Time-Limited Therapy in a General Practice Setting

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How to Help Within Six Sessions

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To my GP colleagues and friends,
without whose support and trust, this
book could not have been written

Contents

Preface

Counselling has become a boom industry with many counsellors coming out of the training-course pipeline with basic skills. Counselling in General Practice has become a popular goal for counsellors, and it is now considered that nearly a half of all surgeries offer some form of counselling service. However, GPs have increasingly set a limit to the number of counselling sessions they are prepared to offer to their patients; most commonly six, ten or twelve sessions. Yet counsellors are trained to work in an open-ended way, and may not have the skills required to work within a time limit. With the large number of referrals a counsellor receives in primary care, the counsellor needs not only the counselling skills acquired during their training, but also a psychological knowledge of the human process.

Time-limited therapy is not long-term counselling cut short, but a specific set of skills enabling the counsellor to deal with the vast range of difficulties presented in a short space of time. It is not just about counselling skills, which is why it is called time-limited *therapy*. It is also about other skills that can enhance the counsellor's role in primary care. These skills include teaching, guiding, administering, and even (dare I say it?!) advising. It is essentially a skills book for the counsellor that integrates counselling skills with psychological knowledge. It aims to fill a training gap by providing an overview of how to develop a primary care counselling service, teach the underpinning required to work within a time limit, and then offering skills and tips for the counsellor to use. It will be of interest to student counsellors, newly qualified counsellors, and any counsellor planning to work within primary care who has hitherto worked in an open-ended way. GPs interested in the counselling service offered by their practice might also find it of value.

The reader will note that the topic of psychotherapeutic groups has not been covered in the text. This is not because I feel groups have no value. Indeed, much developmental work can be undertaken in a group, which can be considered as more cost-effective in terms of therapist hours. However, this book is about the one-to-one skills that can reduce a client's presenting distress in the shortest time possible.

The book is divided into two parts. Part I is about the management and administration of a counselling service within primary care, and discusses the political side of working within a time limit. It provides a brief evaluation of a time-limited service in Chapter 2, and in Chapter 3 elaborates the integrated psychotherapeutic skills used to make the therapy shorter and more focused. Part II applies the theories of Part I to specific client presentations. It provides an outline of the psychological and physical aspects of each presentation, and then offers tips on how the therapy can be more efficient. The skills elaborated in the earlier chapters will be of equal relevance to the later ones, but are not reiterated, for the sake of brevity. So if you skip to later chapters (as I often do in books like this!) you will miss some of the skills proposed. I hope you will find something of use to you in the following pages.

I would like to express my grateful thanks to Graham Curtis Jenkins, Director of the Counselling in Primary Health Care Trust for his advice and support in the preparation of this book.

Glyn Hudson-Allez
April, 1997

PART I

1

The Management of a Counselling Service in General Practice

Ten years ago, I was involved in a research project looking at preventative health care in General Practice in the Bristol area. Principal GPs were interviewed, elaborating on their practice's preventative health care measures. Some of the questions asked related to the prescription of psychotropic drugs and counselling services within the practice. One particular question required the respondents to assess what proportion of their patients attended their surgery for psychological or social reasons. The doctors responded that only 53 per cent of patients attended purely with a physical illness. And it emerged that in some of the poorer, working-class areas of the city, GPs reported that up to 75 per cent of presentations had a psychological or social underpinning (Hudson, 1988). Parenthetically, this is consistent with other research which found that 60 per cent of patients presented with illness but no disease (Shapiro, 1971). Of course, there were variations in the perception of these patient presentations. Some doctors suggested that virtually all the ailments presented to them had some form of psychological underpinning. Others felt that even psychological problems cause illnesses and should therefore be considered physical. What became clear was that approximately half of a GP's patient presentations had a psychological element. The doctors themselves said that they had little or no psychological training, and often felt inadequate to deal with such a large psychological caseload.

The GPs interviewed were aware of, and predominantly frustrated by, their inability to tackle these issues within the space of their 6–10 minute consultation time (Noon, 1992). Counsellors in primary care were rare at this time, often working for nothing, and anyway there was a distrust of what were seen as well-meaning, non-professional do-gooders. Only patients with more serious problems manifesting

severe physical or psychiatric illnesses could be referred to the secondary mental health teams. So that left a large number of patients who were finding it difficult to cope with life, being maintained pharmacologically on repeat prescriptions of psychotropic drugs. These patients became the GPs' 'heartsinks', often referred to as the 'worried well' or the 'walking worried'. This was a large proportion of the patient population, as one in 50 adults takes mood-altering drugs permanently, and one in ten men and one in five women will take them at some time in their lives (Mitchell, 1984).

Nearly a decade later, it is considered that a half of all fundholding practices and a third of non-fundholding practices offer a counselling service. Fundholding in General Practice has given doctors the freedom (and the money) to widen the services offered to their patients. GPs knew what the patients needed (Kriesel and Rosenthal, 1986; Small and Conlon, 1988); but they had been unable to persuade those holding the purse-strings that non-medically qualified staff might have something to offer. Once GPs had the financial freedom to employ counsellors, the introduction of counsellors into the primary health care team mushroomed (Sibbald et al., 1993). And, once installed within the system, counsellors became their own best advocates, with GPs and patients alike wondering how they ever managed without them. GPs know that caring for people is labour-intensive. As Mitchell (1984) argued, machines cannot do it and it cannot be done against the clock. Yet GPs have only 10 minutes to offer for each consultation (some appointments are only five minutes apart). The great medical writer Balint (1964) agreed: if patients need something special, like time, only time will do. One of the contributions that a counsellor gives to a client is time. Even time-limited therapy offers a client abundantly more time than the doctor can give. Balint continued that the more one knows of the problems in General Practice, the more impressed one becomes by the immediate need for psychotherapy. Thirty years later, it is still not a universal service.

Advantages and disadvantages of primary care counselling

What are the benefits in having a counsellor in General Practice? For the GPs, outcome research indicates a reduction in psychotropic drug prescribing (Ives, 1979; Gath and Catalan, 1986; Spiers and Newell, 1995) and a reduction in patient presentations with numerous minor physical ailments (Marsh and Barr, 1975). GPs can refer early to someone they know and trust, and receive direct feedback

from their patients and their counsellors. Having a counsellor liaising within a primary health care team introduces a person experienced in interpersonal relationships, with more time to listen and to hear the full extent of the patient's difficulties, thus reducing the tendency to medicalise the patient's problem. This also makes the other team members more aware of an alternative non-medical approach.

For the patient, there is an opportunity to unload and be heard in familiar, safe surroundings, without the fear of stigmatisation that secondary referral can bring. Secondary referral can take months of anxious waiting, and may not necessarily be taken up even when the person reaches the top of the waiting list. Mental health teams are so under-resourced that they are selective in the referrals they receive and only take what they consider to be the more severe cases.

A counsellor can normalise many of the client's difficulties rather than exaggerating them into 'mental health problems'. Much has been written on the tendency to prescribe psychotropic drugs to change the way patients feel about a situation, rather than helping them deal with their problems (Parish, 1971; Gravelle, 1980; Wells, Goldberg and Brook, 1986). This has led to widespread addiction and in some cases permanent physical damage from prescribed psychotropic drugs (Johnstone, 1989; Breggin, 1991). Now, patients are more likely to end pharmacological interventions when they have been counselled than when they have not been counselled (Ashurst and Ward, 1983). Plus GPs are less likely to reach automatically for the prescription pad when a counselling alternative may be considered more appropriate.

For the counsellors, the advantages are that they receive a challenging and interesting caseload of regularly referred clients, a regular income, a consulting room, and the benefit of reception and secretarial facilities. Working within a team is less isolating than working in private practice, usually from home.

What are the disadvantages of having a counsellor in primary care? Well, cost is always a consideration of services provided in the 1990s. Gone are the days when counsellors chose to work for nothing, and rightly so. As the discipline has become professionalised, counsellors have demanded a fair remuneration commensurate with their qualifications and experience. Equally this has ensured that only appropriately qualified counsellors are employed in the capacity, rather than interested health visitors or the GP's wife. However, the cost has to be met either by the patient (soon to become the counsellor's client) or from the practice budget.

There is also the ubiquitous criticism of the lack of evidence that talking therapy actually works, especially given the knowledge that some patients spontaneously recover. Evaluation of the service is

covered in more depth in the next chapter. Some argue that having an in-house counsellor encourages patients to go to the doctors even when they are not 'ill'. There are also fears from the psychotherapeutic profession that confidentiality may be compromised in a team setting. This concept will be addressed more fully later on in this chapter.

Finally, because of cost restrictions, there is usually a limit on the number of sessions offered for each client. You will notice that I have placed this in the disadvantages section. Some people strongly believe that placing limits on therapy inhibits the process. I have written this book because I disagree. Thus, the ability to undertake brief therapeutic work is the focus for this book. Arguments for and against time-limited therapy will be addressed in Chapter 3.

Funding the service

FHSAs vary in their approaches to counselling services. Some promote the idea of an 'in-house' counsellor by offering GPs reimbursement of up to 70 per cent of the cost of employing one under the ancillary staff scheme. However, when the range of trained staff eligible for reimbursement was extended in the GP contract in 1990, some FHSAs withdrew this benefit under the ancillary staff scheme. Other practices have employed a counsellor under the scheme for health promotion clinics, but this tends to be unsatisfactory as it is likely to be the first resource cut if the books are not balancing towards the end of the financial year.

Fundholding or non-fundholding practices will invoke different methods of employing counsellors. In order for non-fundholding practices to offer a counselling service when they have not got an interested FHSA, some practice managers have made a room available in the surgery for the counsellor to use. The counsellor and client make their own arrangements for the payment of a fee. Some practices charge the counsellor a nominal fee for the use of the room; others do not. The counsellor pays for his or her own supervision and professional liability insurance. The advantage of this method is that the counselling service is offered to patients at no cost to the practice. The disadvantages are that the patient has to pay, and not all patients in need can afford to do so. Thus the counselling service will not be as well used as in fundholding practices. Plus the practice partners have very little say in how the counselling service *per se* is organised, especially with regard to the quality of service.

Fundholding practices are more likely to employ their own counsellor directly, offering the service to their patients free of charge.

The counsellor's salary, or fee if employed on a contract basis, can be taken from either the mental health budget, hospital services budget, or from savings made from the FHSA allowance. Under these arrangements counsellors may receive financial assistance for their supervision and insurance commitments. The disadvantage of this approach, for the counsellor, is that job security exists only as long as fundholding is maintained by the government of the day. For the practice partners the service is expensive in an already tight budget, and can be frustrating when patients fail to attend for appointments that have been paid for. Advantages of this approach are that the patients get the service free, thus it is available to all who need it, and the practice partners can monitor, evaluate, and generally participate in the service they are providing.[1]

Qualifications and training of the counsellor

Counsellors are now coming off the training course conveyor-belt in large numbers; it is a boom industry (Hudson-Allez, 1994). GPs are frequently petitioned as to their willingness to employ counsellors, or to refer to the counsellor practising around the corner. Yet how do doctors know that they are getting someone suitably qualified for the job? One practice I know advertised in the local press for a counsellor. Amongst the numerous applications received, the partners had to consider applicants who did not have any paper qualifications but 'people enjoy talking to me', an astrologer who had to counsel in the course of giving horoscopes, nurses trying to escape from the hospital regime, community psychiatric nurses and newly qualified counsellors with shining new certificates but no working experience.

The British Association for Counselling (BAC) and Counselling in Primary Care Trust have been working hard to try to establish specific criteria which doctors can look for when employing counsellors, and have published guidelines (BAC, 1993) to help them do so. The BAC has recommended that GPs only employ counsellors accredited by their organisation (Curtis Jenkins, 1993b). This accreditation procedure applies rigorous training and experience criteria. However, there are comparatively few accredited counsellors, as the accreditation procedure has many critics from within the discipline – especially from those who do not meet the accreditation regulations. With all this controversy within the discipline, we can hardly expect outside professionals to have confidence in the standards that are being set.

Working in General Practice, although very rewarding, is also very demanding. As it is the first port of call for most people with any sort

of difficulty, it produces a large number of clients with a wide range of difficulties. It therefore needs a very experienced and very emotionally stable counsellor to tackle such case-loads. As Curtis Jenkins (1996) argues, it is no good employing a Relate counsellor trained only in relationships and expecting them to be able to treat people with post traumatic stress, anxiety and depression. Controversially, I believe that the job also needs a substantial amount of psychological knowledge; that counsellors who have been trained only in counselling skills are probably underqualified for this work. The reason I hold this view is that time-limited therapy requires good early assessment skills. The ability to assess appropriately in a short space of time requires more than just listening skills; it requires a psychological understanding of the dynamics of presenting problems and what may underpin them. It is also equally important that the counsellor have knowledge and understanding of people with mental health problems, and that they do not, naively, embark on trying to counsel people who are mentally ill. Part II of this book brings together psychological underpinning and counselling skills to aid people when working in a time-limited way.

Once a counsellor is in post in primary care, it is important for both counsellors and GPs to remember that training for the job does not end there. It is part of counsellors' professional working ethic that they continue with personal and professional development. This means continuing to attend training and therapeutic workshops to keep abreast of new techniques and theoretical research. A counsellor's supervisor, and line manager if appropriate, should monitor the continuing professional development of her supervisee.

Referrals to the counsellor

Counsellors need to be aware of the mixture of emotions that referrals to the counsellor elicit, both in the client and the GP. Counsellors also need to be aware of the effect of this referral in terms of the triangular relationship (i.e. client, GP, counsellor) on the therapy (Palazzoli et al., 1980). If you are a new counsellor within the practice, the GP may feel a little unsure about referring a patient for whom s/he has hitherto had sole responsibility. Delegating the work while maintaining that responsibility is difficult. Younger and newly trained GPs tend to find it easier to refer to a counsellor than older doctors do (Neilson and Knox, 1975; Waydenfeld and Waydenfeld, 1980). But whatever the age of the GP, it is important to keep the channels of communication open. As discussed later, in the confidentiality section, the way to alleviate nervousness and

anxiety about the counselling service, and to promote trust and confidence in your skills as a counsellor, is to be open with the others in the team about what you are doing. Cloaking the counselling process with a mysterious veil on the grounds of confidentiality inhibits the team relationship.

If you are the first counsellor to work within a certain primary health care team, it is useful to write a memo to the GPs as to the type of referral that you feel is appropriate for you to receive. GPs need to be made aware that it is fruitless to send their 'heartsink' patients to the counsellor as a means of getting the patients off their backs for a few weeks. There is a limit to what a counsellor can do, especially in time-limited therapy, and it is up to the counsellor to reinforce these types of boundaries (Curtis Jenkins, 1993c). Inappropriate referrals reduce the cost-effectiveness and efficiency of the counselling service. Having said that, small but significant changes can occur with some of these patients simply because the quality of the listening service has been enhanced (i.e. 6 to 10 minutes of GP time is increased to 50 minutes of counsellor time). Maybe for the first time, the patient has felt heard and their feelings acknowledged.

Patients who become the counsellor's clients will also be feeling nervous. They may have known their GP for years, and feel safe and confident in his abilities. Now the patient is being asked to see someone new, who is not a doctor. In this referral, the message being transmitted is that the patient is not really ill, but has something wrong in their head. Words like 'psychiatrist', 'shrink' and 'mad' fly around in their minds, producing feelings of anxiety and fear. It feels safer to have an illness that can be labelled, like 'nervous debility', 'irritable bowel syndrome' or 'stress', than to admit both to oneself and to others that one cannot cope with life. It is not enough for the counsellor to understand these feelings of the client. The counsellor needs to convey this to the GPs too, so they can be more sensitive when discussing the referral with their patients. For an outline of the sort of person who is referred to the counsellor, see the next chapter.

Having accepted a referral from the GP, it is important for counsellors to feed back progress of the counselling process to the referring doctor. This feedback may be in two forms. First, there is the informal conversation. It is this kind of discussion that some counsellors are so vehemently opposed to. It is interpreted as coffee-room gossip, and is considered demeaning to the client. Yet this sharing is as important for the counsellor as it is for the doctor. Clients are selective as to the information they convey between the two helpers. They often also have implicit assumptions about the counsellor and GP discussing their case, and about the counsellor

having read the medical notes. They expect the counsellor to know why they have come and to know about the major events in their lives. Clients frequently express surprise when I tell them after I have introduced myself at an assessment session that I know nothing about them. If the counsellor and doctor are used to liaising informally, it can relieve a lot of pressure for them both. Saying, 'I am not really sure what is going on here' becomes easier on both sides. Difficulties can be shared, and appropriateness of referral can be questioned. Differences in philosophy can be discussed, e.g. the medical versus the humanistic model, thus allowing for a deeper understanding of different perspectives. Remember that keeping the content of the client's sessions to oneself can still preserve confidentiality. What may be shared, however, is the process, and this sharing is too valuable to lose.

The second form of feedback is the counselling formulation. At the end of the counselling contract, a formal acknowledgement of the termination of that contract is appropriate. A formulation of the counselling process and progress made will inform the GP of the current situation. This is important, not only because counsellors should be seen to be working in a professional manner, but because GPs are entitled to know of the outcome of the service for which they have paid. The formulation should include the counsellor's evaluation of the counselling process, an assessment of the progress made, and any recommendations the counsellor may wish to make for consideration in future dealings with the client. This formulation should not be filed in the patient's medical notes, but in a separate locked place without any identification of the person on it. Formulations can be identified by client number, which the counsellor will allocate at the assessment session. When a formulation is sent to a GP, patient identification should be detachable. The GP can note its contents, detach the identification label, and the formulation can then be filed away safe from curious eyes. Medical case notes may be marked discreetly with the formulation number to refer back to at a later date, if appropriate.

Reception facilities for the client

As mentioned, being referred to a counsellor for the first time may be scary. And the patient, soon to become the client, does not wish to be distinguished from the other patients in the doctor's waiting room. It is important, therefore, that receptionists are briefed as to the sensitivity of this situation. Stories abound of unthinking receptionists

who have boomed across crowded waiting rooms, 'Mrs Jones, you're next for the counsellor. Go to room six!'

Very often doctors in group practices use an intercom system to summon patients from the waiting room to the consulting room. Counsellors, however, prefer to greet a client personally, and may choose to fetch the client from the waiting room and take him or her to the consulting room. But this immediately distinguishes this client from the other patients. Patients in waiting rooms talk to one another, and if something different is noticed, it is commented on. It is preferable that clients are summoned to the consulting room in exactly the same way as other patients, in order to preserve the anonymity of the consultation.

Leaflets should be available at the surgery to explain to the client what to expect when being referred to the counsellor. Clients should be made aware of the qualifications of the counsellor, what to expect in terms of a time-limited contract, and what the confidentiality boundaries are. Ideally, these leaflets should be handed to the patient when the doctor first makes the referral to the counsellor, but it would also be helpful to have the leaflets available in the waiting room, so that other patients can read about the service being offered. An example of such a leaflet can be found in Appendix 1.

It is very difficult to de-medicalise a medical setting, especially if the counsellor is receiving clients in one of the doctor's consulting rooms. Yet it is important for the clients to feel, as soon as they walk through the counsellor's door, that this is a different form of consultation. Attention must be given to the detail of the room structure. If the counsellor is in a special room for the purpose, then it is easy to place comfortable chairs at non-threatening angles, to have pictures and plants to soften the room, and to have an occasional table with the necessary tools of water, paper, tissues and a well-positioned clock.

If the counsellor is seeing clients in a medical consulting room, it is much harder to soften the atmosphere. It is common for GPs to have high swivel chairs positioned at a desk, while the patient sits in a small, hard dining-chair perched at the corner of the desk. Of course, these are not appropriate for a counselling setting, so two (or three, if seeing couples) soft armchairs of equal height will need to be transported in from another room. The curtains can be drawn around the examination couch and the computer monitor should be placed well out of view of both the client and counsellor, to avoid distractions.

The counsellor should never fall into the habit that some GPs have, of not greeting the client appropriately. Patients frequently lament that when they enter the consulting room the doctor asks

what the problem is before even looking up from completing the previous patient's notes. This makes the patient feel small, undervalued and often angry. The relationship between client and counsellor is very important in a counselling interview. It is even more so in time-limited therapy, where there is not the luxury of additional time to be spent on enhancing the relationship and checking out its progress as in other therapeutic interventions. The counsellor should have read any previous notes before a client enters the room, and should greet the person in a warm, friendly and informal manner.

Confidentiality

I feel very strongly that counsellors working within primary care lose an essential benefit of team-work when they adhere to a very strict code of confidentiality (Hudson-Allez, 1995), to the extent that they refuse to share the process of their work with other professionals within the team. This is one of the most common criticisms of counsellors from the medical discipline. Doctors are used to working in team settings, and are trained to make comprehensive notes to which colleagues can refer. They share case histories and bounce ideas between each other. Doctors treat the counsellor's unwillingness to share with suspicion, making them reluctant to refer if they cannot keep abreast of what is going on. It must be remembered that GPs have a confidentiality ethic, too.

Counsellors are also trained to adhere to a strict code of confidentiality (BAC, 1992). The BAC reinforces that the counselling relationship is, by its nature, confidential, and we are aware that many clients would not open up as they do if they were not assured of this confidentiality. But strict adherence to the rule can isolate the counsellor from the rest of the primary health care team, causing distrust and resentment, and the loss of a lot of important sharing. And it has to be remembered that the persona presented by the client to each member of the team is different. If the professionals share with each other their impressions of the work that needs to be done with a client, a much clearer, holistic view is built up, enhancing the service that the client receives.

So how can this bipolar approach to confidentiality be resolved? Counsellors can never assure clients of absolute confidentiality: the Children's Act and Prevention of Terrorism Act prohibit us from doing so. But there are also personal moral boundaries that may encourage counsellors to break the confidentiality code. For example, suppose your client tells you that she sells illegal drugs

outside the local primary school, or that he is sexually abusing an adult with learning difficulties? These are the cases that we take to our supervisor before deciding what to do. We will probably discuss with our client our intention to break confidentiality, and suggest that it would be better if he or she does so. But the client can still refuse, and demand that we keep the secret. When working in primary care, it may be valuable in such cases to discuss difficulties with the GP. The GP usually knows the family well, and can not only offer a clearer insight into the dynamics of the person, but can also provide the counsellor with professional back-up if the situation becomes difficult.

Another grey area in our confidentiality code is when the client expresses serious suicidal intentions. Medical staff are trained to interpret this as a severe psychiatric disturbance which needs medical intervention. Counsellors are more likely to consider that, although some clients may be severely psychologically disturbed, they are still autonomous individuals who have the right to make their own choices. Bond (1993) suggests that legally it is doubtful that being suicidal is sufficient grounds for breaking confidentiality. But when the counsellor is working in a team setting, there is more than just the client to consider. If a client takes at once all the medication prescribed by the GP for a month, and the counsellor who had been seeing that person in parallel knew this was very likely to happen but kept it confidential, how would that GP feel about that counsellor? What would it do for the trust and confidence of working within a team?

In practices where I work, we have discussed this at length. Our way around this problem is to annotate the medical notes 'at risk' following the counselling endorsement. Confidentiality boundaries are protected as no further information is provided. But the doctors and nurses are alerted to distress calls when in attendance or when prescribing. A similar annotation can be used when a counsellor is concerned that a child or an elderly person may be in danger, but has insufficient information or evidence to warrant social services intervention. Thus doctors can be alerted and be vigilant when these people attend the surgery. Here again, confidentiality is not broken, yet vulnerable people are protected.

What does the client feel about confidentiality in the doctor's surgery? In my experience the client comes with an implicit assumption that the doctor, who may be in the next room or down the corridor, will know some of our conversation, despite my explaining the confidential nature of our relationship when we first meet. As I have said, clients often express surprise when I say that I do not know why they have attended, or what their difficulties are. Sometimes this