**Recommendations to psychiatry registrars regarding a systematic approach to determine who would be an appropriate psychotherapy patient for the Psychotherapy Written Case (PWC)**

There are several factors to consider when choosing an appropriate psychotherapy patient:

- the patient has to experience a significant improvement within 40 sessions.  This may sound like enough time, especially when compared to a CBT course, but many patients are so unwell that they require years of psychotherapy (not just 1 year).

- This means that you should not take on a patient who is seeking a replacement therapist after their previous therapist, (whom they had been seeing for years), has retired/become unaffordable.

- ideally, you want to avoid patients that have complex medical issues or multiple comorbidities. Remember, you have a word limit of 10,000.  That’s not a lot when you have to write up a summary of 40 sessions.

- The process has to meet the needs of the trainee as well as the patient.

- We (the College), want you (the trainee) to have a positive, satisfying experience with psychotherapy. So seeing someone for 40 sessions, then transferring their care when they are still quite unwell would be unsatisfying for both parties and potentially damaging for the patient.

The following is a picture of Maslow’s Hierarchy of Needs.  While you may be familiar with Maslow, please bear with me as I explain how I conceptualise Maslow and where psychotherapy sits within it.



Maslow observed that we have all these various needs. Maslow’s key contribution to the field of psychology was to rank these needs from the most critical to the least critical.  Maslow considered that the most critical needs (i.e. at the base of the pyramid) were what he termed the “Physiological" needs, such as

a) breathing,

b) food,

c) water,

d) sex (you can tell a man wrote this list as sex is rated as being as critical as food and water!),

e) sleep,

f) homeostasis (“things being in balance with each other”, i.e. being healthy.  So if you have a broken bone, you might need surgery; if you have an infection, antibiotics; if you have a biological depression, ECT/antidepressants; if you have an alcohol addiction, you need detox and rehab),

g) and excretion (i.e. not being faecally loaded).

Once you have these needs met, you will then automatically want to have what Maslow termed your “Safety” needs: i.e.

h) security of body; although Maslow was only referring to physical safety (eg not living in an area which is violent), I also include emotional and verbal safety (e.g. not working in a job where you are being bullied; not being in a family where there is high Expressed Emotion),

i) security of employment (being in a safe, satisfying job),

j) security of resources (i.e. having enough money),

k) security of morality (this is to do with justice and fairness),

l) security of the family (this is to do knowing that your loved ones are happy and healthy),

m) security of health (this is to do with access to healthcare, which is less of an issue in Australia),

n) and security of property (living in a safe, comfortable abode).

Once you have these needs met, you will then automatically seek what Maslow termed “Love/Belonging”.  Essentially, this refers to being in a loving, supportive relationship.  It never ceases to amaze me how greatly this factor influences a person’s prognosis in psychotherapy: a person who is in a loving, supportive relationship has a much better prognosis than someone who is not.

Once you have these needs met, you will then automatically want to have what Maslow termed “Esteem”.  This is to do with acquiring the skills that lead to being respected by others and to respect others.

Finally, there is “Self-Actualisation”, which is about reaching your highest potential.

The point that I am trying to make here is that ALL types of psychotherapy, whether it is psychodynamic psychotherapy, CBT, EMDR, whatever, are all in the “Esteem” and “Self-Actualisation” part of the pyramid.  And so it is very hard to get any traction in this part of the pyramid, if the person has any unmet needs in the bottom part of the pyramid.

So, what you need (especially if this is your first time doing psychotherapy), is to have a patient that ticks **all** the boxes in the “Physiological" and “Safety” domains of the pyramid.  So:

*- no drugs or alcohol for at least 2-3 months (there is no point doing formal psychotherapy with someone who can’t remember things from one session to another because they are permanently drunk or stoned)*

*- no acute mental health issues (risk of harm to self or others should only be low to medium).  Any acute mental health issues e.g. clinical depression, should be stabilised and mostly in remission.*

*- for now, stay away from eating disorder patients; it’s likely to be too complex for your stage of training*

*- no untreated, acute medical issues, and no ongoing, chronic, debilitating medical conditions*

*- the patient has to be physically and emotionally safe in the present (e.g. not be currently in a domestic violence situation)*

*- no uncertainty Re: job, finances, accommodation*

*- no ongoing medico-legal claims (there will be no chance of your patient getting well if there is a current claim)*

*- no active, justified concerns regarding a loved ones welfare*

At this stage you’re probably thinking “that pretty much rules out all the patients I see!”.  And that is exactly my point!!  99% of the inpatients would be unsuitable as you are essentially only focussed on just the “homeostasis” part of their pyramid and they are often missing other critical Maslow needs.

The patients that would be suitable are the ones that the Acute Care Team would aim to close after just a single assessment because they are deemed not sick enough to require our service and so would be referred back to their GP or a private psychologist for ongoing care.  Those are the patients you want (who have some degree of developmental trauma and ongoing moderate level of symptoms, but are functioning OK in the present). Typically, these patients can only access the care they require in private practice mental health.

This will represent a significant shift in thinking on your part as there are different (but complimentary) underlying principles between public mental health and private practice mental health.  In public mental health, you are trying to neutralise risk; you are trying to prevent someone killing themselves or someone else.  In private practice, you are trying to keep someone as a functioning member of society, in order that they can keep working, pay taxes, which then pays for the public mental health system. Yin and Yang as it were.

Careful patient selection is critical to ensure that a particular medical intervention will be successful.  This is no different when choosing your psychotherapy patient.  Otherwise, it is a total waste of everyone’s time.

By the way, although you no longer have to do an OCI as part of the College Exams, this clinical exam used to assess the trainees’ ability to think more broadly about the entire person.  Having a framework like Maslow’s helps you to consider the other key factors to address in your formulation and management plan other than simply saying that you would increase the antidepressant dose.

Maslow’s hierarchy also provides a guide when deciding what to do first and the order in which to do them.  For example, there is no point trying to do CBT with an adolescent who has not even eaten all day.

I hope this helps and I would be happy to receive any questions.  Please email me at my practice email address:

[admin@citysc.com.au](mailto:admin@citysc.com.au)

Kind Regards

Peter Devadason