

Family systems ideas in the 10-minute consultation: using a reflecting partner or observing team in a surgery

ROBERT MAYER JOHN LAUNER
 HILARY GRAHAM DAVID TOMSON
 CHRIS SCHUBERTH JACK CZAUDERNA

SUMMARY

Background. Family therapy and the ideas that underlie it have not had much impact on general practice, although there is good reason to think this could be a useful approach.

Aim. As a group of general practitioners (and a practice nurse) with experience of family therapy, we were interested in demonstrating whether family therapy methods could usefully inform general practice consultations.

Method. Two surgeries were observed by the general practitioner's colleagues.

Results. Selected cases are discussed to illustrate the impact of the use of family therapy ideas and a reflecting colleague or team.

Conclusions. Family therapy ideas can be a helpful framework within which to think about both demanding and ordinary consultations. Inviting a colleague to contribute respectfully could be useful both as a method of teaching, and in resolving difficult or faltering consultations.

Keywords: family therapy; consultation; general practice; systems theory.

Introduction

WE are a group of general practitioners (and a practice nurse) who have come together through a shared interest in family therapy ideas. We wanted to explore different ways of achieving therapeutic effects that drew on our knowledge of both family therapy and general practice.¹

Ideas from family therapy have been applied enthusiastically to general practice by a small number of general practitioners (GPs),^{2,3} but the experience of this work has not found a large audience among our peers so far. Family therapy approaches have been taught in courses for general practitioners; the Highgate Group Practice has established a family therapy clinic in a general practice setting,³⁻⁵ and there are a few similar projects elsewhere.⁶ Using a systemic family therapy approach, psychologists have worked with a single-handed GP, offering a range of work in the surgery including supervision and consultancy.⁷ As a natural development from these approaches, we decided to explore how family therapy ideas could be used as a helpful framework in which surgery consultations could be viewed.

R Mayer, MSc, MRCPsych, MRCP, general practitioner; H Graham, MBBS, general practitioner; and Chris Schubert, RGN, practice nurse, Highgate Group Practice, London. John Launer, MA, MRCP, general practitioner, London. David Tomson, BA, BM, BCh, general practitioner, North Shields. Jack Czauderna, MBBS, general practitioner, Sheffield.

© British Journal of General Practice, 1996, 46, 229-230.

At the heart of family therapy lies a simple idea. Human beings form relationships and live within social systems. We communicate with each other, and thus, affect others and are affected by them. Therefore, the focus of interest in family therapy tends to be the interaction rather than the intrapsychic. Rather than dwelling on symptoms, family therapists prefer to ask questions that emphasize the context or relational aspect of people's experience. This is based on a strong belief that people's personal and family networks play a large part in how they view their own problems and how they manage them. It is a style that can be as effective in consultations with individuals as it is with families.⁸

Because consultations in family therapy can be complex, various techniques can help to reflect on what is going on in the consulting room. Some of these are simple, such as the use of genograms. Others include having another therapist in the room, and/or a team of observers watching from behind a one-way screen or video, who may communicate with the therapist through a phone or an audio link, or during breaks in the consultation. Members of our group decided to create opportunities for joint surgeries, so that we could explore how to apply some of these ideas in practice. We here describe two representative cases seen while exploring such opportunities.

Method

Two surgeries were conducted by members of the group, about a month apart, one in north London and the second in North Shields. Both areas are predominantly working class. The north London surgery simply had another doctor sitting in. In the North Shields surgery other members of the team watched through a one-way screen in an observing room. A video-recording was made of the North Shields surgery. Both surgeries were booked normally, but patients were told of the arrangements in advance and given the opportunity to decline. Consent was obtained for video-recording.

Case studies

The depressed man – changing the pattern

Dr A picked up Mr Simpson's notes and sighed, 'Things never go well when I see this man. He's chronically depressed and I always feel stuck with him.' Dr A was expecting a familiar interaction. The observer listening to the consultation became interested in the patient's life outside his role as depressed patient and suggested that the general practitioner ask Mr Simpson more details of his family, and particularly about his role as a grandfather. When asked these questions, Mr Simpson talked proudly and with unaccustomed authority about his grandchildren and his role in the family as a baby sitter without his wife's help. He left the surgery very different from normal. His GP was pleasantly surprised to hear such a different and positive story about one aspect of Mr Simpson's life.

Commentary

What had happened to this 'heartsink' patient? The theory of family therapy holds that doctors become pessimistic when they

cease to be curious about a patient's dilemma⁹ and share the patient's view that the only way of existence is the one adopted (in this case being depressed). What seemed to happen here was that the GP, prompted by an observer who was able to maintain neutrality,¹⁰ was able to move from his entrenched view to appreciate his patient through other eyes. This new perspective presented by the observing doctor was one that subverted the notion of 'the depressed patient' as the totality of that person's existence, and allowed the patient to value some part of his life. We would speculate that the patient felt a sense of empowerment different from that experienced during either a normal consultation or one with a trainee or student 'sitting in'.

Monday morning nightmare

Dr B recognized the fat folders instantly. Mrs Ellis was about to come in with her two stepsons. Their father was an unemployed steelworker. With her own two children from two previous relationships there were four under the age of eight to look after. She was at the end of her tether because the elder stepson was continually soiling, and neither she nor his father knew what to do. He had given up and left the problem to her. She was in danger of disengaging and leaving the children with social services. Dr B was aware that they were a family known to multiple agencies, all of which felt they had come to a dead end. The non-soiling brother also had serious educational problems. The family was already waiting to see a clinical psychologist urgently and the GP had clearly done his best to liaise with the other professionals. For this reason, the GP chose to use the consultation to clarify the network of professionals involved, seeking the mother's view in what was helpful with a promise to continue his liaison with the network. However, from behind the screen, the observers noted the mother's expertise in handling the two small children in the room and in her understanding of the helping network. We intervened to suggest that the general practitioner should report our observations about her competence. Subsequently, the general practitioner made a point of examining the areas in which the mother was coping, acknowledging the many difficulties but supporting the ways in which she was managing (i.e. presenting a different view to that of not managing). Although the consultation produced no new solutions, Mrs Ellis was able to identify her strong commitment to her new family, and resolved to try and cope with help, not only from the professionals but also her partner.

Commentary

The consultation changed a hopeless problem into a difficult but not insoluble one. There was a visible and powerful effect in the room from a team of experienced professionals giving a genuine view of competence, both to the mother and to the GP, which allowed the crisis of disengagement and giving up to be turned around. The team had used positive connotation¹¹ to empower the mother. In therapeutic terms, this would be seen as stimulating change in both the patient's personal network and the professional one.

Discussion

We found that observing and sitting in on ordinary consultations was a remarkable and interesting experience for all parties, including the patients. We believe that it is unusual for most GPs to be observed except in 'training' situations, in which another party is not usually invited to be curious or respectfully to 'interfere'. Although it is not suggested that this approach be adopted routinely, for obvious reasons of staffing levels and expense, our experience leads us to believe that it is a good way of both studying the consultation and increasing its effectiveness. We believe

that it would be an effective way of introducing colleagues to ideas and techniques from the area of family therapy that are relevant to general practice. We feel that it could also be adapted for training of both medical students and doctors, and be of use to practising general practitioners with difficult or intransigent problems. For those who wish to pursue this philosophy, there is a growing literature,^{2,12} courses are being developed for practitioners in primary care and a special interest primary care group has been sponsored by the Association for Family Therapy.

We are not suggesting that the presence of an extra person at the consultation always results in a better outcome, although it does necessarily alter the dynamic. Clearly, there is potential for being helpful, unhelpful or making no apparent difference. Thought needs to be given as how to this encounter might be set up. The invited colleague may be another GP, as in these cases, or other colleagues, including therapists and counsellors, particularly those with systemic training or skills, could be asked. The combination of psychosocial and medical skills could be particularly useful.

This notion of interprofessional collaboration in the consultation is increasingly being discussed.¹³⁻¹⁵ Clearly, the invitation needs some thought; the relationship between the two needs to be trusting and respectful. It would be damaging if the invited colleague were to take over the consultation or undermine the GP. However, a trusted colleague could begin to participate respectfully and free up a 'stuck' doctor to think creatively again for the benefit of the patients.¹⁶ Conversely, it might be possible for GPs to support therapists who have themselves become stuck. After all, we all run the risk of becoming stale with the same old stories to tell about our patients. You might think that the last thing you want when you feel like this is someone observing your work. Our experience is the opposite, and that it can be a most enabling and supportive intervention.

References

1. Tomson P, Asen E. Can GPs be taught family therapy methods? A contribution to the debate. *Fam Syst Med* 1987; **5**: 97-104.
2. Asen E, Tomson P. *Family solutions in family practice*. Lancaster: Quay Publishing, 1992.
3. Graham H, Senior R, Lazarus M, Mayer R, Asen K. Family therapy in general practice: views of referrers and clients. *Br J Gen Pract* 1992; **42**: 25-28.
4. Graham H, Senior R, Dukes S, Lazarus M, Mayer R. The introduction of family therapy to British general practice. *Fam Syst Med* 1994; **11**: 363-373.
5. Senior R. Family therapy in general practice: 'We have a clinic here on a Friday afternoon....' *J Fam Ther* 1994; **16**: 313-327.
6. Launer J. Psychotherapy in the GP surgery: working with and without a secure therapeutic frame. *Br J Psychother* 1994; **11**: 120-126.
7. Deys C, Dowling E, Golding V. Clinical psychology: a consultative approach in general practice. *J R Coll Gen Pract* 1989; **39**: 342-344.
8. Jenkins H. Family therapy with one person: a systemic framework for treating individuals. *Psihoterapija* 1989; **19**: 61-63.
9. Cecchin G. Hypothesizing, circularity, and neutrality revisited: an invitation to curiosity. *Fam Process* 1987; **26**: 405-413.
10. Selvini Palazzoli MS, Boscolo L, Cecchin G, Prata G. Hypothesising-circularity-neutrality: three guidelines for the conductor of the session. *Fam Process* 1980; **19**: 3-12.
11. Palazzoli M, Boscolo L, Cecchin G, Prata G. *Paradox and counter paradox*. New York: Jason Aronsen, 1978.
12. Neighbour R. Family therapy by family doctors. *J R Coll Gen Pract* 1982; **32**.
13. Doherty W, Baird M. *Family therapy and family medicine*. New York: Guilford Press, 1983.
14. Dym B, Berman S. The primary health care team: family physician and family therapist in joint practice. *Fam Syst Med* 1986; **4**: 9-21.
15. McDaniel S, Hepworth J, Doherty W. *Medical family therapy*. New York: Basic Books, 1992.
16. Andersen T. The GP and the consulting psychiatrist as a team with 'stuck families'. *Fam Syst Med* 1987; **5**: 486-491.

Address for correspondence

R Mayer, Highgate Group Practice, 44 North Hill, London N6 4QA.