

Group therapy in a general practice setting for frequent attenders: a controlled study of mothers with pre-school children

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SUMMARY. *The frequent attendance of women suffering from anxiety and depression is a common problem in general practice and the problems are often externalized through the women's children. A small controlled study was carried out in a general practice surgery to see whether demand for medical attention by mothers of pre-school children would decrease after they attended a discussion group. Twenty women who fulfilled the study criteria of more than double the national average consultation rate for their age group and of having at least one pre-school child, were sequentially allocated to a treatment or control group. The group therapy was held over two terms of 10 sessions, each of 90 minutes, and was led by a psychologist and a general practitioner. Consultation rates (including surgery visits, house calls and prescription requests) were recorded for five consecutive six-month periods before and after the intervention. At follow-up six months after the end of the treatment a significant reduction in consultation rate had been achieved and maintained by the treated group compared with the controls ($P < 0.01$). This study shows the value of attending to the cause of frequent consultation as well as to the complaints presented.*

Introduction

A PROBLEM common to many general practices is the frequent attendance of women suffering from anxiety and depression.^{1,2} Sometimes the mother displaces her own stresses on to the child, who is then presented as the problem member of the family, while in reality the child is reacting to the behaviour of the mother.³ This is illustrated by a recent community study of 308 mothers,⁴ where those rated as depressed were more likely to report their three-year-old children as having recurrent stomachaches and headaches and to have behavioural problems. Marital difficulties were reported in 50% of the families of those children with recurrent stomachaches compared with 21% of those without stomachaches, although there was no association with the recurrent headaches.

In other cases a mother will bring her child to the surgery not necessarily because the child is ill, but as a pretext to obtain attention from the doctor because she herself is upset. A study by Howie and Bigg⁵ found that mothers who are high users of psychotropic drugs have children who are high users of antibiotics for episodes of acute respiratory illness. Furthermore, when the mother's anxiety was less controlled she presented the child more frequently for treatment.

These findings support the suggestion that a mother's psychological state is related to somatic complaints in her child and the mother's influence must therefore be seen as an impor-

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tant part of the consultation. At present these women suffer considerably in the emotional field and demand a great deal of attention in the way of repeated 'emergency' care. These consultations are usually unproductive, as they are mostly carried out under conditions not conducive to examining the problems in depth.

A more constructive way of helping these women might be through group therapy. In addition to the cost-effectiveness of working with a number of people at the same time, there are other advantages to this approach. The setting provides discussion and group support for testing alternative coping methods.⁶ Further informal contact develops between members⁷ and this helps to decrease the sense of isolation experienced by many housebound mothers of toddlers. Attending a course in a group encourages the growth of confidence in the mothers' own capabilities to counteract dependence on the medical practitioner. In other words, members of a group take an 'active learner' role rather than that of a 'passive patient'. Being in a group and meeting others with similar problems has been found to be an important therapeutic factor.⁸ Participants in a group⁹ frequently comment that the 'opportunity to share problems with others in the same boat' is the most helpful aspect of treatment. Thus it seems that the group itself can be a valuable part of the treatment procedure.

Pilot study

A small pilot study was conducted with six mothers who were presenting a high demand for medical attention for themselves and their pre-school children. The aim was to see whether the frequency of surgery attendance and other requests for medical support would change after the women attended a discussion group on children's behavioural problems.

At nine months post-treatment, the mean number of calls for medical attention had dropped to less than half that at baseline and below the national average for this population.¹⁰ Self-rating depression scores which had shown mild depression at the start of the study were normal nine months later. Some degree of anxiety as assessed by scores on self-rated tests was still evident when the study ended, but this was considerably lower than at the beginning.

Although the subjects involved had been observed to be anxious personalities, their demands for medical attention were not specific for anxiety disorders, and the group course was not offered as specific treatment for anxiety but as an aid to coping with everyday parenting problems.

The encouraging results of this pilot study justified setting up the controlled study described here.

Method

The practice in which the group was held is in north London and has four principals, two trainees and two part-time nurses, with one community nurse, one midwife and two health visitors attached part-time. The group was held over two terms of 10 weekly sessions, each of 90 minutes, and was led by the authors (a psychologist and a general practitioner). A creche was provided on the premises so that mothers were able to attend with their pre-school children.

Before the start of the study frequency of consultations were noted for women patients with at least one child of pre-school age; consultations were defined as requests for house calls and prescriptions as well as surgery attendances for both the mothers and all their children aged seven years and under. The national morbidity survey¹⁰ mean consultation rate for this group is 3.6 face to face consultations per year and the first 24 mothers who exceeded twice this rate were invited by the general practitioner to take part in a study which looked into the problems of child rearing and its effect on family life. Four women refused to participate.

The 20 women who agreed to take part were allocated sequentially to either the treatment (group therapy) or the control (no therapy) group. No psychotropic drugs, sedatives or hypnotics were offered to any of the mothers or their children for the period of the study.

Consultation rate over six-month periods was used as an objective measurement of change in behaviour. Frequency of attendance at the surgery, house calls and face to face requests for prescriptions for the participants (including controls) and for all their children aged seven years and under were recorded for five periods — 12 and six months before the intervention, the six months which included the first term of treatment, the six months which included the second term of treatment and six months post-treatment follow-up. The consultation rates of the two groups were compared using a t-test with unequal variances.

Because anxiety and depression are known factors in the consultation rate among women in this age range,¹ psychometric self-rating tests for anxiety¹¹ and for depression¹² which have known reliability and validity were used for comparison between the groups at the beginning, middle and end of the intervention period. It was hypothesized that marital problems could be a further contributing factor and a validated marital problems questionnaire¹³ was also administered. In addition all the women were asked to give their husbands copies of the same marital problems questionnaire. However, because of the poor response to the questionnaires by both treatment and control groups it was not possible to obtain meaningful data on the scores, and they are not reported here.

Results

Characteristics of the groups

One woman dropped out of the therapy group at the end of the first session, and two of the women who had been allocated to the control group did not respond to any of the questionnaires. These three have been excluded from the study, leaving nine in the treated group and eight controls. Mean attendance at the meetings by the women was 8.0 times out of 10 in the first term and 6.3 out of 10 in the second term.

As can be seen from Table 1, the two groups were similar in age, social class and number of children aged seven years and under.

Table 1. Characteristics of the study population.

	Treatment group	Control group
Number of mothers	9	8
Mean age of mothers (yrs)	33.8	33.3
Number of mothers in social class:		
1 to 3N	5	5
3M to 5	4	3
Number of children aged 7 yrs and under	17	16

Table 2. Mean and standard deviation (SD) of total number of consultations in consecutive six-month periods (comprising surgery attendances, house calls and prescription requests) for the mothers and their children.

	Mean (SD) number of consultations in six-month period	
	Treatment group (n = 26)	Control group (n = 24)
Period 1 (12 months pre-treatment)	4.6 (2.8)	5.8 (5.3)
Period 2 (6 months pre-treatment)	5.5 (3.3)	5.0 (3.4)
Period 3 (including 1st term of treatment)	2.9 (2.2)	4.2 (3.0)
Period 4 (including 2nd term of treatment)	2.5 (1.6)	3.2 (2.8)
Period 5 (6 months post-treatment)	1.5 (1.5)	3.1 (2.5)**

** $P < 0.01$ versus treatment group. n = total number of mothers and children.

Consultation rates

The mean consultation rates of women and children in the two groups are given in Table 2. The consultation rate of the treatment group was lower than the controls during the two terms of treatment and significantly lower at the post-treatment follow-up ($t = 2.84$, 36 df, $P < 0.01$).

A further follow-up was intended at 12 months after the group had ended but by this time records were no longer available for five families who had moved from the area. This left five mothers with nine children in the treated group and seven mothers with 12 children in the control group. Mean total consultations over the six month period for the treatment group were 1.6 compared with 3.0 for the control group.

Group intervention

The form of the group was that of a general discussion, structured at the beginning by the leaders and later by the group members themselves. The role of the leaders was to encourage members — particularly those who were more withdrawn — to join in the discussions, to facilitate group supportive processes (sometimes by role play) and to assist in the testing and development of alternative coping strategies.

Members of the group shared their guilt at disliking their own children at times, and admitted their lack of patience with them. One mother described the frustration of spending all day with small children: 'Some days I never speak to anyone at my eye-level. It's like living in Disneyland'.

The group looked at how as adults they were still being affected by some of their earliest childhood experiences. For example, the over-protective parents of one of the women had insisted that she carry her wellington boots to and from school every day, causing her to be made fun of by her schoolmates. She began to see that she was still metaphorically 'carrying her wellies' — expecting to be mocked — and during the course of the group was able to assert herself with positive effect.

Several of the women had lost a parent in childhood and realized how this experience had created anxiety regarding their own health and that of their children, resulting in increased attendance at the surgery for reassurance.

As the group progressed, discussion became more general, encompassing the problems of adapting to the needs not only of their children, but of their husbands, parents, in-laws and — in one case — of step-children. One of the most useful strategies

learned was to recall their own feelings as children when dealing with present conflicts across the generations.

Discussion

It was not possible in this study to provide direct evidence for the effectiveness of group therapy in the relief of anxiety and depression. However, there was a reduction in the consultation rate of frequent attenders, which was maintained over the follow-up period and this suggests that doctor-initiated contact in the form of such groups enables mothers with young children to develop and maintain a more constructive coping strategy. Although individual psychological treatment was found by Trepka and colleagues⁷ to be the most effective method of bringing specific anxiety disorders under control, we would suggest that for more general anxiety problems group treatment is effective and financially viable. Each member of the treated group was given 30 hours contact time for the comparatively small cost of 6.7 therapist hours.

The poor response to the questionnaires measuring anxiety and depression and marital problems by group members as well as controls was probably due to the restrictions of the study design. Although both groups completed the initial questionnaires at the surgery the controls were subsequently sent the forms by post and the treated group were asked to complete their forms at home and to return them the following week in order to maximize the time spent in group discussion. It was difficult for the group leaders to keep control of the forms by this method, as it was felt more important that the women should continue to attend the group freely without feeling pressurized if too much attention were paid to the return of the forms. For both groups the husbands' forms were handled through the intermediary of their wives and one reason for the poor response here may have been fear of loss of confidentiality; in fact several control group members expressed reluctance to analyse their marital situation. Any further studies of this kind should allow time for questionnaires to be completed in the presence of the researcher. In a study by Waters¹⁴ the response rate to personal calls by trained interviewers was 86%. If the response rate to the psychometric questionnaires could be improved it would be possible to assess the relationship between psychological and marital problems and consultation behaviour.

A report by the Royal College of General Practitioners¹⁵ proposed that the primary health care team could organize and participate in patient-doctor groups, with the assistance of a professional group leader. Ruel and Adams¹⁶ described the successful progress of such a group aimed at exploring parenting problems, although no objective measures of effectiveness were used. The reduction in consultation rate found in our study demonstrates that new behaviour patterns may be learned which perhaps make individuals more capable of handling some of the stressful demands of family life.

It has been suggested⁵ that in certain cases of frequent consultation the mother rather than the child should be thought of as the patient. Our study has used consultation rate to show the effectiveness of treating the cause of the consultation as well as the complaint offered. It is to be hoped that future work in this area will make use of other measures in support of these findings.

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MRCGP EXAMINATION — MAY/JULY 1989

The dates for the next examination are as follows:

Written papers: Tuesday 9 May 1989 at centres in London, Manchester, Edinburgh, Newcastle, Cardiff, Belfast, Dublin, Liverpool, Leeds, Birmingham and Bristol. Oral examinations: in London from 29 June to 8 July inclusive and in Edinburgh from 26 to 28 June inclusive. The closing date for applications is Friday 24 February 1989.

Further details and an application form can be obtained from the Examination Administrator, Royal College of General Practitioners, 14 Princes Gate, London SW7 1PU.