

GP or therapist – or both?

The medical model, emphasising diagnostic classification and cures, has been transplanted wholesale into the field of human problems (Duncan & Miller, 2000, p. 19).

▶ The western medical model

Our western medical model is based upon assessing the problem, making a diagnosis and then prescribing the correct treatment. Neat, tidy and easily quantifiable! The problem is that when we try and match this across to mental health issues, we immediately run into difficulties. We are dealing with complex human beings with a myriad of ideas, beliefs, expectations and symptoms that rarely fit snugly into a single label.

Primary care practitioners have been brought up and trained in the medical model and often feel most comfortable when working in this way. But what are we doing to our clients? If you medicalise a condition, whether anxiety, depression or addiction, you imply that the cause is probably inbuilt or genetic, that the client is relatively powerless to change and that the doctor will provide a 'cure' or 'manage' the condition. This may be good for the professional's ego but does little to teach the client new perspectives or new skills.

▶ Pathologising emotions

We continually talk about emotional distress as an illness or pathology that needs to be 'cured'. Perceived wisdom is that if you are mildly depressed then counselling may help, whereas moderate to severe depression requires medication. But it has been shown that there is

no relationship between diagnosis, selection of approach and outcome (Beutler, 1998; Beutler & Clarkin, 1990). How can you be ‘mildly’ depressed? You can be unhappy, fed up, pissed off, depressed but each label has a spread of attributes and is multifactorial.

We need to learn how to deal with adversity in a resourceful way – it is unrealistic to think that we will feel happy all the time. Positive thinking may help but only up to a point! We need to teach our clients how to begin to tolerate uncertainty, to tolerate sometimes feeling low or anxious in the knowledge that they can learn the skills they need to keep emotionally healthy if they do not have them already.

Unfortunately, Health Professionals, especially GPs, have huge time constraints and often it seems much more time-effective to reach for the prescription pad than expend time and energy on other approaches.

The health professional may have worries that leaving the security of their standard approach may take too much time or cause them to expend too much energy. The ideas presented in this book are not rocket science but like most effective things, quite simple. It depends more on a change in mindset of the health professional than any deep and profound additional knowledge.

▶ The first steps

Coming to see a health professional can in itself be therapeutic; after all, the word therapy comes from the Greek word for ‘attendance’. How the health professional directs the consultation will dictate whether it is therapeutic or not.

I have found that asking the right question, noticing the minimal cues that the client gives me and listening to what the client is actually saying cuts consultation time down because the client begins to focus on their strengths and we cut to the heart of the problem and the solution much more quickly. Very often, if you do not pick up on something the client has said, maybe not noticed some non-verbal feedback, then the whole consultation is spent barking up the wrong tree and getting nowhere.

▶ Applicability of the medical model

There are times when one very definitely needs the medical model – one needs to exclude pathology when dealing with pain, one needs to

treat the heart failure or diabetes. If someone has a heart attack, one needs to act quickly within the medical model. But one needs to be aware, once the medical emergency is over, that the client has emotional issues that need addressing. I have met several people who had previously been very fit and well, who, following a sudden heart attack become depressed and overly worried about their physical symptoms. They become cardiac invalids, even when there is, from a medical viewpoint, nothing to stop them leading a normal life.

I believe that good and effective GPs already, very often, act as therapists. Some, dependant upon character, inclination or training will feel uncomfortable in this role, but using the techniques outlined in this book will make it easier for them to deliver drip-feed psychotherapy to those clients who are willing and eager to learn new skills or re-awaken old ones.

► Problems with being a therapist

Health professionals also need a degree of realism. Most people can be helped; some greatly, some only in minor ways, but health professionals are not going to be able to help everyone all the time. The Messiah complex, the feeling that you can help everyone, is not only unrealistic, it is unhealthy. It is important that anyone who is trying to help people with emotional issues should ensure that they pay attention to their own emotional health. If we are feeling tired, low in mood or stressed, we cannot give our best to our clients and everything seems an uphill struggle. Maybe we should use for ourselves some of the ideas in this book before we teach our clients, in order to stay emotionally healthy ourselves.

One difference between primary care clinicians and therapists is that most therapists work with supervision and have someone with whom they can share the highs and lows of therapy. GPs tend not to have this, but if it is at all possible it is very useful to meet a colleague and discuss cases, even if it is only over coffee! Sharing one's thoughts about a case not only elicits support and reassurance from a peer but can also stimulate creative therapeutic ideas.

Classically, the health professional feels tired and dispirited after having had a consultation with a 'heartsink' client. With the approaches described in this book, because there is some structure and the client feels validated and listened to, the health professional's energy levels are not sapped by focusing on the client's problems. Taking a psycho-

logical perspective in such cases has been shown to be useful (Balint, 1957; Elder & Holmes, 2002).

It is important to step into a client's shoes so as to begin to understand them, but it is important to keep our own shoes on as well. If we become immersed in a client's problem then there are two people with a difficulty rather than one. Equally, it is unwise to take the 'expert' role as this disempowers the client and buys into the medicalisation of emotional distress. I like the concept of being a 'travelling companion rather than a travel agent' (Deitchman, 1980, p. 789).

One of the fears that I think many primary care physicians have is that they will get swamped by clients if they start to work with their emotional problems. In my experience, if you structure it correctly then those 'heartsink' or 'fat file' clients whom you work with will actually start to rely on you less and eventually see you much less frequently, as well as using up less resources with investigations and medication. Also, because we are both focused on, and working towards, the same goal, it stops that sinking feeling that we may often feel when Mrs Bloggs comes in again for the second time that week with a myriad of different symptoms, none of which fit neatly into a diagnostic label and which leave the doctor feeling confused and frustrated.

▶ Setting the contract

Deciding with the client on what their goal or goals are and together defining how often and for how long you should meet is essential, especially for clients with great emotional needs. A regular review of progress is also essential and can alert you to problems that are blocking progress. These can then be explored. We will talk more about goal setting in later chapters but deciding on these parameters right at the start and allowing the client to tell you how often they think they should see you and 'negotiating' a plan means that the client 'owns' this decision.

The other advantage of the client 'owning' the decision as to when to come for a consultation means that less time is wasted on DNAs (did not attend).

Case 1: David

David was a 57-year-old mechanic who had been out of work for two years with stress and depression. He comes to the surgery frequently with various physical complaints and symptoms and has been on an antidepressant for several months with no noticeable improvement.

After explanation, he is keen to try a different approach and we decide to have a 10-minute consultation every week for one month and review progress.

At the month review, there has been a noticeable improvement and when asked how often he needs to attend surgery now, David suggests every two weeks.

We decide to meet every two weeks for two months and review.

By eight weeks, he is doing so well that we lengthen the time between consultations to four weeks . . .

▶ Selection

Some clients do not wish to work with you on their emotional problems. They want the doctor to take control and give them something that will ‘make them better’. Sometimes one can gradually lead such people to take a different perspective but there are many clients who are willing and eager to start to take control of their lives, so perhaps we should look at where we can most usefully direct our energies and be a little selective as to whom we should take on for formal therapy. The ideas in this book can, however, inform all of your consultations and be implemented less formally when appropriate. Try taking a solution-oriented, rather than a problem-focused, stance generally and notice how your consultations change. . . .

There are times when it is not appropriate to begin working with someone on their difficulties, but there are still tools that you can teach that are simple and effective.

When someone is drowning, it is not the time to offer them a swimming lesson – but one can throw them a lifebelt.

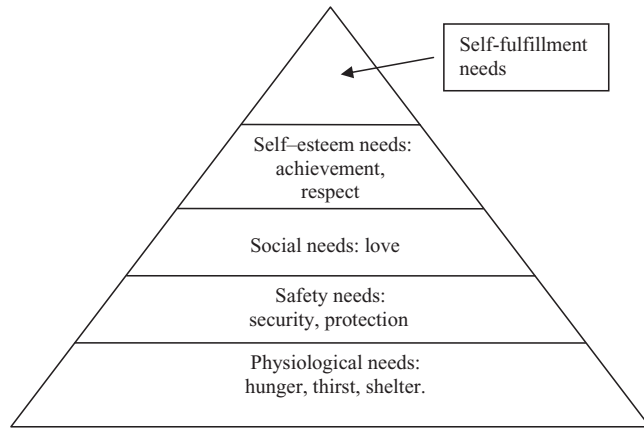


Figure 1.1 Maslow's hierarchy of needs

Sometimes the health professional needs to decide whether support or change is appropriate in a particular case. Sometimes practical help is needed before any emotional difficulties can be addressed. Maslow's hierarchy comes to mind: when someone is worrying about where their next meal is coming from or where they can stay because they are homeless, it seems inappropriate to focus attention on their emotional state. They have pressing practical needs that have to be addressed first.

► Onward referral

This book deals with ways of helping people with anxiety and depression, with the common neurotic disorders that we all suffer with from time to time. The severe end of the spectrum of mental illness (I'm afraid going back to the medical model here) such as psychosis needs onward referral to specialist services in the acute stage. But once settled, a solution-focused approach is eminently suitable and learning some of the ways described in this book to break into previous patterns of behaviour can be useful and effective.

When working with people at the high-risk end of the spectrum, those that are likely to self-harm or harm others, it is of great importance that the health professional does not work in isolation and that they work within their field of expertise and training. Alerting the local mental health team so that support can be given and keeping good notes are essential.

▶ Disengagement

Disengagement is less of a problem when working in the way I describe because the approach is collaborative and the focus is on helping the clients help themselves. Sometimes it is necessary to disengage slowly and to build a client's confidence that they can manage without your support by gradually lengthening the time between consultations. Primary care physicians are in an especially good position to keep minimal support for clients when appropriate, by seeing them for a follow-up appointment every few months, for a while.

I find asking the client to decide when they next need to see you can be very helpful. It gives the client confidence and control and if the health professional feels that the time selected is not appropriate, it can be a useful pointer to further work required and can be subject to negotiation.

With some clients, particularly those with a borderline personality disorder, it is necessary to define with the client, at the outset, a contract that you yourself are comfortable with.

This is where review can be so useful; if progress is not being made towards the client's goals, then it is necessary to disengage or try something different. Two quotes seem appropriate here:

When you discover you're riding a dead horse, the best strategy is to dismount.

Native American Dakota tribal wisdom

It is common sense to take a method and try it. If it fails, admit it frankly and try another.

But above all, try something.

Franklin D. Roosevelt

▶ Relapse

It is commonly found that clients improve during the therapeutic process, but then relapse after disengagement. Using the methods described in the following chapters, relapse is considered and strategies devised with the client that minimises this risk, although sometimes clients need to return for a few 'refresher' consultations. As health professionals, we can work for a while with clients until they reach a stage that is satisfactory for them and then, if a crisis arises, see them again for a while, until things stabilise or improve.

Recovery does not mean that a person will no longer experience symptoms; it is much more about how they live their life in the midst of those symptoms. We all face setbacks and find life a struggle at times and should take care not to blur the margins between these and a person's symptoms. We must 'stop pathologising daily life and focus instead on how we can better navigate through life's difficulties to help people achieve what they desire' (Rapp & Goscha, 2006).

▶ Time constraints

We work under huge time constraints but all the ideas presented in the following chapters I have used successfully within 10-minute consultations. Sometimes it is necessary to schedule a double appointment time, but in my experience once the health professional starts working from the perspectives suggested in this book, the time is just used in a much more effective and focused way.

It is entirely possible to use these tools within groups, and over the years, I have run many groups of 6 to 10 clients where we work to these ideas over two-to-three-hour sessions and then offer individual sessions if needed later.

▶ Summary

If alcoholism, depression or smoking is regarded as an 'illness', it then follows that:

1. It is not my fault.
2. I can do nothing about it.
3. I take tablets to correct the problem.
4. It is genetic.
5. The doctor is powerful.
6. The patient is powerless.

However, one needs to exclude pathology especially when dealing with physical symptoms, such as pain, but equally the health professional needs to address emotional issues when dealing with physical pathology.

We, as health professionals, need to have regard to our own emotional well-being and this should involve someone to talk to about difficult issues that may arise. Do not try and be a Messiah – you can help many clients – but only those that want to be helped. Utilise a solution-focused approach and be aware of when onward referral is appropriate. Always work within your field of clinical expertise and keep reasonable notes and you are unlikely to find yourself in trouble.

Set a contract with your client both as regards frequency of contact and the goals you are working towards. Disengagement is not a problem if you regularly monitor progress towards these goals.

