The contribution of a psychotherapist to general practice

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THE experiment described here is a study of the contribution that can be made to group practices by the presence in the surgery, for one session a week, of a professional worker with specialised training in a psychotherapeutic approach.

In 1971 the Community Unit of the Adult Department of the Tavistock Clinic invited four group practices to join in a study of the role in general practice of professional workers who were not only trained specialists in social work, psychology, and psychiatry, but who also shared a formal training in psychotherapy in which some were well advanced. For convenience, these workers will be referred to as the ' clinic workers ', and as ' she ', although some were men (see addendum). The general-practice team will be called the surgery workers, or, briefly, the ' surgery '.

Although nurses and health visitors have been attached to general practitioners' surgeries for many years, the attachment of social workers to general practice was introduced only in 1959 (Clayton, 1963–65). Despite its success, further work developed slowly. Forman and Fairbairn (1968), Ratoff and Pearson (1970) and Cooper (1971), are among those who reported on work in this field in the next decade. Goldberg and Neill (1972) have provided the most comprehensive study to date of the full-time attachment of a social worker to general practice, and Ratoff (1973) has reported a study of how social work/general practice liaison schemes are working.

Although Broadhurst (1972) has described some of the work that can be undertaken jointly by psychologists and general practitioners, we have not read of any previous project in which a clinical psychologist has worked regularly with a general practitioner in his surgery. However, the Trethowan Report (1974) envisages psychologists extending their role into general medical practice and some of the possibilities have been discussed by Kincey (1974).

Similarly, there have been few reports other than those of Brook (1967) and Lyons (1969) of psychiatrists having worked systematically with general practitioners in their surgeries. A recent World Health Organisation working party, has, however, devoted itself to this subject (1974).

Method

The experiment we are describing has two components. First, a number of clinic workers have been attached for one session a week to group practices in the vicinity. Secondly, a weekly workshop is held at the Tavistock Clinic and attended by the clinic workers and by two members of each surgery team: one is usually a general practitioner and the other a health visitor, community nurse, medicosocial worker, or trainee general practitioner.

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Preparatory work

Our experience in this and previous projects has confirmed the crucial importance of giving time and thought to advance planning if severe misapprehensions and communication difficulties are to be avoided.

We therefore first visited each practice to discuss the project with the staff and to make sure that everyone felt that they could work together. We wanted to discuss how the clinic worker could best avoid merely transferring her office from the clinic to the surgery without increasing her communication with the surgery staff.

We agreed that when a general practitioner felt that the clinic worker might be able to contribute to the understanding of a problem he should first discuss it with her: only then should they decide together how to proceed. The doctor might feel, after discussing the patient with the clinic worker, that he understood something additional and was able to help the patient with this himself. We expected, however, that frequently the clinic worker would be asked to see the patient and make a psychodynamic assessment, which would be followed by discussion with the general practitioner, or any other member of his team involved, and decisions on how to proceed further would be made jointly.

Some patients might then be seen a number of times by the clinic worker for help over a personal or family crisis: or she might see them less often over a longer period to help the surgery contain a more chronic problem. Especially where the problems were family ones, we hoped that the clinic worker and the surgery staff might see members of the family together or have the clinic worker, for instance, see one spouse and the general practitioner the other.

We also drew attention to the importance of the surgery ' referrer ' and the clinic worker discussing together in advance how, in those cases where the patient was to see the clinic worker, this would be explained to the patient.

We found it helpful to clarify the types of skills the clinic worker might have so that the general practitioners should not expect, for example, social workers and psychologists with psychotherapy skills to give them opinions properly sought from a psychiatrist. It was also understood that those clinic workers who are social workers would not be able, in one session a week, to arrange the practical social services or provide the long-term help to problem families given by their colleagues in other agencies, nor would the clinic worker be able to take on patients for long-term psychotherapy.

Even when the clinic worker was a doctor, we had to make it clear that ultimate responsibility would remain with the general practitioner, who would make the decision if there were a conflict of opinion.

We then agreed on some practical arrangements. A room was set aside for the clinic worker to see patients on her own, and we tried to arrange the attachment so that the clinic worker's session overlapped with a lunch time or some other surgery staff meeting. We stressed that the clinic worker and the surgery team would need to communicate easily and regularly about what was happening and about the general management of the case. As can be seen, our approach was radically different from that of Smith (1973) who indicated that the value of a social worker in general practice was that he and his partners could hand over all their social problems to her. Our aim was to reduce the amount of splitting and dissociation that so often occurs in patient care when different professionals may be played off against one another. This splitting can be a reproduction of the patients' need to keep various aspects of themselves in separate compartments; it can also result from the staff's reluctance to bear looking at the patient's situation *in toto*.

As a practical way of developing the working relationship we suggested that the

clinic worker might sit in at a surgery session with a general practitioner or accompany him on some of his home visits. In this way clinic worker and doctor began to know each other in a professional setting and could make satisfactory working arrangements. We also arranged that during the first year at least, the clinic worker would be supervised by one of us at the Tavistock Clinic. Finally we discussed the weekly multi-disciplinary workshop. We made it a requirement of the project that each surgery would send two representatives so that we could have a regular forum for examining the project and especially its interdisciplinary aspects.

Patterns of collaboration

We indicated that how the clinic worker and the surgery staff worked together would be, within the guidelines indicated, a matter of individual variation. Gradually, different patterns of collaboration in the various surgeries began to emerge. Three of the clinic workers spent most of their time at the surgeries seeing patients referred to them for assessment or brief therapy.

In other instances, consultative work with the surgery staff became the main focus, either in formal discussion about patients or in informal discussion as it arose in the office. One clinic worker calculated that she had discussed twice as many patients with surgery staff as she actually saw herself. When patients saw the clinic worker, mostly they saw her alone, but in one of the practices the general practitioners became enthusiastic partners in joint interviews, despite the rearrangement of their programmes that this involved. The same surgery sought, to some extent, the clinic worker's comments upon the group dynamics of the staff team and the way in which staff relations were being affected by the shared care of particular patients.

It often took time before a mutually satisfactory form of collaboration evolved. One clinic worker described the expectations with which her arrival was met " that symptoms would fly out of the window, marriages would mend, hopeless cases would become hopeful and referral to psychiatric hospitals become unnecessary . . . to be endowed with such omnipotent hopes was seductive and frightening ". She found that " gradually the boundaries of my expertise were more realistically assessed, but this was not achieved without a struggle ".

The attitudes of the general practitioners in making referrals varied greatly. One of the clinic workers was impressed by how the more organically minded doctors would so much prefer their patients' ailments to be amenable to drugs and common sense, but in fact made frequent and very perceptive referrals, using her, she felt, as their left hand of whom their right hand had reluctant, though appreciative, knowledge.

Work in the surgeries

Patients were seen by the clinic worker for 30–60 minutes at a time and from two to four patients or family groups of patients were seen at each session. The average number of individuals or families seen by each clinic worker during the course of a year was about 30. Some were seen only once, some four to six times and a few on more numerous occasions when surgery and worker felt this was appropriate. Patients came from varied social backgrounds, reflecting the social composition of the areas served by the surgeries. Most of the interviews with patients occurred at the surgery, a few at the patients' homes, and at least one in the street.

On reviewing the project, the four surgeries discovered that the patients they referred to the clinic workers had characteristics in common. It was rare for patients of over 40, unless they came in their capacity as parents, to be referred. It was also rare especially at the beginning of the project for the patient's emotional problems to be secondary to their physical illness or disability—the great majority being physically well or suffering from neurotic or psychosomatic disorders.

Where chronic physical or fatal illness was the central problem, the clinic worker sometimes worked in a consultative capacity. Many of the referrals—and here the clinic workers were pleased to be able to work with the health visitors—concerned young married couples and families with young children. Although there had been no intention to focus on these particular groups, the project was satisfied with this development—young adults, and especially those involved in the formative stages of marriage and parenthood are crucial groups in any programme of preventive mental health.

Some of the patients seen by or discussed with the clinic workers were referred to psychiatrists. The project preferred, however, to concentrate on increasing the resources with which the surgery itself endeavoured to help those patients, often disturbed, who were unlikely ever to accept referral to specialised agencies and who might not be helped by such referral in any case—such patients are most effectively helped by their surgery team. As well as the patients who got some help from a few sessions with the clinic worker, there were those helped by the indirect effect upon the surgery staff of the clinic worker's attitudes. For example, a surgery nurse, particularly interested in the project, began to realise that, as she examined women internally in the course of family planning clinics, they confided to her problems they had previously kept to themselves. She now felt that it was not irrelevant to her job to receive and comment on these confidences. Surgery staff were helped to have a proper respect for what they themselves were doing for their disturbed patients and they came to see what psycho-dynamically trained colleagues could offer and what they could not.

Myths about the magic that expert psychotherapy could produce were dispelled and each side gained a more realistic and modest respect for what the other could achieve. The surgery staff for instance commented on their new appreciation of how much covert family disturbance might lie behind the presented sick patient. One general practitioner thought that as a result of this greater realism about what can be achieved by the surgery and by psychotherapeutically trained colleagues, referrals from his practice to the formal psychiatric services dropped substantially.

Illustrative cases

When the clinic worker was involved directly, seeing patients or their families for assessment and then perhaps for a limited number of therapeutic interviews, she would be working as a specialist, using her clinical skills as a psychotherapist, e.g.:

Mrs A was a mother of three young children. Her husband had left her and she had turned to her general practitioner for help because she was depressed. Mrs A was a competent professional woman well regarded by the surgery for how she managed her responsibilities as a mother. She had, however, in the past been obese and had severe psoriasis. The general practitioner asked the clinic worker to see Mrs A in the hope that she would be able to help her further with her depression. The clinic worker noticed that she first referred to her unease about her adequacy as a mother, and then spoke at length of her difficulties in coping with a black woman, with a terrible temper, who shared her house.

The worker suggested that Mrs A had within herself another, a black and violent, side which she feared and with which she could not cope. Mrs. A replied by telling her that she had, at a time of particular stress, hit one of her children so hard that his front teeth were knocked out. She had not told her doctor or the dentist the truth about this. She felt guilty and also afraid that she might again become violent to her children. After further interviews with the clinic worker Mrs A felt that this could be talked about with her doctor and the health visitor. She could now regard them as her allies rather than as people who would be shocked and condemning.

It was the special skill of the clinic worker to be able to recognise the unconscious meaning of Mrs A's preoccupation with her dangerous black lodger: it was as a result of her interpreting this lodger as someone within Mrs A that Mrs A was able with great relief to admit what she had previously regarded as too terrible to confide in anyone. It was agreed that Mrs A should feel able to contact her doctor at any time if she felt scared of what she might do. The health visitor promptly, and tactfully, expedited nursery school places for the children. It seemed to the clinic worker that Mrs A might also be helped by long-term psychotherapy and she discussed with the general practitioner whether to explore the possibility of obtaining this.

The clinic worker could also be involved indirectly, not seeing patients, but discussing with the practice workers any psychological problems they wished to raise; in this case she would be taking on a consultant role:

Mrs B was a new patient. She consulted her doctor at a friend's suggestion because of the behaviour difficulties of her 2½-year-old daughter. The child was over-active and kept wandering, or running away from her mother. Mrs B was divorced. Her husband was still in Australia where they had lived together. Her parents were in the diplomatic service and she had had little sense of belonging anywhere.

She talked twice to the general practitioner, who decided that rather than refer her and the girl to a child guidance clinic, he would ask the advice of the clinic worker at the surgery. The clinic worker suggested that the doctor allow Mrs B to talk with him about herself and her predicament concerning her marriage and being a mother. She also suggested that he ascertain from the girl's day nursery how she behaved there. The doctor was interested to learn that the day nursery found the little girl's behaviour in no way disturbed. After he suggested to Mrs B that she should continue to talk with him about her problems, there was so little further mention of the girl that he had to enquire about her. She was no longer running away and had also suddenly become toilet trained.

The doctor then wondered, in view of Mrs B's loneliness, whether to refer her to some social or therapeutic group. He and the clinic worker decided to discuss the case in the workshop. It was there suggested that his success with Mrs B was partly due to his keeping her psychological care in his own hands, thus resisting the temptation to repeat the pattern of her life, i.e. of being passed from base to base, so that she had no sense of belonging.

She was subsequently able to share with her doctor her grief about her husband and to acknowledge that at times she felt anger as well as gratitude towards her general practitioner. He described how she then emerged " as a strong personality instead of the nondescript person she had been before ". Her contacts with the doctor then diminished, but she and her daughter maintained their progress.

The doctor felt that it was due to the clinic worker's advice and guidance that he had been able to handle the case himself. He felt that this family would have been no more effectively helped had they been subjected to the complex procedure of transfer to a specialist clinic. His confidence was increased in his own ability to manage other patients with similar emotional difficulties.

Workshop

The multidisciplinary workshop, consisting, as described above, of the clinic workers and the surgery workers, has met regularly tor 1¼ hours each week at the Tavistock Clinic. One general practitioner and one of his non-medical colleagues were invited to attend the workshop regularly, although we did not insist rigidly on this membership. Some members of the surgeries sampled the weekly workshop once or twice and decided it was of doubtful use.

In their surgeries, however, where they could regulate their contact with the clinic worker and her psychodynamic views, a useful working relationship was often established and, at their own pace, they took part in a dialogue with the clinic worker through which both learnt much.

At the workshop one of the clinic worker/surgery ' teams ' usually presents material, an individual patient, a family or a specific problem. Spontaneity of presentation has been encouraged as this provides a vivid picture of what has been happening. The workshop is partly concerned with understanding the emotional difficulties of the patients discussed, and partly with looking at the impact the patient's problems are having upon the team members involved.

In the more reflective atmosphere of the workshop sometimes both the clinic worker and the general practitioner or health visitor can gain a new perspective on something that has troubled them. One young doctor brought up for discussion his anxiety about a depressed man he had been treating medicinally and whom he had also introduced to the clinic worker in the surgery. Both workers realised, as they talked, how the patient, a very ' rational ' controlling man, had contrived to make them as fearful as he himself was of pursuing the hints he dropped about suicide and about his sexual problems. Because of his fear, they had not been able to obtain a realistic picture of how suicidal he was and whether they should be considering sending him to hospital. After the

discussion, the doctor found that in a natural, unconstrained way, he could now discuss the patient's problems with him. He had been so dismissive of feeling, so afraid of his own, that both workers had unawares adopted these standards, undervalued *their* feelings and become as constrained as he was.

The workshop also examines how the team members are working together and wondered if a different collaborative pattern might be more efficient or beneficial to the patient. As the surgeries have increasingly developed their own individual styles of co-operation, the discussions in the workshop are often challenging and there has been much examination of the irrational fears and fantasies which influence the way people of different professions relate to each other.

Interprofessional rivalry has been one of the phenomena much discussed. It proved to be at the root of many apparently intractable difficulties between professional workers. The psychologists and social workers envy the doctors their status: the surgery staff feel uneasy respect for the psychological sophistication of the clinic staff: both groups feel competitive with the psychiatrists who have both public status and psychological know-how. Each profession can learn from the other, but there has also been discussion of how being over-impressed by other professions' skills can cause practitioners to undervalue and even to abdicate unawares their original and specific skills.

Social workers, for example, can omit to find out the basic facts of how someone is currently supporting himself financially and general practitioners can overlook the possibility of organic illness, so bemused are they both with the psychodynamics of the patient.

Quite apart from rivalry between the professions there is also the difficulty, irrespective of profession, in sharing the care-giving role. We each like to feel that it is we, nurse, doctor, or psychotherapist who have our patients' special confidence and we feel irrationally hurt and competitive if they seem to find it easier to tell some things to a colleague rather than to us.

These conflicts can express themselves in various ways, for instance, by an over-eagerness to withdraw and allow the other staff member to demonstrate his ' superior ' skill. It has been particularly useful to acknowledge these rivalries because so often the working relationship between the staff members has become infiltrated by the emotional conflicts of the patients and can reproduce them without the staff realising it.

A young married woman with severe character problems provoked a great deal of exasperation in the practice as a result of her intrusive and demanding behaviour. Insisting that her complaints were pressing she often managed to get to the head of the queue ahead of people who had been waiting longer. In her interviews both with the general practitioners and with the clinic worker she managed to obtain information about their private lives which they would not ordinarily communicate to a patient. On one occasion she managed to persuade one of the partners to show her, against his better judgment, a report about her which he had received from a psychiatric clinic. She then began to besiege the surgery with demands that the psychiatric report be removed from her notes and destroyed. Both the surgery workers and the clinic worker found it hard to contain and restrain her and decided to discuss her at the workshop.

Her general practitioner arrived at the workshop meeting a quarter of an hour late when discussion had begun on another case. Immediately, however, the clinic worker and the practitioner asked if their case could have priority and the rest of the workshop agreed, with polite irritability. It gradually became clear that the general practitioner and clinic worker had both been acting out of character in being so pressing, but were in fact so overwhelmed by the patient that they themselves were impelled to act like her and pressed to be head of the queue. The reaction of the group had been the same as the reaction of the workers in the surgery, namely a feeling of inability to do anything other than acquiesce with resentment.

As this parallel was examined in the workshop the clinic worker and practitioner realised how the patient had stampeded them into abandoning their clinical judgment. When the patient continued with her importunate demands both clinic worker and GP now found it possible to respond to her firmly, telling her, for example, that the patient's notes were the property of the surgery.

The surgery was impressed that thereafter the patient seemed more composed and ceased to pester them, presumably because she was reassured to find that someone could now resist her and contain her anxiety.

The workshop has given the Tavistock staff a support group which has helped them to work at the issue of what their role should be in general practice. It has also unexpectedly emerged as a support group for two other professionals new to general practice, a medicosocial worker employed by the local social service department and a surgery nurse. Neither of these feels as yet really endorsed by her professional body and both have used the seminar partly in order to explore and consolidate their professional identities in the new setting and *vis-à-vis* the representatives of various professions present at the seminar.

It also provided a forum in which questions of common concern to the project could be discussed. There was discussion of the kind of records the clinic worker might keep so that they were easily recognisable and quickly read by surgery staff who might not otherwise immediately recall that the patient had seen her.

We also discussed confidentiality. This arose particularly in connection with surgery meetings, bearing in mind the special vulnerability of a neighbourhood agency, such as general practice, to breaches of confidentiality. In general it was felt that all information should be shared by the clinic worker and the various members of the surgery team involved, but there were situations when discretion indicated that some details should be kept confidential by the person who had received them. It was then necessary however, for enough general information to be passed to the other professionals concerned to enable them to fulfil their roles adequately and responsibly. We sometimes noted that the resistance which staff members can show to receiving pertinent, but disturbing information about their patients was quite as much a problem as the likelihood of their passing it on too freely.

Discussion and conclusions

Unless people are sophisticated or desperate they do not readily turn either to the psychiatric services or to the social service departments. Everyone, however, has his general practitioner whom he has probably met and whom he can consult easily without any sense of social stigma.

General practice, therefore, offers unique opportunities for the early identification and treatment of emotional difficulties. It allows a wide variation in the directness with which a patient can convey his emotional conflicts to his doctor. Some patients indicate clearly their wish to receive only bodily diagnoses and physical remedies. Others may drop hints of their wish to receive some understanding of their underlying emotional problems, cautiously testing whether the doctor will respond, before committing themselves further. Others ask directly for help with their psychological difficulties.

Similarly, there is a wide variation in the attitudes of doctors. Some are primarily interested in looking for illnesses to treat. Others, while showing a lively appreciation of the relevance of emotional conflicts in their patients' complaints, are concerned to define them on a medical model and treat them accordingly. Others, however, are concerned to adopt a psycho-therapeutic approach appropriate to the setting of general practice. There are, therefore, many variables which influence the outcome for a particular patient.

The aim of our project was to study how a worker with psychotherapeutic skills could help general practice to develop its resources as well as exploit its special advantages in the field of mental health.

In assessing our three years' work, we have had to consider its implications for the patients, for the surgery team, and for the clinic workers themselves.

In considering the direct value of the project to the patients, it has become clear that many patients have obtained help with emotional problems at a much earlier stage than would normally be possible. We have also been able to help a substantial number of patients who would have not accepted a referral out of the practice to a psychiatric clinic or other specialised agency. Those patients who were seen by the clinic worker have often indicated their appreciation of being seen on familiar premises where they felt more secure rather than being referred to an unknown institution.

The project was also designed to help the surgery team as an indirect means of helping the patients. The clinic worker, because of her specialised knowledge of psychodynamic processes, could often help the surgery team deepen their understanding of their patients' problems and of their response to them. Strengthened in their ability to assess what could and what could not be done, they could feel more confident that they were helping the patient effectively.

The workshop at the Tavistock Clinic, as well as being an extension of this support system, provided a valuable forum for examining the various therapeutic strategies and patterns of collaboration that were evolving in the surgeries. It was particularly effective for looking at the interprofessional rivalries and fantasies which bedevil any interdisciplinary programme.

Sutherland (1971) has indicated how work towards better community mental health entails new roles for the psychotherapist. Only a small number of patients can be accepted at a clinic for systematic psychotherapy. A psychotherapist who has to limit his activities in this way is, therefore, making only a minimal contribution to the treatment of neurotic disorders in the community and, in our view, is not doing justice to his specialty or to the needs of the community.

The clinic workers in this project found that it provided them with a valuable experience in learning how to apply their insights and skills to a much broader field. They were able to help directly a wider range of patients than those who find their way to psychiatric clinics. More important, however, they were able to help the workers of first contact in general practice to increase their skills in identifying, tolerating, and alleviating the psychological distress they encounter in their daily work.

As yet there are no agreed standards and little official recognition of the skills of the kind practised by the clinic workers in this project. In a broader context we feel that our experience may contribute to any debate about the appropriate training for psychiatrists, social workers, and psychologists to work in general practice.

Addendum

The Tavistock Clinic workers attached to the group practice were:

Social workers:	Jane Temperley, Sally Box, Mannie Sher.
Psychologists:	Sue Holland, Anne Kilcoyne.
Psychiatrists:	Hyla Holden, John Lundgren, Elizabeth James, Wendy Rostron.

The practices were:

James Wigg practice, N15	Caryle Steen and five partners, general-practitioner trainees, medicosocial worker and health visitor.
Abbey Road practice, NW8	Lotte Newman and three partners, general practitioner trainees, health visitor and practice nurse.
Mackenzie Road practice, N7	Jack Norell and two partners, general practitioner trainees, health visitor.
Jackson's Lane practice, N6	Bill Smith and five partners, health visitor.

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NEGLIGENCE IN BRITISH GENERAL PRACTICE

Medical evidence showed that, in the absence of complications, a patient with ordinary influenza began to feel better after three or four days, but a patient who had no complications yet deteriorated, should be the cause of special concern. The doctor did not show special concern.

In these days of fast travel, general knowledge and medical literature had for some time alerted doctors to the dangers of illnesses from abroad.

Malaria was not a disease which normally came in the way of the ordinary general practitioner, but if a general practitioner knew that a patient he thought had influenza had just come back from the tropics, and was not getting better, it should have entered his head that it might be a tropical disease of some kind. He might not be capable of diagnosing malaria, but he should be alerted to the possibility that it might not be some indigenous disease.

The doctor had fallen short of the standard of care that should be observed by a general practitioner in his position, and therefore he was negligent.

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