Marriage guidance counselling in general practice

ROSLYN H. CORNEY, BSc, MSc, PhD
Senior Lecturer, General Practice Research Unit, Institute of Psychiatry, London

SUMMARY. This paper discusses the results of a survey of all general practitioners and counsellors involved in attachments in the area covered by the London Marriage Guidance Council. The replies of both counsellors and doctors were generally enthusiastic and few problems with attachments were encountered. However, while subjective accounts are positive, it seems essential that more objective research into effectiveness should be conducted if counsellors are to argue their case for being paid.

Introduction

MARITAL and other relationship difficulties are commonly associated with both physical and mental ill-health[1] and people with these problems are more likely to contact their general practitioner for help than any other social service.[2] Although a number of general practitioners are interested in counselling and have received some relevant training many more have not or do not feel they have the time available for this work.[3]

In recent years, the number of marriage guidance counsellors working alongside general practitioners in health centres and surgeries has increased. While it is not known accurately how many attachments are operating in Britain, it has been estimated that there are approximately 100.[4]

In 1975, Marsh and Barr[5] described the part-time attachment of a marriage guidance counsellor to a group practice for the first time. In the first year, individuals and couples (involving 21 marriages) were seen in 160 appointments for a wide range of difficulties — such as sexual problems, depression and breakup of the family. In another study the counsellor considered that a unique contribution could be made by having the time and skill to allow patients to look at their problems in depth and at their own pace and to help them work towards a solution.[6]

In order to investigate the provision of marriage guidance counselling, it is necessary to have some idea of what counsellors actually do in their sessions with clients. A basic guide to the selection procedures, training, theoretical base and practice of marriage guidance counsellors has been provided by Tyndall[4] and in addition, a booklet for general practitioners has been prepared by the British Association of Counselling.[7] Marriage guidance counsellors normally arrange to meet their clients for a variable number of weekly sessions lasting 50 minutes. Tyndall describes counselling as essentially a 'non directive' listening process which avoids overt advice-giving. However, he emphasizes that counselling is not a standardized service and no two counsellors operate in the same way.

A survey

In 1985 a postal questionnaire was sent to all general practitioners and counsellors involved in attachments in the area covered by the London Marriage Guidance Council. The questionnaire was returned by 28 doctors (a response rate of 74%) in nine practices and by all 10 counsellors attached to these practices. Two of the doctors were new to their practice and were therefore unable to complete the questionnaire. Five of the practices were in health centres and two of these had a counsellor located in the building but not specifically attached to the practice. The majority of these schemes were well-established, having been set up in the 1970s. The majority of the counsellors had held their post for several years and half had held their post from the start of the attachment.

Many of the findings of this survey were similar to those found in earlier work.[8] All of the general practitioners felt that the counsellors' main task was counselling referred clients but a third of the doctors mentioned that the counsellor also provided support to practice members. Individuals with a variety of problems including relationship difficulties of all kinds, bereavement, alcoholism, unwanted pregnancies and adolescence were referred to the counsellors. However, the types of problems referred did depend on the other professionals attached to the practice. If psychiatrists and social workers were attached the counsellors were more likely to be referred only marital problems. The doctors were also asked to give details of their last referral to the counsellor. Their replies suggested that women were more likely to be referred than men or couples and that a high proportion of the referrals were depressed or anxious. The majority of patients were married and aged between 30 and 50 years. However, single women aged 20 to 29 years were another commonly referred group. Although marital and sexual difficulties were common, problems involving other relationships, work and personal identity were also frequent.

The results of this survey also indicated that some general practitioners referred many more people than others. While the number of referrals did depend on the number of hours the counsellor spent in the practice, there was also considerable variability within each practice. The median number of referrals in the last year was six but three doctors had referred more than 20 patients. Self-referrals and referrals from other members of the primary care team were much less common. However, the counsellors considered that the majority of their referrals were appropriate and they passed any inappropriate referrals to other agencies.

The number of hours the counsellors spent at the surgery varied considerably. Six counsellors spent six hours or less per week at the surgery while three counsellors spent between 12 and 20 hours per week. This meant that the number of clients seen by the counsellors also varied considerably from 16 patients per year to over 100.

Advantages of attachments

The replies of both counsellors and doctors indicated that few had any complaints about the attachment. The great majority were enthusiastic and had not encountered any major problems. However, it must be remembered that most of these attachments were well-established and any teething problems would have been overcome. It is also possible that the 10 doctors who did not reply to the questionnaire did not feel strongly about the arrangement or were more dissatisfied than the respondents.

Both counsellors and general practitioners considered that the attachment facilitated referrals of patients as well as feedback and that it also had advantages for patients who could receive counselling in a familiar setting. The counsellors also indicated that they enjoyed working as part of a team and that this reduced their feelings of isolation. They considered that they were part of a service offering comprehensive care to patients and that they had personally gained from having direct access to the doctor.

Of the 26 respondents, 20 doctors indicated that they found the attachment very helpful, a further five found it helpful and only one did not find it helpful. All of the doctors indicated that in the future they would like the attachment to carry on

© *Journal of the Royal College of General Practitioners,* 1986, **36**, 424-426.

as before or with an increase in the hours spent by the counsellor at the surgery.

Possible disadvantages of attachments

The counsellors had few complaints about working arrangements and, although in many practices there were no regular practice meetings, the majority of counsellors indicated that there were no problems of communication. Few general practitioners mentioned problems of confidentiality or disagreements regarding treatment or working arrangements. There were also no real problems of overlap between professionals, although some of the doctors found it difficult to know whom to refer and whom to counsel themselves.

One of the major problems mentioned by counsellors and doctors was the lack of payment to counsellors. Counsellors do not fall within the categories of auxiliary staff for whom doctors can claim reimbursement and many of the counsellors indicated that they would be able to work longer hours if paid. It is the policy of the London Marriage Guidance Council that all clients are asked by their counsellor for a financial contribution towards their counselling and none of the doctors indicated that any problems had arisen from this.

There is little evidence from replies to the questionnaires of any rivalries, conflicts or status problems between the general practitioners and the counsellors. This is surprising in the light of accounts of attachments of other professionals to the primary care team.[9] This may be due in part to the fact that marriage guidance counsellors are used to working independently and do not become frustrated when communication with other team members is infrequent or irregular.

While the majority of counsellors said that they enjoyed working in a team, it is difficult to ascertain from their replies how much collaboration and communication actually took place. Marriage guidance counsellors regard confidentiality as very important and although all the counsellors in this survey had access to medical notes, it seems likely that the interviews between the counsellor and the client are completely confidential and little detail is disclosed to the doctor or other health care professional. Can the counsellor therefore be regarded as an integral part of the team? The Trethowan report[10] discussed where the final medical responsibility for the patient receiving counselling rests; problems can arise when the doctor is not told all that transpires in the counselling session.

This strict adherence to confidentiality might be more difficult if the counsellor became a paid member of the team.[11] Should paid counsellors have access to other professional's notes but restrict their own? It is also likely that the counsellors' voluntary status allows them their independence: 'Non remuneration ... gives them the freedom to retain the advantages of being professional, independent practitioners, when working in a medical setting'.[11]

Many of the previous studies of marriage guidance referrals suggest that clients come from all social classes and are not predominantly middle-class.[8,12] However, it was apparent from the questionnaires returned in this survey that the attachment with the most difficulties was situated in one of the poorest and most deprived areas of south London. The clients of the counsellor in this practice were often unwilling to commit themselves to a series of sessions and often failed to keep appointments. The senior general practitioner was also aware of the problems and stated that 'the approach of marriage guidance counsellors needs to be flexible to reach the poor, the less articulate and the unemployed'. He stated that his patients had difficulties coping with the 50-minute sessions. The non-directive approach employed by most counsellors may be difficult to understand by the poorly educated client.[13-16] Heisler found that clients from the lower socioeconomic classes were more likely to drop out of counselling after one or two interviews than middle-class clients (*Some one interview cases and their apparent dynamics.* National Marriage Guidance Council. Unpublished). It is therefore most important that counsellors should adapt their method of working to fit their client population.

Effects on the work of the general practitioner

Many studies have indicated a decrease in the number of visits to the doctor by patients after cessation of counselling in comparison with the period before referral[5,8] and other studies have found a reduction in the prescribing of psychotropic and other drugs (Meacher M. *A pilot counselling scheme with general practitioners: summary report.* London: Mental Health Foundation, 1977. Unpublished).[6,8] It has also been found that attachments have led to a reduction in referrals to psychiatrists.[17] It seems reasonable to conclude that unhappy and distressed patients whose main need is to discuss their personal difficulties are more appropriately referred to a counsellor than to a busy psychiatrist.

In this survey the doctors were asked if the attachment had affected their work in any way. The majority considered that the attachment had reduced the number of referrals made to psychiatrists and other agencies and one-third considered that it had reduced the number of psychotropic drugs prescribed. The majority also felt that it had decreased their workload but six doctors felt that their workload had increased mainly because of additional meetings and discussions.

Conclusions

While the results of the studies reported here are mainly positive, it must be remembered that most of the doctors involved had a special interest and involvement in psychotherapy. This does not apply to medical practitioners in general; the majority of doctors have little training in counselling, no specific expertise, no time available, and possibly no inclination.[18] It is therefore difficult to extrapolate from the experiences of a group of enthusiastic general practitioners and to argue for a more comprehensive marriage guidance service. As the number of marriage guidance counsellors is not increasing substantially, placing a counsellor in a general practice reduces the number of counsellors available at council offices and, while attaching a counsellor to a practice will increase referrals from that practice, it does nothing to reduce the long council waiting lists.

If counsellors are to argue their case for being paid[19] it is essential that objective research is carried out to assess whether patients benefit from receiving counselling in their general practice. Counselling can be time-consuming and it is therefore important to determine whether patients benefit more when seen by a marriage guidance counsellor than other professionals in the team. Virtually no research has yet been undertaken in this area but positive results are necessary to substantiate the counsellors' case for payment and incorporation into the primary care team.

References

1. Chester R. Health and marriage breakdown: experience of a sample of divorced women. *Br J Prev Soc Med* 1971; **25:** 231-235.
2. Royal College of General Practitioners. *Present state and future needs. Reports from general practice no. 16.* 3rd edition. London: RCGP, 1973.
3. Home Office Working Party on Marriage Guidance. *Marriage matters.* London: HMSO, 1979.
4. Tyndall N. The work and impact of the National Marriage Guidance Council. In: Dryden W (ed). *Marital therapy in Britain.* Volume 1. London: Harper and Row, 1985.
5. Marsh GN, Barr J. Marriage guidance counselling in a group practice. *J R Coll Gen Pract* 1975; **25:** 73-75.
6. Cohen JSH. Marital counselling in general practice. *Proc R Coll Med* 1977; **70:** 495-496.

7. Irving J, Heath V. *Counselling in general practice: a guide for general practitioners.* Rugby: British Association of Counselling, 1985.
8. Waydenfeld D, Waydenfeld SW. Counselling in general practice. *J R Coll Gen Pract* 1980; **30:** 671-677.
9. Clare AW, Corney RH (eds). *Social work and primary health care.* London: Academic Press, 1975.
10. Trethowan WH. *The role of psychologists in the health service.* London: HMSO, 1977.
11. De Groot M. *Marriage guidance counselling in the medical setting. Research report no. 1.* Rugby: National Marriage Guidance Council, 1985.
12. Heisler J, Whitehouse A. *The national marriage guidance client 1975.* Rugby: National Marriage Guidance Council, 1976.
13. Mayer JE, Timms N. *The client speaks.* London: Routledge and Kegan Paul, 1970.
14. Corney RH. Client perspective in a general practice attachment. *Br J Social Work* 1981; **11:** 159-170.
15. Gaunt S. *The first interview in marriage guidance. Research report no. 2.* Rugby: National Marriage Guidance Council, 1985.
16. Hunt P. *Clients' responses to marriage guidance counselling. Research report no. 3.* Rugby: National Marriage Guidance Council, 1985.
17. Illman J. Is psychiatric referral good value for money? *BMA News Review* 1983; **9:** 41-42.
18. Neilson DG, Knox JDE. General practitioners and marriage guidance counselling. *J R Coll Gen Pract* 1975; **25:** 462-464.
19. Rowland N, Irving J. Towards a rationalization of counselling in general practice. *J R Coll Gen Pract* 1984; **34:** 685-687.

Acknowledgements

This study was carried out as part of a research programme planned by the General Practice Research Unit at the Institute of Psychiatry, under the direction of Professor Michael Shepherd and with the support of the Department of Health and Social Security. I would particularly like to thank Mrs Renate Olins of the London Marriage Guidance Council and the counsellors and general practitioners who participated.

Address for correspondence

Dr R.H. Corney, General Practice Research Unit, Institute of Psychiatry, De Crespigny Park, Denmark Hill, London SE5 8AF.

GREAT EXPECTATIONS

Cervical screening in Serbia?

Cost-effectiveness of a tenth telephone in the practice?

Blood sampling in Transylvania?

Great Expectations GP Trainee Bursaries — from an educational fund organized by trainees for trainees — exist to help you with your brainwaves.

Following the Nottingham 1985 GP Trainee Conference, three awards of £200 each per annum are available for research and/or travel to study an aspect of family medicine. Submissions consisting of a formal research protocol are invited for consideration.

Closing dates are 1 October 1986 and 1 March 1987. Further details are available from: The Awards Secretary, The Royal College of General Practitioners, 14 Princes Gate, Hyde Park, London SW7 1PU.

COLLEGE PUBLICATIONS

The following publications can be obtained from the Central Sales Office, Royal College of General Practitioners, 14 Princes Gate, London SW7 1PU. All prices include postage and payment should be made with order.

POLICY STATEMENTS

1.	Evidence to the Royal Commission on the NHS	£3.50
2.	Quality in General Practice	£5.50

REPORTS FROM GENERAL PRACTICE

18-21.	Combined Reports on Prevention	£4.50
22.	Healthier Children—Thinking Prevention	£5.50
23.	What Sort of Doctor?	£5.00

OCCASIONAL PAPERS

4.	A System of Training for General Practice	£3.00
6.	Some Aims for Training for General Practice	£2.75
7.	Doctors on the Move	£3.00
8.	Patients and their Doctors 1977	£3.00
9.	General Practitioners and Postgraduate Education in the Northern Region	£3.00
10.	Selected Papers from the Eighth World Conference on Family Medicine	£3.75
11.	Section 63 Activities	£3.75
12.	Hypertension in Primary Care	£3.75
13.	Computers in Primary Care	£3.00
14.	Education for Co-operation in Health and Social Work	£3.00
15.	The Measurement of the Quality of General Practitioner Care	£3.00
16.	A Survey of Primary Care in London	£4.00
17.	Patient Participation in General Practice	£3.75
18.	Fourth National Trainee Conference	£3.75
19.	Inner Cities	£3.00
20.	Medical Audit in General Practice	£3.25
21.	The Influence of Trainers on Trainees in General Practice	£3.25
22.	Promoting Prevention	£3.00
23.	General Practitioner Hospitals	£3.00
24.	Prescribing — A Suitable Case for Treatment	£3.75
25.	Social Class and Health Status—Inequality or Difference	£3.50
26.	The Classification and Analysis of General Practice Data (Second edition)	£6.50
27.	Clinical Knowledge and Education for General Practitioners	£3.50
28.	Undergraduate Medical Education in General Practice	£3.50
29.	Trainee Projects	£4.50
30.	Priority Objectives for General Practice Vocational Training	£3.50
31.	Booking for Maternity Care — A Comparison of Two Systems	£3.50
32.	An Atlas of Bedside Microscopy	£8.50