Group-based care: does it change problem behaviour?

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SUMMARY. As a result of disappointing experiences in managing problem behaviour presented by patients in general practice, a system of team or group-based care was developed at the Ommoord Health Centre in Rotterdam, the Netherlands.

However, despite all the care given by social workers, general practitioners, physiotherapists and other members of the primary health care team, the problem behaviour of about half the patients was unaltered.

This report concerns the aims and methods of our group meetings and the conditions such as empathy, sincerity and non-possessive warmth which we regard as essential in dealing with problem behaviour. The conditions necessary for improvement, such as independence and responsiveness by patients, are also considered. During our group meetings the team deals with the emotions which patients are experiencing at the time, and patients are encouraged to discover as much as possible about their own possibilities for both influencing and making choices in their lives. Some examples of this type of care are given.

Patients react positively to the group-based care approach and some reduction in the consultation rate and in the prescribing of tranquillizers by general practitioners has been shown.

Introduction

LIFE is often described in terms of joy and happiness, but in reality a vast number of people suffer considerably, often for psychosocial reasons. In modern societies such people frequently turn to the medical care system for help and hence present an increasing number of problems to general practitioners and their colleagues in the primary health care team.

The team at the Ommoord Health Centre in Rotterdam has offered patient groups (relaxation groups) as one logical solution to this group of problems.

Aims

I wish to describe first, the content and arrangement of these group meetings, what happened, who participated and who led them; secondly, I wish to report the reasons for starting such groups; and thirdly, I wish to consider their effectiveness or outcome.

Ommoord Health Centre

The Ommoord Health Centre is situated in a suburb of Rotterdam, the Netherlands. About 17,000 of the 27,000 inhabitants are registered at the centre. The nuclear team, which has already been described by Lamberts and Riphagen (1975), comprises seven general practitioners, five doctors' assistants, eight district nurses, four physiotherapists, two midwives, a social worker, a practice manager, a practice nurse, a laboratory assistant, and a secretary. All team members may take part in our group work either as referrers or as team leaders.

Organization of group meetings

The groups consist of two group leaders and six or eight patients/participants. They meet once a week for eight successive weeks, each meeting lasting between two and three hours. The first meeting is used for the participants and group leaders to get to know each other, to experience what it is like to be in a group, and to discover each person's problems, expectations, and objectives. During the following meetings we work on all these aspects, and use the eighth and final meeting for evaluation.

The principle upon which we base our groups is that all the participants must have expressed their willingness to work on their problem in the group. This willingness is explored by the patients and group leaders before the start of the group so that we are sure that those who eventually attend group meetings really do intend to do

something practical about their problem during the eight sessions.

It is difficult to describe personal behaviour in groups because they are rich, colourful and dynamic. The development of the group process reminds me of a flock of ducks flying over the flat windswept Dutch fields: they speed from horizon to horizon, changing direction unexpectedly but undoubtedly flying with a purpose.

The content

The content of our group work is twofold: first relaxation exercises, and secondly talking.

The relaxation exercises resemble autogenic training. The group members learn how to relax, and different exercises are used on different occasions to enable everyone to find the exercise which suits him or her best. Participants are encouraged to practise their relaxation exercises at home.

Apart from relaxation, and probably more important, the exercises serve as a way to gain greater experience of the language of the body. Pain is not the only bodily sensation; our bodies can emit many signals.

People can talk about their problems for hours and hours without changing anything. We try as much as possible to let patients *work* on the problems rather than just talk about them. We look for the feelings and emotions relating to their problems as they are at that time and then work on them within the group.

The participants

Participants are asked to express how they feel. Their emotions (anger, fear, confidence, or misery) are not just described but have to be shown. Group members give feedback on each other, for example: "You say you feel sorrow, but I see something else . . . . . I sense anger in your face."

As a rule people in everyday life often repress their emotions and avoid unpleasant experiences. In the group, participants are given the opportunity to 'stay with' their emotions, to feel what it is to laugh, to cry, to be angry, and to express it to other people; to hear what others think about it in order to break down the barriers erected by their own imagination, which is usually based on the feeling that showing emotion is objectionable to other people.

At the same time, the participants are challenged to discover aspects of their personality which they have only partly realized existed, and to experience that they are greater than their complaint and more than their misery.

Special techniques

We ask everyone to tell the group about any funny, good, or new experience which they have had today and have found this to be quite a good way to start. Another technique is to combine fantasy trips with a relaxation exercise. In order to substantiate the possibilities of a fantasy, we sometimes ask participants to draw it, an approach that often considerably reinforces the person's self-image. These techniques are used only when the spontaneous process in the group comes to a halt and when it is relevant to our aims.

Group members themselves, of course, decide whether to 'stay with' their emotions or to avoid them, whether to share amusing experiences with the group and whether to let their fantasies be described or repressed. They do not try to force each other. It is fundamental that each person should choose for himself: it is not 'fate' nor 'circumstances' which are responsible for the choice he makes and its consequences. During group meetings, as in daily life, you cannot have your cake and eat it, but you can choose either to have it or to eat it.

The group leaders' group

We see our responsibility as group leaders as being to create and preserve the conditions necessary to enable all the members of the group to show their emotions. It is up to the participants whether they take an active part or not.

Group leaders have their own organization, the group leaders' group. This, in fact, is how our involvement with group-orientated support began, when we first formed a group of enthusiasts to formulate aims, gain skills and knowledge, and learn the right attitudes. It may be asked why we lead these groups ourselves, whether we are capable, and whether there are others who would do it better.

The group-orientated approach to personal growth is currently of great interest in the Netherlands and there are many institutes which concentrate on it. However, they are often isolated and may be far away from primary care, and furthermore, they may fail to attract those whom we believe need group therapy most.

If a group-based approach in primary care is to be justified, the method it uses must be closely linked with the aims of the primary care system itself. This is one of the main reasons that we started group-orientated care ourselves.

Every member of the primary care team in our health centre can become a group leader, but the decision involves a considerable degree of commitment. The group leaders form a distinct group within the team and they meet regularly to discuss their work in organizational as well as emotional terms. They share their own successes and failures, their joys and disappointments with each other.

The reason for having such a peer group of leaders is extremely important. We are trained as a group by a psychologist and learn to work on our own emotions. We learn how to 'stay with' our anger or sorrow and how we avoid our feelings. We learn how we choose to hold back our feelings and what consequences these choices have for us. We learn how surprising our fantasies are and what happens when we draw them out.

As a result of these activities our attitudes in dealing with problem behaviour have been modified considerably. At first, our main concern was how to change the behaviour of patients. Now, in dealing with problem behaviour, we place greater importance on the need to offer appropriate conditions for the patient to be able to experience what is going on, so that he can decide for himself what is wrong, what he wants to do and what he wants to change. The decisions are his responsibility, the framework for offering the conditions is ours.

This approach is not limited to our work in the relaxation groups, but has consequences for our care of individual patients as well. Furthermore, the members of the group leaders' group share their experiences with the whole nuclear team at the health centre. In this way, working with relaxation groups has influenced the whole team and modified its progress through the rough country of modern primary care.

Why group meetings?

Ever since the team of the Ommoord Health Centre started to work together, we have concentrated especially on psychosocial problems. We introduced the term 'problem behaviour' as a distinct entity from 'illness behaviour'. This idea of problem behaviour is now well documented, as is the frequency with which it is found (Lamberts, 1975a; Buyten *et al.*, 1977).

However, one of the aims of our team, apart from distinguishing between problem behaviour and illness behaviour, is to provide care for problem behaviour. Much individual counselling is often done by general practitioners, physiotherapists, social workers, and others. However, when we came to evaluate this counselling it became clear that the results were disappointing. Nearly half (47 per cent) of the patients retained their problem behaviour for three successive years or more (Lamberts, 1956). Thus we turned to group-based care. We appreciated that our involvement with problem behaviour was still too much within a medical model and still led to the medicalization of problem behaviour rather than to the socialization of psychosomatic complaints.

We hoped that when working in groups we could more easily 'deprofessionalize' the process of giving care and so obtain the conditions generally thought to be essential in dealing with problem behaviour: namely, accurate empathy, non-possessive warmth and sincerity.

So, what has been the outcome for our patients with problem behaviour?

Assessing outcome

It is difficult to measure the results of therapy, let alone the results of therapy for something as variable and changing as problem behaviour. How do we define change for the better and when can we call such a change cure or improvement?

It is difficult to evaluate problem behaviour. Life, which is full of problems and misery, is full of events as well. What our participants experience in our groups is only a part of all these events. Do they change, and if so is it in any way due to their participation in the groups?

Eysenck (1966) shows a spontaneous remission rate for neurotic problems of 70 per cent in two years, and of 90 per cent in four years. In our practice we have found a slightly different picture. Apart from a group with problem behaviour which lasts for just a short time, there seem to be a hard core of people who have problem behaviour continuously for four or more years. This finding is comparable with results of other studies in general practice (Cooper *et al.*, 1969; Lamberts, 1975b).

Goal attainment scaling

One promising way of assessing experience of this kind might be 'goal attainment scaling'. To use this method successfully it is necessary for the participants to have stabilized goals throughout the therapy.

After a series of eight group meetings I gave each participant an identical list of 10 statements, 10 possible goals for the meetings, and asked them to put these statements in rank order starting with the one they thought to be the most important and going on to the one they thought to be the least important, leaving out any they felt did not apply to them.

I analysed the 22 participants who finished this test twice. When these 22 pairs of ordering are compared, no consistency is shown by the individuals (Table 1). Apparently our participants often changed their minds about how to cope with their problem behaviour, which has implications for the possibility of measuring outcome. On the other hand, it might point to a dynamic personal involvement during group meetings. Further research is necessary involving details of personal goals and changes during group meetings.

Opinions of participants

I also tried to obtain some impressions of the effect of our group meetings. In order to do this I sought information in three different ways:

1. By asking the participants' opinions about the meetings.

Table 1. Comparing goals for participation before and after group meetings. Consistency in ranking top three out of 10 statements (goals).

Statements (goals)	Number of participants
Less than two same statements in top three	15
Two to three same statements in top three	7
Total number of participants	22

2. By measuring the participants' frequency of consulting their general practitioner before and after group meetings.

3. By measuring the general practitioners' prescriptions for psychotropic drugs to the participants before and after group meetings.

Eight groups with 78 participants were surveyed. Twelve participants failed to complete the series of eight meetings, a drop-out rate of 15 per cent.

The selected group of 66 people who finished the eight meetings completed a questionnaire with 12 questions about:

1. The atmosphere in the group.
2. The support they received from other members of the group and the group leaders.
3. The possibility of speaking honestly within the group.
4. The empathy and warmth they experienced.

Eighty to 100 per cent of the patients questioned (average 88 per cent) expressed a very positive response to the various aspects of our group meetings. Flattering as these results may be for us, it fails to help us understand our work more deeply. The patients' satisfaction seems overwhelming: the effect seems to be one of 'hello-goodbye'. When the ways of the provider and the patient part the patient seems to be anxious to please the provider as much as possible. We can only speculate on these results (van Weel, 1977).

Frequency of general practitioner consultations

All 78 participants were evaluated; in three cases data were incomplete and are therefore excluded.

The frequency with which the 75 remaining patients consulted their general practitioner fell from 3.80 in the half year before the start of our group, to 2.51 in the six months after its end (Table 2).

A period of six months is of course very short, but was chosen on practical grounds. It avoids the period at the start of the problem behaviour and the consequent bias in the figures because of the consultation during an acute phase. The change in consultation frequency is significant ($p<0.01$); however, it leaves us with a group who are still consulting the general practitioner more often than average.

The use of psychotropic drugs

Of the 78 participants surveyed two had to be excluded because of missing data. Of the remaining 76, 28 received psychotropic drugs from their general practitioner in the six months before the start of the group. Of these 28, 18 did not receive these drugs any more in the half year following the final group meeting, but five patients not on psychotropic drugs before did receive a prescription for tranquillizers after their group experience. This change is significant ($p<0.05$, Table 3).

Table 2. Participants' frequency of consulting their general practitioner before group (six months before the start of the first group meeting) and after group (six months after the last group meeting).

	Before group	After group
Number of consultations	280	188
Number of persons	75	75
Average number of consultations	3.80	2.51

The change in consultation frequency is statistically significant ($p<0.01$).

Table 3. Psychotropic drugs prescribed by the general practitioners to the participants before (six months before the start of the first group meeting) and after (six months after the last group meeting).

	Psychotropic drugs after	No psychotropic drugs after	Total
Psychotropic drugs before	10	18	28
No psychotropic drugs before	5	43	48
Total	15	61	76

The change in prescribed psychotropic drugs is statistically significant ($p<0.05$).

Nevertheless, this is a small change and the question remains, is it necessarily due to the help offered by the group? Peer review on the prescription of tranquillizers has influenced the prescribing habits of the general practitioners simultaneously (Lamberts and Wolgast, 1975; Lamberts, 1976).

Conclusion

Working with groups offers providers and patients a great deal. We have, however, not demonstrated adequately objective improvement.

The conflict remains between the deprofessionalization of care and the traditional approach of the 'skilled' professional. It is questionable whether people with life problems should be channelled into the primary care setting in the first place.

In order to evaluate accurately one must be sure about the aims and objectives of the participants. Our experiments with groups seem to add to a change in these aims rather than their stabilization. One consequence has been to set a new course for the struggle of our primary health care team through the rough and dangerous country of primary care.

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Prognosis of patients admitted to hospital with acute chest pain

To determine the prognosis after hospitalization of patients hospitalized with acute chest pain in a coronary care unit, we undertook a prospective study of 211 consecutive admissions to the Stanford Coronary Care Unit. On the basis of pre-determined criteria, 16 patients were found to have noncardiac chest pain, and myocardial infarction was ruled out in 89, one of whom died in hospital. Infarction was documented in 84 others, six of whom died in the hospital. Prospective follow up after hospitalization was carried out in the 88 patients in whom infarction was ruled out and in the 78 patients who survived infarction. The rate of myocardial infarction or death was 8.0 per cent at six months and 21.6 per cent at a mean of 27.8 months of follow up for patients who had infarction ruled out, as compared with 7.7 per cent at six months and 21.8 per cent at a mean of 27.8 months of follow up for those who had documented infarction during the initial hospitalization. Cardiomegaly, congestive heart failure and angina after discharge from the hospital tended to increase the risk of morbidity and mortality in both groups. The patient hospitalized with acute ischaemic chest pain without evolution of a myocardial infarction has a six- to 24-month prognosis similar to that of the patient hospitalized with an acute infarction, and therefore requires similar diagnostic and therapeutic assessment.

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