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Research papers

An introduction to psychotherapeutic perspectives in primary care: a qualitative and subjective observation on underlying clinical trends in common mental health problems

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ABSTRACT

This paper considers some of the interesting and developing clinical trends beginning to appear since psychological therapists (practice therapists) have been introduced into primary care settings to meet the standards outlined in the National Service Framework.

Since the advent of the Common Mental Health Problem Service in Leicestershire around two years ago, practitioners have noted increasingly high referral rates and significant emotional need in people presenting with what is currently being referred to as 'common mental health problems'.

Examination of the nature of some forms of common mental health problems is provided, noting a clinical population that requires specific attention at this time, and recognising implications, both in terms of the sophistication and diversity of presentation, and indeed the therapeutic expertise required to provide adequate treatment.

In describing some of the clinical features emerging, a greater understanding of this population can be drawn. The nature of working and providing this kind of service is outlined, and three case samples highlight some of the underlying dimensions to clinical states, as well noting how psychotherapeutically informed thinking is applied to assist clinical progress.

The paper addresses key aspects of the patient's and therapist's unique clinical encounter more specifically than the implementation and configuration of the Common Mental Health Problem Service in Leicestershire (which will be reported elsewhere); however some brief descriptions are offered to assist in providing a context to the reader.

Keywords: common mental health problems, primary care, psychotherapeutic

Common mental health problems in primary care settings and psychological services

It has been noted that demand for psychological therapies will continue to outstrip supply, however the reconfigurations of mental health service delivery by providing much needed skilled input at the 'point of access', i.e. in primary care, is now beginning to address this.[1,2] In Leicestershire, within the initial two-year period, over 7000 referrals were made and there has been significant impact on reducing referrals to secondary services.[2]

The Common Mental Health Problem Service is a 'managed' psychological, mental health service. It was developed in 2001 following National Service Framework (NSF) recommendations for Standards 2,

which aims to 'provide people with a common mental health problem, access to effective treatments … in non-stigmatised environments'.[4] In Leicestershire, the majority of primary care trusts (PCTs) are now purchasing the service, which is hosted by the Mental Health Trust. The service adheres to many of the aims presented in most recent Department of Health (DoH) guidance: *Organising and Delivering Psychological Therapies*, 2004,[5] and a further article will follow mapping these features more extensively.

In brief, there are now over 30 clinicians recruited to the Common Mental Health Problem Service from a variety of mental health professional backgrounds, including social work, occupational therapy and mental health nursing, and where staff have undergone more than five years' clinical practice and training in key psychological approaches (cognitive-behavioural therapy (CBT), psychodynamic, CAT, IPT and other contemporary methods). Further details about the structure, development and activity of the service can be found in a recent report from the Sainsbury Centre for Mental Health.[3]

Underlying psychological features in primary care

The clinical team has been particularly interested in noting some of the early impressions, from a psychotherapeutic position, as substantial clinical work has been developing within primary care across the variety of city and county general practitioner (GP) surgeries; both small and large.

A number of key features in relation to clinical delivery and the wide range of presenting complaints in primary care settings have already been stated. Wiener and Sher describe how the psychological therapist needs a broad range of skills and approaches, highlighting the need to be a 'generalist specialist', in order to manage the broad diversity of presenting personalities and clinical need.[6] Furthermore Wiener notes the texture of the primary care field, describing the setting as comparable to that of an Arab 'souk' or market place, where everything is on offer and equally in demand.[7] Within the field of psychological therapies, counselling and primary care mental health work, similar experiences occur.

The freedom to use an accessible 'in-house' therapist provides a helpful model in managing mental health difficulties, not least offering a responsive service to GPs and the primary health care team. This answers many of the questions raised by GPs and commissioners over the last ten years, since mental health services were directed to focus all their resources on the serious enduring mental illness. It also answers many issues raised by commissioners and organisers more recently, in delivering a coherent and comprehensive mental health system to a broader population presenting with common mental health problems.[5,8]

As a result of the vast range of personal issues housed under the umbrella of 'common mental health problems', we have noticed that patients use assessments and follow-up sessions in many different ways.

Some patients seek consultation over a single issue that is bothering them now, knowing they can return if there are further problems. Some sessions may be used to apply a direct psychological intervention such as teaching, other cognitive education or debriefing following a particularly distressing time. Alternatively, a therapeutic contract may be more protracted over greater intervals, offered primarily as support or as an important opportunity for further assessment.

This paper proposes that psychotherapeutic interventions can often be seen as processes of relationship building, as well as offering remedial and facilitative opportunities. As such, skilled and experienced practitioners can usually manage both brief and medium-term interventions across a range of referrals.

In referring to psychotherapeutic interventions, this is a significantly broad area to break down. There is of course, fervent debate in attempting to understand the qualities necessary for successful therapeutic approaches. A number of key activities can be highlighted here, however it should be noted that their practical application will naturally vary across practitioners trained within differing psychological disciplines. I am providing Frank's brief summary below.[9]

Psychotherapies:

- provide reasonable meanings and descriptions regarding my problems
- help to explore traumas or conflicts
- encourage hopefulness
- prompt success experiences (within and outside the session)
- provide a close confiding relationship.

In the subsequent case discussions, reference to developmental psychology and psychodynamics provides a conceptual background which guides both therapeutic attitude and highlights therapeutic need within the patient.

The experience of the clinician in first level assessments is seen as significant in many ways, not

least in order to contain and manage some of the psychological features which will be described here, but also to provide skilful functions such as the 'gateway' function.[10] Furthermore, a skilled assessment and access to supplementary personnel such as the primary healthcare team and the graduate mental health worker, means that the approach of 'stepped' or 'tiered care' can also be adopted.[11] Indeed it is seen as an implicit aim with the service, and by therapists who are mindful of the case of Mrs A highlighted by the DoH;[5] skilled clinicians at this stage are crucial.

Accessibility and direct clinical pathways

Referral and care pathways are as follows: a patient has been visiting the doctor over the past three months, possibly with three or four consultations, often with a diagnosis of depression. The GP may have identified some of the psychosocial factors – that the patient is having difficulty coping with a fairly recent event, has endured a period of difficult life events or is seeking clarification about the mental health component of the condition and how best to proceed.

The GP discusses the option of using a practice-based therapist with the patient, invites the patient to think about the offer and then to make their own booking with the therapist, when they are ready. (This is seen as a significant process in providing the patient with choice without coercion, and to underpin the notion of patient motivation towards psychological help. It also respects the notion of psychological defence mechanisms within the patient, or what can be noted as 'readiness'.) Of course, in good practice, the GP reviews the patient following referral to the practice therapist, and where there may be risk factors present or risk of deterioration, then an assessment can be sought more assertively (i.e. use of invitation letter, phone call etc). In the meantime, the GP will provide referral details to the therapist who provides a weekly clinic within the surgery. Initial appointments are set at between 30 and 40 minutes. The patient arrives for their appointment 2–4 weeks later, which is seen as acceptable with GPs and patients.

Initial consultations are viewed by the therapist and GP as opportunities for the patient to convey their difficulties and their need, and for the therapist to begin the process of clinical assessment, seeking to determine a variety of features ranging from severity and risk, to ability and desire to benefit from proceeding with further meetings.

When this happens, patients are displaying a variety of characteristics; these can include intense anxiety, elements of shame and doubt, anger or depression. Many stories, indeed, have been truly grim, and that the therapist can contain the impact of such deliveries is both demanding and necessary.

Initial sessions can yield dramatic findings, both by the therapist and within the patient. This may include extreme distress, significant emotional expression and the verbalisation of a story which doesn't seem to have been told before. Distress may be presented acutely, in the form of nervous exhaustion or clinical depression, and may often have been held at a low grade of denial for many years, as I will demonstrate.

Anecdotally, follow-up sessions, often up to 12 within 6 months, have led to general reduction in clinically distressing symptomology, including anxiety, addictions and abusive behaviours. The organisation of clinic provision and structure affords opportunity for protracted follow-up, where indications for longer term and rehabilitative psychotherapy or assessment can be attended to.

In a high proportion of clinical cases, the patient's subsequent involvement with the GP has significantly reduced following therapy. The therapist and patient are confident that sufficient work has been achieved to sustain achievable, lasting change and increased health, both mentally and physically.

Clinical examples

1 A 60-year-old woman presented with panic attacks; on examination, she was having trouble with a domineering boss at work, felt that the emotions generated in her were disproportionate and very unreasonable. She sought help through her GP and was referred to the practice therapist. While she expressed some of these feelings in the session through tears, anger, and overwhelming distress, she also disclosed a tale of abuse and poverty during her childhood, with deep feelings of self-hate and physical illness since.
2 A 50-year-old lady presented with a brief onset of panic symptoms and distress. She recounted how 20 years ago, her baby was diagnosed with a life-long disability, which led to deafness and a subsequent life of difficulties for herself and the family. She felt anger at the medical profession as well as in many other areas of her life.
3 A 20-year-old man presented with substance addictions and explained that he had seen his father die one morning at home when he was 12.

The family went into shock and no one ever asked him how he felt.

Case 1

It turned out that the patient who was in her early sixties, and had been having panic attacks at work with associated temper responses, had lived a difficult childhood, where there was no father because he had died in the second world war. Her elder brother was a victim of tuberculosis and was either bedridden or in isolation when she grew up. As a result, her exhausted mother had little time for her, and she found making friends difficult because of the association with her brother. On the other hand, she reported a lovely childhood having fun with her dying brother as she looked after him.

It was difficult for her to express how she had experienced the long periods of her own isolation, her feelings of rejection when she looked to play with friends at school. Most of all, this was no one's 'fault'. However, because the little girl was generally aware of feeling different from other children and had no one to tell these things to, she began blaming herself for the things that didn't go well for her.

When her mother was tense and yelled at her, it felt relentless, especially when she longed for a nurturing look. But she kind of knew how much pressure mum was under and 'she was to be grateful that she wasn't poorly like her brother'.

Her subsequent adult relationships had been poor in quality: her husband had left her for another woman, and based on the fragmented profile of her family network, her children had similar difficulties with co-dependency, alcohol abuse and general relationship problems.

In the past three months she had stopped going to work and showed moderate social phobia, depressive features such as low motivation and drive with a pessimistic outlook, agitation and free floating anxiety. Her appetite and sleep were poor.

Regular first-line antidepressant medication therapy was now in its sixth week and yielding little benefit. (NB: Switching antidepressant medication at this stage is an option. Thought must be given to the benefits of medical interventions at this stage, both in terms of increasing side-effects, such as lethargy or agitation, as well as the issues around emotional containment, which are being examined here.)

Initially, I was able to arrange a number of sessions to see the patient, over a two-month period. Contact was never lost for longer than three weeks.

The attention paid to the narrative offered, gave an opportunity for the patient to be heard and understood in a way that had never been possible before. Being attended to in this way helped to affirm the difficult experiences she had undergone, but more so, helped to identify *how* she had survived.

Expressing significant emotion about her difficult childhood was a sign that she was grieving in some way for what she had lost, and also signified an ability to realise that she was important and that she *did* count. This new learning meant that she could begin to find new ways of expressing herself and her needs with much less fear. She learned that she could now take control of herself and influence her environment.

Being contained or psychotherapeutically held allowed for the patient to experience natural impulses and respond with tears and anger (as well as other emotions such as joy).[12] Becoming comfortable enough within herself to bear the majority of such expressions without shaming, judging or criticising herself, was radically different from her childhood experience.

By the time therapy closed, she had been involved in assertive discussions with her employers, highlighting her work needs and rights, as well as assertively dealing with her boss's bullying attitude through the complaints procedure. She began to feel more comfortable in her own home, less tense and afraid, and began talking more hopefully about relationships with others in her life.

Case 2

I don't think that this patient was consciously aware of the connected feelings beneath the surface when she first attended to discuss the panic attacks she had been getting at work. The first few sessions of this work were spent with the patient in overwhelming floods of tears. Simply attending the session, with permission to allow herself to touch this difficult area, seemed to create an intense emotional reaction.

Her son, who was now grown up, had recently left home for the first time to study away. Though she had gone on to have other children, her own feelings were wrapped up with the plight she had been thrust into when her first son lost his hearing after contracting meningitis some months after being born.

She expressed anger about everything that happened to her at that time – the interventions by GPs, nurses, hospitals, her husband, his family and so on. Furthermore she was angry about how her life had been taken over by her son's special needs, fighting for services and special help.

In reality, she had done remarkably well in helping her son overcome a significant handicap

and it was as if, once he had finally left home, only then could she finally declare and acknowledge to herself, how this whole experience had *felt.*

There had been casualties, as a result of the circumstances. Her marriage had deteriorated over the years because of her perceived lack of support, and although qualifying as a teacher at the same time as bringing up a family, the patient did not feel that she had achieved very much. She felt as if she had been on a rollercoaster for the past 20 years, she was exhausted, pent up with feelings, and unsure about how to carry on.

We elected to spend six sessions together, allowing a discrete space for this woman to express and understand her difficulties more clearly. Much despair and anguish was able to surface, and consequently panic experiences reduced both at home and in her work setting.

Further analysis of her early life influences also proved useful in understanding aspects of her personality. This included a rather stoical upbringing, with an emotionally inexpressive, yet dominant, father and absent mother, who was looking after her elderly mother. It did not seem acceptable to express needs and feelings within the family. In short, the patient had learned to hide and suppress herself, something she was to continue doing later on, even in the face of adversity and crisis.

Case 3

Often these stories have never been aired before, certainly outside of those involved, and in particular, without the full emotional impact. Moreover, such patients have described a brief story of how they have been functioning (or not), with associated anecdotal material related to the onset of the state of distress. Evidence of full emotional experience has been quite immediate within the consulting room, and while such feelings are occurring, the patient has gone on (usually unprompted) to reveal suppressed traumatic material.

The first session highlighted this process: the 20-year-old man was not consciously aware of how his drug abuse was serving to protect his childhood trauma. The consultation within the initial sessions paid significant attention to this underlying matter, therefore allowing it to be fully expressed, attended to and subsequently processed. This involved the therapist being able to experience something of the impact of this event (see discussion).

Significantly, the patient attended only once, and poured out this most shocking and tragic moment in his life. It was as if he did exactly the same to me as had happened to him. He seemed to 'hit' me with this revelation, without warning as well as without sticking around to receive any more care for this gaping wound. The ability to form a proper narrative around the experience was brief and left me feeling that I couldn't tend to him.

At best, the outcome may have been a significant emotional release, or, more pragmatically, may have helped him to learn that both his depression and drug abuse were serving to keep him numb. Such insight may lead to greater choice and options at a later time and, indeed, he may return. It is noteworthy that the GP later informed me that the patient reported benefit from the session, and subsequently spent less time in GP consultations.

Case discussion and psychotherapeutic interventions

The case studies presented, all demonstrate early, unresolved conflicts, as well as 'here and now' distress, with clinical presentations such as anxiety, phobia or depressive illness. They show that when these earlier conflicts are tended to, unprocessed personal material can begin to be worked through and addressed.

The majority of current research into successful psychotherapeutic work is increasingly being attributed to the therapeutic relationship. While this cannot be understated, it must be understood within the context of the unique and special environment created by the therapist. This always involves the establishment of safe therapeutic framework, a working alliance and sound rapport-building skills.[13,14] While there is a variety of contemporary psychotherapeutic systems (such as CBT, IPT, CAT among many others), they all aim to create an opportunity for learning and discovery, and carefully attempt to draw attention to areas outside the full awareness of the patient.

This attention and attitude within the room ('what else could be going on here …?', or, 'what does this person need to learn in order to move on …?') combine to become the central features of the work. While this may be understated in practice, it nonetheless contributes to the patient's ability to begin to think, feel and behave differently.

Developmental psychology also has much to offer. Winnicot's descriptions of the core conditions of parenting provide suitable metaphors for understanding some of the earlier wounds that may become apparent within the patient's story.[12] Furthermore, they guide the practitioner in the core values of therapeutic stance, namely the process of holding and containing and the notion of the 'good enough mother'.[12] Bowlby's work describing the

'secure base effect' as well as early contributions from Ainsworth (and many more) noting the role of the mother in attunement and responsiveness, helps us to consider both how psychological impairment can occur, as well as indicating the necessary position for healing and understanding.[15–17]

Bion proposes that good experiences are digested and transformed into thoughts, but bad experiences that are undigested will then be projected onto others (the caregiver/therapist).[18] As the therapist is able to contain the (infant's) bad experience, then it can be mentally processed and digested into conceivable thoughts, images and narrative. If the therapist cannot contain such experiences then it is repressed once more, adding to the initial injury and forcing the continued exacerbation of defences (or intractable depression). Each of the case examples demonstrates these features, which involve the notion that the individual has been unable to transform their emotional experiences into narrative.

Attention is paid to all aspects of such disclosures (i.e. what the patient brings and how they bring it), whatever shape and size issues come in; such is the environment of primary care. This includes subsequent analysis in terms of the effects and habit-forming aspects of defences. In the case of the 20 year old, he had subsequently struggled with issues of trust and dependency in relationships, (ab)using substances to avoid emotional intimacy, so that he didn't have to experience anything like the level of emotions that he pushed down on that day.

Examining various relationship systems and family dynamics also helped each patient to develop insight into the positions subsequently adopted by themselves and/or within the patient's traumatised family, and how this maintained aspects of frozen defences. For some, events and experiences have felt as if they are too big to contemplate.

Bion's findings, summarised by Seinfeld, are significant.[18,19] They note how there becomes a 'psychic space inside the caregiver where she processes the infant's anxiety', and how the 'infant projects into the mother its unbearable anxieties and dread of annihilation'. The caregiver experiences the infant's anxieties, and through reverie is able to calm herself and therefore the infant.[19]

Observing the therapist's expertise and skill in managing such experiences, also highlights the significance of clinical supervision as an extended container to help manage and process the reactions experienced by the clinician.

The dialectic position of nurturance and (often) painful discovery within the therapeutic relationship, while also being challenging, often leads to a maturing of ego and powerful development of self, with profound emotional and cognitive changes.[20] The safety within the psychotherapeutic relationship, that it has shared and borne, is an experience that leads to immense self-esteem and confidence in the patient, who has now been able to feel their way through significant developmental events that had formerly been repressed.

When we think of psychological defence mechanisms, we can see that the lady in case 1 had minimised and repressed the extent of her experiences.[21] She had adapted by never challenging authority (including her husband and later her boss), despite continuing to work in a number of unsafe and unsatisfactory conditions. She had never felt she had any right or permission to make demands on anyone, and when a series of difficulties occurred at work, she had no internal resources to manage the situation, hence she was thrown into confusion and panic.

It is important to pay attention to a wide range of other clinical data at this time, as well as listening carefully to detail, the narrative behind the detail and the process in which the patient presents themselves. The initial or one-off session creates a powerful combination of rich and meaningful re-enactments, benevolent and pernicious, often disproportionate, but nonetheless, informative to the willing and interested therapist

Conclusions: common mental health problems and skilled therapeutic interventions

It is recognised that over a third of GP consultations are involved with emotional or psychological features of the patient.[22] It has been a long-held tradition (though not always paid its full attention) that the relationship between the physician and the patient is significant in the management of whatever symptoms are brought.[23] Furthermore, GPs are involved in providing protracted personal treatment and care to patients and their families, sometimes up to three or four generations. Held within this context, a psychosocial family profile of illnesses and physical predispositions with social and life events develops.

Clinical depression is a prevalent condition[24] Stories of social and personal struggle are increasingly present within 21st century British communities, and often lie behind the presentation of common mental health problems, as described, and are evidently present in health settings.

When patients present with mental health problems, it can be difficult to hold and contain their distress in ways that can lead to emotional growth.

Physical features may be treated symptomatically, although they may benefit from an alternative approach, such as emotional processing. Furthermore, it is possible to see the benefits in helping primary care staff, such as health visitors, nurses, midwives and, of course GPs, to assist in timely emotional support when family members visit the surgery routinely.

Regrettably, much confidence is placed in medication (by both the medical officer and the patient), to manage crises. It has been alarming to see the extent to which medication has been used to mask and avoid many complex and traumatic experiences, and while this may have been justified at the time, it is possible to suggest that it has impeded subsequent emotional growth to the extent of further defensive and depressive processes (including secondary chronic physical symptoms).

The recognition of emotional breakdown (evident through high levels of non-organic illness such as stress, work stress, alcohol abuse and family breakdowns) displayed via medical presentations continues to support the holistic mind–body dynamic, and this recognition provides opportunities for the role of psychological interventions in the primary care setting.

Mostly, trauma events have occurred between the patient and 'an other', and whether this has created a distorted, false-self, or a sense of worthlessness, the rupture, nonetheless, is held as a dynamic force. From this point of view, healing occurs within a dynamic, therapeutic relationship. The patient gradually feels accepted by another person (the therapist), *in spite* of having told their 'secret', or expressed painful emotions to that person. This is incredibly curative and, as I have demonstrated, has been achieved through the therapist's attention to the technical stance that allows containing, holding and emotional processing to occur.

There is more to explore and research regarding the effects of psychotherapeutic relationships and physical presentations in primary mental healthcare settings. The body continues to attempt to contain and hold its owner's story, yet can often need some emotional support when its structures let it down.

Furthermore, working psychologically in primary care settings is not a panacea or treatment of choice for all those referred. Attention needs to be given to the level of psychological work provided and the levels of psychological disturbance evident. Indeed, some patients may be helped to access more suitable specialised psychotherapies away from the GP surgery.[25] Alternatively, psychological interventions may not be indicated and such advice from skilled therapists to GPs in primary care is invaluable when it comes to decisions about referring to psychiatric specialities.[5].

When over 30 staff are employed to meet some of the needs of the 95% of people presenting in primary care with mental health or psychological health problems, an immense amount of clinical activity begins. This is demonstrated in high rates of clinical contacts among practitioners. Attention is required towards the nature, process and outcome of such work, and there are significant opportunities for further audit and research activity. The recent introduction of graduate mental health workers is now able to begin assisting in such governance activity.

Based on the demonstration of the paper's central claims, however, there is a need to proceed cautiously with some forms of evaluation, not least with the possibility of contaminating the therapeutic relationship or inhibiting the patient. For the commissioning of services, broad costing and purchasing requirements, an attempt to reduce psychotherapeutic procedures into standardised formats is, however, a limited science.

Large managed services, such as the Common Mental Health Service in Leicestershire, will nevertheless, increasingly develop opportunities to demonstrate to PCTs and public health departments the benefits now available to society as result of meeting with people presenting with issues such as work-related stress, anger and domestic violence, chronic grief, family difficulties and psychosomatic problems, to mention but a few. The range of access to expert clinicians across the service, trained in or providing clinical supervision to staff, means that the 'generalists' are afforded access to senior practitioners with a specialism in psychotherapy (such as IPT,CBT,CAT and psychodynamic, intercultural) and a good grounding in working psychologically.

This paper has described some of the features of common mental health problems. When attention is paid to the key developmental aspects described above, we can begin to understand both the effects of early life conflict moments and to assist in improved diagnosis, as well as realising some of the treatment approaches that are fundamental to recovery. As this field experiences a renewed and fresh input of psychological influence, it is important to explain and share findings to generate increased awareness amongst clinicians and commissioners where necessary, as well as to stimulate debate about presenting issues within such settings.

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CONFLICTS OF INTEREST

None.

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