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TRAINING THE FAMILY THERAPIST

Family Therapy and the Family Doctor - 1

by Graham Martin*

The author shows that the family doctor's burden of responsibility in the area of psychological dysfunction in the community is immense. Traditionally he has little training, limited knowledge, and a paucity of skills, in the areas of counselling and psychotherapy. The author argues that structural and strategic family therapy skills may be applicable to family practice and of benefit to the family doctor. A brief introductory course and subsequent feedback are described.

Suburban community studies in Victoria (Krupinski, J., et al, 1970), in Canberra (Hennessy, B.L., et al, 1973), and in Sydney (Andrews, G., et al, 1975) suggest that one in every four Australians reveal psychological disturbance.

Hewetston et al (1963) assessed 23% of attenders at a general practice as having a psychiatric disorder.

Goldberg and Blackwell (1970) suggest that 20% of consecutive attenders at a general practitioner's surgery show psychiatric morbidity.

Parker and Brotchie (1977) using the General Health Questionnaire (GHQ) developed by Goldberg (1972) found that 39% of patients presenting for the first time with a somatic complaint scored positively on the G.H.Q., suggesting psychological dysfunction. At the ten week follow-up, psychological morbidity had fallen to 23% as measured by the G.H.Q., a figure similar to the Sydney general population norm. (Andrews, G., et al, 1975). The authors note, in their discussion, that in refining the G.H.Q., the designers reported that those items best at discriminating psychiatrically disturbed patients were those items inextricably connected with the patient perceiving himself to be unable to deal with his problems and social difficulties. Presumably there was a group at first presentation who were made to feel temporarily unable to cope by the somatic symptom they presented.

Lamberts (1979) gives the prevalence of "problem behaviour" (defined as 'the behaviour of the patient in his contact with a general practitioner . . . . where it is clear to both of them that a life problem is being discussed which, so far, is differentiated from illness behaviour') in primary health care as 31% (four general practitioners diagnosing approximately 30,000 presentations in their daily contacts with 11,000 patients during 1972).

However the psychological dysfunction is termed, the magnitude of the problem is great; too great for the available psychiatrists, social workers and psychologists to cope with. This much has been clear since Shepherd et al revealed in 1966 that general practice is the scene of most consultations for mental and emotional illness. In fact, estimates of prevalence of frank psychiatric illness varying, as they do, between 7% and 14% suggest that even this may be of such magnitude as to overload the available psychiatric specialists.

The overflow is dealt with by the family doctor. As Bransby, (1974), tells us: "The number of persons who consulted their doctor in the course of one year on account of mental disorder was 140 per thousand population. Only about one in twenty had been referred to a consultant psychiatrist or to the social services.

Referral itself does not lighten the burden of the family doctor. As Hassall and Stilwell, (1977), show, psychiatric patients consult with their family doctors just over twice as often as a control group ($p < 0.001$). "Contact

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with the psychiatric services did **not** reduce the psychiatric patient's demand for general practitioner time".

Other studies (Nunally, 1961; Rawnsley et al, 1962) have emphasised the role of the family doctor as the initial source of help for psychological distress. This is in some sense traditional, but also related to the general public's understanding of psychological distress in terms of the medical model — mental illness is an illness (set of symptoms) to be cured. Bates (1975) has suggested that Australians also consider the family doctor to be the first professional to whom a mentally ill person should be sent.

The family doctor shoulders, then, a massive responsibility for initial intervention and follow-up with the mentally ill; a responsibility for long term intervention with psychosomatic illness and those somatic illnesses having psychologically deleterious sequelae; a responsibility for crisis intervention; long term follow-up and tertiary prevention of "problem behaviour" (Lamberts, 1979).

Whilst the advent of the primary care health team with other professionals assisting in this area has been of help to the family doctor (Cohen, 1977; Trethowan, 1977; Koch, 1979; Ives, 1979; Anderson and Hasler, 1979), reservations as to the reception of such other care have been stated (Brock et al, 1975).

Further, the relative paucity of such experiments does not as yet relieve the family doctor of his responsibilities. Some help may be forthcoming in the guise of support to the family doctor from the psychiatric specialist, (Editorial, 1978) but, certainly in Australia, this consultative/support role from psychiatrists is still in its infancy.

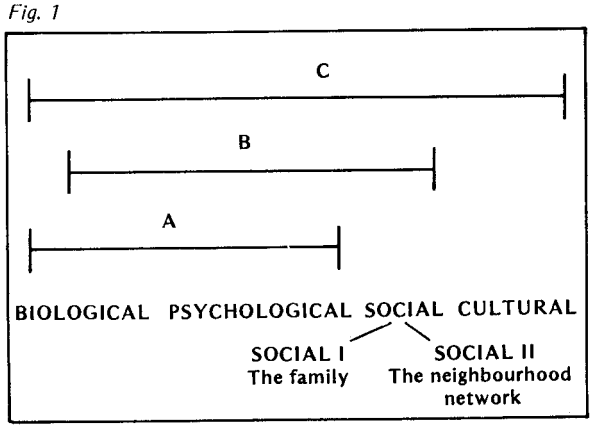
From the foregoing, it seems to the author that there is a paramount need to ensure in the family doctor a broad understanding of psychological disorder, a correct positive attitude to those with psychological disorder or "problem behaviour", (Levine, 1972, and Bates, 1977 have suggested that the effectiveness of help is strongly influenced by the way the mentally ill are perceived), and extensive practical skills for intervention.

Until recently undergraduate medical training included brief teaching in psychiatry, but much of this was based on the medical model of illness. Viewing psychological disturbance as an illness like any other carries with it the danger of **treating** it like any other — focusing on the symptoms and **their** treatment rather than the underlying causes or the dynamic interactions which perpetuate them. Increasingly drugs may be used for symptomatic relief. However, as Michael Balint wrote: ". . . .one danger is that doctors, conditioned by their training, prefer diagnosing and treating physical illnesses to considering even the possibility of a psychological illness. The opposite danger, however, is that the doctor may be tempted to brush aside all physical symptoms and make a bee-line for what he thinks is the psychological root of the trouble. This kind of diagnostic or therapeutic method means that the doctor tries to take away the symptom from the patient, and at the same time force him to face up consciously to the painful problem which possibly is causing it. In other words, the patient is forced to change his limited symptoms back into the severe mental suffering which he tried to avoid by a flight into a more bearable physical suffering" (Balint, 1974, p. 273.).

The author agrees with Balint when he says that the family doctor must remain a good doctor and not become an amateur psychiatrist. Nevertheless, the family doctor must have the skills necessary to deal with the problems he will find in his consulting room.

Currently in undergraduate medical training there is a broadening of view and a shift along the continuum from A to B (see Fig. 1.).

Fig. 1



With this shift, and underpinning it, has been an acceptance by the medical profession of some aspects of psycho-analytical theory and its implications for psychological therapy; and the newer interpersonal theories (e.g. the client-centred approach) with their accompanying practical skills in counselling. Over the last few years the journal Modern Medicine has included a series entitled "Psychiatry for the Non-Psychiatrist" which series is a good example of the broadening out of post-graduate training from the medical model. Recent articles by MacFie (1979 a, b) exemplify the clear simplified exposition of psychotherapeutic intervention. Even so, often the family doctor is not told precisely what to do and may still have to go on to learn from experience.

Incidentally it is the author's view that medical education should be broadened even further to include much more experience in the neighbourhood and cultural norms (C in Fig. 1.). One major problem for the family doctor with these interventions is that necessarily they consume time, (both per session and over the course of treatment) a commodity in short supply for the average family doctor. Ryan and Osborne, (1976), report that the mean time for family doctor consultations in the surgery is around six minutes, only 12.7% lasting longer than 15 minutes.

A further problem is that there is little clear decisive evidence that psychotherapeutic intervention does much good in the short or long term. In fact some authors (notably Eysenck, 1952) state that of all "neurotic" complaints, or "neurotic behaviour", 70% disappear within two years and 90% disappear within five years with no intervention. This issue has been hotly debated and is yet unresolved which must be daunting to a family doctor intent on helping a patient in distress.

A further problem is that as Balint (1974, p.278) says: "In psychoanalysis the ideal case is the patient who, after an intensive period of therapeutic work is able to terminate his relationship with his analyst for good". To a certain extent this can be applied to all psychoanalytical based psychotherapies. Further on he states: "The essence of general practitioner-patient relationship is its continuity, and any treatment, particularly a successful one, should represent a further and considerable increase in the joint capital of the 'mutual investment company'." Balint cites a number of cases where, after apparently successful therapy the 'mutual investment company' was wound up. No family doctor would set out on the therapeutic path with that in mind.

Finally, one untested suspicion held by the author is that if good progress is made during the psychotherapy hour once a week, this progress can be so easily undone by the patient's family and immediate social sphere in the subsequent 167 hours before the next session, even not taking into account the natural homeostatic mechanisms, and the natural fade that occurs with all new learning.

Balint (1974, p. 276-7), himself a psychoanalyst, suggests an answer to some of these problems: "Some people fall ill to secure the attention and concern they need, and the illness is a claim to, a justification of, and simultaneously the expiation for, the extra amount of affection demanded. These interconnections are often transparent enough, but it is pointless to force the patient prematurely to recognise and then renounce them. His need of love, concern, sympathy, and above all to be taken seriously must be accepted and to some extent gratified in the treatment before he can be expected to experiment with methods other than his illness of obtaining the affection and care for which he is craving . . . . . the patient develops an illness in order to be able to complain, since he was not able to complain about his original problem or conflict. . . . . Complaining is a social phenomenon. . . . . .the partner, i.e. the person complained to, is nearly as important".

Complainers live in family situations and the "complained to" may well be each and every other family member, each reacting in their own way to the illness or illness behaviour, often reinforcing the symptom by their reaction.

As Minuchin (1974) states: "Pathology may be inside the patient, in his social context, or in the feedback between them. The artificial boundary becomes blurred, and therefore the approach to pathology must change. Therapy designed from this point of view rests on

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view rests on three axioms. . . . .

1. An individual's psychic life is not entirely an internal process. The individual influences his context and is influenced by it in constantly recurring sequences of interaction.
2. Changes in family structure contribute to changes in the behaviour and in the inner psychic processes of the member of that system.
3. When a therapist works with a patient or a patient's family, his behaviour becomes part of the context.".

The author agrees whole-heartedly with Kirkby and James (1979) that: "It is unlikely that any single model of mental illness, whether a medically oriented model or a psychosocially oriented model, will supply a treatment paradigm that can be used ubiquitously, but the medical profession should be aware of the shortcomings of the medical model and should be given a genuine opportunity to consider alternatives. It would seem that this opportunity could well be presented in undergraduate and continuing education programmes in medical education."

One such alternative is structural family therapy based on systems theory. It consists of a relatively discrete body of theory based on careful practical observations of families' communications and relationships. A growing literature is validating its methods (see for instance, Minuchin, et al, 1978).

In a systems view "the therapist's intervention is based on a systemic analysis of the family's problems and on the activation of the family's self-therapeutic potentials. The family takes charge of its own interactional problems as these are gradually brought to light, so that the family itself becomes the protagonist of the therapeutic process. To achieve this goal, the therapist must bring to therapy not only his full store of technical experience but his own personality, imagination, sense of humour and ability to share other's emotions as well. And he has to give up his role as a healer". (Andolfi, 1979).

The therapy style tends to be active and directive, and the fact that the ultimate goal is for the family to take over its own therapeutic process seems to avoid possibly two of the problems for the family doctor already mentioned — firstly, that the family can undermine progress (although of course families can resist progress, in which case, such resistance can be brought to the family's attention in subsequent sessions). Secondly, there seems less need for the family to break off a long term relation with the family doctor. The family learn not to go to him as to a healer but rather a problem-solver capable of sharing his skills and continuing to do so. Most of the theoretical concepts are simple and relatively easy to learn; the attitudes of family therapists appear to be positive; the therapy style is active and directive. Whilst full family therapy sessions can take as long or longer than individual psychotherapy sessions, the usual course of therapy is brief, and many of the strategies (relabelling, positive connotation, reframing, task setting) can be applied and re-applied in the brief surgery consultation of the family doctor.

Whilst the author does not believe that family doctors should give up their medical model basic skills in diagnosis and therapy, nor that after a brief introductory course the family doctor will be able to cope with, say, psychotic families, he does believe that family therapy intervention skills are of immense value to the family doctor.

With this in mind, an introductory course in family therapy was developed, the simple aim of which was to apprise family doctors of basic systems theory, the pioneers and other workers in the field, and the growing literature on both structural and strategic family therapy.

THE GROUP

Course participants were self-selected, answering an advertisement in the Australian College of General Practitioner's South Australian newsletter. From 12 responders, two could not meet the course timing (7 p.m. — 10 p.m.) or the commitment to 10 sessions of three hours each, over 20 weeks. A third dropped out after the first session due to practice commitments when a partner unexpectedly went on holiday.

Nine participants completed the course with an average 91.1% attendance.

SEX:
There were six males; three females.

AGE:
Mean age 39.89, range 29 – 52.

MARITAL STATUS:
All were married, except one male.

CHILDREN:
Mean number of children 2.22, range 0 – 5.

GRADUATION YEAR:
One each in 1953, '55, '62, '64, '67, '71, '73, '75.

YEARS AS A FAMILY DOCTOR:
Mean 7.11. Range 2 – 21.

BASIC MEDICAL TRAINING:
Four doctors qualified in Australia; One each in India, Singapore, Malaysia, U.K. and the Republic of Ireland.

PSYCHIATRIC TRAINING:
In only two cases was Psychiatry not taught as an autonomous special subject (1 India, 1 Australia). However, the total time in undergraduate training exposed to Psychiatry and psychiatric patients was limited to less than three months in four cases; less than one month in three cases, between four and six months in only two cases (1 Malaysia, 1 Australia). Further, since graduation, eight of the doctors admitted to reading relevant psychiatric literature. Only four had attended workshops and only one had worked part-time in a psychiatric facility.

TYPE OF PRACTICE:
Currently, six doctors were in solo practice, three of whom worked in the city. The other three solo practitioners worked in the suburbs as did two senior partners of groups. The remaining doctor was a partner in a semi-rural group.

THE COURSE

The overall design was to give a high didactic input over the first five sessions gradually reducing this in the latter five sessions, replacing it with experiential participation – for instance case-sharing and follow-up.

A high level of audio-visual input was maintained using video film and overhead projector slides. Clinical example was used freely to amplify theoretical points, in particular because it was felt family doctors are essentially practical people who respond well to clinical material.

Overall an attempt was made to keep the atmosphere informal, with free discussion allowed, and refreshments served half way through each session. However there was a high expectation demanded of participants both within the session and in terms of background reading.

Six books were recommended, four required reading during the course; viz: Minuchin, S., (1974.), **Families and Family Therapy**. Satir, S., (1975), **Peoplemaking**. Haley, (1977), **Problem-solving Therapy**. Watzlawick, P. et al., (1974), **Change**.

Two books were added as reference volumes, viz:– Ackermann, N. W. (1966), **Treating the Troubled Family**. Guerin, P. (ed.), (1976), **Family Therapy**.

Each of the first four books is brief, concise and clinically orientated with practical advice – highly suited to the family doctor. All six books had been found useful during the author's own introductory family therapy training.

The course was structured as follows:

SESSION 1

Aims:
Introductions to the author, each other, the basic concepts, and the course. A research questionnaire on attitude was administered for 30 minutes of this session (and repeated in session 10). Results of this research will be presented in a further paper: "Family Therapy and the Family Doctor – II".

Presentations:
1. **Differences** between individual and family therapy.
2. **Indications and contra-indications for family therapy.**
3. **The major criteria of healthy family functioning.**

Video:
SALVADOR MINUCHIN "The weekend fights". Minuchin joins with a young professional couple in simulated therapy, focusing on one major problem which is dissected minutely; a relevant change in the patterns of response is prescribed as a task.

Homework:
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SESSION 2.

Aims:
Introduction
techniques.
Discussion:
Systems The
Presentation
1. **Normal fa**
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2. **Dimensio**
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3. **Joining.**
Video:
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discussed.
Homework:
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SESSION 3.

Aims:
To delineate
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Discussion:
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2. Problems
Presentation
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Video:
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Homework:
Participants were asked to create for themselves their own family tree.
Recommended Homework Articles:
"What is Family Therapy" and "General Systems Theory", both in Foley, (1974).
"Beginning Family Therapy" (M. White, unpublished course handout—see acknowledgements).

SESSION 2.
Aims:
Introduction to family dynamics and therapy techniques.
Discussion:
Systems Theory. Family Trees.
Presentations:
1. **Normal family development** and normative life crises.
2. **Dimensions of family life** (diagnostic parameters such as 'open vs. closed systems').
3. **Joining.**

Video:
A first interview of the author with a family. The phases of first interviews exemplified and discussed.
Homework:
Leadership Style and the LASI Questionnaire—drawn from Hersey and Blanchard, (1977).
Recommended Homework Articles:
"Problems of the Beginning Family Therapist". (Napier and Whitaker, 1973).
"Techniques of Family Therapy with Adolescents". (J. Brian McConville, 1973).

SESSION 3.
Aims:
To delineate the special problems of the family doctor using family therapy techniques.
Discussion:
1. Leadership style, flexibility and its relevance for the family doctor. Leadership style in Family Therapy. (J. Cross, 1979).
2. Problems of the Beginning Family Therapist.

Presentation:
1. **The family interview** in general practice — both in the surgery and in the home.
2. **Problem delineation.**

Video:
VIRGINIA SATIR: "Sisters: A family finds options". Demonstrates the use of space and action to promote change. Two-thirds of the tape was shown.
Homework:
To seek out suitable families for discussion, family therapy intervention and follow-up.
Recommended Homework Articles:
"Relabelling, reframing and positive connotation". (M. White, unpublished course handout).
"Scapegoating" (J. Gerrard, unpublished course handout).
"Family rules" (Jackson, 1965).

SESSION 4.
Aims:
Understanding family dynamics and change.
Discussion:
Relabelling.
Scapegoating.
Family Rules.
Presentations:
1. **Type of Therapist** — a comparison of therapy styles.
2. **Family dynamics** — interventions and strategies.
3. **Change** — what factors in the therapist and the patient mediate change.

Case presentation:
A participant presented a case history for discussion.
Homework:
Beginning to use family therapy with a family in general practice.
Recommended Homework Articles:
"Breaking the Homeostatic Cycle" (Lynn Hoffman, 1976).
"An integrated theory of Family Therapy" (Sorrells and Ford, 1969).

SESSION 5.
Aims:
Understanding task setting.
Discussion:
Breaking the Homeostatic cycle.
Presentation:
Tasks and task-setting.
Video:
VIRGINIA SATIR: "Sisters: A family finds options". The final one-third of the tape was shown, followed by discussion.

Homework:
To continue clinical work and to find a family to be interviewed during a later session.
Recommended Homework Articles:
'A conceptual model of psychosomatic illness in children' (Minuchin et. al., 1975).
'Towards the use of systemic Paradox' (Peggy Papp, 1978).

SESSION 6.

Aims:
Consolidation and feedback.
Presentation:
Paradox and task-setting.
Video:
An initial interview: The author interviewing a second family.
Homework:
To get involved with families only if knowledge and skills allow it.
Recommended Homework Articles:
'Brief Focal Family Therapy, when the child is the referred patient – II Methodology and Results'. (Kingston and Bentovim, 1978).
'Original concepts of Family Therapy' (a handout based on 'The Double Bind', 'Pseudomutality and Pseudohostility", and 'Schism and Skew', in Foley, 1974).

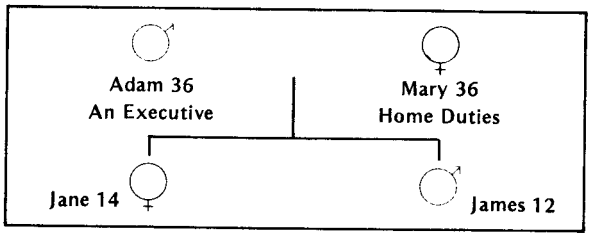
SESSION 7.

Aims:
Practice of Relabelling, Reframing and Task-setting based on clinical cases.

Discussion:
Brief focal therapy.
Video:
CARL WHITTAKER: "An isolated father in the family". Whittaker consults to a social worker, showing his own idiosyncratic style.
Case Presentation:
Follow-up on previous casework with presentation by participants of two further families and their problems.
Recommended Homework Article:
"Depression and Marital Interaction". (Feldman, L.B. 1975).

SESSION 8.

Aims:
A demonstration interview during which the group had a chance to develop ideas on relabelling, reframing, restructuring, and task-setting.
Demonstration:
The author interviewed a family of four referred by a member of the group.



The presenting problem was recurrent abdominal pain over nine years in a teenage girl, but the mother had a depression of eighteen months, father a duodenal ulcer of three years, and the son complained of recurrent headaches and hip pains.

After 45 minutes the family was asked to adjourn and the group developed a management plan and interventions aimed at restructuring the family – improving the sibling subsystem and developing each child's autonomy; improving the parent couple subsystem and their parenting mutuality.

The family returned and the group's interventions put to them. The family was asked to return in one month.

As far as possible, anonymity and confidentiality were preserved in this unconfidential atmosphere. Only first names were used. The family were offered follow-up appointments in therapy with the author.
Discussion:
Centred around the family interview.
Recommended Homework Article:
"The Role of the Family in Chronic Asthma". (Liebman et al, 1976).

SESSION 9.

Aims:
Case-sharing.
Discussion:
The role of the family in chronic asthma.
Video:
RONALD LIEBMAN: "Lawrence Family – Segments". Ronald Liebman interviews a family with an asthmatic child. The video was followed by discussion.

Case-sharing:
A number of case vignettes, drawn from the family doctors' own experience, were presented and relevant relabeling, reframing and task-setting subsequently discussed by the group as a whole.

Recommended Homework Article:
"Structural and Strategic approaches to psychosomatic families" (White, 1979).

SESSION 10.

Aims:
Feedback.
Completion of follow-up research questionnaires.

Discussion:
"Structural and Strategic approaches to psychosomatic families".

Demonstration:
The referred family seen in session 8 returned and were interviewed once again, in front of the group.

There had been little reported change in presenting symptoms but the group was able to perceive that both son and daughter were bright and more active (at home and in interview); the son's headaches had abated; father was more involved with the family and mother felt more supported.

Again, management planning was developed by the group. (This family has continued in therapy with the author and now after seventeen sessions there has been complete symptomatic improvement for son and daughter. Mothers's antidepressant intake has been curtailed. However the son has recently produced behaviour of the acting out sort and father's ulcer has once again become symptomatic).

FEEDBACK

A formalised anonymous sheet was filled in by all course participants.

1. **What did you like best about this course?**
'Marvellous overall'; 'the informal atmosphere and sharing'; 'developed new concepts about psychoneurotic illness'; 'sharing in information and experiences in small group of concerned persons'; 'the best postgraduate course I have attended. A big impact on my personal and family life'; 'general overview obtained re family therapy'; 'small number – effective programme'; 'Video presentation of actual family therapy and the family interview'.
2. **What did you like least about this course?**
'One of the participants'; 'rotten video tapes'; 'some of the theoretical issues – my critical analysis is becoming very misty'; 'what next?'; 'the poor quality video tapes'; 'not enough practical experience'.
3. **If you had to change one thing about the course what would it be?**
'It's length – should be longer'; 'nothing in particular'; 'an earlier involvement in practical situations'; 'tiring – tired after a days work. 7 p.m. too rushed – suggest 7.30 p.m.'; 'the video tapes I could not hear'; 'I don't know – course too short'; 'more detailed discussion of participant's cases and follow-up'.
4. **How strongly would you recommend the course to another family doctor?**
Scored out of 5 for each participant.
Total: 39
Mean: 4.33
5. **Rate the group leader on how helpful he was.**
Scored out of 5 for each participant.
Total: 41
Mean: 4.55
'Very hard working'; 'He did not make us feel he knew all the answers'; 'easy humerous manner but made it all seem too easy at times'; 'skills, committment, survived psychiatric training and remained in the real world'; 'made me think and re-examine attitudes'; 'open mind'; 'warmth, preparation of course, techniques'; 'too difficult to answer'.
6. **Could be improved by:**
'Further meetings later on, say one or two for the next year to exchange information'; 'my ideas of psychotherapy have been changed in that there is one approach which is direct and directing rather than passive. This has been a dramatic change in approach for me'; 'lengthening course by two sessions to include more practical experience'; 'greater exposure of own practical skills'; 'literature that could be more precise for G.P. consumption'; squashing inappropriate contributions from participants'; lengthening course'.

CONCLUSIONS

The number of participants was small, it was a self-selected group, and conclusions always have to be guarded under such conditions.

Nevertheless, the group is representative of family doctors in terms of age, sex, marital status, year of qualification and number of years in general medical practice, and type of practice.

Noteable was the paucity of 'psychiatric' training in professionals whose daily currency is human relations. This group was particularly keen to learn and develop new skills though no formal examination of knowledge, at the end of the brief course, was performed. Further, the author has no knowledge of how much the knowledge and skills gained are continuing to be used in day to day practice.

From the attendance, the feedback and the enthusiasm, the impressions are that the course was relevant, that family therapy has something to offer the family doctor who demands clear simple directions and practical applications.

Perhaps courses similar to this one go some way to relieving the immense responsibilities of the family doctor in the field of human suffering.

SUMMARY

Psychological dysfunction has been variously estimated at about 25% of the suburban community and 25% of the family doctor's daily consultations. Of these consultations about one third may be frank psychiatric illness whilst the rest show what is described as problem behaviours. Psychiatric intervention has been shown not to relieve the burden of the family doctor's responsibilities in this area, and he is often left to struggle with a paucity of knowledge training and skills.

The author reasons that individual psychotherapies have inherent difficulties for the family doctor whose basic training has been in the medical model. He argues that family therapy with its clear simple concepts and practical direct application may suit the family doctor more.

In the light of this a ten session course was devised and presented to a small group of family doctors. It is described in some detail. The feedback, although from a self-selected group, suggests that the basic hypothesis may be correct – structural and strategic family therapy may be of immense value to the family doctor.

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REFERENCES

Ackerman, N. W., 1966. **Treating the Troubled Family** Basic Books, New York.

Anderson, S. and Hasler, J. C., 1979. "Counselling in General Practice". **J. Roy Coll. Gen. Practice** 29:352-6.

Andolfi, M., 1979. **Family Therapy – An Interactional Approach** Plenum Press, New York, p.12.

Andrews, G., Tennant, C., Schonell, M., See, G., Joyce, K., Abernathy, K. and Cantori, G., 1975. **Occasional Research Paper No. 1.** Human Communications Laboratory, University of New South Wales.

Balint, M., 1974. **The Doctor, his Patient and the Illness** Pitman and Sons, London.

Bates, E.M. 1977. **Models of Madness** University of Queensland Press, Brisbane.

Bates, E.M., 1975. "Models of Mental Disorders: An Australian Survey". **Social Science and Medicine** 9:549-551.

Bransby, E. R., 1974. **Health Trends** 6:56-58.

Brock, R. R. A., Cosh, H. A., Gipslis, J., 1975. "An Evaluation of Social Worker Participation in primary health care" **Aust. Fam. Phys.** 4:830-7.

Cohen, J.S.H., 1977. "Marital Counselling in General Practice" **Proc. Roy. Soc. Med.** 70:495-6.

Cross, J., 1979. "Effective Leadership styles in Family Therapy" **Aust. J. Fam. Ther.** 1:1, 2-8.

Editorial, 1978. "General Practitioners and Psychiatrists – a new relationship". **J. Roy. Coll. Gen. Pract.** 28:643-645.

Eysenck, H. J., 1952. "The effects of psychotherapy: an evaluation" **J. Consult. Psychol.** 16: 319-324.

Feldman, L. B., 1976. "Depression and Marital Interaction" Family Process. Vol. 15 No. 4 p. 389-395.

Foley, V. D. 1974. **An Introduction to Family Therapy** Grune and Stratton, New York.
Goldberg, D. P. and Blackwell, B., 1970. "Psychiatric Illness in General Practice. A detailed study using a new method of case identification. **Brit. Med. J.** 2:459.
Goldberg, D.P., 1972. **The detection of psychiatric illness by questionnaire** Oxford University Press, London.
Guerin, P. (ed), 1976. **Family Therapy**. Gardner Press, New York.
Hassall, C. and Stilwell, J. A., 1977. "Family doctor support for patients on a psychiatric case register". **J. Roy Coll. Gen. Pract.** 27: 605-608.
Haley, J., 1977. **Problem Solving Therapy**. Tavistock Publications, London.
Hennessy, B. L., Bruen, W. J. and Cullen, J., 1973. "The Canberra Mental Health survey. Preliminary results". **Med. J. Aust.** 1:721.
Hersey, P. and Blanchard, K., 1977. **Management of Organisational Behaviour** Utilising Human Resources Prentice Hall, Englewood Cliffs, N.J.
Hewetson, J. C. McEwan, J.A. and Ollendorf, R.H.V., 1963. "The incidence of psychiatric disorders in general practice. **Practioner**, 190:127.
Hoffman, L., 1976. "Breaking the Homeostatic Cycle" in Guerin P. (ed), **Family Therapy**. Gardner Press, New York.
Ives, G., 1979. "Psychological treatment in general practice". **J. Roy. Coll. Gen. Pract.** 29: 343-351.
Jackson, D. D., 1965. "Family Rules" **Archives of General Psychiatry** 12: 589-595.
Kingston, W. and Bentovim, A., 1978. "Brief focal family therapy when the child is the referred patient – II Methodology and results". **J. Child. Psychol and Psychiat.** 19: 119-143.
Kirkby, R. J. and James, A., 1979. "Attitudes of Medical Practitioners to Mental Illness'. **Aust. and N.Z. Journal Psych.** 13: 165-168.
Koch, H. C. H., 1979. "Evaluation of behaviour therapy intervention in general practice". **J. Roy. Coll. Gen. Pract.** 29: 337-340.
Krupinski, J., Stoller, A., Baikie, A. G. and Graves, J. E., 1970. **A Community Health Survey of Heyfield, Victoria, Australia**. Mental Health Authority Special Publications No. 1 – Melbourne.
Lamberts, H., 1979. "Problem Behaviour in primary health care". **J. Roy. Coll. Gen. Pract.** 29: 331-335.
Levine, D., 1972. "A cross national study of attitudes towards mental illness". **J. Abnorm. Psychol.** 80: 111-114.
Liebman, R. et al., 1976. "The Role of the Family in the treatment of chronic asthma". In Guerin, P. (ed), **Family Therapy**. Gardner Press, New York.
MacFie, C., (a), 1979. "Psychotherapy – a personal view. Part I". **Modern Medicine of Australia** Nov. 9-11.
MacFie, C., (b), 1979. "Psychotherapy – a personal view. Part II" **Modern Medicine of Australia** Dec. 14-16.
McConville, J. B., 1973. "Techniques of Family Therapy with Adolescents" **Aust. N.Z. J. Psych.** 7: 4.
Minuchin, S. et al., 1975. "A conceptual model of psychosomatic illness in children". **Arch. Gen. Psych.** 32:1031-1038
Minuchin, S., 1974. **Families and Family Therapy**. Tavistock Publications Ltd. London.
Minuchin, S., Rosman, B. L. and Baker, L., 1978. **Psychosomatic Families – Anorexia Nervosa in context**, Harvard University Press, Cambridge, Mass. U.S.A.
Napier, A.Y. and Whitaker, C., 1973. "Problems of the beginning family therapist". In Bloch, D. (ed.) **Family Therapy**, Grune and Stratton, New York.
Nunnally, J., 1961. **Popular Conceptions of Mental Health** Holt, Rinehart and Winston, New York.
Papp, P., 1978. "Toward the use of systemic paradox" **Unpublished paper**, Ackerman Institute, New York.
Parker, G. and Brotchie, H., 1977. "Psychological disturbance in general practice setting". **Aust. Fam. Phys.** 6: 450-452.
Rawnsley, R., Loudon, J. B. and Miles. H.L., 1962. "Attitudes of relatives to patients in mental hospitals" **Brit. J. of Prevent. and Soc. Med.** 16: 1-15.
Ryan, A.G. and Osborne, C.B., 1976. "An analysis of the activities of general practitioners". **Aust. Fam. Phys.** 5: 1226-1231.
Satir, V., 1975. **People Making**. Science and Behaviour Books New York.
Shepherd, M., Cooper, B., Brown, A. C. and Kalton, G., 1966. **Psychiatric Illness in General Practice**. Oxford University Press. London.
Sorrells, J. M. and Ford, F., 1969. "Toward an integrated theory of families and family therapy". **Psychotherapy: Theory, Research and Practice**. 6:3, 150-160.
Trethowan, W. H., 1977. **The role of the psychologist in the health service**. H.M.S.O. London.
Watzlawick, P., Weakland, J. and Fisch, R., 1974. **Change** W. W. Norton and Company, New York.
White, M., 1979. "Structural and Strategic approaches to psychosomatic families". **Fam. Proc.** 18:3, 303-314.