Family therapy in general practice: views of referrers and clients

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SUMMARY. Family therapy is being used in a variety of settings, including general practice. To assess the views as to the effectiveness and acceptability of a family therapy clinic in a north London surgery, questionnaires were given to general practitioners referring patients, and to clients. Replies were received from seven doctors and 20 clients, representing 11 families. There was a high level of satisfaction among general practitioners referring patients. The clinic proved to be highly acceptable for clients, with 90% agreeing that it was easier to attend a clinic at the practice than at a hospital; and only one patient thought that knowing the general practitioner worked in the practice made it harder to talk openly. Eighty per cent of patients felt the problem had improved at the time of follow up. Where the problem had not improved, 60% felt that they were dealing with it better. Almost all of the patients felt that the family therapy clinic should become a permanent part of local services.

The family therapy clinic in general practice has been shown to be effective and popular with users of the service.

Keywords: family therapy; family consultation; family relationships; difficult patients; GP clinics; general practice.

Introduction

THE past two decades have seen a rapid expansion in the field of family therapy. The work of the early pioneers[1-3] has been adapted for a great variety of contexts, in hospitals, social services and primary health care settings.[4] While there is an increasing interest among doctors and general practitioners to translate principles derived from family therapy into their daily practice, general practitioners usually do not see it as part of their job to treat whole families. Instead they prefer to refer patients to specialist services. However, a number of such referrals never materialize, as families are reluctant to accept that they should see a psychiatrist or allied worker. Family therapy offered in the surgery, by a general practitioner and his or her team, seems an attractive idea aimed at engaging families in treatment in a familiar setting.

Family therapy is a relatively new form of conceptualizing and treating symptoms and problems. It is based on the idea that people are part of a variety of contexts, the most important being the family, and that those close to the patient are not only affected by the patient and his or her symptoms, but may also be affecting the symptoms. In this way the family can become part of the problem. Family therapy is a method of treatment which involves the whole family in resolving the patient's problems by looking at the way in which the problems occur, by exploring or redefining their meaning for family members, and by trying out new ways of dealing with the problematic situation.

The project was established in May 1989 in a large group practice in London, comprising eight partners, two trainees, two nurses and one social worker, and the aim was to set up a family therapy clinic. The therapy was aimed at both 'heartsink' practice attenders, who showed little response to traditional interventions, and families in crisis, such as those unable to cope with a newborn baby, families with problems with an adolescent or a family member with self-harming behaviour, or families with difficulties in coping with an acute or chronically physically ill family member. The practice partners felt that such clients might benefit from family intervention at the group practice rather than referral to specialist centres. Moreover, many of the families or individuals had already received a variety of psychological treatments in specialist centres, mostly with poor results. This, and the relative difficulty of obtaining family therapy locally led the authors to form a team to run a family therapy clinic at the Highgate group practice surgery.

The current climate in general practice is one that encourages and increasingly requires evaluation and audit. The use of consumers' opinions in the audit of family therapy has been widely applied.[5,6] The service may also profitably be evaluated in terms of the referrers' views and this has been used with success elsewhere in psychiatry[7,8] and has particular relevance at the Highgate group practice clinic where all referrals are from other general practitioner partners who are in a position to refer to other services.

The aim of this research was, therefore, to assess the views of the general practitioners making referrals, and the clients' opinions regarding the effectiveness and acceptability of family therapy. Two case histories are presented, to illustrate the value of family therapy.

Method

One of the partners (H G) had gained considerable experience in the practice of family therapy at a London teaching hospital. Team members also included the practice social worker (M L), a family therapist (R S), and later a general practitioner trainee (R M). Supervision was obtained from an outside consultant (K A).

The team met on a fortnightly basis for a whole afternoon, during which time up to three families could be seen. Referrals were taken from members of the practice and made on a small, specially designed referral form. Families were sent an appointment time with a card to be returned accepting or declining the appointment. If the card was not returned, the letter was followed up by a telephone call. Average waiting time was approximately four weeks although there was usually an urgent appointment time available if required.

When a family arrived, it was seen in one of the practice rooms by the whole team. A team member was nominated as a therapist while the others sat in the room as observers. There was usually a break after 45 minutes to have a discussion and perhaps design a therapeutic intervention or message to help the family.

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Sometimes the team would ask the family to leave the consulting room; on other occasions the team would have its discussion in front of the family. The majority of meetings with the family were videotaped with the knowledge and consent of the patients so that the team could later discuss specific clinical issues with the supervisor.

After the clinic had been running for 18 months, it was decided to assess the views of those general practitioners making referrals, and all referrers were therefore given a questionnaire which asked about 19 closed cases (cases no longer being seen at family therapy) to determine the helpfulness of family therapy for the presenting problem, the family involved, and the value to the referrer him/herself. To assess the views of the clients, adult members of families (those aged over 16 years) of the 19 closed cases were invited to complete a questionnaire regarding acceptability and effectiveness of family therapy. This had been specifically designed for the purpose, on the basis of discussion within the team and from a review of the literature. The questionnaire contained questions regarding the severity of the problem over time and how it was being dealt with, and eight questions with responses to be marked on semantic differential scales. It also contained a section for comment. The questionnaires were completed at home with a therapist (R M) who was not, in most cases, known to the families. Non-responders who had declined a visit from the therapist were followed up with a postal questionnaire. The results were collated and tabulated. The chi square test was used where applicable.

Results

In the period between May 1989 and November 1990 the clinic received 42 referrals. Twenty eight families (66.7%) were seen. Of the remainder, six families (14.3%) declined the offer of an appointment, two (4.8%) failed to turn up for the first appointment and another two families indicated that the problem had been resolved. Four families (9.5%) had been given appointments but had not yet been seen at the time of writing. Of the attenders, ten families (35.7%) were seen for one session only, 15 (53.6%) for between one and five sessions and only three families (10.7%) for more than five sessions.

The majority of referrals were for child-oriented problems, including infantile feeding problems, sleeping problems, issues of behaviour and control in pre-school and adolescent children, parasuicide, and parental management of chronic physical illness. Adult referrals comprised marital problems, alcoholism, depression and psychosomatic disorders, as well as separation issues involving adult children.

The mean length of time before follow up was four months after the end of family therapy.

Referrers' views

A 100% response rate was obtained from general practitioners regarding the 19 closed cases. Referrals were made by seven of the eight practice partners. There was a high level of satisfaction with the service. Referral to the clinic was felt to be helpful both for the presenting problem and for the family in the majority of cases (general practitioners strongly agreed or moderately agreed in 15/19 cases (79%)). General practitioners either strongly agreed or moderately agreed that referral had been helpful for the general practitioner him/herself in 18/19 cases (95%).

Consumers' views

Responses were obtained from 20 out of 37 adult clients (54% response rate). This represented 11 out of 19 families (response rate 58%). Non-responders did not differ significantly from responders in terms of number of sessions attended or referrers' satisfaction.

Acceptability. The clinic proved highly acceptable; only three respondents (15%) agreed with the statement that 'we had to wait too long for our first appointment', while 90% agreed that it was easier to attend a clinic at the practice than at a hospital or child guidance clinic (Table 1). Knowing that their general practitioner worked in the practice caused no problem of confidentiality, 85% disagreed that this was an issue while only one person agreed that it was. Most clients (70%) disagreed with the statement that 'it was difficult having the team in the room', although 25% agreed.

Effectiveness. Fifty five per cent of respondents (11/20) felt the problem had improved when they last attended the clinic. A total of 80% of clients (16/20) felt that the presenting problem had improved at the time of follow up. One person felt the problem had got worse, and three people thought there had been no change. Even if the problem had not improved, 60% felt they were dealing with it better, and no one thought that they were dealing with it worse. Only three patients indicated that another problem had replaced the original problem. Sixty per cent of respondents agreed with the statement 'the clinic has helped with our problems', while 30% disagreed. Twenty per cent of respondents would have felt unable to return to the clinic with further problems. Since ending therapy, three families had received additional professional help: one adolescent child had contact with a social worker, one adolescent child had meetings with teachers, and one couple had sought marriage guidance. A total of 95% thought that the service should become a permanent part of local services for families.

Table 1. Clients' views of family therapy ($n = 20$)

	No. of respondents				
	Strongly agree	Moderately agree	No opinion	Moderately disagree	Strongly disagree
Too long to wait for first appointment	0	3	2	6	9
Easier going to GP surgery than hospital	11	7	2	0	0
Hard to talk openly knowing GP in practice	0	1	2	1	16
Difficult having team in the room	0	5	1	6	8
Another problem has replaced original one	0	3	6	3	8
Clinic has helped with problems	3	9	2	3	3
Would feel able to return to clinic if further problems	10	5	1	2	2
Should be permanent part of local services	16	3	1	0	0

n = number of respondents.

Other comments. The majority of comments were generally appreciative and positive. Four respondents commented on the sensitive and supportive atmosphere. Although some respondents were initially daunted by the large number of observers in the consulting room, no one continued to find this a problem and two respondents indicated that they had hoped that the observing team would participate more. Those who felt least helped wished for more frequent family therapy sessions or longer meetings and one patient complained that 'the problem had not been got to grips with', a criticism echoed by two other patients. There were also criticisms of style which some thought to be too superficial or rigid.

Case histories

Family A

The A family was referred by a practice partner because of worries about the health of the older daughter, X, aged 19 years. Both parents had professional jobs. They had one other daughter, Y, aged 17 years.

X had been a multiple attender at the practice over the preceding year with non-specific bowel symptoms and had been investigated by gastroenterologists, and was diagnosed as having irritable bowel syndrome. X failed to do as well in her A levels as had been anticipated. At the time of referral, she was re-sitting two subjects but was suffering, according to her mother, from 'a crisis of confidence'. Mr A had recently been diagnosed as suffering from early multiple sclerosis and Mrs A had requested that we did not mention this in the sessions as the girls were apparently unaware of their father's illness.

Prior to meeting with the family the team formed a hypothesis on the basis of the referral information: X was growing up and therefore almost ready to leave home. This, however, posed a dilemma since it meant that she had to convince herself that her parents could cope without her at a time of uncertainty surrounding her father's health. Being unwell herself had the effect of distracting the family's worries over Mr A.

The family therapy team chose not to challenge the issue of Mr A's diagnosis directly but, in the first session with the family, explored the theme of worry about each other's health. The family agreed that X was close to her father, while Y was closer to her mother. The girls spoke articulately and protectively about their parents and the question was raised of what might happen once the children left home. Mrs A became very tearful. Y expressed fears that her father would be unable to comfort her mother. X stated that she was more concerned that her father would be overwhelmed by her mother's anxiety. The children seemed more worried about their parents than the parents were about the children. The team challenged Mr and Mrs A to help their daughters to worry less by convincing X and Y that they were able to look after each other. In this way the team indirectly addressed the issue of father's multiple sclerosis without going against Mrs A's wishes.

At the second session four weeks later, the family described how they all felt more relaxed. It appeared that Mr A's illness had still not been discussed. The girls were both planning trips abroad. There was an argument during the therapy sessions over who should make X's appointments with the doctor: X or her mother. Things seemed to be going better for the girls but Mrs A looked tense and upset and Mr A appeared older and slower. The team predicted that the parents might become more worried and anxious once the girls had gone abroad and offered to see the parents as a couple if they felt they could not cope. Mr and Mrs A did not take up this offer. The team later learned that X had stopped consulting the practice about her bowel problems and that she did well enough in her re-sits to take up the place at university that she had been offered.

This case illustrated how physical illness, in this case multiple sclerosis and irritable bowel syndrome, can affect family relationships, which can then recursively influence the course of the illness, both for better and for worse.

Family B

Z was a young man who had suffered severe head and facial injuries in a car accident when he was 18 years old. His injuries had apparently precipitated a psychotic illness necessitating hospital admission. The diagnosis was uncertain but he was thought to be suffering from schizophrenia. Z had a very anxious mother, a relatively new stepfather and a successful older brother. Z's parents had separated when he and his brother were very young and there was now no contact with his father.

Referral to the clinic was precipitated by a crisis in the home in which Z threatened his stepfather with a bread knife. The out-of-hours social worker was involved and Z was admitted to the local mental hospital for a short period before being discharged to bed and breakfast accommodation. The practice social worker received many letters and telephone calls from the mother and, when the situation was discussed at a practice meeting, referral to the clinic was offered. Despite the level of violence and involvement of the family in Z's difficulties, no other agency was in a position to offer any family intervention.

The therapy focused on the influence that Z's illness had on the family and on how the family might best help him. Issues of personal responsibility, safety and family members' differing needs were discussed, including the needs of the mother and stepfather to have space without the intrusion of physical violence; the needs of the brother to express his rivalrous resentment of Z and have claim to his own problems; and the needs of Z himself to have help in sorting out his medical and social problems.

Over the course of the therapy, the parents were able to help Z move into his own flat. Rules and boundaries were set up, for example, Z agreed not to visit his parents' house without letting them know beforehand. His brother stopped attending the family sessions and was offered help in pursuing individual therapy. Violence ceased to be an issue and, while Z's psychological health continued to be a source of considerable concern, his parents were able to live with the doubt concerning his prognosis and to continue to offer him realistic help and support from a far less critical position.[9] The practice social worker, from her unique position as team member and representative of an outside agency, continued to support the family, in particular the mother, between sessions, but the family relied less and less on the practice as their belief in their own skills and coping grew.

This second case illustrates the benefits of a multi-disciplinary team, including in this case the attached social worker and the possibility of working with a whole family facing violence and psychiatric illness.

Discussion

The provision of a family therapy clinic within a general practice setting has a number of advantages. First, many families are concerned about the possible stigma attached to a referral to outside agencies and may not therefore take up their doctors' referral suggestions. Being seen as a family in the surgery is less threatening, particularly when a trusting relationship with the surgery has been established over a long period of time. In this study, 90% of respondents agreed that it was easier attending the clinic in the surgery rather than a hospital. The high attendance rates (66.7%) and the low level of non-attendance support this.

Secondly, it is possible to respond swiftly to family crises, such as a suicide attempt by an adolescent, where referral to an outside agency would take much longer, with the intensity of the crisis dissipating and thus the opportunity for change passing. General practitioners respond swiftly and this is best done by involving the family as quickly as possible. It is of interest that only 55% of patients felt things had improved by the last family therapy session, while 80% felt the presenting problem had improved at the time of follow up. This may suggest that improvement in the presenting problem often takes place some time after the therapy session.

Thirdly, general practitioners often have knowledge about illnesses suffered by different family members. Connections between such illnesses may be made by the family doctor which may help to explain family problems. These are also accepted by the patient, thereby possibly avoiding referral to a specialist with the disadvantage of psychiatric labelling. Fourthly, the siting of the clinic within the practice and the weekly information-sharing meeting of the whole group practice, has meant that a considerable amount of information concerning family members has been available. However, such intimate knowledge can raise problems with issues of confidentiality which may prejudice the therapeutic efforts. However, only one patient thought that there were problems with confidentiality. In addition, it is of value having a member in the team (R S) who does not work in the practice in any other context and who can provide an objective view.

The clinic offers some relief for general practitioners, albeit often temporary, from difficult or worrying cases. The general practitioners using the service felt it to be helpful for the presenting problem and for the family (79% of cases). In 95% of the cases the general practitioners agreed that the referral had been helpful to him/herself. The team's initial fear that the clinic might become a dumping ground for intractable cases proved unfounded. The fact that this had not happened reflects the high level of understanding of the uses and limitations of family therapy among the partners in this practice. Referring families to the clinic has been seen as a first resort rather than the last. Families themselves have been quite enthusiastic about the clinic, 95% agreeing that the clinic should be a permanent part of local services. All the practice partners have now made use of the clinic by referring families or couples.

Our experience suggested, and the findings confirmed, a great variability in the number of sessions required for different families. Much work was completed in one session and the majority under five sessions. We hope to discuss in a further paper how the nature of the referral and the clinical problem relate to number of sessions, illustrating that some sessions are for clarifying family issues leaving them free to follow their own preferred route, while others may empower families in a few sessions to cope with problems in a changed way and to avoid recursive patterns. Deeply entrenched problems, like established anorexia nervosa, may require longer term therapy. Similarly, therapeutic effectiveness may vary between resolving a problem in an identified patient which has become chronic, and helping a family find its own coping strategies to resolve internal conflicts created through a family crisis or life cycle change.

The climate in general practice is changing. The pressures imposed by the new contract have increased workloads in line with the government's intention to expand the range of problems handled by primary care workers. Part of this movement has seen an increasing number of consultants such as obstetricians, diabetic physicians and psychiatrists, running clinics in general practice and acting in a supervisory capacity.[10] These have been demonstrated to be more popular with patients, to produce better attendance rates than hospital outpatient clinics and, arguably, to be a better use of available resources. While we would not share the view that cost-effectiveness and market-place economics should be the sole determinant of health care provision, we believe that the feasibility and the potential effectiveness of providing a family therapy clinic in a primary care setting has been demonstrated, and this provides a useful model for other practices.

With between three and four therapists, this particular clinic may appear to have been well resourced, largely at the expense of the practice. However, it was a necessary level of staffing to develop sufficient expertise and confidence, but with more experience and regular supervision, fewer therapists may be needed. The family health services authority has recently agreed to fund a therapist for a two year reviewable period.

The effectiveness of family therapy as a treatment for specific conditions remains controversial[11] although controlled trials in the treatment of schizophrenia, anorexia nervosa, chronic pain and childhood asthma have all supported family intervention, and Lask has reviewed those conditions in which family therapy seems valuable.[12] Few would challenge the appropriateness of involving parents in the management of behavioural problems in children or the logic and good sense of offering therapy to families in distress over loss or separation. General practitioners routinely address these issues in their surgeries and much of the distress that they see does not fit comfortably with diagnostic labels. In these situations, research into consumer and referrer satisfaction may be useful.

Further research is needed to ascertain whether or not families would attend so readily at other practices as at this general practice surgery but it could be predicted that, whatever the nature of the practice population, families would find it easier to attend their local surgery than to go elsewhere.

At this point, one can only speculate about the long-term preventive implications of such projects. It seems probable that, if families can be seen quickly for family therapy in the practice, many problems may be treated at an early stage and thus be prevented from becoming chronic or intractable.

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