A practice counsellor

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Introduction

THELMA is fat and unhappy; Mrs Brown never gets on with her neighbours and is always moving; Mr Jones has been given the sack again; Caroline always has 'tummy ache' when grandma comes to stay. All general practitioners will recognize some of these patients.

In the 1930s and 1940s it was thought that illness was rational and could be defined and that its presence could be determined by a doctor. Even today it is still assumed that patients decide to seek medical advice on clear-cut and rational grounds and that the doctor's decision on treatment will likewise be clear-cut and rational. It was previously believed that by removing financial barriers to medical care need would become equated with the services available (Minister of Reconstruction, 1942; Beveridge Report). Studies have shown that this is not so (Roberts, 1952; Abel-Smith and Titmuss, 1956). In particular, it is now clear that the decision whether or not to seek medical advice is influenced strongly by psychological and social factors (Taylor, 1968; Robinson, 1971).

The concept of the clinical iceberg was described by Last (1963), who suggested that there were huge unmet medical needs which had no definite dimensions and, with the increasing sophistication of medicine, the size of the iceberg was unpredictable. Thus, attempts to bring it above the surface merely emphasize the apparently inexhaustible demand for medical care.

In the 30 years since the beginning of the NHS, despite enormous increases in running costs, there has been little change in morbidity. In the present period of financial restriction it is relevant to take a critical look at the system for providing medical care. In this context the need to curtail costs, to provide better community care, and to keep people out of hospital encourages the general practitioner to look more closely at whole-person medicine.

A factor increasing the range of medical care in recent years has been the "medicalization of social problems" (Office of Health Economics, 1975) by which doctors have taken over the pastoral role previously provided by the Church. In general practice many patients are consulting about family strife, economic difficulties, unsatisfied goals, anxiety, insecurity, sexual problems, and deviant behaviour.

Often, a doctor is not trained to deal with these problems and receives little support. Nevertheless, he or she may give helpful, intuitive advice based on years of experience.

It is difficult for the general practitioner to abandon the authoritarian role engendered by his training. However, for many of the problems confronting him there is no single solution, diagnosis, or definitive treatment. Thus, there is a need to devise a counselling technique, particularly one that is non-directive. Non-directive counselling has been defined as an interaction between two people which seeks to alter, modify, or change the behaviour of the patient or client without the counsellor expressing any judgement of the alteration (Royal College of General Practitioners, 1972). Counselling is often performed by the general practitioner himself, either in a series of short interviews or in a long interview arranged outside surgery hours. Alternatively, a practice counsellor can be employed.

The practice counsellor

Our practice, in a north-western suburb of London, has two doctors and about 4,500 patients. We operate an appointments system and have a practice team of health visitor, district nurse, midwife, social worker, and practice counsellor.

The practice counsellor is an important member of the team who accepts referrals from within the practice and often discusses patients' problems with other members of the team.

A practice counsellor should be able to deal with

those personal or family crises which are not specifically psychiatric in all age groups: from the difficulties of adolescence, sexual maturity, problems of adjustment to work and personal relationships, difficulties with marriage or children, intergenerational conflict, and economic or legal difficulties. In older people there may be the need to discuss unfulfilled goals and expectations and illness, loneliness, isolation, or death.

One of us is a trained marriage guidance counsellor who has been working in the practice for about three years. Patients are seen at the surgery on one afternoon each week. The doctors offer patients who have emotional problems the opportunity to see the counsellor; only if patients agree are they referred. Each session lasts for one hour and the counsellor may arrange four or more sessions. She is seen as part of the practice staff but at present is unpaid. Appointments are made for an afternoon when the surgery is quiet.

Details of referrals with the doctor's interpretation of the patient's problem are given to the counsellor in advance. Confidentiality is maintained throughout.

To be successful the counsellor must have an understanding of people. She must be caring and consistent. In the past two years about 30 patients have been seen. There have been a wide variety of problems, of which the following are examples.

Example 1

Mrs A. presented to the doctor with twin problems of obesity and psychosomatic illness. The counsellor saw her for ten sessions between early December 1976 and the end of February 1977. Mrs A. felt that she was entirely to blame for her situation. She described her marriage as 'ideal', with an affectionate husband, while she worried about her inability to show warmth. Her husband later agreed to come to a joint session in order to help his wife, at which he emanated a radiantly positive approach under which the counsellor watched Mrs A. shrivel. However, this mutual and informed observation was our turning-point, after which the client was able to free herself from many of her sexual fantasies. On realizing that the counsellor was able to contain these thoughts, she was able to face in counselling what she could not face alone; she could thus achieve the freedom to gain further insight into herself and her family. Although Mr A. did not come again, Mrs A. was helped to understand more of what Mann (1977) terms the 'collusive bond' so that she gained in self-esteem and found the motivation to diet.

This was an example where initially the client would have refused marital counselling but was able to accept it in the context of the surgery.

Counselling is a time-consuming process, where many feelings are acted out but contained within the safe counselling relationship. Subsequently, conditions for the patients may not change, but they feel freer to cope with them more satisfactorily, as illustrated by the following case.

Example 2

Soon after her divorce, Mrs B.'s ex-husband died, leaving her to cope with unadmitted and unresolved guilt feelings about his mental illness and death, and subsequent emotional disturbance in her daughter. Guilt and sexual jealousy were strong components, and the patient found it difficult to focus on either of them too closely, preferring to talk of her role as victim. She seemed to think herself destructive, although she barely articulated this—she always spoke in terms of outside events or people. In finding the counsellor's acceptance of her in her real life and in her fantasies, she gained further insight into her mechanism of constant self-justification, and so she was able to change. Mrs B. was seen 12 times between September 1976 and March 1977. She has recently returned for further counselling sessions; she wanted to share a further family problem (which arose after March) "before I crack up and can't communicate it at all".

This case is still in progress.

Example 3

The following case also showed the benefit of co-operation between counsellor and doctor.

Mr and Mrs C. were seen by the counsellor between October 1976 and July 1977. Unfortunately their young child was left in the waiting-room and in spite of the thick walls their shouting and hysterical screaming could be heard coming from the surgery.

Mrs C. had initially come to the doctor for help with nervous tension. She was a highly volatile woman, spitting and using violence, while at her every onslaught Mr C. retired still further into his protective shell, keeping his contact with her and his conversation to a minimum for fear of a hostile reaction. Of course, Mrs C. was by her behaviour excluding the close relationship she both craved and dreaded, yet with which she did not know how to cope.

In joint therapy lasting for 28 sessions, both reluctantly looked at their past lives, and it became clear to Mrs C. that her son was now at the age she had been when her father had committed suicide. She had previously denied any relevant feelings about her father or her mother, who was still alive.

During these sessions her headaches and hysteria noticeably increased, and she evinced rage, frequently revisiting the doctor. Meanwhile Mr C. appeared as a man under siege. However, he gradually found the strength to repel her attack, first in the counselling room and later at home. As he grew in strength so her acceptance of him increased, so that her need of psychosomatic illness was dissipated. The counsellor's rather longer than usual 28 sessions spent with Mr and Mrs C. gave each of them time for interpersonal learning, which could act as a mediator for change (Yalom, 1970).

Example 4

Mr D. was seen by the counsellor five times between January and April 1976. He was 19 and working as an accounts clerk. He presented to the doctor with a variety of abdominal and head pains which were not thought to be organic. The counsellor discovered he was a gambler. He was the youngest of three children; there had been a 17-year age gap between Mr D. and his brother, who was now dead, and his sister was ten years older than he was. His father had left his mother for another woman when he was 12 years old and had since shown no interest in the family. It emerged later that this had been his mother's second marriage. His brother and sister were children of the first marriage and their father maintained contact.

He had recently contacted his father to try to obtain a financial loan, but was rejected. He showed a good deal of anger and hatred about this. His older brother had died six months earlier from multiple sclerosis and Mr D. had taken a large share in nursing him, particularly at the end. His

brother's mind was confused and from time to time he adopted different attitudes and cults, so that Mr D. felt he was unable to invite friends home. He felt that his mother and sister were of a lower ability and intellect than himself and there were considerable financial difficulties. His sister was unmarried and lived at home; in any discussion she took the side of the mother.

Mr D. was intellectually and emotionally frustrated in his family setting. He was ambivalent about their need of him and his need for the security they offered him. He had feelings of resentment that he had never achieved happiness in youth. He had a girlfriend who he said had been helpful to him, although her parents did not approve of their relationship.

Mr D. and the counsellor discussed his need to get away from the house. It was difficult for him to accept this as a permanent solution so that the possibility was explored on a temporary basis. He showed feelings of being trapped, which extended to his job. He felt the need to earn because of a shortage of money at home and yet this conflicted with his boredom with being in a "dead end" job.

The counsellor found him to be intelligent, articulate, and likeable but he found it difficult to plan ahead. Jobs and finance were a permanent manifestation of his insecurity.

She wondered whether the home and maternal interdependency were his own conscious excuses for non-achievement, and the need for a sick person within the family was also discussed. She felt his need was for a father figure and someone who would take practical steps on his behalf. He was grateful for being able to be himself and to express his bad thoughts about his family to someone, whereas perhaps this had been denied initially.

When last seen he was considerably improved; he was able to understand his dilemma and he had benefited from the experience. What had been presented initially as a physical problem was seen after exploration to be a psychological one.

Initial communication between us as doctor and counsellor takes place whenever it is deemed necessary or helpful. We have further discussions if tensions increase unbearably for the patients while they are trying to come to terms with previously unacknowledged parts of themselves. In such cases as Mr and Mrs C., the counsellor will tell the doctor of this, so that when they return to him, he will sometimes prescribe medicaments on a temporary basis, or offer other help, so that they see not just one therapist but a team.

Becoming a member of such a team, with different disciplines and approaches, is a fascinating challenge for the counsellor, although extra work is required in communication and understanding of the different roles.

Results

Benefits of counselling to the patient

The patient has an opportunity to look at his or her problem in depth and find a tolerable and acceptable solution in his own time and in his own way, often at a much earlier and more remedial stage than might otherwise occur.

Benefits to the doctor

The doctor has provided a way to help the patient to face his or her real problems and come to terms with them without necessarily having recourse to drugs. It has made him more aware of this part of his work in many ways.

Benefits to the counsellor

The counsellor benefits from the contact, reassurance, and support from her close association as part of the practice team and from her satisfaction at seeing improvement, tolerance, and acceptance by the patients she has helped.

Discussion

Counsellors may come from different backgrounds with university degrees or diplomas, postgraduate experience, or the part-time training offered to marriage guidance counsellors.

The selection and training of counsellors by the Marriage Guidance Council is quite rigorous and approximately 40 per cent of those offering themselves for selection are accepted for training and, of these, 80 per cent complete the two years' part-time training. This includes seeing at least three patients a week, writing up their notes at length, attending a case discussion group, regular personal sessions with a tutor and five full weekend sessions at the National Marriage Guidance Council's training centre at Rugby. After acceptance as a counsellor these tutorials and case discussion groups continue and a regular number of patients has to be seen.

The counsellor often deals with problems which involve patients from adolescence to old age. Apart from marital problems the topics covered have included: accommodation problems, job difficulties, depression due to unemployment, redundancy or imminent retirement, vocational guidance, financial and business problems, intergenerational conflicts, unsatisfied goals, and fear and loneliness in the elderly (Cohen *et al.*, 1977). As the practice counsellor is seen as an extension of the doctor and is seen to be working with him, the feeling of rejection which may be produced if the doctor refers a patient to a distant agency is avoided, and early discussion of problems is made easier.

The task of the counsellor as described is different from that of the social worker. The latter may indeed counsel patients whom he or she sees as part of her work, and there have been several studies of the co-operation of general practitioners and social workers (Goldberg and Neill, 1972; Ratoff *et al.*, 1974; Graham and Sher, 1976), but they are usually local authority employees faced with the conflicts which this produces. They are full-time professionals and may be seen by patients as associated with the local authority or welfare authorities. With increasing constraints on finance and staffing, the social worker may be able to deal with only major problems of child care, mental illness, and homelessness and be obliged to spend less time with remedial and preventive casework than is desirable.

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There have also been attempts to link psychotherapists and general practitioners (Brook and Temperley, 1976) but this is only likely to develop on a small scale in the foreseeable future.

The counsellor, on the other hand, is seen as an unbiased person working closely with the doctor in his surgery. The counsellor is concerned in helping the patient find a tolerable, self-engendered solution to the problem.

The doctor can and often does include counselling in his work. He, too, is faced with constraints in time and there are other tasks for which he might consider himself better trained and equipped. There is no doubt that doctors and counsellors working together will reveal whether many more patients can be helped in this way.

A new approach for working with non-professionals and initially part-time colleagues will be needed. In this way not only will patients be helped to face their problems realistically but the number of psychotropic drugs needed might be considerably reduced (Meacher, 1977).

Several practices in London, Hampshire, and Teeside now have counsellors (Marsh and Barr, 1975) and several research projects are planned.

The counsellor is seen as an additional member of the practice team who has a separate, useful, and unique role to play in caring for the whole patient who presents in general practice.

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