | – | 2 |
| Much improved .. .. | 6 | – |
| Improved .. .. .. | 8 | 5 |
| Doubtful progress .. .. | 1 | 1 |
| I.S.Q. .. .. .. | 2 | 2 |
| | | 4 gone away. |
| | | 2 others did not reply. |
| | | 1 broke off treatment. |

This table reads deceptively, as of the 6 I+ cases 2 improved to I++ and the other 4 had gone away, which unfortunately decreases the value of the follow-up.

That is 82 per cent. were discharged improved, 35 per cent. much improved.

On follow-up, of those that replied 70 per cent. remained improved, 20 per cent. very much improved.

| | |
|---|---|
| Average time for Long treatments | 24 hours over 12 months. |
| Average time for Medium treatments | 6 hours over 15 months. |
| Average time for Short treatments | 2 hours over 9 months. |

To sum up, apart from the six cases which had Long treatment, the large majority, 89 per cent. are divided between Medium and Short treatments, with a natural tendency for some increase in length in the resistant cases. The Medium treatments, which were slightly over half, varied between 3½ hours in the acute anxiety states and hysteria, to 6 and 7½ hours in the chronic anxiety states and obsessionals, and the Short treatments from 1½ hours in the acute anxiety states (1 hour in one case of hysteria) to 4½ hours with the obsessionals. Though a virtue is not made of shortness, these figures cannot be far different in psychiatric time from those for physical treatments of neurosis and group treatment, and possibly shorter in some cases.

Figures may vary with the sample and the way cases are selected and rejected for treatment. As has been said, this series is an average teaching hospital referral, somewhat weighted with cases for more extended psychotherapy; and there are various alternative disposals to psychotherapy. The

percentage of cases accepted is as follows: Of the 80 available cases of neurosis, 49 (61 per cent.) received out-patient psychotherapy only, as the treatment of choice. Another 15 cases (19 per cent.) were started on psychotherapy, but were later referred for other forms of treatment. If one includes the psychopaths and minor depressions, the percentage receiving psychotherapy alone sinks to 54 per cent.

Of the 49 neurotics of all types, whose therapy was carried through, 41 were discharged improved, 24 much improved or better. If then these figures are applied to the original 80 neurotics, slightly over half would appear amenable to treatment by out-patient psychotherapy.

## Therapeutic Approach

The discussion of the approach of one therapist cannot claim to be comprehensive, and concerns here more matters of aim than technique. In undertaking shortened treatment, which shall still be reasonably full, there is a more pressing need to balance the claims of reality against the psychic drives which may be uncovered, and also to bear in mind how the patient may react to this stringency. Short cuts in themselves may increase complexity by mixing the psychic levels under examination.

The shortened analytic approach was rather on the lines of Alexander, French *et al.* of Chicago, in which methods were evolved to avoid the worst of the negative transference, by leaving that burden to rest as far as possible on the outside situation. Selective support was given to the patient depending on his previous traumata, and the more positive transference was used to help the patient to cope realistically and tolerate greater insight. But this struggle for insight could be to a certain extent by-passed by identifying and removing special emotional obstacles to it, often covered in their turn by much defensive rationalization. Indeed it was becoming apparent in many cases that some strengthening of the ego was essential before increased insight became tolerable, so that insight more or less set the conscious seal on an advance already achieved.

It may be argued that it is only a step further, but to the writer's mind a step into a different kind of treatment, for interpretation to be made to a preconceived pattern, which deals high-handedly with the data, and then uses persuasion to impose the interpretation on the patient. If this happens, then we are back in suggestion under a new guise. But there is a difference between giving the ego the kind of support, based on analytic assessment, which will allow it to begin to test reality for itself in its own style, and the continued force of wholesale indoctrination, which dictates a new pattern of reaction, while actually reinforcing passivity. In practice there must be an infinite number of grades between the two positions, but clarity is obscured by the varying psychiatric disciplines, and by the suspicion that an enthusiast could believe himself to be doing one thing, while he is doing another. This is not to say that the second method is not a perfectly valid approach, suitable to certain cases, provided one admits the mechanisms involved and their limitations. One might see the contrast here as one more example of the general as opposed to the localized approach. It cannot be disputed that certain specific physical and physiological dysfunctions, and perhaps in a less dramatic way certain localized psychological stresses, may exert a critical influence on the behaviour of the whole organism; but the very success of specific treatments may obscure the contrasting fact that each individual modifies and makes use of these common

reactions in his own way. This may be of little or of extreme importance in understanding a case, as well as in validating a new test or treatment.

Most of the treatment labelled "Medium" and "Long" was orientated towards the shortened analysis, with in one long case a swing towards the classical Freudian method, and in some others more than a trace of persuasion. But reviewing the Medium cases, one sees that theory often gave way to practice, and in rather over half the actual treatment did not differ much from the method of Adolph Meyer, with some interpretation of a practical Adlerian kind.

The interplay between the real situation and the internal subjective one cannot be assessed on any rule of thumb. One cannot afford to overlook the cases where, in spite of psychopathology, circumstances are largely decisive, or to assume that an apparently dramatic psychic precipitation is as neat and sudden as it seems. The same caution attaches to approaches from the sociological as opposed to the individual standpoint. The conception of neurosis as a disease of society opened up aspects currently neglected, and it is demonstrable that patterns of unfavourable behaviour accompany bad conditions. Therefore prophylaxis, the favourable alteration of these conditions, remains one of the major hopes of psychiatry. Nevertheless, removing bad conditions, particularly of a material kind, which are easiest to alter, will not inevitably produce a maturation of attitude, nor does the alteration of behaviour due to propaganda necessarily indicate an adult assumption of responsibility. What is still at stake is the responsible acceptance of the change in attitude, morale and understanding.

The examination of group behaviour has led to important new approaches to treatment; but it is an over-simplification to see all maladjustment as social illness, unless one extends the social concept to pre-social levels, i.e. primitive levels of the psyche, where the "objects" are not even fully personal. As with a young child, much testing out and weaning may be necessary before a sick individual can cope with the social situation. Here the group may provide one version of a therapeutic community, which is an extension beyond what the therapist alone can supply. It is sometimes overlooked that in spite of the necessity to form relations, the normal person may also need solitude, or may have to learn to face himself. The individual subjective life still carries a spark which enlivens mass human activities, and underlies convictions and innovations which penetrate society. The individual and the social life are of course complementary, and it is unrealistic to think exclusively in terms of one or the other.

The psychotherapeutic approach in out-patients must depend partly on practical considerations, and this largely individually treated series is presented without any implication that social factors, or the whole battery of group techniques, are dismissed, though in an age of rationalization one might fairly expect some of this pressure to reach psychiatry. In the writer's opinion there is much to recommend individual treatment followed by group treatment, though this is less favourable to research, due to the difficulty of distinguishing the effects of either approach, and the change in the transference situation may be resisted. Two patients of this series had such treatment. The rest were treated individually, with such social help as seemed advisable from the Almoner, though this applied chiefly to "Short" cases.

Saving of time was originally one of the factors encouraging treatment in groups. In spite of the first relief at taking on say, eight new patients in a bunch, a saving is not necessarily made as the group continues in being, and comparison is instructive with the actual time taken here in individual treatments—which however have not overlooked non-medical social clubs.

Apart from strictly interpersonal difficulties, there is often a need to reconcile the patient to the rigidity of modern organization. Modern groupings tend to be large and impersonal, and may precipitate reactions of indifference, suspicion and feelings of impotence. Organizations started to counter these difficulties may themselves ossify, and again produce similar reactions under different guises. The urges which brutalize life in a bare struggle for existence, can still produce destructive tensions under more controlled conditions, with their unavoidable regimentation, barriers to ambition, and emphasis on status, unless there is some understanding of deeper issues and a feeling of common aim; and the neurotic seeing all this in the light of his own internal difficulties tends to be especially vulnerable. Therapy can hardly alter circumstances of this kind, but it can help to short-circuit useless defiance or defeatism. Much of what is called illness of society might be said to resolve itself into problems of distribution, not only of goods and conditions, but of activities, i.e. finding people an adequate share in contribution. But what is fair or reasonable can never be agreed, unless there is some unity on values and aims. All this may seem far from clinical psychiatry, but the therapist is constantly facing this problem, as it is not only a philosophical and political problem but a matter of psychological balance and maturity, and a patient must be helped towards a practical aim and a morale. The background is the constant antithesis between the subjective individual and the mass, be it human or mechanical, with its inexorable momentum.

To return to methods, the attempt to find a way back to shorter treatment, while still preserving analytic insight, brings complexities which might seem of the therapist's own choosing. It must be admitted that there are cases where the therapist, largely by exploiting the positive transference, eases the crisis, and a satisfactory adjustment follows; and such a simple approach was normal in pre-analytic days, though some of its success might have depended on an unconsciousness of the forces involved. In fact no therapist can work for long without some anxiety over deep and apparently destructive transferences, or wondering how far he dare go in supporting a patient, who obviously needs support, but once started seems insatiable. In the face of the secure impersonalness of physical methods and the uncommitted position of the strict analyst, how far dare he go? Admittedly there is a difference between active identification with a patient, which is usually unwise, and more objective sympathy and support; but correctness of theory cannot always satisfy human need.

Short treatments usually entail persuasion of one kind or another, but there is hardly time or opportunity for an intense transference to develop. The difficulty comes with severe cases, needing more prolonged treatment, who, one feels would never start to move, unless they received active support. A rather similar situation is found in attempts to treat psychotics by psychotherapy. The therapist seeks to become a bridge for them to re-establish a hold on reality, and this may depend rather on the patience and insight with which contact is made, and the acceptance of whatever is given, than on any more directly interpretative technique. Accepting the patient's neurosis is not only a tactical move to encourage his own tolerance and to cut down masochistic gains, but also a recognition of the genuine potential diverted there, and of the universality of the problems exposed. It stands to reason that a patient who has entered a regression, has only done so under pressures, with which he could not cope, and therefore anyone who gives support and then tries to link it with reality, may reactivate the original stress, plus the disturbed reactions of that time and their later developments, including primitive dependence and aggression.

Such cases may become tests of endurance, whatever approach is used, as well as tests of our knowledge, and rigidity of technique is no talisman. The giver of support must constantly ask himself what is happening at deeper levels, as well as at the surface. In deep treatment, active support by the therapist may be suited to the patient's maturity, but it risks implying that reality is still bribeable, and the necessary crisis may thus be sidetracked or finally faced with more bitterness and recrimination. Yet in certain cases this could be the better alternative. Deep treatment must imply a certain robustness of the psyche, and the need for support opens a doubt on the patient's fitness.

## Consideration of Results

Though there were treatments under the same diagnosis of varying length and intensity, it was not felt justifiable to regard them as alternative methods for comparison, except in the way of broad discussion. There are indeed cases which may be better left with as little treatment as possible; but in general there is barely time to give each patient a chance to work through his case sufficiently, and therefore in spite of diagnosis, differences in treatment imply differences in the total situation. Short treatment is confined to those whose trouble is superficial enough, or whose personality is too rigid, or whose symptoms too chronic, to be suited by deeper treatment. As between Long and Medium treatment, the choice is again of the minimum applicable. Given a potentially adjustable personality with valuable qualities, but with an ingrained, long-elaborated disorder, can treatment have any coherence psychologically without time to explore the origins, and for the therapist and patient to work through and through recurring versions of the traumatic situation? Even so, circumstances are often paramount. Of the six Long cases, five were men. This may be chance, but a neurotic with sufficient intelligence and capacity to face a long treatment, and with sufficient standing in his or her job to be allowed latitude for regular attendances, is more often a man. There are some cases it is only right to refer elsewhere for long term analysis; but the wait may be of years, or the list may be completely closed. In these circumstances one can offer support or take them on experimentally, but this usually is not adequate treatment.

It has been noted that the simpler classification makes no distinction in the setting in which symptoms occur. There is of course bound to be every kind of variation, but from the point of view of aetiology, prognosis and treatment, it is important to define whether the state is mainly a reaction to a problem of the present, or secondary to long standing personality difficulties, when it is largely a question of time before sufficient stresses accumulate. The emphasis is on "mainly", because it is difficult to conceive of a case where past personality does not to some extent determine present reactions and even experiences.

In the table below, the classification has been subdivided according to the apparent degree of personality involvement.

P+ Large personality involvement.
P± Significant personality involvement.
P− Reactive factor more prominent.

This assessment is bound to be a generalization and is favourably influenced by such compensations as drive and ability, which may yet give a neurotic considerable power of manœuvre. Such qualities, as well as negative ones, may be indirectly reflected in length of treatment.

In chronic cases the personality assessment is hardly adequate, as while nearly all cases come under the P+ designation, there are great variations in the amount of overlay and protective elaboration, and the degree to which the system appears penetrable and potentially reversible, not that the "irreversible" case is necessarily inaccessible to support. These cases have been classified:

R+ Reversible.
R± Partly reversible.
R− Irreversible for practical purposes.

It must be admitted that this assessment depends on the same investigation as the treatment, and therefore cannot stand as an independent finding, and this also applies in a lesser degree to the P assessment.

It will be seen that the acute and subacute anxiety states are favourable conditions to treat, and that the longer treatments have been reserved for cases with less personality weighting. The Short treatments were divided between the acute episodes in predisposed personalities, and the more superficial states.

The giving of longer treatment to hysterics might be questioned. These cases were largely personality disorders, but not of the grossly chronic kind, and appeared capable of some insight. The tendency of many hysterics, with their easy transference, to appear to respond quickly to treatment is notorious, and it was felt that if any impression was to be made, treatment must be in some concentration.

The same distribution of treatment is apparent among the obsessionals, whose tenacity to their pattern is even more ingrained.

With the chronic anxiety states, concentration of treatment has depended more on the apparent "reversibility" and general endowment. As might be expected, the R+ group is the one with better results. Reversibility is likely to go with lesser personality weighting, so that the favourable tendency here, would correspond with the better results in the P± groups among the hysterics and obsessionals.

As a whole there is very little falling off on follow-up from the results obtained on discharge, except in the acuter anxiety states. Here, without trying to explain anything away, it must be remembered that we are dealing largely with higher ratings, where 1+ is still a satisfactory condition, so that variations between 1++ and 1+ may not be very significant, particularly as many people prone to anxiety show a rather quick reaction, which may contain constitutional factors. Another consideration is that in these states Medium treatment at least was continued considerably less long than in the obsessional and chronic anxiety states. Nevertheless, maintenance of improvement, or further progress on follow up, were only rated where there was solid evidence. In fact a change of attitude can start a cumulative process. In the more chronic states the end results are, of course, less successful, but it is remarkable that no case of regression on follow up was recorded among the chronic anxiety states, and only one among the obsessionals, which suggests that psychotherapy of the chronic states, admittedly selected, is worthwhile.

As has been said, the groups receiving the longer and Short treatments are not fully comparable. In the acute anxiety states there is on paper a greater tendency for the Short cases to regress, though this may be partly accounted for by the kind of case selected. Among the obsessionals and chronic anxiety states, maintenance of maximum rating or further improvement only occurs with cases which received longer treatment, though this is only in three cases. In the one obsessional, the writer accepts the result as an effect of treatment,

which was followed up for three years, though as has been noted there was a relapse, and there were certain depressive features. In the chronic anxiety states the two cases were mainly of sexual maladjustment. Both received Medium treatment, but one was fitted with a Loewenstein's splint, which had a marked effect in the resolving of his impotence. These sexual cases very easily accumulate secondary anxiety because of their partner and prevalent attitudes, and there is a correspondingly greater release, if success is attained. There was also one other case, registering a technical improvement at follow up; but it was never felt that his improvement was fully explicable in terms of therapy, and though he showed more tension than depression, it is conceded that he might have been classifiable as an atypical depression. He was followed up for a further two years, by which time he had gone back to about his original level on discharge. The risk of results being unduly boosted by recoveries of disguised depressions has been borne in mind and this case was the only doubtful one. The progress of the three cases was however solid, and may well indicate a trend, similar to the less positive one among the acute anxiety states. Indeed more intensive treatment should give more chance of lasting results; but it is not considered that a conclusion can be drawn from small numbers such as these, complicated by differing severity, involvement and endowment, which in the same case may or may not counterbalance.

## Long Cases

Of the series, six cases were given Long treatment, two chronic anxieties and four obsessionals; one of these, a case of ulcerative colitis, was taken on experimentally in view of the apparent connection between the physical state and the onset of much increased obsessional difficulties. As with all cases, a process of elimination also decided the choice of Long treatment: in view of the difficulty and the positive potential of the case, it did not seem reasonable to attempt less. The material question is whether in spite of the difficulties, results justify the time, however short this is in analytical terms, and whether looking back, it is felt that all the treatment was necessary in each case. It is somewhat difficult to be objective about a patient known in so much greater detail. One is more conscious of a journey travelled, but equally of further tracts in view, and with this horizon the immediate result seems a less convincing assessment.

Nevertheless on stability and achievement the results read:

| | | On Discharge | On Follow-up |
|---|---|---|---|
| Chronic Anxiety Neurosis | 1 | I++ | Gone away |
| with group therapy | 2 | I | I |
| Obsessional Neurosis | 3 | I | I |
| with group therapy | 4 | I++ | I++ |
| | 5 | I+ | I+ |
| | | but with writer's cramp unchanged | |
| | 6 | I? | Returned to medical treatment |

There is no doubt that the results in Case 1 were most satisfactory. The patient married and moved away, incidentally from his parents, to take up a responsible job, and was then lost sight of. It is difficult to see how his background and his many capabilities could have been dealt with in a much shorter time. Case 2 was older and more set, for a long time discouraged, and with less drive. He was one of the two Long cases receiving also group treatment. Know-

ledge of his rigidity has caused him to be graded low, though superficially he retained advances he had made, with a definite lowering of anxiety. His was one of the shorter treatments, partly because of the group, and in the light of the results it seems he might have done as well on Medium treatment, followed by group treatment, though he had marked dependent needs, and it was hoped to achieve more.

Of the obsessionals, Case 3 was young and gifted but clearly rigid. Cases 4 and 5 were less strongly obsessional, and compared with 3 had shorter treatment, Case 4 also having treatment in a group. In the writer's opinion the rigidity of Case 3 justified the approach—the treatment could not be full enough. Case 4 showed an increase of insight and capacity, which allowed him to ride a set-back and then make further progress. Case 5 gave up an attitude of depressive indecision and adapted himself to a completely new job, which he made for himself, and at the same time reached a much improved relation with his wife, which had been poor for years. It is on this ground that he was rather doubtfully rated I+, in spite of a writer's cramp which remained largely uninfluenced. It is not felt that treatment could have been reduced in either of these cases without worse results.

The experimental case fell down on a dilemma. It is usually agreed that psychotherapy of an ulcerative colitis cannot be pressed deep because of the weakness of the ego. In this case it was equally difficult to see how the specific ideas of guilt could be influenced without a good deal of probing in the present and past, and it was finally decided that if support were the only course over a long period, she might get this as well from medical treatment which she was having anyway and believed in, whereas she resisted any attempt to change her ideas. As has been said, it was independently noticed that there was an improvement in her attitude, and this had coincided with an improved physical state; but the case was a comparatively mild one, in which a temporary remission would not be unusual. Time could have been saved here, if she had not been considered a research case.

The time given varied from 50 hours over 2 years in Case 3, to 16 hours over 14 months in Case 4, only 8½ of which were individual treatment. Case 2 attended the group for rather shorter, the time being calculated by dividing the total hours by the average number of patients attending.

There is one factor which is important, even if the patient is not directly benefited. A therapist can hardly be expected to keep his senses alert in the middle of continual pressure to save time, unless sometimes he can extend his approach, with fuller investigation and experiment. There should be facilities for enlargement of special experience, as well as contacts outside, to preserve a sense of proportion, and in this conferences are valuable.

These long cases hardly suggest some of the dangers and complications of deep treatment of doubtfully suitable cases under out-patient conditions. In distinction to the six cases described above, five of the six cases which occasioned most uncertainty and difficulty from the time of this paper to the present and were tested for long term treatment, were young women. The case of ulcerative colitis might well also have come into this category if psychotherapy had been pressed.

The only two such cases in the series were referred for in-patient treatment, in one case for long term analysis, in the other, after various physical treatments, for leucotomy, both with poor results. Four outside the series were taken on for out-patient psychotherapy, though two were later tried on physical treatments, largely without success.

These cases were deceptive in first appearances. They were all well below middle age, of reasonable personality, and without severely neurotic past histories, though there had been unfavourable circumstances. They usually presented as tension states with varying hysterical and obsessional features; but they were particularly intolerant of stress, especially the risk of loss of love or security. They were capable of depressive swings of quasi-psychotic intensity, which nevertheless remained influenceable by support. In many ways they could have been called hysterics, but they had a capacity for acute regression, and their symptoms were really polymorphous. In contrast to some other groups, all six showed marked sexual frustration with guilt, and the power of the instinct appeared to act as a catalyst in the regressive process. The transference took on the dependent, demanding ambivalence mentioned earlier, and the frequent oedipal material appeared to screen oral components, which were also apparent elsewhere.

It is of course getting the treatment little further to note that such cases cannot easily be fitted into the crowded out-patient programme. Equally, their apparent potential and capacity for insight made one doubtful of referring them at first for in-patient or physical treatment.

Clearly, before any deep psychotherapy is to be considered, the patient's capacity for rebound has to be assessed, and as has been said a need for support raises the question of the ego's capacity to stand deep analysis. Also the possibility of a developing psychosis must be borne in mind. But there are cases where a psychotic change is latent, and may occur only during treatment. This happened in two of these cases, one while having psychotherapy and one during physical treatment, and it is fair to add that both of these cases had previously seen three or more psychiatrists, without such a condition being suspected. The shift may be pre-ordained, but the method of treatment, analytical or physical, must be re-examined, and this is even more so, if in psychotherapy lack of time and of the availability of the therapist have altered the line of treatment.

These cases are often such that no line of treatment offers an easy prognosis. Therapeutic risks are justifiable but as far as possible should be assessed beforehand. The success of treatments such as leucotomy, in states where a certain penalty is willingly accepted, should not hustle the therapist out of a line of exploration, where with success the penalty might be considerably less. On the other hand, cases could be quoted, where the decision to give up was made years too late. If after full consideration, deep reactive factors still seem more important than endogenous ones, and the patient's contact is still satisfactory, it would seem the reasonable course to try to ensure a permissive environment, in or out of hospital, and to continue the analysis, allowing him to work through the transference. This must take time. Mere admission to hospital does not imply fuller treatment, and in any case it is better continued by the original therapist. Only some young women with a too hostile maternal figure would do better with a woman therapist; but this applies equally from the beginning of treatment.

The point is that the therapist should not be forced to try to work through the dependent demanding stage in at most three half-hour sessions a week, which, however "practical", is likely to heighten the feelings of deprivation. The alternative is for the therapist to be available in emergency for daily sessions, which may be prolonged, and may have to be continued for some months, until it is clear whether the crisis can be worked through. This is asking much, but it is less realistic to start shortened analysis of a difficult case, unless

a much fuller version is available in emergency. Cases of this kind are still pressing material for research, if facilities can be made adequate.


## Summary

1. Out-patient psychotherapy under the National Health Service is considered, with special regard to the difficulty of fitting it to the large demand, yet preserving the individuality of the patient.

2. One hundred and forty consecutive cases are reviewed, 80 of whom were available for treatment. Forty-nine (62 per cent.) received psychotherapy alone.

3. The results of psychotherapy on discharge and follow-up after an average interval of 18 months are examined. The figures varied from 83 per cent. much improved or better for the acuter anxiety states, to 33 per cent. much improved in the chronic anxiety states. Of the 49 cases only 7 were not rated "improved".

4. Eighty-nine per cent. of these cases received Medium or Short treatments, which compare in psychiatric time with physical treatments of neurosis, and group therapy.

5. The fact that long term analysis under the National Health Service is not available means the practical abandonment of some cases, and in spite of the small number of long treatments undertaken, the time available may be insufficient. This is particularly so in some emergencies which are not met by ordinary admission to hospital.