WHAT TYPE OF PSYCHOTHERAPY, AND FOR WHOM ?

A COMPLEX TRIO :
THE DOCTOR, THE PSYCHIATRIST - OR PSYCHOTHERAPIST - AND THE PATIENT.

Facing the general practitioner, the patient,

Facing the psychotherapist or psychiatrist, the patient,

Facing the patient, the GP, the psychotherapist and also sometimes the psychiatrist(s), each not always aware of the existence of the other or else reminded of the words or decisions which the latter has - or might have - suggested.

If neurosis or perversion gains advantage from this, it is not certain that the patient, if not the doctor or 'shrink' - therapist, will not suffer the consequences.

If the GP suggests psychotherapy or some specialist advice, the patient might agree or not.

If the patient wants to have psychotherapy or take some specialist advice, the GP might agree or not.

If the psychiatrist suggests psychotherapy :

- the GP might support the suggestion, whereas the patient might not,
- or the patient might agree, whereas the GP might be reluctant, or else both might agree or not about what is suggested.

In all cases, and for all, according to the prejudices, reluctance, resistance or experience of everyone, the trio is complex, without taking into account the potential problem of - homoeopathic or not - treatment, asked of both, and often of both simultaneously.

In the case of psychoanalysis in the classic sense of the word, it is important to bear in mind that the prescribing psychiatrist is not usually the 'psychotherapist'. It should be noted and respected so that the patient might feel they are supported and not left to themselves.

The patient's medical nomadism, rushes of anguish and emergency hospitalisation sometimes result in a doctor on duty being sent for ! Together with some more advice, greater confusion will be added, which the patient will inevitably transmit to each of the actors…

A complex trio and quartet… Everyone's part should be defined and individualised and enough room should also be left for everyone's self-questioning. It is essential that everyone realises what happens as regards mental patterns, defence, prejudices or personal closings, according to the history, personality and 'responding type' of each of the protagonists.

The practice as homoeopath is most helpful as it makes it possible, even without any prescription, to spot more precisely what is at stake in words and thus to give a more appropriate response.

The doctor, the patient and the 'shrink' :

It is obvious that a good doctor of the Sulphur or Nux vom type, this being said without any value judgement, will not have the same approach or attitude to what belongs to the psychological field as a colleague influenced by 'tuberculinisme'. As they are interested in everything mysterious that the psyche conceals, the latter will have a different approach to what those facing them say. Moreover, it is not uncommon for them to be - or have been - tempted to experience psychoanalysis or any other type of psychotherapy.

And fear appears… That of the patient as regards what is 'related to shrinks' and will class them as 'related to shrinks' and that of the doctor confronted with the necessity to tell them and hand over to someone else. That may sometimes be felt as abandonment.

There is also the defence of the GP, confronted with what is often beyond rationality and what the singular interview with another person reveals of their part and own questioning. The mysteries of the relationship, how uncommon it is, the treating person's positive or negative aura and the anguish or resistance to everything psychological will play a part...

And then… the patient who turns to them for advice as soon as something is wrong and asks them to be 'Mother Mary' or *The* judge… The anguish and narcissistic reactions generated will emerge together with all the risks inherent in the pathology in question concerning what it will cause.

Facing them, the 'shrink'… They are not better off from the moment that the patient is evasive, outwits them and sometimes even adopts a course that will lead to greater ill-being.

The relationship to control, the relationship to power, loss and what escapes oneself and the other, sitting opposite… Everything is there to create confusion among what creates fusion so that, at last, less restrained words and 'growing' of the subject may emerge when nothing should either undergo fusion or create confusion.

The 'luetisation' of society and pseudoknowledge do not contribute to make things easier.

THE TYPES OF THERAPY

Their single aim : **the subject's autonomy.**

One rule : to help and not to 'assist', to support and not to carry…

A question… It is asked frequently by the patient, who is often unaware of what psychotherapy implies : ' I'd like a type of psychotherapy for which I'll get my money back from the NHS'. No one is ignorant of the fact that any type of therapy 'of psychoanalytical inspiration' or psychoanalysis usually requires the subject who has chosen to work on themselves to 'take care of' the cost of their treatment one way or the other. The rule, if it is sometimes transgressed for reasons inherent in the patient's pathology and way of life and also sometimes in the therapist's ideological position, remains intact and shows its soundness every day.

In point of fact, adjustments are sometimes made, according to the subject, type of pathology and conditions in which the therapy takes place. They will always be individualised. But, as a general rule, the patient's involvement in the therapeutic process and the fulfilment of their desire through the payment of the sessions, even partially or

minimally, are a sort of basic rule. At the present time, it is bent in many ways which are often detrimental to it but it represents a form of separating limit with 'support' therapy. It is necessary to say so to the patient. That will not be useless for the future and if it is necessary to confront them with the reality of their desire for change. An effort from them, such as a long distance to cover or a long time away from work, together with an amount adjusted to their means, will sometimes play that part. The main thing is that the reality of what the patient sees as their profound desire should be fulfilled.

Except in certain cases when the therapist has settled on a strict and final position, as a general rule, the subject's real obstacles will soon emerge as they speak and will bring about various adjustments, considering their frequently apparent efforts and real desire to work on themselves at all costs.

The obstacles to progress :

The unconscious is subtle and there will be strong resistance even if the patient looks well-motivated.

In any case, the undertaking given by the NHS that the therapy - which will thus not be called, strictly speaking, 'psychoanalytic therapy' - will be *wholly* paid for nonetheless represents most of the time an obstacle to its progress. Quotidian clinical practice illustrates this. The subject will eventually come up against a part of themselves that cannot be mobilised. The loss, much greater than the benefit, is real… It keeps the subject in the illusion of 'work' which will eventually collide inside them with what does not want to 'lose' anything or alter what keeps their system working.

In the end, the patient - or at least their unconscious - is not always taken in. When they feel uncomfortable to 'go round in circles', they will often seek advice from someone else without saying anything. As they will be ready to make the effort they refused to make at first, they will decide to resume, in a different place, the work begun. They often admit that the new modalities of refunding by the health service, the fact that it costs them some money as well as the 'loss' that the payment - even if it is partial or modest - of the sessions represents will be enough… By taking them away from dependence, it leads them to autonomy and inner liberation. Paradoxically and sometimes very rapidly, the results will be amazingly spectacular.

It is necessary to fix the scope and aims of the therapy

In order to avoid any confusion, it is often useful for both the psychiatrist and doctor to clarify from the start the scope and limits of what is set up to make it possible for any necessary adjustment to be done later in the same place and according to other modalities, or else in a different place when it seems more appropriate.

It is possible to substitute support psychotherapy with analytic psychotherapy or an analysis. The important thing is to redefine the modalities and rules and to see to it that what is different may emerge, but the unconscious is never taken in by it.

Support psychotherapy, when taking place in a medical environment, will become part of what constitutes care. The patient will get their money back from the NHS with no difficulty.

As **psychoanalysis or 'analytic' therapies** do not theoretically aim at curing, they do not constitute, at least by definition, care - even if they have curative effects. They require the real personal involvement of the subject. They should be confronted with the reality of their desire, whose mobilisation obeys certain applicable rules whether the treatment takes place in a psychiatrist's consulting room or that of a non-psychiatrist psychoanalyst. The undertaking given by the NHS that they will be *wholly* paid for represents a source of difficulties accentuated by the supposed greater competence linked to the qualification as a doctor. In point of fact, this will not be really fundamental, since it will **not** be a **medical but psychoanalytic** - or deriving from it - process. The unawareness of the fact that only analytic work on oneself, belonging to a group in a position to offer advice and guidance on the work in progress and provide the necessary knowledge with regard to it are required is in question.

Some multilevel problematic confusion will thus arise for both the patient and 'treating people' who listen to their complaints and are often led to reformulate the usual basic rules.

As they have never looked into the question, have not been trained for it or have not assessed its effects, the latter will often fail to grasp its real foundation. Sometimes they will not necessarily be able to spot the stumbling block that the subject faces… And yet, as they most commonly say, they are willing to do 'anything possible to get over it'. The 'luetisation' of society, confusion of all professions, growing loss of benchmarks that may keep structures in place and of clear differentiation of roles, which was still real only about twenty years ago, do not make things easier, even in the peculiar field of psychiatry.

THE PATIENT

What do they want ?

A solution to their symptoms ?

Better-being ?

Personal development, according to their activities, ideals, needs or personal search? This is a very common need at the moment. In a world where the discovery of one's inner space and that of the functioning of the psyche are more fashionable than a few dozen years ago - when this desire engendered suspicion, rejection or ironic looks - it is even 'quite the thing'.

THE PATIENT AND THE DOCTOR

If the patient wishes to ask for their advice, the practitioner may be led to give their point of view. They will do so in the light of what they learnt about it, met or the experience they may have got from practice and the information they received about it.

In any case, it is the patient's choice… It is important that the knowledge of the consulted - or advisory - doctor, if it is a psychiatrist the patient was referred to by their GP to get some advice on the appropriateness or choice of a therapy, should in no way be an obstacle to the experience that the subject wants to have. If asked, they should try to give their point of view but, above all else, let them walk along. The therapist they will consult with this aim will, at any rate, also give them their point of view afterwards.

If the subject proves ill-equipped or the chosen method appears to entail serious risks or inadequate security, it may sometimes be useful to tell them so that they may be aware of it. They should somehow or other be told, even if it means to suggest to them that they should ask several competent people for advice. Certain homoeopathic types, which are too fragile, 'tuberculinique' or anxious sycotics, will not be very compatible with non-adjusted psychoanalysis. Others will take risks in trying hypnosis… To be aware of this will already be helpful.

The doctor, either a GP or psychiatrist, can see to it that all the precautions are taken, without necessarily presenting themselves as 'knowing everything'.

It is important that they should be open-minded or attentive so as to be able to help the former, if necessary, and that they should not see themselves as children who 'do not dare to go home' if they have taken the liberty of taking a different route from that which had been advised, which also deserves to be talked about and analysed.

Does the patient want to have a therapy ?

If they do and it is advisable, it is essential to take the time to explain its rules, constraints and methodology to them. This will make it possible to eliminate the ignorance that is often linked with it and will make it possible for them to choose it with full knowledge of the facts in due course.

To take into account the subject's reactional modalities by means of the homoeopathic type to which they correspond will be appreciably helpful. The 'impatient people' about materia medica will often have to be calmed down, 'pragmatic' ones will have to be steered to the method that corresponds to them best, 'internalised' ones will have to be reassured and sometimes exhorted… The knowledge of the Hahnemannian discipline is of definite interest, also at that level.

A consultation with a specialist can also be contemplated with, also in that case, the organisation of the preliminary talks that will enable the patient to define the roles and positioning of everybody.

To be continued…