Group Therapy in Family Medicine: Part 1

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Group psychotherapy may often be the treatment of choice for patients whose somatic symptoms are a reflection of interpersonal difficulties which are not of sufficient magnitude to warrant referral to a mental health professional. This type of treatment can be offered in the context of family practice, with benefit to both patient and physician. The physician may function as co-therapist with a more experienced group leader; it is essential, also, that competent supervision be available. Such a group was established in a family practice center; it met for 20 weekly sessions. Patient improvement ranged from minimal to considerable; in addition, the frequency of visits to the Center for essentially non-medical reasons decreased considerably, with the greatest decrease in such visits occurring 6 to 15 months after termination of group treatment. This is the first part in a four-part series dealing with group therapy in family medicine.

Practitioners in family medicine are being trained to attend to the health needs of the whole person—including emotional as well as physical health and, in particular, to the interaction between stress and physical illness. Training in one or more of the psychotherapies may help the family physician address this interaction more effectively. A number of family medicine residency programs have established curricula of behavioral science. Faculty responsible for these curricula are teaching to family practice residents some skills which have traditionally been the domain of the mental health professions.

Among the questions posed by these new curricula for those responsible for the training of family physicians is whether the development of any sort of competence in the psychotherapies is a legitimate goal for family practice residency training. Our answer to that is very strongly in the affirmative. The family physician has traditionally assumed responsibility for the entire person and not just some portion of his/her anatomy. All that is really new in the recent development of behavioral science curricula in family practice residency training is the formalization and systematization of teaching of a sort which had previously been done by example at the bedside. The physician cannot avoid dealing with the emotional problems of his/her patients. Some formal training in the psychotherapies simply equips him to do so more effectively and efficiently. It is not suggested that the physician should retain primary responsibility for those of his patients who have major mental illnesses. Such patients frequently require the services of mental health professionals and referral in such cases is a prudent path to follow. Rather, the concern here is with equipping the physician to deal competently and confidently

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with those patients who are not suffering from major psychiatric deficit or impairment and who do not regard themselves as in need of psychiatric intervention. For these patients medical management in the context of a family practice center is most appropriate. Some of these patients may require an inordinate and disproportionate amount of the physician's time because there is something significantly more than the patient's physical complaint involved in what the physician is attempting to treat.

Role of Group Therapy

Group psychotherapy may be the treatment of choice for patients whose somatic symptoms are a reflection of interpersonal difficulties. It may be regarded as a potent alternative prescription which enables the physician to intervene effectively in the interpersonal and emotional problems of his patients while continuing to attend to their physical health. It is a commonly expressed opinion of family physicians that the exigencies of medical practice in the United States during the latter part of the 1970s militate against the physician doing very much counseling or psychotherapy with individual patients. Even if the physician is particularly interested in individual counseling, it is often difficult to do because it involves significant time commitment and financial sacrifice. Group therapy offers the clinician an opportunity to attend directly to the emotional factors in his patients' complaints without the drain on his time, energy, and resources which would occur if each of six or eight patients were to be seen for an hour and a half weekly. In addition, the group itself becomes a resource of collective experience and wisdom from which the individual patients can draw as they attempt to resolve interpersonal difficulties. The group thus functions as an ancillary supportive therapeutic system supplementing the physician's own skills and wisdom.

To provide group therapy in the office, the family physician needs training, a co-therapist, and supervision or consultation. For the most part, the basic skills and attitudes which the physician needs are those which can be used in individual and family consultations as well as in group therapy. In addition to interviewing skills, the physician should learn how to function as an effective co-leader and should be familiar with the criteria for referring patients to a group. It is also important to know which patients should *not* be referred or accepted in a group. The physician need not develop the level of skill required for the independent practice of psychotherapy in order to make an *effective* contribution as co-leader in a therapy group.

The time required for the physician to reach a level of skill whereby he can make an effective contribution as a co-leader in a group will in many cases be minimal. The training of mental health professionals in group therapy does not usually involve a great deal of didactic work, and there are several good introductory textbooks in the field.[1-3] While some training is done in two or three-day workshops held usually on weekends, the most intensive training begins with the student functioning as co-leader with a more experienced group therapist. It is this model which is recommended for the family physician. This model requires about two hours of the group leader's time each week: roughly 90 minutes for the group session and a minimum of one half hour afterward to discuss what happened. Probably the most important part of learning group skills occurs during this discussion period. In roughly a year's time, a physician following this model will likely find that he is consistently making significant, effective contributions as co-leader and not as an apprentice.

The economics of group therapy in family medicine will vary, depending on financial arrangements with co-therapist and supervisor. While group patients may be charged for a regular office visit, charges of up to 150 percent of the standard office visit fee are not unreasonable for a 90-minute session. In these fee ranges, group therapy in family medicine need not involve financial sacrifice on the part of either the physician or his patients.

An Operational Program

An educational project was recently completed in the Family Practice Center at The University of North Carolina School of Medicine involving the formation of a therapy group. The objectives were to demonstrate that (a) such a group could be successfully conducted within the Family Practice Center, (b) significant change could be accomplished with this therapeutic modality in patients who had responded poorly to conventional forms of treatment, and (c) a family physician with little or no previous experience could learn some group

Table 1. Visits of Group Therapy Patients (N=5) to the Family Practice Center

Six months before group	36
During group	21
One to six months after group	20
Six to fifteen months after group	5

psychotherapeutic techniques in a relatively short period of time. Screening interviews, therapy sessions, and supervisory sessions were video taped. The progress of the group was discussed at educational sessions for family practice residents and staff, and those sessions were also video taped. Data thus obtained are being used to produce video tapes for the training both of family practice residents and mental health professionals interested in group psychotherapeutic technique.

The group consisted of six women who were patients in the Family Practice Center of a large southeastern teaching hospital. They ranged in age from 27 to 39. One patient withdrew after the third session; there was no other attrition and most sessions were attended by all group members. Of the five who completed the course of therapy one was married, one divorced, and three single. All had had at least some college education, and two had done graduate work.

None of these patients presented major medical problems. What they had in common were their somatic complaints (persistent abdominal pain, palpitations, headaches, etc), their high frequency of visits to the clinic, their minimal response to medication, and the common feelings of hopelessness, frustration, and sorrow which they generated in the physicians who saw them in the Family Practice Center.

The group met for 90-minute sessions for 20 weeks. It was led by a family physician and his wife, a nurse with previous experience in group therapy. Also present in the room during all of the group sessions was a video-tape camera with a crew of two. The camera did not require special lighting, but relied on ambient light, so that a studio atmosphere was not created. Sound recording equipment was similarly unobtrusive: the patients did not wear microphones, and the usual clutter of wires and stands was absent. Patients rarely looked at the camera and in general seemed accustomed to its presence.

Supervision was provided by a clinical psychologist with extensive experience in the training of group therapists. Technical, theoretical, and procedural issues—what to expect, what to do, how to do it, when it should be done, and why—were the main topics of the supervisory sessions, which were held weekly and were also video taped.

The theory and techniques used by the co-therapists were those of Transactional Analysis.[4] This approach offered a number of advantages: the theory is couched in terms easily understood by psychologically unsophisticated group members; it is not conceptualized in terms of mental illness or psychiatric deficit; it seems less ambiguous than more esoteric theories; and it is powerfully oriented toward behavior change and symptom relief. In addition, it is the theory and technique with which the co-therapists were most familiar.

The frequency of clinic visits by the group members to their physicians began to drop almost as soon as the group started. One patient, who had made ten visits to the center during the six months before the group began, did not come in again during the months that the group met, and came in only once during the six months following group. At the other extreme, one patient averaged seven clinic visits during the six months preceding the group, during the group, and the six months following the end of the group. Throughout this time, her complaints appeared more characteristic of emotional stress than of physical illness. There was a decrease in clinic visits during the interval from 6 to 15 months after termination of the group; the visits which she made during that interval were more clearly for medical reasons. These data are summarized in Table 1.

All of these women are still active patients, coming to the center for regularly scheduled check-ups (not included in the totals in Table 1). They have fewer physical complaints and more awareness of the interaction between emotional stress and physical illness. There is little doubt of the positive impact of the group, and that its effects persisted for well over a year. The video tapes of the sessions offer dramatic support for this conclusion. The tapes also offer support for the suggestion that a family physician with little or no previous experience in group therapy could learn group psychotherapeutic techniques in a relatively short period of time. Thus, the objectives of the project were accomplished.

Discussion

Group psychotherapy in family practice is likely to be an interdisciplinary effort. (In the present case, it was not only medicine, clinical psychology, and nursing which were involved, but also the professional disciplines or career fields of the group members and of the media specialists involved in the educational function of the project.) There are likely to be interdisciplinary differences in conceptual models for the delivery of therapeutic services to patients, and these differences may lead to dissimilar kinds of therapeutic contracts with patients. In the mental health professions, conceptual models for service delivery usually generate a collaborative type of contract, in which the therapist does something *with* the patient for the latter's benefit. The medical model often involves a more dependent relationship in which the therapist does something *to* the patient in order to make him/her feel better.

Physicians in family medicine are most likely to be following the medical model. This approach involves finding out what is concretely wrong with the patient and then actively doing something to fix it. Accepting the notion that group psychotherapy is a legitimate activity in family medicine, and seeking to acquire some group psychotherapeutic skills involves, to some extent, the temporary relinquishment of this model and the adoption of a model which sanctions patient-therapist transactions at a level different from that typically found in the medical model. Perhaps putting his own service delivery model aside is the most important learning task before the physician who seeks to work within the framework of what is essentially the service delivery model of another profession.

The physician seeking to gain competence in group therapy needs to learn and to be able to adopt a point of view which is subtly different from that which he adopts while seeing patients in the Family Practice Center. The medical model point of view, for example, might lead the physician to prescribe group psychotherapy. From that point of view, such a prescription is not inappropriate and involves the physician's doing something—even if it is only writing a prescription—to fix or take care of what is wrong with the patient. From the standpoint of most of the psychotherapeutic models, such a prescription would be inappropriate because, in part, it assumes that the technique, and not the patient, is the therapeutic agent. The difference between a recommendation and a prescription may be slight; and yet it is precisely the ability to make this kind of distinction consistently and to be aware of its importance, that the physician must acquire if he is to be an effective partner in the group psychotherapeutic enterprise.

Group therapy in family practice is a kind of hybrid representing the grafting of psychotherapy onto a medical practice. Hybrids possess some of the characteristics of both parents as well as some which are unique and perhaps novel. Was this hybrid group therapy? Yes. Was it family medicine? Yes, given the increasing interest of family physicians in emotional factors in illness and their willingness to deal effectively with those factors in the context of a family medical practice. What characteristics does this hybrid have which are different from those of its parents? They include apparent effectiveness with patients who would tend to respond poorly, if at all, to psychotherapy in a psychiatric setting or to conventional medical treatment in a family practice setting. It is upon this criterion of *effectiveness* that the fate of group therapy in family medicine will ultimately hinge. It was clearly effective with the small group of patients in this Center. Further experience and research are needed to better define the characteristics and potentials of this unique and novel hybrid, group psychotherapy in family medicine.

The second paper in this four-part series will deal with the prerequisites necessary for the establishment of a therapy group in family medicine.

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