Group Therapy in Family Medicine Part 2: Establishing the Group

William H. Friedman, PhD, Eric Jelly, MD and Pamela Jelly, SRN
Chapel Hill, North Carolina

This paper is the second in a four-part series and describes some of the prerequisites necessary for the establishment of a therapy group in family medicine. In setting up a group, it is necessary to have group leaders, a supervisor, patients, a suitable room, and time set aside for the purpose. Referral sources and criteria for referral are presented, as well as a description of patient characteristics. Factors leading to referral are discussed, and contraindications for referral considered.

Present day family physicians are being trained to care for the whole person. It is now widely accepted that there is little dichotomy between organic and functional illness. Training of the family physician ideally includes the acquisition of confidence in therapeutic skills, in order that he/she may be better equipped to deal with this interaction of emotional and physical illnesses. In an earlier paper[1] it was suggested that group therapy may provide an alternative prescription which the physician might wish to make available to those of his patients who seek from him more than medical and less than psychiatric intervention. The training and time involved in providing group therapy may render its offering feasible in many family practice settings. Group therapy in family medicine is a kind of hybrid which enables the physician to reach therapeutically in his own office those patients who neither respond favorably to conventional medical therapy nor would accept (or need) referral for psychiatric diagnosis and treatment.

Office counseling by physicians of individual patients is now a widely accepted practice. The physician's experience and training in the medical model tend to emphasize sequential rather than simultaneous treatment of patients. While such an approach has many advantages, in some instances it has limitations. Among these are the time and energy expenditure required for both physician

From the Department of Family Medicine, School of Medicine, University of North Carolina, Chapel Hill, North Carolina. Requests for reprints should be addressed to Dr. Eric Jelly, Department of Family Medicine, Room 738, Clinical Sciences Building 220H, The University of North Carolina-CH, Chapel Hill, NC 27514.

and patient. Group therapy provides an additional form of intervention which itself is a learning forum for the physician. It is suggested that development of group therapeutic skills may enhance the physician's technical skills in interviewing and counseling patients.

No attempt is made in this series of papers to provide a detailed road map for individual patients and physicians. Such a road map is evolved through the interaction of group leaders and supervisors, and depends largely on the patients' needs.

One cannot learn how to practice either medicine or psychotherapy simply from reading about them, but an entirely appropriate way is to learn from and participate in a good model. A therapy group was conducted in the Family Practice Center at the University of North Carolina at Chapel Hill, and in a previous paper[1] some of the results of that experience were presented and discussed. Here, some steps are suggested which could be followed in establishing a therapy group in a family practice setting.

Setting Up a Group

In order to conduct a group, it is necessary to have group leaders, a supervisor, patients, a suitable room, and time set aside for the purpose. Should a physician wish to learn and participate as the coleader, he/she needs little previous experience in groups. However, if he has had little or no training in psychotherapeutic—especially group psychotherapeutic—techniques, it is important to work with a cotherapist who has had such experience. This person need not be another physician, but may come from the disciplines of nursing, social work, or clinical psychology.

How might the physician identify potential cotherapists who have sufficient experience to lead groups in the relatively novel setting of a family practice? The American Group Psychotherapy Association maintains stringent training and experience requirements for membership, which may serve as a guide to the physician in selecting a cotherapist and supervisor. Membership in that association does not certify competence, but it does certify a great deal of training and experience.[2]

Ideally, the cotherapist should be someone with whom the physician is already acquainted, with whom he feels comfortable, and whose professional competence he knows and respects. Conducting a group with a person one already knows and likes is considerably easier than conducting a group with a stranger, and holds fewer surprises. Therapists who are strangers would be introduced to the complex interpersonal situation within the group while they are still learning to work together.

To engage as a cotherapist a person one does not like but whose competence one respects is not recommended.

The place of the supervisor in group therapy in family medicine is a central issue. Competent psychotherapists assure themselves of ongoing supervision throughout their professional careers. Supervision is even more important for the novice therapist; it enhances the probability that he will do more good than harm.

Although one of the cotherapists may have considerable experience and competence, supervision is, for both group therapists, a learning situation in which help and support are provided. Supervision should take place either immediately following the group or at some other regularly scheduled time and not on an ad hoc basis. What has happened in the group can be discussed and analyzed, and a certain amount of anticipation and route planning may be done for the next session. The supervisor should have previous experience in supervising group therapy. Such individuals are most likely to be found in the mental health professions. He need not be a member of the family practice team; indeed, there are some advantages in having him come from entirely outside the system. Supervisors sometimes meet with several cotherapist pairs simultaneously in a group. Such an arrangement has technical as well as economic advantages.

Theory has an important role in group psychotherapy. There are a number of excellent theories. Some, such as Transactional Analysis and the various behavioral therapies, emphasize symptom relief and behavioral change. Some psychoanalytic theories emphasize the development of insight prior to focusing on the problems from which the patient is seeking immediate relief. In the pragmatic situation in which family medicine finds itself, the motto probably should be

"change now, analyze later." Therefore, Transactional Analysis and similar theories are more appropriate for the family medicine setting, emphasizing as they do healthy functioning in the here and now.

It is helpful if both cotherapists and supervisor share the same theoretical framework. The authors have not, however, found this to be an absolute requirement. Sharing different theories may indeed add extra depth to the experience.

Traditionally, groups meet for an hour and a half once a week, usually in the afternoon or evening. An obvious advantage of a late afternoon or evening group in family practice is that it would not preclude attendance by people who hold regular jobs. One of the objectives of group therapy is to help people remain functional in their work. Physicians may understandably be unwilling to devote some of their evening time to this form of treatment, particularly if their on-call schedule is rigorous. The motivation to make such a commitment of evening time comes from the sense of personal and professional satisfaction that the exercise of these skills offers. To this must be added the considerable time that can be saved by seeing eight to ten patients at one time. These are the very patients likely to make heavy demands on the physician and his after-hours time.

The group should be held in a room that is quiet and free from interruption, with pleasant decor and comfortable chairs. Many modern family practice offices have such a room. For an evening group, an office waiting room may be suitable, provided that it would remain free from emergency visits and telephone calls during the group session.

Referral Sources and Criteria

Patients may be referred for group therapy from one's own practice and from one's professional associates or partners. While it is possible to accept referrals from the general medical community, problems may be created in the continuity of care. A major advantage of holding a therapy group within the framework of a family practice center is that it strengthens the continuity of care which family medicine emphasizes.

It is important to have a clear idea of the types of patients one seeks or does not seek to refer. Then it is easy to describe such patients' characteristics to the referral sources or to identify them from one's own practice. Criteria for referral for group therapy come under two general headings: the patient's own characteristics, and the physician's response to them. Each of these shall be discussed in turn.

Patient Characteristics

Patients who benefit from group therapy in a family practice center are the frequent attenders who usually present with persistent physical complaints of indeterminate etiology. Inquiry by the physician may reveal emotional stress, tension, or interpersonal problems often preceding the onset of symptoms and the sequence of visits to the center.

For example, one patient in our group complained frequently of abdominal pain. Following extensive workup, the pain remained of uncertain etiology, and her response to management, including various analgesics, was poor. She was persistent in her demands for relief from symptoms, while at the same time exhibiting some hostility toward the physicians for their apparent inability to provide relief.

This patient, whom we shall call Mary, was making regular visits to the Family Practice Center. She was white, 29 years old, and in the process of separating from her husband. Diagnosis listed in the chart included acne, coccygeal pain, and recurrent "urinary tract infections" with negative cultures. Her most recent visits concerned upper abdominal pain, and she admitted to being depressed. Mary had made even more frequent visits with her two children, both during and after hours. During the course of group therapy, some facts about her past family life became apparent. Her father had died suddenly some years after being incapacitated by poliomyelitis. Mary was 13 years old at the time, and being the "responsible" member of the family all her life, she felt responsible for his death.

Thus it became apparent that Mary's complaint was something more than abdominal pain. Medication alone therefore had little effect, since it was not designed to remedy that for which she was seeking medical attention. Similarly, other patients may present with conventional "tickets of

admission'' such as persistent headache for which no physical cause can be found. Yet referral for psychiatric treatment seems unwarranted.

Thus complaints with a psychosomatic component are a positive indication for referral to a group since in some instances these symptoms respond poorly to medical intervention. Yet the pain of which the patient complains, although actually experienced, may be metaphorical, much as in the phrase, ''She hurt my feelings.'' Patients who find themselves quite unable to say to their spouses, ''You make me sick,'' may present at the family practice center with some form of metaphorical illness. Interpreting psychosomatic complaints with this somewhat humorous simplicity can easily be overdone. Yet there is considerable evidence that the strata of the mind which underlie consciousness utilize metaphors and even puns in just this manner.[3-5]

The astute clinician soon becomes aware of the difference between complaints of pain which stem from physical illness or injury and those which are psychogenic. Nonetheless, it is often difficult to allow one's head to admit what one knows in one's heart. The pressures are such that the patient is often put through a prolonged and expensive workup which produces the essentially normal findings so common in these circumstances. The purpose of doing all these tests is to rule out the presence of serious physical disease, but so often the effect may be to reinforce the patient's belief that the problem is solely physical. Hence, with the prescription of medication, the patient responds only minimally, and there may be increased hostility and frustration on both sides.

The Physician's Response

The feelings engendered in the physician may often help him make the diagnosis. There may be first of all a faint sense, which grows stronger with time, of being foiled. Yet the patient often is so likable and sincere that the physician wants to believe him and may ignore this feeling. The physician's feelings progress to puzzlement—*a feeling that something else is going on*–something intangible and difficult to name and deal with. Finally, the physician begins to feel helpless, frustrated, impotent, and ultimately overtly angry as the patient continues to complain and make demands. He has also prescribed medication which normally helps other patients but does not help this patient. It is as though the patient does not want to be cured.

Options available to the physician at this point include:

1. Angry dismissal: The physician may feel that he must meet his responsibility to those with genuine physical illness or injury.

2. Persistence with investigations and frequent switching of the medication: The patient, faced with continued expenditure of time and money without significant relief may eventually choose to go elsewhere.

3. Referral to a specialist for further medical assessment: For the patients described above, the pattern of complaint, investigation, prescription, and frustration repeats itself.

4. Referral to a mental health professional: Again, for the patient, such referral may be a variant of number 1 above; ie, angry dismissal. The patient, sensing the inappropriateness of the referral, may be reluctant to accept it. It should be emphasized, however, that patients with significant emotional impairment should be referred for psychiatric assessment.

5. Conventional office counseling: This procedure, while potentially beneficial to the patient, can put considerable strain on the physician's resources.

The addition of group therapy to the prescriptions available to the family physician facilitates the provision of comprehensive and continuing care in a holistic manner. The availability of this technique may make it less likely that the physician will find himself in the kind of fruitless endeavors described above.

Contraindications for Referral

In considering the selection of patients, it is important to identify those who should *not* be included in a therapy group in a family practice setting. It has already been indicated that the acutely disturbed patient should be referred for psychiatric assessment. It is likewise inadvisable to include in group therapy people who are suffering from impaired consciousness due to physical disease or injury, such as cerebral arteriosclerosis. Spouses or life companions should not be assigned to the

same group unless it is to be composed of couples; otherwise the group tends to focus exclusively on that one relationship.

Patient Response to Referral

The initial patient response to the physician's suggestion of referral to a therapy group is likely to be puzzlement followed by reluctance. In the majority of cases, this hesitancy is based on four factors:

1. The patient's original assessment of his difficulties as primarily or entirely physical. Group therapy is a psychological treatment which may seem irrelevant to the patient. The fact that the group will meet in the family physician's clinic rather than a mental health clinic is an acknowledgement of the importance of the somatic component of the patient's difficulties, which for him may be most salient at the moment. However, few patients are unaware of the emotional stress in their lives, though they may not yet have acknowledged any relationship between that stress and their physical symptoms. The physician's suggestion of group therapy may be perceived as his acknowledgement of the patient's emotional stress, and the referral may be accepted with relief by the patient, provided that other fears about the group are allayed. If the patient denies experiencing emotional stress, then a referral for group therapy is not likely to be accepted.

2. The popular misconception is that patients must reveal their innermost selves to one another in group. While it is true that some group therapy techniques emphasize such self-revelation,[6] these practices are not required for the patient to benefit from group therapy. Patients can be reassured that their inner privacy will be respected.

3. The patient's feeling that his difficulties are of such complexity and uniqueness that only a physician has the wisdom requisite for understanding and alleviating them. Group therapy offers the patient an opportunity to discover that he is not so alone, that complexity depends in part upon perspective, and that human beings without special training may be capable of understanding and empathy. The task of the therapists is to forge the group into an instrument of healing, not to be the instrument themselves.

4. The attention of the physician must be shared with several other people. There are two compensating factors here, and they appeal to different people. One is that group therapy represents an opportunity for the patient to spend 90 minutes with the physician, even though that time is shared with others. The other compensating factor is that instead of an audience of one, the patient is offered an audience of six or eight, an opportunity which appeals to some patients.

Concluding Comment

Group therapy in family medicine is something of a hybrid, having characteristics of two health-care professions.[1] It is the authors' impression that patients with psychosomatic symptoms do well in this hybrid. The reasons for its effectiveness are not altogether clear, but may lie in the continuity of care provided by the family physician as well as in the potency of the technique. The patient feels that the family physician remains interested, available, and engaged in his treatment. The more routine medical contacts between patient and physician thus occur in a broader context of the interaction of emotional and physical factors.

The third paper in this four-part series discusses some of the principles and practical aspects of the management of the first few group sessions.

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