The integration of psychiatry and psychotherapy

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1993 saw two important landmarks in the history of British psychiatry. Members of the College chose not only the first woman but also the first psychotherapist, as their democratically elected president. In the same year the College published guidelines making training in psychotherapy a mandatory requirement for qualification as a psychiatrist (Grant *et al*, 1993).

It is for historians to decide why, in contrast to Europe and the USA, it has taken so long for psychotherapy in Britain to achieve equal status with social and biological psychiatry (Pines, 1991). It has perhaps to do with the ambivalent relationship between the arts and sciences in British culture, and with the sceptical tradition of British empiricism. It owes something to the intransigence of Aubrey Lewis and Ernest Jones, those doyens of British psychiatry and psychoanalysis respectively, each determined that their discipline should not be contaminated by ecumenicalism. It relates to the fact that from the onset of the NHS, psychotherapy has never been fully integrated into public sector psychiatry, in contrast, for example, with Germany, Australia and Canada where national health insurance covers intensive psychoanalytic psychotherapy. It depends also on a split in which each discipline invents a partially despised *other* onto which is projected uncertainty and difficulty, thus attempting, through negation, to strengthen its own fragile identity.

For many years psychotherapy was identified with psychoanalysis. The present shift results partly from the realisation that psychotherapy, like psychiatry itself, is a broad church, encompassing behaviour therapy, family therapy, and the creative therapies, and that cognitive-behavioural therapy and psychoanalysis have more in common than each would have previously cared to admit (Ryle, 1990).

This acceptance of psychotherapy as a major force within psychiatry is the product of many years of painstaking research and advocacy, not all by psychotherapists. The efficacy of family intervention in schizophrenia, and of cognitive-behavioural therapy in depressive disorders, has been firmly established now for over a decade although these research findings have still to be translated into routine clinical practice. A psychiatry that cannot deliver psychotherapeutic interventions to these patient groups is gravely handicapped. There are so far no unequivocal controlled studies showing the effectiveness of psychotherapy in personality disorder but what evidence there is (Stevenson & Meares, 1992) suggests that as little as a year of twice-weekly psychoanalytic psychotherapy, even if delivered by relatively inexperienced therapists under close supervision, can produce significant benefits. It is a sign of the times that even such an implacable critic as Marks now concedes that psychoanalytic psychotherapy has a role in the long-term treatment of patients with personality disorder (Marks, 1994).

The health service 'reforms' of the 1980s have also, for good or ill, played their part in cementing the rapprochement between psychiatry and psychotherapy. The 'consumer' is sovereign and the consumer wants counselling and psychotherapy as much as social and physical treatments. The managerial assault on medical hegemony has meant that medical psychotherapists and psychiatrists need to make common cause if their voice is to be heard and their weight felt. The hectic unravelling of the institutions, and pell-mell rush towards inadequately funded community care, mean that psychiatric services are often delivered by health care workers whose philosophy is vaguely psychodynamic but who have had little or no systematic training in the psychotherapeutic skills needed to produce health gain in their clients. Within social service departments, as professionals are more and more corralled as

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purchasers, the delivery of care is increasingly deprofessionalised, offering at best containment rather than growth and change.

This new climate presents both opportunity and danger, and many questions needed to be clarified. There is pressure on psychotherapists to work within community mental health centres so bringing their skills, supervision and training nearer to the patient and to the footsoldiers of psychiatry. How far can they do this without losing the critical mass and degree of separation and distance that enables psychotherapeutic creativity to flourish? Will 'integration' mean that all will consider themselves therapists, thus devaluing the special skills of psychotherapists and the many years of training needed to acquire them? Is it really possible to combine psychiatric and psychotherapeutic work when their 'feel' is so very different – the one based on 'doing to', the other on 'being with' the patient?

The Psychotherapy Section of the College and the British Psychological Society have jointly advocated an integrated Psychological Treatment Service in which medical psychotherapists and psychologists work together with common referral systems and waiting lists (Binns *et al*, 1994). Is such an agreement feasible, and can the different psychotherapeutic approaches usefully bed down together, or do they need to retain separate identities? The market in health care has threatened tertiary centres of psychotherapeutic excellence such as the Tavistock Clinic, and the Cassel and Henderson hospitals. When the chips are down, will psychiatrists accept topslicing of 'their' budgets to support them even if it means slight reductions in their own resources? Underpinning all these questions is the problem of inadequate funding for psychotherapy, its tendency to lose out in competition with expensive new drugs or new pairs of relatively unskilled hands. Psychotherapeutically-informed psychiatrists need to make the case for investment in 'interpersonal technology' no less cogently than physicians and surgeons clamour for bigger and better machines.

Various solutions have been proposed. Whyte (1995) advocates psychotherapy directorates, facilitating separation-individuation of the service itself and its workers. Holmes & Mitchison (1995) are firm believers in integration, favouring a hub-and-spokes model, in which psychotherapists make forays into psychiatric settings while retaining a core psychotherapeutic identity. The attachment of psychotherapists to teams works well in child psychiatry and could usefully be emulated by adult psychiatrists.

The Society for Psychotherapy Research has established a flourishing British chapter but health planners tend to pick out from the literature whatever best suits their purposes. Continuing funding of psychotherapy research is urgently needed to establish which therapies are best suited for which psychiatric conditions, to sift the wildly overoptimistic claims made for brief treatments and to counter critics who, sadly, continue in an antediluvian fashion to question psychotherapy's effectiveness.

Modern medicine is wrestling with an identity crisis triggered by declining morale and falling public confidence. Psychotherapy has all but overcome its esotericism and scientific Luddism and today embodies some of the central endangered values of medical culture: healing as opposed to treatment; reflection as opposed to frenetic action; collaboration with the patient as opposed to an imposed passivity; acknowledgement of pain as opposed to denial; the reciprocity of patient and doctor. A psychiatry which is fully integrated with psychotherapy can give a lead to medicine as a whole, whose task for the 21st century is to reconcile as yet unimaginable technological advances with the need for humanity, social justice, and compassion.

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