

# Clinical psychology: a consultative approach in general practice

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**SUMMARY.** *General practitioners tend to regard psychologists as an alternative resource for patients. This paper describes an approach to clinical psychology in general practice in which a team of psychologists works with a general practitioner on a consultancy basis. In this way the psychologists and general practitioner work together, with the general practitioner retaining responsibility for the patient. The method pays special attention to the context in which the problems occur, and to the set of relationships in which difficulties are experienced. The relevance of brief focused work is discussed and illustrated with clinical examples.*

## Introduction

**T**HIS paper is based on a project offering psychological services to a single-handed general practice within the Hampstead health authority. It describes how a team of psychologists can work with a general practitioner on a consultancy basis.

In this context 'consultation' is viewed as a relation between peers where the general practitioner (the consultee) explores a work-related issue with the psychologist (the consultant). The consultant's task is to facilitate the exploration and understanding of the issue. The responsibility for patient care remains with the general practitioner and the psychologist does not use his or her own expertise but rather that of the general practitioner. This use of the term consultant is very different from the usual medical model where the consultant is the expert. It also differs from supervision, where the responsibility for the work resides with the supervisor, and from training, where a body of knowledge may be imparted.

Eastman and McPherson<sup>1</sup> in their survey of a random sample of 30 general practitioners found that psychologists tended to be regarded by the general practitioners as an alternative resource for patients. There seemed to be no awareness of the advantages of a consultative approach or the sharing of skills through working together. Although a strong case is currently being made for the funding of clinical psychologist posts in general practice,<sup>2</sup> there is evidence to suggest that general practitioners tend to make referrals to the psychologist with little contact or opportunity for discussion about the patient.

It was agreed at the outset of the project that a family systems perspective should be used and that a team approach should be adopted, with one or more colleagues — usually behind a one way screen — acting as consultant to a psychotherapist conducting the session in the room with the family. This increas-

ingly popular way of working with families is well documented in the literature on family therapy,<sup>3,4</sup> and we felt it could be adapted to the context of general practice.

A 'systemic' perspective on families was used — this involves taking into account the relevant network of relationships, and understanding the symptom as a means of communicating the tension or discomfort in the family. Systemic interventions address the relational meaning of the symptom, for example, thinking about what an asthma attack may be communicating and what would be the consequences for the family if the child got better.

When setting up the project described here the needs of the practice were explored at an initial meeting and the two psychologists agreed to meet with the general practitioner for two hours on a fortnightly basis, initially for a period of one year.

At this stage mutually acceptable ways of working were negotiated and issues related to clinical responsibility and confidentiality were discussed. Brook and Temperley have pointed out the importance of preparatory work and knowing clearly who is responsible for the patient.<sup>5</sup>

## Nature of the work

### *Consultation between colleagues*

Each session begins with a period of consultation as described earlier. The content of the consultation can be an individual family or patient, a cluster of problems which the general practitioner may have come across over a number of cases or the recurrence of a particular event over a period of time. Decisions are made as to whether it would be appropriate for the psychologists to conduct the therapy or whether the general practitioner would most appropriately continue doing the work. These discussions bring forward aspects of the case which enable the general practitioner to work from a different perspective. Other members of the practice team are included in the initial consultations if necessary.

A useful tool in the course of these consultations is the genogram or family tree. Graphical representation of the various components of the family system often reveal connections and patterns which may be repeated across generations. In the course of systemic mapping of the family composition over three generations, we have repeatedly come across instances of un-mourned losses which often clarify our understanding of the presenting symptoms. This un-mourned loss can be a parent, a sibling or a child. Experiences of early abuse, physical or sexual, are also discovered in the process of building the family tree. The general practitioner, while recognizing her knowledge of families and their relationships, has found that this way of working enriches and deepens that knowledge to considerable advantage.

### *Consultation with the client*

This approach involves one of the team interviewing the family or patient with a colleague acting as consultant either behind a one way screen or, as in this project, in the same room. The consultant remains apart from the therapeutic encounter and addresses his or her observations to the therapist in the course of the session.<sup>6,7</sup>

Decisions about who will see the family and who will act as consultant are made during our discussion, taking into account

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the nature of the problem and the nature of the patient or family's relationship with the general practitioner.

Several arrangements are possible: one psychologist acting as consultant for the other; the general practitioner and the psychologist working together; the two psychologists working together and the general practitioner invited in at the end of the session in order to hear a summary of the work and to plan any further action. In all these arrangements the ultimate responsibility for the care of the family remains with the general practitioner. This was seen as an important principle in the consultation process.

The presence of a consultant in the room requires a different discipline to observing behind a one way screen, since the dialogue between the therapist and consultant is conducted with the client listening. This way of working, though more demanding at times, is more effective as it has to be conducted with the client's understanding in mind. The discussion between therapist and consultant therefore concentrates on the interactional processes rather than the content of what is taking place. We are helping the client to struggle with uncertainty while developing hypotheses which we can test out with the clients there and then. The clients are then in a position to observe and listen to a dialogue about themselves and their interpersonal behaviour.

Clients with whom we have worked in this way have shown considerable interest and eagerness to understand themselves. It is our view that this way of working, which allows clients to have access to the therapist's thinking and respond to it, enhances their capacity to take charge of their own development. For example, 15 minutes into a session with Marie, a young woman with a two year old son, the therapist found herself asking question after question and getting little in return. The therapist turned to the consultant and commented on her experience of having to work very hard at keeping the session going, saying she felt actively shut out from the relationship with the client. The therapist asked the consultant whether she thought Marie behaved in this way towards other significant people in her life. This statement by the therapist was confirmed by Marie who was then able to appreciate for the first time the part she played in provoking the experience of being shut out. That led to a discussion about how Marie manages her angry feelings and the part she plays in provoking anger in others. At a subsequent interview it became evident that she was managing to integrate her positive and negative feelings in a way that allowed her to make choices about relationships without feeling abandoned and rejected.

A team consisting of the psychologist and the general practitioner has been particularly useful when the family presents a child with physical symptoms and the general practitioner knows that the parents also have symptoms which may be contributing to the problem. One family, comprising a mother suffering from agoraphobia, loss of memory and breast cancer, a father who was alcohol dependent and a son of 15 years old who had fits, presented a daughter of 14 years old who was refusing to go to school and was the family's principal concern. The parents wanted a psychologist to 'put her right'. It was decided that the general practitioner and the psychologist would make a home visit together. The general practitioner was able to bring into the open the father's drinking behaviour and the mother's illness — secrets which might have taken much longer to emerge with a non-medical therapist. This made it possible to gain an understanding of the girl's symptomatic behaviour in the context of her family. Her mother's loss of memory appeared to be a form of denial of the implications of her breast cancer. We explored with the family how the daughter's fears of her father's excessive drinking and of her mother dying were preven-

ting her leaving home to go to school. We had three sessions with this family and the daughter returned to school. After a year we have reports from the school that the girl has since been attending regularly.

It is important to stress at this point that the aim is not to deal with all the problems a family may be experiencing. When involved with this family, for example, the most pressing problem was to free the trap which prevented the adolescent girl attending school by linking up her symptoms with her fears.

### What we have learned

Although general practitioners are constantly managing and coming to terms with the death of their patients, there is little opportunity for them to monitor their own reactions. It is perhaps obvious that relatives need to mourn their dead, but it may be less obvious that general practitioners also may need to mourn the deaths of their patients and to reflect on their own patterns of behaviour in responding to this constantly recurring event. The cost of not doing this leads to stress for the general practitioner and the experience of strain and exhaustion. The consultative approach provides an opportunity to explore with the general practitioner issues which are not immediately concerned with patients and their problems. The opportunity to talk about the experience of managing her dying patients and the sometimes angry, accusing relatives has enabled this general practitioner to acknowledge her own angry and distressing feelings about the situation. She is then able to be available for and to bear the angry feelings projected on to her by the distressed family members.

The opportunity for consultation with the psychologists about some patients has also enabled the general practitioner to gain a new understanding by making connections between life events recorded over the years in the patients' notes.

The time required for intervention is limited to one to three contacts, and enables a family or patient to cope with situations that might otherwise escalate into a referral to other agencies.

The psychologists have learned to work with patients who are unlikely to be seen at an outpatient psychiatric clinic, for example children and adults regularly coming to the surgery with recurrent physical complaints, or adults missing work. This is because the general practitioner's surgery is the one place where an individual feels able to present himself with or without an appointment whenever he feels 'unwell', depressed or anxious. Patients have many years of experience in using a general practitioner whereas a psychiatric outpatient clinic may be viewed far more as a place where 'other people go' but 'not me'; a place where you have to be obviously mad. With such patients the brief psychotherapeutic technique in the surgery setting has proved useful. For example, Joan, who worked as a supervisor in a hospital setting, was depressed and off work and could no longer cope. The brief work focused on Joan's unexpressed anger about the significant losses in her life: her mother's abandonment in early childhood and her father's death. Six weeks later after three interviews the general practitioner reported that Joan was back at work coping and 'even laughing'.

Another example of how the psychologist has encountered families presenting with multiple physical problems is the Smith family. Each individual member consulted the general practitioner with a different complaint: the father was deaf and out of work, the mother had eczema, the daughter suffered from headaches and the son was hyperactive at school. At the initial family interview connections between past and present experiences were explored and angry feelings were recognized and allowed to be expressed. In the course of the interview strong alliances across generations became apparent (mother and son and father and daughter), and we therefore arranged to see the

couple on their own to focus on and strengthen the marital relationship, enabling them to act more effectively as parents. The result was that Mr Smith found a job and was able to keep it and physical symptoms in other family members were reduced. During the interview with the couple, a very central theme was the difference between the two partners regarding how to think about the past. For Mr Smith it was important to dwell on it in order to resolve things and for Mrs Smith the past was the past and you get on with life. Having a consultant in the room enabled the therapist to stop, reflect and consider the meaning of these differences in front of the couple. During discussion the therapist and consultant wondered how to negotiate differences and explore how different perceptions of an event can both be valid, and not necessarily right or wrong.

In this case it was useful for the consultant to feel free to reflect on past events mentioned, while the therapist concentrated on the 'here and now' and offered her observations when appropriate. The focus of work was selected in front of the clients and this helped them accept different aspects of their lives as relevant even when these are not in the foreground all the time.

We have found that approaching even individual patients (as opposed to dealing with symptoms) with a systemic family perspective enables an understanding of interactional problems in the patient's life to be worked with and that this leads to a reduction of symptoms.

The general practice consultation is a private and personal meeting. The presence of another professional, such as a student or trainee can intrude on the doctor-patient relationship. Through this project the general practitioner has learned to work with another person present and to talk about the patient in his or her presence without losing the relationship with the patient. This has been appreciated by the medical and nursing students who are taught in the practice.

### Outcome

The regular discussion of their work together has enabled all three authors to develop creative insights into their work. We have come to view this as an opportunity for professional development and as a coping strategy to deal with the stress and strain of general practice.

A particularly relevant aspect of this work has been the development in the general practitioner's style of working. Where appropriate, the general practitioner now consults with the other members of the primary care team in the patient's presence, which enables patients to be party to the thinking process and contribute by clarifying any factual ambiguities, providing feedback to the thinking and taking a more active role in decisions about their health. This active involvement of patients in discussion enables them to join with the professionals in understanding their health situation. This way of working has also proved helpful in the training of medical and nursing students. Patients are encouraged by the general practitioner to actively contribute to the students' learning by sharing their own knowledge rather than being the passive recipient of examination procedures.

The authors are aware that some of the advantages of working in this way were particular to a single-handed practice. An interesting future development would be the application of this model in a team practice.

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## MRCGP Examination

The dates for the next two examinations for Membership of the College are as follows:

*October/December 1989*

Written papers: Tuesday 31 October 1989 at centres in London, Manchester, Edinburgh, Newcastle, Cardiff, Belfast, Dublin, Liverpool, Ripon, Birmingham and Exeter. Oral examinations: in Edinburgh on Monday 11 and Tuesday 12 December and in London from Wednesday 13 to Saturday 16 December inclusive. The closing date for applications is Friday 8 September 1989.

*May/July 1990*

Written papers: Wednesday 9 May 1990 (NB. This date has been changed from 8 May). Oral examinations: in Edinburgh from Monday 25 to Wednesday 27 June inclusive and in London from Thursday 28 June to Saturday 7 July inclusive. The closing date for applications is Friday 23 February 1990.

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

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