



Therapy

Family Therapy in a General Practice

COUNSELLING AND LIASON

A Pilot Study

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Summary

Seventeen patients who had previously not responded to therapy provided by specialist mental health services or a primary care counsellor but who were still frequently presenting significant problems to their GP were referred to a systemically trained family therapist based in the General Practice. Three failed to attend. Seven gained significant benefit achieving their aims, and additional health gain which resulted in a reduction in GP consultation rates in the ensuing six months following the therapy intervention. The results of the study suggest that incorporating training in systemic theory and practice for primary care counsellors and mental health liaison workers based in Primary Care would benefit patients and their families.

Introduction

The South and West Devon Health Authority has been purchasing a district-wide Primary Care Counselling Service since May 1995, covering 56 of the 61 General Practices in the Plymouth, South Hams and Tavistock localities'. Our General Practice has employed a counsellor for eight years before that, since 1987, and as we knew and valued her skill range well our referrals were usually appropriate (confirmed by audit). We were, however, aware that a number of patients and families had not been helped either by the one-to-one counselling

methods used eclectically by our counsellor or by the specialist mental health services, and the question arose whether the systemic thinking used in the Milan approach to family therapy^{2'3'4} could be used in a primary care setting to complement individual-focused therapy used by counsellors. Falloon et al (1993), for example, had found evidence in favour of a family-based approach to adult mental health disorders⁵:

The preliminary results of providing adult mental health care in this manner suggest that integrating family and primary care resources is not only feasible, but may contribute to reductions in clinical morbidity, particularly in the number of major episodes of schizophrenic, depressive and manic disorders, and the subsequent need for intensive crisis management, either at home or in hospital. Not only is clinical impairment reduced, but also benefits include reductions in social disability and household stress. (P157)

The adult mental health services' referral guidelines in our district specifically excluded social interventions, requiring GPs to refer patients or families where social factors were considered relevant to Social Services. At the time, Social Services reorganisation and financial stringency meant that a number of our patients could not be seen by social workers, and so our difficult cases who had already failed to respond to individual-focused counselling were falling between two stools' and for these reasons we decided to carry out a pilot study of the feasibility of using systemic methods in primary care counselling.

We decided to see whether we could extend the service already available in our Primary Care setting to include a systemic approach to adults who were continuing to present with psychological symptoms and to those in significant relationships with them. One of the training aims of therapists in the systemic approach is to learn how to have 'creative conversations' with more than one person at a time, for instance in a family or relational group. No other speciality provides this training. The method enables those involved in the disturbed relational system to look at the complexity of meaning different people apply to the same words, phrases or attitudes, and to be aware of the impact on others of the way the patient project aims, fears and resistance to change. This can then be assessed and worked with.

The Milan systemic approach used in the study is of proven benefit in family therapy where the index patient is a child^{6,7}, for adolescents and adults with anorexia and bulimia nervosa^{8,9}, and for the prevention of adult schizophrenic relapse by reduction of expressed emotion in families¹⁰. Systemic methods have been more widely applied into the management of large businesses and the civil service, and within the health care professions in settings other than the video-suite of a family therapy centre^{11,12,13,14} We therefore decided to attempt to integrate a systemic therapy service into our General Practice.

Method

With the benefit of a grant from the Health Authority Primary Care Development Fund we employed a systemically-trained therapist who had over twenty years experience of using the Milan systemic approach in family therapy and in settings other than the traditional 'video-suite' for family, individual and couple counselling.

The criteria for referral of patients by GPs to the service were that index patients were to be adults who had not been helped by previous therapy by adult mental health services or the primary care counsellor, and for whom the GPs felt relational and communication factors may be important.

GPs, the therapist and the patients recorded their outcome 'hopes' at the beginning of therapy, and whether or not they had been achieved by the end. Each index patient at the beginning and end of therapy completed a GHQ and SF-36 general health questionnaire, and an opportunity provided to record any unexpected benefits.

Referrals were made over a three-month period, with six months allowed for the period of therapy. The number of GPs consultations was recorded from the notes retrospectively during the six months before therapy, while therapy was going on, and during the six months after therapy.

PROBLEMS ENCOUNTERED

Timing

The pilot project was advertised to neighbouring general practices seven months after a district-wide GP counselling scheme started. We had hoped to receive referrals of difficult cases from these other practices, but discovered that the GPs were so enthusiastic about the reduction in their own stress levels since their GP counsellors had started work that they did not want to refer their patients to anybody else. It could thus be said that our study indirectly demonstrates the success of Primary Care counselling from the GPs points of view. However, we suspect that just as we have discovered the limitations in a Primary Care setting of therapy focused upon the individual, so to other GPs and purchasers will discover the same in a few years time.

Patient Turnover in Practice

Of the 17 referrals from our practice during the three-month intake to the study, four (23%) had moved by the time the outcomes were analysed and so could not be fully followed up. This is consistent with our practice's average turnover.

Compliance and Non-cooperation

Many of the families or individuals referred were very negative about themselves and previously failed therapy. Of the 13 assessable referrals five individuals failed to complete GHQ and SF-36 questionnaires. We thus have complete data on only eight index patients (47%), and incomplete data on the further 30%.

Results

Three patients and their families refused to attend. Twelve were seen within 2 weeks of referral and all were seen within seven weeks.

Six men were referred (35% of the sample), all aged between 30 and 40 except for one of 60. Eleven women were referred. Nine were aged between 20 and 40, one aged 45 and one 60.

General Health Questionnaire entry scores ranged from 12 to 39 with a mean of 24.5, five of the eight being in the 20-26 range, showing that most of the patients referred were chronically resigned to the way they felt, tending to answer, "The same as usual" to most of the questions even though they were living with considerable distress or discomfort. The mean exit score was 22, showing a slight improvement although the numbers of completed pairs of questionnaires on this pilot study was small. The sample was too small for the various SF-36 measures to have any significance.

Effect on GP Consultation Rates

Research indicates that building a therapeutic alliance between therapist and patient is crucial to successful outcome. The therapist reported a failure to establish an alliance with four patients. Table 1 demonstrates that the number of appointments for these patients with the GP before and after are either unchanged or increased:

	No. of appointments 6 months before	No. of appointments 6 months after
Patient 1	11	10

Patient 1	11	10
Patient 2	3	9
Patient 3	2	2
Patient 4	Moved	Moved

Table 1. GP Consultations for Patients who Did Not Establish a Therapeutic Alliance

The therapist established a therapeutic relationship with the patient in 8 instances. Table 2 demonstrates that six of these patients demonstrated a fall in GP consultation rates in the six months after therapy.

	6 months before therapy	6 months after therapy
Patient 1	5	2
Patient 2	4	3
Patient 3	10	5
Patient 4	8	2
Patient 5	11	5
Patient 6	5	4
Patient 7	2	2
Patient 8	5	8

**Table 2 GP Consultations for Patients who Did Establish a
Therapeutic Alliance**

The one patient whose rate increased with whom the therapist reported that she had developed a therapeutic alliance had started to discuss with their GP their general management of lifestyle while waiting to join an eating disorders group, the need for which had been identified during therapy.

Satisfaction at Outcome

Patients were asked to identify what they hoped to achieve by therapy. On no occasion did the therapist's hopes for outcome differ from the patient's. We used the term 'hopes' rather than 'goals to achieve' because many of the referred patients were rather hope-less after previously failed attempts at therapy, and we felt this term might be more engaging. More about the specific problems will be mentioned in the discussion.

Of the fourteen patients for whom we have adequate records, seven felt they did fulfil their hopes and seven felt they did not. Of the seven who felt that therapy had not fulfilled their hopes, the therapist reported only one patient for whom she felt her hopes had been fulfilled. For this group of patients the referring GP also reported that their hopes had not been fulfilled. Of the seven patients who did feel they had fulfilled their hopes, the therapist's hopes were also fulfilled for all seven, while the GPs hopes were not fulfilled in two cases. Comment will be made on this discrepancy in the discussion.

The patients' recorded satisfaction at outcome, whether successfully engaging with the therapist or not, are compared with the number of attendance's in Table 3.

Patient Nos.:	1	4	1	2	1	1	1	2	1	1
Appointments:	1	2	3	4	5	7	8	11	12	14
Hope fulfilled:	1	1	1	2	1	1	1	1		1

Hope fulfilled:		1		2		1	1	1		1
Not fulfilled:		3	1		1			1	1	

Table 3 Patient's Satisfaction at Outcome Compared With Duration of Therapy

Discussion

We believe that these are satisfactory outcomes. All the patients referred had previously been discharged from follow-up by other specialist services, including mental health services, social services and/or our primary care counsellor. Few of the patients had had any expectations that they could be helped, and yet they were all felt by the GPs to be using significant amounts of GP time and mental energy.

Those patients we failed to help include a convicted child sexual abuser, a woman with chronic fatigue syndrome who was convinced nothing could help, a couple with personality and sexual problems, a long-term bulimic and alcoholic, a family where the mother had been sexually abused as a child and was projecting her fears onto her daughter, a cancer phobic woman affecting her family, and a recurrently depressive man having difficulty step-parenting a tearaway child. The General Practitioners too in most cases felt equally powerless.

Those patients who failed to attend had all been referred by GPs to the pilot after discussing the request for therapy with a relative of the index patient. In these three cases the family dynamics were known by the GP to be disturbed, but the reason for failure to attend was probably due to insufficient introduction of the therapist to these complex situations. In retrospect, the possibility of making a therapeutic alliance might have been improved if the therapist had been asked by the GP to make initial visits to the home rather than inviting the patient and family to attend at the GP practice (a possible advantage of having systemic skills available within the Primary Care Team).

There were two cases where the GPs hopes for the patient had not been fulfilled (even though the patient's hopes had been fulfilled). In one the GP stated he hoped the patient could be helped with his agoraphobic symptoms. The counsellor and patient, however, only wanted to clarify how best this might be achieved and so were satisfied with a more restricted outcome. The other was a man who had a repetitive cycle of depression. The GP hoped that the patient would gain sufficient insight to break out of this cycle while living with regrets about a difficult

family situation. The patient reported a short-term improvement in symptoms and defaulted from treatment, in the same way he had from previous attempts to offer therapy.

The successful outcomes included three patients who were adjusting to physical disease that was having an impact on the family. The therapist commented that this was a noticeable difference from the types of referral she had been used to in other settings, but it is of major importance to the average GP. The other four included a long-term marital problem, adjustment to a dominating elderly relative who had moved in creating stress aggravating pre-existing ill health in the carer, adjustment to past sexual abuse affecting a current relationship, and adjustment after a psychotic depressive breakdown of a woman whose husband was a middle-aged heroin addict.

For these successful outcomes, individual-focused, one to one counselling and medication had previously been ineffective or only temporarily helpful, whereas the systemic approach seems to have achieved change and health gain for more than one person.

Commentary

The current trend towards specialist mental health services attaching liaison mental health workers to Primary Care teams is to be welcomed. However, it is worth recalling that General Practice used to be called Family Medicine before mention of families became politically incorrect in the face of post-modern individualism (and monetarism), and a proper understanding of the implications of our style of work is crucial to the provision of appropriate liaison.

Primary Care is all about the health of people-in-relational-networks, whether in the form of bed-sit communities, cardboard cities, single-parent households or families. The work of a GP is, of course, par excellence systemic, although it is only rarely called that, and GPs have only very rarely received specific training in systemic methods and approaches. Primary Care doctors are not just technicians putting into effect protocols or guidelines worked out by specialists. We are Generalists specialising in the whole person, who is incomplete alone without a consideration of the various interpersonal systems in which they thrive, or do not thrive. For instance, we believe that it is wrong to encourage a mobile pool of patients who can switch between GPs because we identify something much more personal about the medicine practised in Primary Care settings than that.

GPs only ever discharge' a patient in extreme situations, and patients only rarely `discharge' their GP. We are invited to enter the patients' systems, and we usually stay with them no matter

how rough the ride is. Mental health liaison workers attached to Primary Care will have to learn a different way of thinking if they are going to integrate usefully with the style of work in General, Family Medicine settings. Here communication patterns can be observed having lifelong, sometimes self destructive, effects. GPs and other members of the Primary Care Team usually have to live with such situations in the absence of credible services. There is nobody else to discharge them back to! The lack of a systemic approach in secondary mental health services sometimes makes the 'assessment to treat' approach irrelevant and unhelpful to General Practitioners. If attached liaison workers were employed by specialist mental health teams simply to screen GP referrals, then their role would be largely unproductive, leading only to the patient simply being referred back to the GP. If, on the other hand, they were to develop a truly interfacing role within the systemic approach of a Primary Care setting, then this pilot suggests that health gain can be achieved.

This pilot study suggests that health gains can be made in patients with chronic symptoms using a systemic approach to therapy when they have previously failed to respond to individual-focused therapies. This is in accordance with other research. We could speculate that early involvement of therapists with systemic skills might well reduce and could even prevent a number of adult mental health and physical adjustment problems. This pilot study shows effects that reduce the GPs workload and help the Primary Care team to be more effective by adding another relevant and useful service to patients. We believe that improved liaison would result if all primary care counsellors had some systemic training. If mental health liaison workers too had systemic skills, then they could make more useful assessments and contributions at the interface of Primary and Secondary Care by identifying those patients who could better be managed in the community with the collaboration of GP, counsellor, nurse and mental health systemic therapist.

Conclusion

This pilot study suggests that it would be wise to encourage the development of training in systemic skills for primary care counsellors and CPNs. Neither of these professional groups would need to become involved in fully developed family therapy services, but both could apply the approach in their work with patients in General Practice. Further research arising from this study would focus upon the impact of that training.

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