A REPORT BY A THERAPEUTIC STUDY GROUP

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In Dr Playfair's interesting account of psychiatric study groups in general practice (*J. Coll. gen. Pract.*, 1962, **5**, 419) the case-conference method appeared to be the most common method of teaching. In only one group, however, was the patient ever present. We thought it might be of interest therefore to give an account of a group, not yet formed at the time of Dr Playfair's survey, of eight general practitioners and a psychiatrist who met eleven times at fortnightly intervals during last winter and had a patient present for a diagnostic and therapeutic interview on seven of these occasions.

This gathering of general practitioners arose out of a College listening group that met in each others houses in rotation and extended its field of interest from listening to tapes and records to having a specialist speaker present on several occasions. A psychiatrist (A.G.) was introduced to the group, most of whom already knew him personally, to give a talk on rapid methods of diagnosis in psychiatric interviewing, and following this particular evening it was decided to organize a series of meetings on psychiatric subjects. Some members wanted lecture discussions whilst others looked forward to case-discussions on the Tavistock Clinic lines. The psychiatrist suggested, however, that it would be much more profitable if selected patients came along and discussions on the general principles of psychiatric treatment could be interwoven.

Seven of the eight general practitioners invited a patient to attend when the meeting was at their own home. Each patient presented difficult problems of diagnosis or management and it was thought that some of them might well benefit by the opinion of a group of doctors given in the relaxed surroundings of a home. The first evening was spent in experimenting on the best way to handle the situation, but the other six evenings proceeded as follows: The nine doctors gathered between 8 p.m. and 8.15 p.m. After a period of general discussion the general practitioner in whose home the group was meeting gave a short summary of the patient's present

condition and the reason for selecting him or her to come along on this occasion, and then introduced the group to the patient as doctor friends of his who were interested in nervous illness and wanted to help him. Another general practitioner then took a psychiatric history, the other six usually asked a few further questions, the psychiatrist conducted a short interview and the patient was then told that the doctors present would discuss his case together and decide upon a plan of treatment which his family doctor would outline to him later on. One of the group would then take the patient home.

After the patient had left the case was discussed and a plan of investigation and treatment worked out. Some of the patients were discussed at subsequent meetings and there was a final meeting at which each general practitioner gave a résumé of the history, treatment, and follow-up of his own patient. All the general practitioners agreed that this method was most interesting and instructive and the surprising factor that emerged was the tremendous help which most of the patients also obtained. Even when several of them had been in hospital or had had individual or group psychotherapy, they obtained yet further benefit from this group.

It appears that this is a new therapeutic force which, as well as being instructive for the family doctors concerned, is useful for dealing with some of our most difficult patient problems. The seven case histories are thought interesting enough to give in detail and each has been written up by the family doctor concerned.

Case 1. Mr G. P.—aet. 43—coal merchant. Interviewed October 1961.

Complaint—" Least little thing starts me worrying ", for last 18 months.

Onset—He had a choked up feeling and slight discomfort in the (L) side of his chest on way home—he went to casualty dept. at Croydon General Hospital was examined and reassured and following this he went to see his own doctor.

Course—He continued to be tense and irritable and was given amytal gr. 1½ t.d.s. p.c. and tuinal gr. 3 nocte because of difficulty in getting off to sleep. He was seen in the surgery on seven or eight further occasions for irritability and poor sleep without any obvious precipitating cause being found.

He was a large cheerful man with mildly obsessional traits.

Childhood—He was one of a large family with no special attachments or discord between the siblings. He was clearly very attached to his mother who had died three years previously. When she lived near him he had popped in for a chat to her frequently each week, and he missed this opportunity to " blow off steam " very much. He also felt a little guilty at moving away from the district not long before her death. He was an average scholar and was reasonably happy.

Marriage—He has two sons both over 21. Wife was pregnant at marriage (at a subsequent interview with his own doctor he did voice a nagging doubt as to whether he was the father of his eldest boy, but at a later interview still, he said that he had no real grounds for suspecting this, and he felt that this

suspicion was an indication of how disturbed he felt earlier on). Soon after marriage his wife told him that she herself was illegitimate by a deaf and dumb man. He himself could remember many quarrels, and on more than one occasion she had hit him with furniture, etc. He also got very cross when she was untidy or failed to darn his socks.

Sexual life—No affairs since marriage, but admitted that in the course of his business he had often thought that another woman would have been a better wife to him.

Work—He got worried by delay with coal clearance from railway stockpile. This was a seasonal headache in the late autumn. His eldest son (both sons were in the business) was, he thought, dishonest and a constant source of worry because although married with two children he philandered and drank and got into debt.

Following interview: Expressed relief at having got it off his chest. He was very grateful for interest shown. Therapy changed to equanil t.d.s. and distaval nocte.

At second attendance said he was getting on better with his wife and had decided he would get out of the business and leave his sons to it.

At a follow-up interview in March 1962 he was feeling very well. He occasionally woke up in the night but soon got off to sleep again. He and his wife were working well together—she was helping a lot in the business. His eldest son was still up to his old tricks, but he did not get so upset as previously—even this week he had received £7 short from his son in one day's takings and his wife had discovered that the son had a pressing bill to pay and had taken the money.

In retrospect, he felt the meeting with the group had been of great value to him—it had reminded him of things he had forgotten or suppressed, and he felt that to have several doctors all helping meant that no aspect of the problem was likely to be neglected.

September 1962—Patient had return of mild anxiety symptoms about 2—3 months ago—probably related to summer build-up of coal stocks, and further trouble with eldest son. Since then he has not been to the surgery although he asked for a prescription to be left out for him at the surgery on two occasions for tabs. amytal gr. 1½ t.d.s. which he clearly does not take regularly and tuinal gr. 1½ nocte again taken p.r.n.

Case 2. Mrs F.—aet. 54—interviewed November 1961.

Had a subtotal hysterectomy in 1953 followed by a low back pain radiating down the legs which was treated by a lumbosacral support and physiotherapy.

In 1955, when seen for these symptoms, she was noticed on occasions to be anxious and depressed. About this time she moved to a new house and became excessively worried by the neighbours banging doors. This was the first time that she had reacted to stress other than as a very capable woman. In 1959 she began to experience panic attacks in which she felt she could not breathe, also sensations of falling and of weakness in the arms and legs. A physician found no organic disease and referred her to the psychiatric department where depression was diagnosed and she was given outpatient ECT. The travelling to London for this was not a success and she was transferred to Warlingham Park Hospital as an outpatient and admitted from May to December 1960. Since her discharge she has not been able to return to her work in the legal department of a public undertaking, but had managed to carry out some of the work at home. She still had panic attacks, and was depressed, tense, and anxious.

During questioning at the group meeting she gave a history of a normal

upbringing with a rather strict father. Married life had been happy with a husband of whom she was very fond and with whom she had no sexual difficulties. She saw no reason for her depression or her panic attacks. She was then challenged by the psychiatrist to tell the whole story as she had told him in hospital. Slowly she released, piece by piece the story of:

A mother who is demanding and difficult, a daughter who was still enuretic at 20 and who did not even strip the wet sheets from the bed; a son who had had money difficulties which she had cleared up but about whose future movements she was very worried; an affair she had had with an associate at the office in which she had experienced sexual satisfaction and physical happiness which showed clearly against the dull background of her life with her dull but dependable husband. Over this affair she felt extremely guilty but the times when work had brought them together officially she still remembered with genuine pleasure. Though she was not now going to the office she still saw her associate when he brought the work to her house.

Discussion centred around the advisability of her making a full confession to her husband as her obsessional and perfectionist character could not forgive her failure to herself or her husband. Some thought that continued meetings with her associate were being perpetuated by her staying in the firm and should be discontinued. Others thought that to cut the pleasant experience from her might cause greater harm. It was also thought that religion could help in allowing her to forgive herself if she accepted that she could herself be forgiven.

Though she had appeared ill at ease she said she was glad that she had come. There has been little change in her since then except that she has had one episode of severe depression. She belonged to a group for therapy which has now broken up, to her relief, for she did not take an active part. She has decided not to confess to her husband. She had seen her associate but says he never loved her and she has no feelings for him now.

Ten months follow-up—Though the panic attacks still occur they are not as severe. Her general practitioner finds she has a much better insight into her problems—as has he—for he heard much of her story for the first time with the group.

Case 3. Mr G. M.—aet. 70—interviewed December 1961.

Mr G. M. presented as a man who for many years had made frequent visits to his doctor, complaining of a variety of vague symptoms. These included—"burning in the nerves of the hands and legs", "pains behind the eyes", "pressure in the head", "pains in his chest" and headaches. He had been thoroughly investigated for an organic cause for his symptoms, but none could be found. Hence he had been treated by reassurance and tranquillisers by his general practitioner but without much success. There was a history of a nervous breakdown in the 1914/18 war.

He was invited to attend an informal meeting of eight general practitioners and a psychiatrist who were anxious to help him get well. He accepted enthusiastically.

His history was as follows:

Occupation—Part-time clerical work for the council.

Parents—Father was placid and easy-going, and the patient was very fond of him. His mother was temperamental and highly strung. She was good to him but favoured his sister. She died of carcinoma of the oesophagus. The patient was jealous of his sister and never saw her. His father's will favoured her. This he attributed to his mother's influence.

His family—He married a wife with a very different temperament to his own.

She was sexually frigid, and he found life with her quite impossible. They separated ten years ago and she subsequently died in June 1961. He now lives with a Mrs Smith who acts as his housekeeper. He is very fond of her, but he is afraid to marry her as he feels it would spoil their friendship! He has two daughters. The younger keeps in touch with him, but the elder he never sees. Neither of them, he said, could accept Mrs Smith's position.

His character—He is highly strung with emotional swings. He is very meticulous in his work and about punctuality. He has a tendency to obsessional ideas regarding health and illness. He has a tendency to cancerophobia. He is frequently irritable and depressed. He sleeps badly. He describes peculiar dreams which he has when half conscious.

The meeting—During the meeting the patient spoke freely of his feelings, and brought to light facts in his history which previously he had kept to himself. On occasions he seemed to be enjoying being the centre of attention, and his recollections tended to be somewhat boastful. He was thought by the group to be a chronic neurotic with a very large depressive tendency. Separation from his wife was thought to be one of the main factors causing his condition. He was thought to have rather a childish immature personality; and his dreams were thought to be more in the nature of hallucinations.

Treatment—was suggested as follows:

1. Frequent short interviews with the general practitioner instead of long ones.
2. Anti-depressant drug treatment, i.e., monase 15 mg. t.d.s.
3. The general practitioner should contact his daughters with a view to putting them in the picture with regard to his mental health explaining his mood swings to them, and obtaining their sympathy and co-operation in helping the patient.

Patient's reaction to the meeting—He slept badly on the night following the meeting, and his mind kept going over all the points brought up at the meeting. He had one of his bad attacks the next morning. Overall effect, however, was good. He found that he was unable to take the tablets as they made him drowsy and bad tempered. He brought his elder daughter to the general practitioner. She showed interest, understanding, and eagerness to help. The younger daughter, strangely enough, refused to co-operate.

Follow-up two months later—Although getting occasional bouts of his symptoms, he has been much better on the whole. He sleeps better; and only occasionally gets a hallucination. He feels better not taking drugs. He attends doctor's surgery very seldom now. He felt the meeting with the general practitioners and the psychiatrist was well worth while.

Follow-up nine months later—This patient has definitely shown improvement which is evidenced by the fact that he has only had to attend at the surgery a matter of about three times during the last seven months. On these occasions he has complained of his original symptoms, but now quite accepts the fact that these symptoms are psychogenic in origin. He seems to have more insight and is more adjusted to his environment.

Case 4. Mr P. D.—aet. 37—bank clerk. Roman Catholic. Married. Interviewed December, 1961.

Chief complaint—Trembling of hands.

Onset—course—This started at about the age of 14 years when one of his school friends remarked that his hands were trembling. Since that time he has always been conscious of his hands trembling especially when he writes, hold

cups, glasses, etc., or when anybody is watching him. He dislikes people remarking on it and has found that it interferes with his work, which involves a lot of writing. He feels that it has stopped his promotion in the bank. Over the years it has gradually become worse. Normal sleep pattern.

Previous treatment—No treatment was sought for a very long time. About seven years ago he started taking persomnia which he found controlled the shaking. When the carbromal was removed from the tablets he found them useless. He now takes one carbromal q.d.s. which controls the shaking. He attended a psychiatrist about four years ago but he said " No one seemed interested so he only went once or twice ".

Marriage—Five years—says that the marriage is a happy one with no sexual problems. Engaged once before but this was broken off. He had had premarital intercourse, used contraceptives, but felt guilty about this. No children—family wanted but unsuccessful so far.

Family history—Father and mother alive and well. He gets on well with them both—sees them regularly. He has one brother two years older than himself, with whom he gets on well.

Previous personality—as it is now—describes himself as unable to let himself go and be angry.

Childhood—Happy childhood—his parents separated when he was five years old but it was done quietly. He was not involved in any quarrels. School days —average—reached grammar school and school certificate standard.

Physical health—good—he developed this year a nodular goitre—he had a partial thyroidectomy in June. This has had no effect on the shaking. The goitre showed no evidence of thyrotoxicosis. Employment record good.

Diagnosis—Chronic anxiety state.

The group were of the opinion that here was a man with a long chronic anxiety state very much dependant on carbromal. Probably only prolonged psychotherapy would be of any use. It was suggested if possible that his dependance on carbromal should be broken. Psychological testing was suggested. This showed he was of bright normal intelligence, but at present he was unable to make use of this. On present testing the dominant feature was anxiety and in spite of some immaturity it was felt that the compulsive elements sometimes found with phobic states were probably more important than those of an hysterical kind.

The patient looked forward to coming to the group and was very grateful for their interest. He was doubtful if it could do any good as the symptoms had been going on for some time. Afterwards he said that it had been very interesting, but he could not see how he could be helped.

Progress—None. Patient interviewed weekly—early life discussed. Interviews stopped because of the investigations for his goitre. He was unwilling to stop taking carbromal until there was something to take its place.

Case 5. Mrs P. B.—housewife—aet. 41. Interviewed October 1961.

She had kept reasonably well until the birth of her second child. Her first child was born in 1946, following a difficult labour. As a result of this her doctor told her she must have no more children. Coitus interruptus was then practised as the only method of contraception. In October 1959 she again became pregnant and was very depressed as a result of this. During pregnancy, considerable supportive therapy was required.

Presenting complaints—1. Depression. 2. Migraine. 3. Sexual frigidity.

1. Since her last child was born in June 1960, the patient had been very depressed and felt unable to cope with housework and making decisions in the home. She had lost weight and was not sleeping well and there had been one or two episodes when she collapsed at home and felt certain she had poliomyelitis and she could not move her legs. These episodes proved to be hysterical and the symptoms subsided rapidly.

2. Her other main complaint was of severe headaches.

3. The patient got on quite well with her husband, but felt he was not dominant enough and she had to make all the decisions. She had lost all interest in sexual relations with her husband and was petrified she would have another pregnancy. She herself obtained no satisfaction from sexual intercourse. She liked going out to work, but realized that now she had another small son, this was impossible. This resulted in a fair degree of resentment.

Many drugs were tried—i.e., tofranil, stelazine, equanil, melleril and eventually covatin, which resulted in some improvement. She was given tabs orgraine for her migraine.

At the group meeting she discussed her problems freely with the doctors present and during the course of discussion, it was pointed out to her that when she became depressed following minor irritations at home, she was punishing herself. Discussion also took place on her sexual problems. Strong suggestion was given to her that as a result of her meeting with us, a schedule of treatment would be worked out and she would definitely get much better. Following this the patient was given tabs. cavodil 12 mg. o.m., and caps. librium t.d.s.

Progress—The patient's condition steadily improved. She began to feel that life was once more worth living. She regained her self-confidence and was able to go out shopping again on her own and make her own decisions. Her sexual life started to become more satisfactory and proper contraceptive measures were taken.

Follow-up—The patient's drug requirements are dropping considerably and she is coping very well. She feels that the thing that made her improve more than anything else, is that eight doctors should have been sufficiently interested in her to discuss her problems with her, but in recent months she has become more depressed and her headaches are recurring. The impression is that the benefits of the group meeting are passing off and she is returning to her original state.

Case 6. Mr G. P.—aet. 37—interviewed January 1962. London manager of engineering firm. Married 1949—two children aged six and four.

Chief complaints—Sore head, irritability, stabbing pains in the arms and chest nd elsewhere, attacks of weakness and shakiness.

Symptoms commenced 1957. A few days after they commenced he was in bed for nine days with an influenzal type of illness, and at about that time he assumed his present position of responsibility and higher social status. The symptoms improved slightly after physical examination and reassurance by myself in 1959, but relapsed. Temporary improvement followed private consultations with a London psychiatrist February—April 1960—treatment included injections of cytamen and tablets of fentazin and desbutal.

Says marriage is satisfactory, but had four years of courtship which was " hell " because his prospective father-in-law did not think he was good enough for his daughter. Children, girl aged six, boy of four, appear normal, happy children, but they were unplanned and the patient feels guilty for letting his wife in for

this, even although things have turned out well since.

Family history—Father and mother are alive and well. Has an identical twin brother who has not had any trouble such as he has had.

Previous personality—Had feelings of inferiority after he came out of the army (On D-day was one of seven left out of nine hundred and had to have four days of sleep therapy), until eventually he became established in his job. Feels that other men who missed the war were able to get on ahead of him in engineering. Gave the impression that he was not willing to let down the façade of a suave, relaxed, business man.

Early childhood—School days and physical health appear to be within normal limits.

Present environment—Symptoms coincided with assumption of an executive job, but he says that he enjoys responsibility and feels perfectly capable.

Subsequent course—Feels a bit better because he is willing now to accept with a little more confidence the fact that his condition is not organic. Is willing to admit that his feelings of inferiority present for many years may still be there beneath the surface and may account for some of his domineering ways. Psychological testing disclosed that his I.Q. (115) was on the low side for his position of responsibility. A subsequent interview with his wife disclosed her complete loyalty to him and continuing love for him, as well as throwing light on some of his guilt feelings. Is confident now that he will eventually master his symptoms.

Case 7. Mrs I. M.—aet. 38—housewife, part-time telephonist. Church of England.

Complaints of panic attacks and lack of sympathy from her husband. She has been an anxious person all her life and had been hypochondriacal on numerous occasions. She was prone to worry that she had a serious disease whenever she got a trivial pain and had frequently talked of cancer in the stomach, or growth in the brain.

Her attacks of acute anxiety with panic manifestations started about 11 years ago. She became pale and frightened and felt as if something dreadful was about to happen, but the attacks passed off quickly and she never lost consciousness. They were very frequent at first, occurring almost daily. She was admitted to Warlingham Park Hospital in 1953 for psychotherapy. She was discharged after six weeks, considerably improved. Since then she has attended psychiatric outpatients on and off and has been seeing me regularly at about monthly intervals, sometimes more frequently, for supportive therapy and reassurance.

In the past year or two she has complained about her marital relationship. She accuses her husband of being most unsympathetic when she gets panic attacks, which still occur, but not so frequently as they did ten years ago. She has felt throughout that if her husband could support and comfort her, she would get over these panic attacks more quickly. He has maintained throughout her illness a certain aloofness and firmly believes that the best way of getting over her weird feelings is to " fight against them ".

Her only child, a girl of 12 years, seems to Mrs M. to be more attached to her father than to her. Because of this lack of sympathy at home, she has sought comfort and friendship elsewhere, and in the past year or two has had a couple of affairs with men which, however, did not last long, but which her husband eventually became aware of. Both affairs have ended, but have not helped to improve relations at home.

Personal history—Her mother died when she was three years old. Mrs M.

was very attached to her father, who married again soon after her mother's death. She did not like her step-mother, who in turn did not like her. Her childhood was a very unhappy one. Her father died about two years ago.

She was interviewed by our group on February 2nd 1962. She was very apprehensive about meeting "so many doctors" but she did not need much persuasion to attend for the interview.

Reactions to group—In her words "Very, very helpful". She was surprised, rather agreeably, that so many "busy men" could be so interested in her problems. She felt definite improvement after the interview and still attends the day centre for group psychotherapy and comes to me for reassurance. She is still anxious, but not so deeply and the panic attacks still recur but are not so severe.

A film and discussion on depression, completed the nine meetings at general practitioners' houses and after these, at the psychiatrist's house a lay-psychologist gave a talk and demonstration on methods of psychological testing (i.e., I.Q., Rorschach, etc.). The final meeting was at the home of the priest attached to Warlingham Park Hospital where a discussion on the various aspects of the meeting ground between religion and psychiatry wound up a most interesting winter.

Observations by the psychiatrist

The first and most striking reaction of the group was their diffidence in face of the suggestion that it should study the problems as presented by the patient "face to face". It was felt to be essential, however, that every effort should be made to avoid theorizing, didactic discussion and sterile supposition, so the group agreed to embark on this new experience.

Fears that a massive confrontation would distress or harm the patient have been absolutely ruled out by our experiences. Indeed, one of the clinical pleasures was the appreciation and the enlivenment which the patients all clearly showed. This clinical freshness was obviously largely due to the effect of bringing into awareness unconscious material: it must be understood that the group took the utmost care to reach a rapprochement of flexibility and sensitivity with the patient and so keep individual and problem in clear focus.

It quickly became clear that the group could waste much time in desultory and repetitive questioning and discussion. So too it became evident that discussion of symptoms was just as tiresome in the group setting as in the surgery, and that rapid progress came with intensive examination of the life situation and relationships.

In order to streamline procedure and to mirror as far as possible the pattern that must be met in a busy practice or outpatient department a form of routine examination was introduced via a printed form. This disciplined the examination and ensured that essential facts were elicited and recorded. With this procedure the whole ground was covered rapidly and most of the significant emotional

factors came to light during the evening.

Although this medical group started as a meeting for study and enquiry it quickly became apparent that it was a clinical force of considerable effect. We were constantly surprised by the depth and richness of material uncovered in this situation and by the factors which came to light for the first time. Far from having a suppressive effect the group approach produced a sense of release. The new discoveries usually produced a feeling of freedom in the patient and of therapeutic refreshment for the clinician.

Considering that all the patients studied presented long-standing problems and many had required inordinate attention what did happen in this relatively brief but intense situation?

Undoubtedly the fundamental mechanism was, we believe, the bringing into consciousness of unconscious material. It looked as if the group acted as a many-sided mirror in which patient and doctors saw the problem and indeed the personality from many angles. The patients undoubtedly welcomed the fact that they were being taken seriously. The relaxed atmosphere of the individual homes and the careful winding up of the individual sessions all played a part. (Every patient was told by his or her doctor to come again for an individual interview). This removed any feeling of being a guinea-pig and if anything in this instance it is the doctors themselves who were the laboratory animals. One of the potent therapeutic forces observed was the way in which different members by their individual approach elicited material which had become deeply buried and yet the eliciting was a complexly interwoven process. It seems reasonably certain that therapeutic progress depends upon depth, intensity, and exactitude rather than length.

Acknowledgment

The general practitioners wish to express their appreciation of the time given by the psychiatrist and realize how fortunate they are to have a person of such energy and wisdom to lead them.

Cases were introduced by Drs Leonard Williams, Barras Todd, Colin Coole, Derek Lindley, Clifford Floyd, Denis Craddock and Paul Boffa. The film discussion was held at the home of Dr Gerald Clementson.