Courses in Family Therapy for General Practitioners: Identifying Learning Objectives

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This paper describes two courses which train general practitioners (GPs) in generic family therapy skills applicable to consultations with individuals, couples or families in the general practice setting, and to patients with physical or psychological problems. Based on feedback from previous participants, eight topics were identified and described as useful. These are stressors, genograms, problem clarification, options, involvement of patients, reflection on interventions, recognition of an interactive cycle and review of treatment. General practitioners' skills in these areas can be assessed by asking them to respond in writing to two case vignettes, featuring respectively an individual, and a mother–child dyad. These vignettes have been piloted in previous family therapy courses for GPs and are written as typical presentations to a GP. We give examples of pre and post-course responses of GPs undertaking a short or long course, present and discuss quantitative assessment of learning objectives using structured criteria scored from 0–10, and include excerpts from a six month follow up.

> Family therapy is like skiing.
> It looks easy, but when you try it
> you realise there's a lot more to it[1]

The family therapy model is important in general practice from a number of perspectives. It is consistent with the biopsychosocial model (Engel, 1977) and is relevant for patients who present with issues having psychosocial and/or biomedical features and which have psychiatric or psychological sequelae (Ouliaris, 2001). General Practitioners (GPs) often have several members of the same family as patients and commonly see more than one person in a single consultation, especially parent and child. In addition, GPs are the interface between the patient/s, and community, welfare and health care providers. GPs often advocate for patients and interpret specialist consultations to them, thereby having a central role in their patients' systems.

An extensive body of literature reports the importance of psychological interventions in health care, both in terms of reduction of medical costs and increased effectiveness of treatment (Groth-Marnat & Edkins, 1996). This is reflected in the developing literature on the benefits of family therapy in medical consultations (for example, Fogarty, 1996; Matalon, Katz & Granek-Catarivas, 2003; Mayer, Graham, Schuberth, Launer, Tomson & Czauderna, 1996; McDaniel, Hepworth & Doherty, 1997; Van Doorn, 1990). The reports vary in the way family therapy concepts and skills are used, and include close collaboration with family therapists (Fogarty, 1996; McDaniel, Hepworth & Doherty, 1992), inviting all family members to come in together (Neighbour, 1982), using family therapy skills as part of counselling or therapy sessions set up by agreement with patients as separate from medical work (Mayer et al., 1996) and using family therapy skills within ordinary medical consultations (Eshet, Margalit & Almagor, 1993; Van Doorn, 1990).

Family therapy courses for physicians practising in the community have been reported in Canada and the UK (Bishop, Epstein, Gilbert, van der Spuy, Levin & McClemont, 1984; Launer & Lindsey, 1997; Thomson & Asen, 1987). Bishop et al. reported on a three hour, three weekly training model, with homework reading for students. The authors evaluated the success of their training by whether the students recruited families and saw them. On this basis, the authors judged the program to be a failure, although they reported that the physicians used the concepts and techniques 'in idiosyncratic and individualistic ways' (1984: 383). Launer & Lindsey (1997), working at the Tavistock Clinic in the UK, developed a course (ten half days) with set readings and discussions, and reported great enthusiasm from the doctor and nurse participants. The authors described guiding principles but did not report

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content of courses or evaluation methods. Tomson & Asen (1987) reported on courses of ten two-hour sessions, held over three successive years in London. The authors identified their objectives as encouraging physicians to think in family terms, to counsel whole or part families and to develop family-related methods for use with individuals, especially using genograms and family circles. Evaluation was by questionnaire after each session and also between six months and two and one half years after completing courses. Twenty of the 21 doctors who completed the questionnaires (from a total of 24) had used new techniques, and about 90% of the results for individuals and families were helpful. Tomson & Asen noted that the work was carried out in the context of the British National Health Service, that doctors' satisfaction was an important outcome and that there were no financial inducements. They concluded that family therapy ideas can be taught to general practitioners and are useful to them, but that 'therapy may best be done by colleagues specialised in psychosocial therapy' (97).

The above reports suggest that doctors who undertake family therapy courses judge them to be beneficial. They also suggest that the cultural context in which the doctors practise may be relevant in devising courses, that the content needs to be relevant to their practice and that the criteria for evaluating the courses need to be carefully considered. In particular, the criterion of seeing whole families may be less appropriate than acquiring new skills with individuals which can also transfer to working with families.

Martin reported a ten session introductory course in structural and strategic family therapy for nine GPs and claimed that it was 'of immense value' (1980: 90). Since then no one else has reported on family therapy courses for GPs developed in Australia. However, funding arrangements (Medicare rebates) mean that for many people in the community, GPs are more readily accessible than psychosocially trained family therapists. Thus, there is an incentive for GPs to learn these skills. Item numbers for GPs for family therapy consultations reflect the expectation that GPs see more than one family member. In order to avail themselves of the recently added item numbers billing for mental health consultations under the Better Outcomes for Mental Health Initiative, GPs need to undertake introductory and advanced training in mental health. Divisions of General Practice (associations of local practitioners funded by the Commonwealth Government) have a key role in upskilling GPs in areas identified by both health needs assessments and by GPs' analyses of their own learning needs.

"When psychosocial issues are involved, most doctors need to learn and practise interviewing skills with patients."

Using our experience of more than 20 years of teaching GPs in Divisions of General Practice and in a University distance education program, we have put together family therapy courses relevant to the general practice context and applicable to patients who present with physical problems, psychological problems or a mixture of the two. The courses are for GPs who plan to use these skills to extend their medical consulting capacities rather than to become family therapists. (For the latter, they need to undertake our accredited two year Diploma of Family Therapy.)

To evaluate participants' learning, we have developed eight learning objectives, with assessment criteria and case study vignettes for participants to respond to before and after undertaking these courses. In this paper, we describe the courses, the development of the learning objectives and report the results from two exploratory applications of the evaluation methods for a short and a long course in two Divisions of General Practice.

The Training Courses

Alma Family Therapy Centre is a private psychotherapy centre in Melbourne, Australia, with practitioners providing clinical services and teaching courses. The courses are designed and led by two family therapists (a clinical psychologist and a general practitioner) and are offered as a series of weekly or fortnightly three hour workshops. Key features of the teaching include positively connoting general practitioners' strengths, and modelling of the therapy relationship in teaching practice, in particular, by creating a safe environment where participants' difficulties can be heard. Teaching methods include preparatory readings, small group activities, case study discussion, role-plays, large group teaching and ongoing monitoring of participants' cases, including generating new strategies which can be tried between workshops.

When psychosocial issues are involved, most doctors need to learn and practise interviewing skills with patients. Once they feel some sense of security in the training group and with the leaders, they are able to participate in role-play interviews which focus on joining, empathy, active listening and reflection of content and feeling. In these role-plays, they can experience being a patient as well as a doctor and an observer. Feedback informs us that it is hard for them to accept how little they know in this area, but back in the workplace, they find it enormously helpful to have role-played being a patient and receiving feedback about their doctor role.

In our program, GPs learn to work with a structured model of family therapy to gather information, look at options, to treat and bring closure (Bishop, Epstein & Baldwin, 1980). They learn as well about life cycle stages, homeostasis, circular patterns with families and couples, seeing the child's presenting problem as an expression of family distress, and the dynamics of illness and

transgenerational patterns in families. A key skill area for participants has been learning to draw a genogram with a patient and opening up discussion around it. One participant's comment on his experience was that the skills and concepts taught in the courses may appear simple ('like skiing') but when they are tried with patients, prove to be highly complex ('There's a lot more to it').

Learning Objectives

Repeat presentations of our courses to different groups of GPs over six years have enabled us to note the key learning areas identified by the participants. We use a standard evaluation form in all our courses. At the end of each session participants were asked to specify 'Important things which I have learned from today's session are ...' The responses of 212 doctors from eleven long and short courses run over this six year period were compiled and arranged in order of frequency. Most frequently cited responses were identified, grouped according to eight areas of learning, and categorised: Stressors, Genograms, Problem clarification, Recognition of the interactive cycle, Options, Involvement of patient in treatment/referral, Review of treatment/referral, Reflection on interventions. Table 1 briefly describes each of these under the heading 'Learning Objectives'.

> "... seeing whole families did not emerge as an important objective for the GPs."

In accordance with Bishop et al.'s (1984) findings, seeing whole families did not emerge as an important objective for the GPs. The objectives which they identified, consistent with the guiding principles suggested by Launer & Lindsey (1997), state that the doctor should be encouraged to have a non-interpretative stance, open to feedback. Identification of stressors and use of genograms as areas of key learning is consistent with Structural, Strategic and Bowenian schools of family therapy. Recognition of interactive cycles is consistent with Strategic and Milan schools. Other topics (problem clarification, options, involvement of patient in treatment/referral, review of treatment/referral and reflection on interventions) are more concerned with engagement aspects of family therapy practice (Flaskas, 1989; Kramer, 1997).

We believe that identifying these topics as central for GPs represents an important step in the teaching of family therapy to this group. Having identified these topics then we developed structured assessment criteria relating to each objective. We also developed two case vignettes (see Case Vignettes below) with a standard form for students to respond to them before and after taking our courses. The intention was to apply the assessment criteria to students' responses to the case vignettes pre and post-course, thereby assessing increase in systemic awareness. Table 1 sets out structured assessment criteria for each learning objective. Ratings were allocated for absence (0), partial presence (3, 5 or 7) or full presence (10) of systemic thinking. For example, to measure learning related to Genograms, the participant obtained 0 points if no reference was made to family members or influences; 3 points if reference was made to family pressures or difficulties; 5 points if in addition reference was made to involving other family members in understanding the difficulties, or in clarifying the patient's relationship with other family members; 7 points if in addition reference was made to links between the presenting problem/s and intergenerational patterns, and 10 points if in addition, the GP expresses an intention to draw a genogram with the patient. Similar criteria were developed for each learning objective, so that assessment can be carried out with minimum subjectivity.

Case Vignettes

We have used case vignettes (Byles, Bishop & Horne, 1983; Perlesz, Stolk & Firestone, 1990) as assessment tools for our family therapy courses by distance education since 1994. The individual vignette, 'John Smith', has been used to assess the learning of 85 doctors participating in family therapy courses, and the mother–child vignette, 'Debbie and her mother' has been used with 125. Each sets out a common presentation to a GP and is followed by prompt questions (Table 2). In our experience, they are a good indicator of the extent to which learning has taken place.

Our first contact with the GPs attending the course is usually through a letter and folder with readings which is sent out to them prior to the first meeting. This package includes information regarding the case vignettes and their purpose and a reminder that as this is a family therapy training course, the vignettes assume that appropriate medical investigations and management have been undertaken and are normal. The GPs are requested to respond to the vignettes prior to the first workshop and after the final workshop, and we allocate time for them to do this.

Applications with a Short and Long Course

Participants and Course Structure

One Division of General Practice had funding for a long course (58 hours over twelve months) and the other Division had funds for a short course (eighteen hours over six weeks). We run the short course frequently and call it 'How to open a can of worms'. Participants in both courses were practising GPs who responded to advertisements within their Divisions to attend an introductory course in family therapy. The same two facilitators led both courses.

The short course was undertaken by 22 GPs: nine men and thirteen women; eighteen were in private practice, one

TABLE 1

Learning Objectives for GPs

Learning Objective (Short Title)	Brief Description	Assessment Criteria and Scores for Degrees of Successful Compliance
Stressors	Identification of life cycles stages and factors in the patient's family, work life, culture and religion. Relationship of individual, familial and cultural stressors to patient's presenting problems.	0: No stressors mentioned 3: Family as possible stressor mentioned 5: Stressor/s as well as/other than family 7: Stressor/s and life cycle stage considered 10: Stressors and life cycle stages identified & related to presenting problem/s
Genograms	Familiarity with and use of standard conventions for drawing genograms (McGoldrick & Gerson, 1985) in psychosocial and medical contexts (e.g., Jolly, Froom & Rosen, 1980; Rogers & Durkin, 1984). Identifying of intergenerational processes.	0: Family not mentioned 3: Family pressure or difficulties mentioned. 5: Family relationships related to difficulties 7: Presenting problem and intergenerational patterns related 10: Intent to draw genogram with patient
Problem clarification	Clarification of problems in a systematic way with patient/s before proceeding to Options and Treatment stages.	0: No mention of clarifying problems with the patient 3: Participant identifies a problem but not with patient 5: Possible patient reaction to GP's view of problem mentioned 7: Active seeking of patient's responses 10: Clarifying with patient their views about the problem
Recognition of Interactive Cycle	Identification of interactive cycle and associated reframing of blaming between family members and between the GP and family members.	0: No statement that there is an interaction happening 3: Behaviour of one influences the other 5: Behaviour of each related to other 7: Interactive cycle holds both parties 10: Cycle maintains stuckness of behaviour of both
Options	Discussion of options with patient/s rather than prescribing for them	0: No options mentioned; GP prescribes the treatment 3: Other options considered by GP 5: GP offers options for patient to consider 7: GP offers options and seeks patient's options 10: GP and patient consider options together
Involvement of patient in treatment referral	Involvement of the patient/s in ascertaining criteria for success of therapy and referral	0: No mention of involving patient in treatment or referral plan 3: GP states what is to happen and asks for patient response 5: GP asks patient for view of their own about treatment/referral 7: GP sets out process of following up treatment or referral plan, e.g., further appointment for feedback 10: GP and patient agree on criteria for success of treatment or referral and process for follow up

TABLE 1 continued

Learning Objectives for GPs

Learning Objective (Short Title)	Brief Description	Assessment Criteria and Scores for Degrees of Successful Compliance
Review of treatment/referral	Identification of criteria for follow up after treatment course or referral and clarification with patient of follow up plans	0: No mention of review or follow up of treatment or referral 3: Possibility of follow up action 5: Patient advised of possibility of review or follow up 7: Follow up visit planned with patient 10: Follow up visit planned. Criteria for success of plan identifed with patient
Reflection on interventions	Reflection on GP's interventions in context of the patient's psychosocial world.	0: No reflection on effects of intervention offered 3: Reflection on effects of GPs intervention 5: Reflection on possibility of positive and negative effects of intervention 7: Reflection on possible outcomes of intervention from patient's perspective 10: Reflection on how patient might experience the intervention, including possible influencing factors on the GPs intervention.

TABLE 2

Case Vignettes Used Pre and Post Family Therapy Courses for GPs

John Smith

John Smith is aged 52 years, married with three children. He has been a patient of yours for about five years and his wife and children also attend your practice. John has held a range of jobs in the University sector and in recent times has presented with symptoms including headaches, chest pains and gastro-intestinal problems suggestive of peptic ulcer. After conducting relevant tests and treating his medical problems, you decided to refer him to a psychiatrist some three months ago. John has come to see you today. He reports that he is still feeling generally unwell and has difficulty sleeping. Please write your ideas about what might be happening to John under the following headings:

(i) What are your hypotheses?

(ii) Write a brief summary of what you would like to say to him at this consultation.

(iii) How might John respond to what you have said?

Any other comments?

Deborah and her Mother

Mother presents in your consulting room with a problem with her seven-year old daughter, Deborah. Deborah wets her bed and her pants and it is driving the mother 'to the point of distraction'. After obtaining your information you have established the pattern which occurs is as follows:

Deborah wets her pants, mother yells at Deborah for making a mess. Deborah feels rejected by mother, becomes more upset and wets some more. Mother thinks Deborah is doing it deliberately, feels Deborah does not listen to her, feels inadequate and a failure as a parent and screams and punishes, which makes Deborah worse ...

(i) Write some suggestions as to how you would respond to Deborah's mother and Deborah if this problem were presented to you

(ii) Set our your thinking in detail and write what you will do next including:

Who you will see?

What you will say to whoever you decide to see?

(iii) Give reasons for your intervention and include some prediction of what you expect the reaction of the family to be.

in teaching and three in community health centres. Between sixteen and 22 GPs attended each session, and the course comprised six three-hour weekly sessions. Twenty-one GPs attended the long course: twelve men and nine women, thirteen in private practice and eight in the public sector. The course comprised four months of nine three-hour weekly workshops, and one full day workshop (34 hours in all). Incorporated into each of the courses were discussions as to how the learning applied to GP consultations. Issues specific to the GP context were discussed: time allocation, differentiating crises from ongoing work with patients/families, how to bring patients back at a more convenient, dedicated time rather than try to deal with things on the spot, how to work with more than one family member in a consultation, how to use

specific item numbers for charging, and how valuable it is if the GP knows and sees more than one family member in his/her practice and is involved in many of the lifecycle transitions faced by the patients/families. All participants completed this 34 hour segment.

Eighteen participants continued with twelve two-hour supervision sessions held fortnightly over eight months. These sessions allowed GPs to obtain expert supervision and peer review and support in applying the knowledge and skills which they had obtained in the first part of the course. The group was divided into two smaller groups with one of the family therapists facilitating each. In each group, two or three detailed cases were presented and processed by the participants at each session. Therapeutic strategies were formulated for ongoing consultations. We provided further readings in relation to new issues at the subsequent sessions. Participants undertaking the long course had a total of 58 hours of face to face contact.

Both courses included the same course material for the first eighteen hours (see above, The Training Courses). The longer course received an additional sixteen hours of workshop teaching, seven hours of which involved small group work in reflection exercises and listening skills. The additional nine hours of workshop teaching covered chronic and life threatening illness, secrets and rituals, children and adolescents and grief.

Pre and Post-course Assessments

Pre and post-course comparisons were received for nineteen participants in the short course, and for fourteen participants in the long course. Examples of responses to vignettes are set out in Tables 3 & 4. Quantitative assessments of responses are in Tables 5–7. In addition to our own assessments, the Division of General Practice coordinating the long course also conducted a six month follow up questionnaire. Excerpts from this report are set out below.

Examples of Responses to Vignettes

Table 3 shows examples of responses to the individual vignette (John Smith) before and after participants undertook the short and long courses. The same GP made the responses to the pre-course and the post short course

TABLE 3

GPs' Responses Pre and Post-courses to John Smith Vignette

Prompt Question	Pre-course	Post Short Course	Post Long Course
What are your hypotheses?	Exclude physical problems e.g. peptic ulcer, depression	Problems with psychiatrist re issues. Depression	Either undiagnosed medical problem or symptoms as a result of psychological distress — possibly problems with wife. Sexual difficulties, issues of middle age/career etc., other family issues
Write a brief summary of what you would like to say to him at this consultation.	Explore how depressed he is; psychological, psychomotor, physiological, affect. Progress with the psychiatrist, briefly explore cause	Allow him to open up with what the problem might be and use reflection. Ask him more about his wife/children and extended family, use of genogram discussion about work related problems	One would have to just decide whether one went down the medical pathway or psychological pathway — doing both may make counselling a bit difficult. Would say to John that we don't seem to be making much progress and that though we have known each other for five years, I feel more information is necessary.
How might John respond to what you have said?	Should open up. Hopefully the rapport is present in other visits	He might open up — stating it's a relief that he is able to talk more about his problems/issues. He may consider that the psychiatrist is not the right person	a) John might be happy with this idea in which case I would proceed to the four-stage model, hopefully with optimism in view of John's willingness to proceed. b) John may say that this is not necessary. In this case I'd just suggest that life events can lead to development of symptoms and leave things open. Would certainly not press the point. c) John may be undecided. Again, I would mention how seeing the whole picture makes my task easier and perhaps leave him to reflect on this and make a further appointment if he's interested.

TABLE 4

GPs' Responses Pre and Post-courses to Deborah and Mother Vignette

Prompt Question	Pre-course	Post Short Course	Post Long Course
Write some suggestions as to how you would respond to Deborah's mother and Deborah if this problem were presented to you	Discuss physiological aspects of toilet training, further treatment re nocturnal enuresis/episodes of dryness, new events in family life, school, siblings, why mother feeling inadequate; her own toilet training methods, recent stresses; coping ability.	Ask what the parenting issues are for Deborah's mother, construct a genogram. Try to establish any problem areas in family/other siblings/Deborah's relationship with husband or other extended family members.	This circular pattern of behaviour is not getting Deborah or her mother anywhere, but they don't realise that it is a pattern, or why it occurs. I would listen to the mother and to Deborah but avoid taking sides or blaming/judging, etc. I would say that 'This sounds like it is a real problem for both of you …' and reflect some of their comments and distress.
Who will you see?	Talk to mother (possibly father), Deborah.	See the mother by herself (in more detail — longer consult). Later consider seeing the father, Deborah and other sibs.	Ask both participants if they could see any options for improving the current situation and exploring these options with the other partner. I would see just mother or mother and Deborah preferably, with both contributing some suggestions to try to resolve the situation. Both should be asked for their views and assessment of what may be helpful.
What will you say to whoever you decide to see?	Explanation of bedwetting, advice to mother re positive reinforcement, query star chart. Deal with any stressful events.	1 To allow the family to explore the relationship problems and to empower them for future change. See family as a whole, allow them to talk about problems and/or relationships. This may allow them to understand each other's feelings. 2 See Deborah's mother on an individual basis, allow her to determine what changes or problems in her past and relationship in her family	At the end of the consultation I'd say that it would help me to help them if I could learn more about the family and would she be willing to come back to do this?

vignette. The post long course response is from another respondent who gave a similar pre-course response to that made by the GP just referred to.

In the pre-course responses, participants focused on physical problems and the diagnosis of depression and/or anxiety. In both post-course responses, answers reflected the participants' capacity to identify stressors, and suggested a genogram for information gathering. The typical post long course response also involved the patient in his/her management through generation of options, suggested a process for doing this and identified possible conflict for GPs between medical and counselling roles.

Table 4 sets out examples of participants' pre and post-course responses for the mother–child vignette (Deborah and her mother). The same GP made the pre-course response and the post long course response. The example of a post short course response is from another GP who gave a similar pre-course response.

Responses post-course showed a capacity to recognise the interactive cycle, to explore this with the family, the importance of family influences, the intention to involve family members in the process and to incorporate options generation. The pre-course response in this instance as well focused on physiological aspects of the case and mother's stresses, with a tendency towards judging the mother. Post-course responses show more openness to familial issues and less judging or blaming of the mother.

Quantitative Assessments

The assessment criteria described above (Learning Objectives and Tables 1 & 2) were applied to GP responses to both vignettes. One of the authors assessed performance on each of the eight learning objectives for each participant pre and post-course. Without knowing whether the

TABLE 5

Mean and Standard Deviation Scores for Paired Samples and Significance Levels of Differences for All 6 Learning Objectives in Short and Long Courses, for Individual and Mother-Child Vignettes

Course	*N*	Mean and *SD* scores				*t*	*p* (2-tailed)
		Pre-course		Post-course			
		Mean	*SD*	Mean	*SD*		
Short course, individual vignette	19	19.21	9.34	33.37	10.51	-4.89	0.000***
Short course, mother–child vignette	19	22	12.71	27.22	8.43	-1.9	0.075
Long course, individual vignette	14	18.71	8.02	49.64	11.54	-9.88	0.000***
Long course, mother–child vignette	13	20.69	12.75	46.92	8.19	-6.1	0.000***

Note: *** $p < .001$

TABLE 6

Mean Scores for Paired Samples and Significance Levels of Differences for Short Course $N = 19$

Vignette	Learning Outcome	Mean and *SD* Scores				*t*	*p* (2-tailed)
		Pre-course		Post-course			
		Mean	*SD*	Mean	*SD*		
Individual	Stressors	8.16	3.42	8.95	3.15	-0.766	0.454
	Genograms	1	1.8	5.58	3.55	-5.891	0.000***
	Problem clarification	2.47	2.84	5.42	3.34	-2.815	0.011*
	Options	2.05	2.7	2.95	2.92	-1.064	0.301
	Involvement of patients	4.84	4.22	6.58	4.43	-1.22	0.238
	Reflection on interventions	0.68	1.67	3.89	4.18	-2.846	0.011*
Mother–child	Stressors	5.47	4.65	4.79	4.76	0.66	0.52
	Genograms	3.53	2.82	5.84	4.05	-2.71	0.014*
	Recognition of interactive cycle	1.32	3.27	1.84	3.8	-0.52	0.607
	Options	0.79	1.87	0.79	1.87	0	1
	Review of treatment	7.5	3.93	8.33	3.92	-1.84	0.717
	Reflection on interventions	4.47	4.68	7.26	3.96	-3.08	0.007**

Note: * $p < .05$; ** $p < .01$; *** $p <.001$

responses were pre- or post- course or who the respondents were, participants were allocated a rating of 0, 3, 5, 7 or 10 for each learning objective.

Responses to both vignettes were assessed for ability to operationalise in their interventions the participants' learning about Stressors, Genograms, Options and Reflection. The individual vignette was also assessed for showing an awareness of the steps to take towards Problem clarification and for Involvement of patient in treatment/referral. We assessed the mother–child vignette also for strengths in the Recognition of interactive cycle and Review of treatment. Participants' assessments obtained before and after the courses were tested for significance using the Statistical Package for Social Science (SPSS). We analysed all learning objectives together for each vignette in each course. Using the t test for paired samples, we then compared separately pre and post-course assessments for each learning objective in each course.

Table 5 shows the mean scores for GPs undertaking short and long courses. The comparison is between scores obtained before and after each course as assessed for all six learning objectives for the individual and mother–child vignettes. Each participant could obtain a maximum score of 10 for each objective, thus the maximum possible mean score was 60 for each vignette in each course.

When responding to the individual vignette, participants obtained significantly higher scores on the six family therapy learning objectives after both the short and long courses. For the mother–child vignette, participants obtained significantly higher scores after undertaking the long course but not after the short course, although the difference of the means was in the expected direction. This may suggest that GPs need longer courses of family therapy training to learn to work with two or more persons in a consultation.

Short Course

Table 6 sets out the mean scores for each learning objective for GPs undertaking the short course and responding to the individual and mother–child vignettes. Each participant

TABLE 7

Mean Scores for Paired Samples and Significance Levels of Differences for Long Course $N = 14$

Vignette	Learning Outcome	Mean and *SD* Scores				*t*	*p* (2-tailed)
		Pre-course		Post-course			
		Mean	*SD*	Mean	*SD*		
Individual	Stressors	7.79	3.77	9.38	0	-1.68	0.116
	Genograms	0	0	7.96	3.24	-10.23	0.000***
	Problem clarification	3.57	2.54	7.86	3.08	-4.64	0.000***
	Options	3.92	2.65	8.86	2.77	-4.43	0.001**
	Involvement of patients	2.36	3.61	7.5	3.88	-4.46	0.001**
	Reflection of interventions	1.07	1.62	7.68	3.73	-6.01	0.000***
Mother–child	Stressors	1.85	2.12	7.46	1.94	-7.12	0.000***
	Genograms	2.92	2.84	9.15	1.35	-9.15	0.000***
	Recognition of interactive cycle	3.08	4.35	7.31	4.39	-2.51	0.027*
	Options	2.31	2.16	4.77	3.42	-2.41	0.033*
	Review of treatment	4.23	2.96	9.77	0.83	-6.83	0.000***
	Reflection on interventions	6.3	4.44	8.46	2.4	-1.39	0.189

Note: * $p < .05$; ** $p = .01$; *** $p << .001$

could obtain a maximum score of 10 for each objective/outcome. This is the case for Table 7 also.

In relation to the individual vignette, for Genograms, Problem clarification and Reflection on interventions, participants' scores were significantly higher after the training course than before. For Stressors, Options and Involvement of patients, the differences, although in the expected direction, were not statistically significant. For Stressors, the absence of significant difference is probably due to high pre-course mean scores, suggesting that these GPs had a good pre-existing capacity to identify stressors. In relation to the mother–child vignette, for Genograms and Reflection on interventions, participants' scores were significantly higher after the course than before. For Stressors, Recognition of interactive cycle, Options and Review of treatment, there were no significant differences.

Long Course

Table 7 sets out the mean scores for GPs undertaking the long course and responding to the individual and mother–child vignette.

For the individual vignette, for Genograms, Problem clarification, Options, Involvement of patients and Reflection of interventions, participants' scores were significantly higher after the course than before. For Stressors, the difference was in the expected direction but not significant, again probably because of the high pre-course mean scores.

For the mother–child vignette, for Stressors, Genograms, Recognition of interactive cycle, Options and Review of treatment, participants' scores were significantly higher after the course than before. For Reflection on interventions, the difference was in the expected direction but not significant.

The Division which coordinated the long course (Melbourne Division of General Practice, 1997), reported on the results of a questionnaire mailed to participants six months after completing the training. Excerpts from this report include:

> GPs began working in new ways with their long-standing patients who had chronic psychosomatic symptoms and often for the first time began taking a detailed history via the genogram. So instead of these patients talking endlessly about their physical symptoms, the consultations were changing to enable the patients to make connections for themselves about their symptoms and their own lives.
>
> ... it was evident that real and positive changes were occurring in the lives of the participants ... One solo GP was for the first time confident to bring an anxious patient and her husband into the consultation together to actively discuss the way that each may contribute to the continuation of the symptoms. There were also many examples where patients well known to participants were able for the first time to disclose 'secrets' about their lives which had made it difficult for them to function well. It appears that a different approach by the GP was able to allow patients to present different information and therefore make significant changes in their lives.
>
> The vast majority [of GPs] could identify patients who had improved quality of life as a result of new skills acquired by the GPs. One example was of a woman whose 'jaw clenching' was reducing as well as a reduction in her medications. Another was a suicidal patient who 'is well on the way to a balanced life'... The confidence and new skills learnt by the GPs had "been very beneficial to the quality of my practice, both for myself and my patients."

Participants wrote: '... the course in less than a year has produced a significant change in my consulting and thinking, learned over the past 22 years of practice ...'; and

'The course highlighted the benefits of peer support as a powerful tool in allowing GPs to bring the cases where for various reasons they find they get "stuck"'.

The Division review suggests that the learning has extended and is maintained beyond the duration of the course. In family therapy parlance, second order changes have taken place in the GPs' approaches and perspectives. The changes reported by the GPs are consistent with the changes in their skill levels as reported in the examples identified in Tables 3 & 4. In particular, these changes document the GPs' increased capacity to consider the relevance of family members of patients and involve them, to draw genograms, to allow more time for the relationship with their patients to develop, and to reduce their need to offer solutions and 'fix' the presenting problem.

Discussion

There are no published reports with which our quantitative results can be compared. However, reports suggest that GPs who undertake family therapy training find it difficult to sustain a pattern of seeing families (Bishop et al., 1984). It may be that general practitioners are more comfortable with an individual than with two or more people in the room and/or they may find it easier to apply new skills to individual patients. Thus they may need a longer course to apply the skills to conjoint work.

Overall, the GPs' skills improved for more objectives after the long course than after the short course. This supports anecdotal reports that family therapy needs to be taught over a lengthy period of time in order to maximise learning (Weston, 1987). Whilst GPs were able to learn skills such as drawing a genogram and applying it to both individual and mother–child presentations in a short course, learning objectives such as Options needed a longer course. GPs showed significant improvement in Generating and Discussing Options in the long course. Involving the patient in choices about his or her treatment seems a difficult concept for GPs to learn (Goodrich & Wang, 1999; Launer & Lindsey, 1997). Like other objectives such as Involvement of patients and Review of treatment, which GPs required longer to learn, Options probably represents a mind set closer to the psychosocial model, which

> ... insists that the patient too has knowledge, wisdom and responsibility, and hence rights and power, which can be shared with or withheld from the physician, as the patient chooses (Antonovsky, 1989: 250).

This was an exploratory study and was not designed to compare learning patterns in short and long courses. Further studies could be undertaken in this area.

We were impressed in both courses by the way participants were able to work together and listen sensitively to each other's presentations and difficulties. In the long course, participants identified areas of their own difficulty and expressed pleasant surprise when they became aware of how empowering this process was for them. They also stated that opportunities of this sort were unusual for them, the emphasis in their training being upon knowing the answers and not showing any vulnerability.

Conclusion

The exploratory applications reported in this paper suggest that when applied to a short and long course, changes in skill levels occur and that extended training/supervision improves learning. Family therapy training courses for GPs should be developed with their specific needs in mind and evaluated accordingly. We have taken an important first step in this process and hope that the tools we have developed will be used by other trainers.

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Endnote

1 Dr Tarquin Oehr, GP, on completion of medical family therapy course

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Editors and their Sheds: Divorce

'According to our study, couple therapy seems to have little influence on prevention of divorce, but has, above all, a positive effect on personal development — even in case of separation/divorce'

(Barbara Meier, Anke Röskamp, Astrid Riehl-Emde and Jürg Willi: Trennung nach Paartherapie im Urteil der PatientInnen: Eine Katamnesestudie, *Familiendynamik*, 27, 2 (2002): 184). (The quotation comes from the summary in English.)

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