Group Therapy in Family Medicine: Part 4: A Case Report

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This paper is the last of a four-part series and presents a case report of a patient who attended a 20-week course of group therapy in a family practice. She was a patient who identified herself as medically, but not psychiatrically, sick. She was appropriately investigated and referred within the practice for assessment of her suitability for group therapy. Her course of treatment is described and explained. The satisfactory outcome of this case suggests that there may be a place in a busy family practice for referral of this type of patient.

This paper presents a patient who took a 20-week course of group therapy in a family practice. The case report illustrates the application of a therapeutic modality which is becoming available in family practice that permits the physician to deal more effectively with a broader range of patients.

Case Report

Mary is a 29-year-old white female who presented to her family physician with abdominal pain exacerbated by meals, especially fatty foods, and by stress and anxiety. She has two daughters, aged six and three, who she brought to her family physician for recurrent colds, otitis media, and enuresis. She had some concerns about their growth and development, especially their persistent complaints of fatigue.

Mary had a skull fracture without complications at the age of 11 and a bilateral tubal ligation the year before coming to the family practice center. Her visits to the center were characterized by complaints of depression, acne, coccygeal pain, and symptoms of urinary tract infection which did not yield positive cultures.

Her mother, aged 55, is in good health. Her father died at the age of 36 when Mary was 11 years old, a few years after he was severely handicapped by poliomyelitis. His death was sudden,

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0094-3509/78/0901-0501$00.75
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and was attributed to myocardial infarction. The paternal grandfather had died early with cancer. The paternal grandmother is alive and well. The maternal grandfather is living and is reported to have congestive heart failure. The maternal grandmother died in her seventies of myocardial infarction. Mary has a sister, aged 32, reported to have high blood pressure.

The patient is a health care professional. She is married to, but separated from, a professional man and has been receiving some supportive counseling from her family physician. She is dating a man with whom she does not appear to be deeply emotionally involved. Her husband takes the children on alternate weekends, thus providing Mary with relief from responsibility for solo parenting. At the same time, she is concerned about what may happen to them while they are away.

The following information was elicited on review of systems:

Respiratory system: She complained of a cough which was often associated with shortness of breath and chest pain.

Cardiovascular system: No symptoms.

Central nervous system: She complained of recurrent, persistent headaches, sometimes associated with a feeling of dizziness.

Urogenital system: Clear, other than the previously mentioned recurrent urinary tract symptoms.

Reproductive system: Her menstrual periods were regular, but often associated with some premenstrual edema. Occasionally periods are heavy.

Locomotor system: She complained of coccygeal pain for some weeks.

Skin: Acne of the face and chest.

General: She complained of tiring easily and worrying a great deal. Sleep was not seriously disturbed.

On physical examination, the patient was found to have mild acne of the face and chest. In general appearance she seemed rather pale and depressed, but full physical examination on a number of occasions revealed no significant abnormalities. Her weight remained steady at 123 lb (height 5 ft 6¾ in).

Laboratory work was within normal limits, including a complete blood count, electrolytes, and blood-urea nitrogen. Urine culture on three occasions was negative. Upper GI series showed no abnormality.

Because of the frequency of her contacts with the clinic, her suitability for group therapy was assessed by the authors as a part of a series of investigations.[1-3]

The working diagnosis and assessment were as follows:

Physical: Abdominal pain and urinary symptoms without organic etiology. Acne of face and chest.

Psychological: Anxiety and depression.

Social: Impending divorce with lack of obvious social support systems.

The plan for management was: (a) A bland diet with more frequent meals was recommended. (b) No medication was requested or offered. (c) Group therapy was recommended.

Early in the course of group therapy Mary was quiet. A pattern was established whereby she stayed very much on the edge of the group activity. This resulted in her becoming angry with herself, and on occasion with the group leaders, for her lack of participation. She recognized this pattern as highly significant in her life. The relationship between passivity, unspoken anger, and her abdominal pain was further discussed in the group. Toward the end of the 20 weeks, this pattern of passivity followed by anger changed; Mary became more assertive and spontaneous. She thus gained insight into how unexpressed anger can manifest itself as somatic symptomatology. In the group Mary was able to practice new ways of handling her anger.

The death of her father was a complicating factor in Mary's case. She had been very much the responsible person in the home, and one day while she was away, he suddenly died. Thinking for years that if she had been there she might have been able to do something, she had continued to fear that in some way she was responsible for his death. Personal responsibility could thus be seen as a major concern for her, stemming from the time of her father's death. In the group, the relationship between these past events and her present dilemma about responsibility was discussed. In addition, Mary told the group that she remembers little overt mourning at the time of her father's death; the suppression of emotional response was apparently a family characteristic. The group was able to effectively give Mary the permission, denied by her family, to grieve. The accomplishment of this long-delayed task may have contributed to

the increase in spontaneity and assertiveness observed toward the end of the course of treatment.

The above issues contributed to the breakdown of Mary's marriage. The group was supportive as she worked through the many emotional, legal, and financial stresses of divorce. There were no complications of group therapy.

At the end of the course of treatment there was a marked improvement in Mary's symptoms, and she was in better spirits. At a follow-up meeting of the group six months later, she reported no further significant abdominal pain, described her increased social activities, and also reported fewer unfounded concerns about her children's health and development.

Comment

This patient's prognosis is good, given the marked improvement observed during the course of therapy. The final diagnosis was considered to be abdominal pain without apparent organic cause in a situation of anxiety and depression, accentuated by previous childhood experiences and exaggerated by a stressful divorce.

This type of case is often difficult to manage in a busy family practice, where much of the emphasis must be on the identification of organic disease at the earliest possible moment. In Mary's case, recognition of the role of emotional, psychological, and psychosocial factors led to an appropriate referral. The therapeutic exploration of the relationship between her early history and her current symptoms may have contributed to the success of the course of therapy.

References

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