From knowledge to action – building recovery into relationships with patients in primary care

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Summary

This article aims to introduce you to, or remind you of, how to recognise and work with significant social risk factors for mental health problems. It aims to support you in making effective use of the insights you gain into people's lives and psychological strengths and challenges, and to understand how to build on these to help recovery. The article introduces principles such as psychic security, trauma informed care, and recovery based language as foundations for active therapeutic relationships. There is evidence that primary care staff using these approaches will maximise the patient's ability to strengthen their own coping mechanisms, and will also help the outcomes of specialist care from other sectors - whatever the cause or diagnosis of the mental health problem. Most of all, it aims to make us feel more able to guide people through the challenges of mental health problems, working with compassion but also clarity, and using our knowledge for more effective care.

Introduction

Previous guidance produced by the WONCA Working Party on Mental Health (WWPMH[i]) has emphasised the importance in family medicine of recognising and responding to personal and psychological aspects of the consultation[1]. Professor Chris Dowrick, the current Chair of the WWPMH, wrote an admirable text called 'Beyond Depression'[2], which showed us how and why it is important to help people to understand the circumstances which can damage them as human beings. This is important not just to diagnose and treat in the conventional model, but to help people to rehabilitate and restore their capacity for living. This call for a generalist approach to the whole person - seeing their relationships, context, and subjective experiences as part of health - is in line with the philosophical and practical goals of primary care[3],[4]. It also aligns with our growing understanding of the impact of life experience on physiology, brain structure, and the immune, metabolic and autonomic nervous systems[5] . Other WP guidance has reminded us of the links between adverse life events and psychological and physical problems[6], and has summarised some of the psychological interventions that can be started in primary care[7]. This guidance note builds on these approaches, intending to share some additional useful concepts that can help us to understand our role in primary mental health care; and to support people in a way that is most productive for our patients and ourselves. It acknowledges that engaging with the person as well as their presenting problems is emotionally demanding, and can be complex, though rewarding. Our aim is to help us use our insights to aid recovery, and reduce risks of untreated psychological pain.

Background

Mental health problems are common in patients consulting in primary care. A well trained family doctor working in a supportive health system will be a good empathic listener, and will elicit and assess emotional cues and psychological aspects of the consultation. This creates positive doctor-patient relationships, and can increase therapeutic impacts: for example

- better engagement of the patient in next steps, including selfcare
- empowerment - the patient is more confident, and feels more able to address their problems
- improved concordance (uptake of interventions).

For many people with temporary distress due to stressful life events, this input is enough - people who have supportive relationships, emotional insight[8], few other ongoing problems, and who learn ways of coping that minimise the impacts of stress[9] are not likely to need our longterm help.

[i] See https://www.globalfamilydoctor.com/groups/WorkingParties/MentalHealth3.aspx

However, some patients have recurrent and more chronic symptoms of psychological distress, and these can lead to significant health burden. There are also a group of sufferers with medically unexplained symptoms, for whom the psychological impacts and loss of quality of life are considerable[10]; patients with addictions and other self destructive lifestyles; and patients with major recurring disorders such as schizophrenia. Some patients will trigger our concern because they attend more frequently than is typical for their age and sex[11], because of a growing picture of problems over time, or because we sense that their use of the service is not resulting in progress[12]. Lack of a clear analysis of what is happening or what can be done to help can lead to recurrent appointments, unmet expectations, and burnout for the caring clinician who attracts a caseload of individuals with ongoing complex psychosocial problems. There are also gendered aspects to this, with literature suggesting both men and women are more inclined to reveal psychological vulnerabilities to female doctors – who in many cultures are perceived to be (and learn to be) the 'carers'. This can lead to issues both for the individual doctor and the team, with female doctors at greater risk of burnout[13].

Working effectively with knowledge of adverse life experiences

Many people with long term psychological problems will have a background of serious adverse social circumstances. As family doctors, we are taught, and expected, to know something of the person – this is essential to making a full diagnosis, and to manage the problem with the person in a way that takes into account their needs, capabilities, expectations and values. So in the course of enquiry as to the background of someone's problems, we often hear their stories of personal adversity; and we know from the literature, that adverse childhood experiences (ACEs) can be particularly important in subsequent psychological vulnerability. In fact, ACEs have been linked more strongly to both physical and mental ill health than any other known risk factor[14], which should make screening a priority. The question is, once these issues emerge, how can the family doctor best use this knowledge to help the patient and those who are close to them?

To use the information well, and to be clear how it can move things forward, we must first explain *why* we are enquiring about such personal issues: otherwise the patients themselves may feel exposed (even retraumatised – "*she kept asking me about my dad, I don't want to think about it*…"), and we could potentially add to their anxieties. We can then acknowledge their challenges, empathise, and explain how such experiences can result in difficulties right into adulthood. But we can also explain that knowing about their background can help to start making sense of why they are struggling, and at the same time show how they have already learned to cope with many challenges. All of this can be therapeutic, and is a big part of the value of family medicine. Evidence shows that a secure attachment to a caregiver can repair attachment issues stemming from inconsistent parenting and caregiving in childhood; in this way, the relationship is potentially healing[15]. A key goal of trauma-specific care is helping the person to 'stabilise': that is, enabling them to take more control over their social circumstances, (including their housing and finances), their close relationships, and inner experiences. A good quality relationship with their family doctor can offer personal continuity of care and restorative relationship that can contribute to this stabilisationm and help with engagement in treatment.

Other WWPMH guidance has addressed what best practice can look like – in terms of getting a broad full picture of the patient's problems, sources of support, 'usual' coping strategies, and offering techniques known to assist stress management. We can start the process of selfguided cognitive behavioural therapy (CBT), give some resources, refer to other agencies, and medicate for related anxiety and depression if appropriate[16]. But for many patients with significant ACEs, more is needed. Family doctors are not psychiatrists, counsellors or psychotherapists - and the rebuilding of an adult psyche which is stronger and more healthy is not our speciality. There are however some concepts which can add value both to our understanding and our work in supporting these patients.

Creating psychological security

The first we discuss here is *psychic security*. A child who grows up confident of reliable care and love in one or more constant carers develops secure attachments[17], and has a graded exposure to the challenges that life can provide. We all fear death and loss, but learn to 'encapsulate' this - as our overall experiences create psychic security**.** A child with less stable or disrupted psychological development will (simply put) have less confidence in the world, and may in turn form or create less stable social relationships. Similarly, at any stage of life, a sudden major threat which destroys

psychic security and leaves the person powerless in the face of a potential or actual major loss – including the disruption of societal norms and safe environments – can destroy psychic security and lead to significant post-traumatic stress and reaction[18].

In order to reduce the ongoing possible impacts of past or recent trauma, six principles can guide our actions. Compassionate and empathic communication is very important; and testing and ensuring how safe the person is (especially if the patient perceives current risk, whether from other household members or outside agencies). Sharing power and respecting autonomy is crucial, because the emotional memory of powerlessness is a major feature of trauma. Recognising strengths that have already enable survival to this point, and using 'recovery oriented language'[19] is another important practical intervention for GPs and primary care staff – while not being unrealistic, there is good evidence that using terms that reflect the possibility of change and improvement can instil hope and motivate people. Much of this will need tailoring to the particular background, context, and state of the person's problems, but the principles remains the same. The conversation style to promote behavioural change is also important: motivational interviewing (MI) highlights the key elements of working in partnership, collaborating to set goals, acceptance of limits, and responding with compassion.

Where else do the core principles of good family medicine need to fit in? At this level, some kind of relationship and 'held' continuity is needed to move through a period of conscious psychological exploration[20]. We declare this as a fundamental principle of the definition of our discipline, but of course no one can be there 24/7 for all their patients. However, a period of prebooked appointments to ensure personal review by a named clinician when needed will be invaluable – again allowing the patient to practise a trusting relationship, with enough security to develop their autonomy over time. This is not to encourage dependence, but to allow support to make what will not be an easy journey; to monitor progress, including self care, relationship dynamics and mental state. One goal is also to monitor when engagement has started with other services, when the GP may be able to move to a less central role – while still being 'there' for the patient. It is also important for the medical interventions to include families or 'significant others' to engage a patient's support system, since the help of personal relationships is an essential part of the patient's therapy and rehabilitation.

Risks and resources

To note - there are some risks to revealing psychological and emotional issues in our patients. This is particularly true where other mental health services are lacking; or if these specialist services have very strict funding or referral criteria; and where previous encounters have failed to improve the situation. There is the common risk of psychological defensiveness and denial in the physician themselves – many of us are poorly trained in psychological aspects of care, some have trained in settings where mental health problems are stigmatised, and some will not tolerate the emotional burden and deep engagement that good mental health care requires of us. Opportunities to debrief, work with others in a shared care model to be supervised for complex case work, or get additional training and resources, all help us to sustain the necessary demands of caring for traumatised and needy patients during their progress towards better health. Given the scarce resources available in many communities, it is worth considering whether at least one team member takes additional training in motivational interviewing, cognitive behavioural therapies, or even dialectical behavioural approaches[21]. Many of these interventions can be applied in the length of time of a primary care visit and can provide the patient with tools that they can use towards emotional self-regulation.

However, the system may not support excellent psychological care – too little time, too much bureaucracy, and conflicting demands can all undermine best practice. Integrated health care encompassing public health, primary mental health care and evidence-based practice remains a neglected area, even in many European settings,[22] and needs to be considered as a high priority for policy makers. This guidance acknowledges that such tensions will need to be addressed if we are to build further competencies and goals into our work in the primary care setting – but good care is worth it and is intensely satisfying when we are enabled to do it[23]!
The primary care team also needs to identify and advocate for the other resources and skills that are needed beyond the team to work effectively with mental health issues, Given the prevalence of ACEs, of mental health comorbidities, and the predicted increase of such concerns accompanying social and ecological disruptions; it is important for community-based resources to address the underlying roots of much suffering that we care for in our practices. Some of the recent work on social prescribing is relevant to the need to increase nonmedical solutions for support and healthy diversion from chronic

patterns of distress[24]. Shared-care models and interdisciplinary community health centres provide examples of when an expansive team approach is available, and we advocate the scaling up and research of these models.
This is also a challenge for academia and medical faculties that will need to reorientate their curricula to a more person centred generalist approach to mental health care. The role of academic institutions is to prepare future physicians to serve individuals with mental health problems and their families with compassion, avoiding discrimination and promoting autonomy, self-determination and dignity; also to promote interdisciplinary and team based work. Restoring humanity in health care through the art of compassion seems to be an urgent priority for the teaching and research agenda in family medicine[25].

In conclusion

Any clinician with an ongoing relationship with patients can use that to therapeutic effect. Family medicine as a discipline teaches and can practise person centered care. For patients who have suffered adverse life events, particularly if this occurs in childhood, there can be significant psychological sequelae. Building on empathic relationships, and personal insights, clinician awareness of the key components which can build new confidence and psychological security can help people to gain or regain better psychological health and lifeskills. The primary care team can play an active part in this process, even if other services are also needed. Planning care together in an active way both manages time and use of services appropriately, and can have better outcomes. While some in the primary care team may usefully extend their skills in mental health to act as a local resource and consultant to others, the majority of staff can play a useful role by:

1. Ensuring they encourage discussion of personal / psychosocial aspects of health in all consultations
2. Explore personal background of people who have significant psychological and personal needs
3. Explain how adverse life events affect us both physically and mentally – help the patient gain insight into their symptoms and how these can be improved over time
4. Empathising, identifying goals and strengths, and reassuring that some improvement can be expected
5. Offer continuity with one or two key personnel during the assessment and recovery period
6. Balance the need for dependency and an aim of autonomy
7. Expand local resources in and outside the clinic which can assist mental health and wellbeing
8. Tackle systems issues which undermine your work, or put people at recurrent risk of trauma
9. Support teaching training and research that address these issues, and assist good practice
10. Live in hope.

References

[1] See '*Core Competencies for Primary Care Mental Health'* written by members of the WWPMH January 2018: http://www.globalfamilydoctor.com/site/DefaultSite/filesystem/documents/Groups/Mental%20Health/Core%20competencies%20January%202018.pdf

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[7] See 'Family doctors' role in providing non-drug interventions (NDIs) for common mental health disorders in primary care' by members of the WWPMH at https://www.globalfamilydoctor.com/site/DefaultSite/filesystem/documents/Groups/Mental%20Health/18%20Oct%20NDIs_updated.pdf

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[9] See for example https://www.nhs.uk/conditions/stress-anxiety-depression/improve-mental-wellbeing/
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