Do primary care psychological therapists ‘think family’? Challenges and opportunities for couple and family therapy in the context of ‘Improving Access to Psychological Therapies’ (IAPT) services

Melanie Shepherd

Very little couple or family work takes place in primary care despite the advantages offered by the context. This pilot study investigated the experiences of primary care adult therapists regarding the place of families in their clinical work. Semi-structured interviews with seven therapists were analysed using interpretative phenomenological analysis. The findings tentatively suggest that primary care psychological therapists ‘think family’ primarily from the perspective of their main therapeutic model when offering individual therapy. Some study participants questioned the appropriateness of their family/context focus. Family members were extremely rarely seen together. Facilitating factors included supervision and training. Barriers to family work were both external (the work setting) and internal (beliefs about it). The impact of the current dominance of cognitive behavioural therapy in National Health Service adult psychological therapy services and the development of Improving Access to Psychological Therapies (IAPT) services on the provision of couple and family therapy are discussed. Some challenges and opportunities presented by IAPT for couple and family therapy are explored.

Keywords: general practice and primary care; IAPT; couple and family therapy; adult mental health.

Introduction

Primary care is increasingly important in the National Health Service (NHS) with the advent of practice-based commissioning in England (Department of Health, 2006) and the UK government’s plans to devolve commissioning to general practitioners (GPs) in England.

Consultant Clinical Psychologist, Lewisham Improving Access to Psychological Therapies Primary Care Psychological Therapies Service, Fourth Floor, Ladywell Unit, University Hospital Lewisham, London SE13 6LW. E-mail: Melanie.Shepherd@slam.nhs.uk.

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(Department of Health, 2010). In 2001 approximately half English GP practices employed a counsellor (Mellor-Clark et al., 2001).

The primary care context offers several advantages for family therapy: the setting is local and non-stigmatizing, and primary care psychological therapists (PCPTs) work as part of a professional system that is familiar to clients. It has considerable potential for couple and family work since on site PCPTs provide therapy as members of a primary health care team that often has a wide knowledge of the clients’ families over time. Family therapy has much to offer in primary care in addition to working with couples and families. A systemic theoretical framework informs individual therapy: others are brought into the therapy by the therapist’s questions and clients are encouraged to view their problems in an interactional context (Jenkins and Asen, 1992). Family therapists working in primary care, such as Altschuler (2005), who describes narrative therapy with immigrants and McDaniel et al. (1992), who work with families facing physical illness, emphasize the value of the family therapy focus on the wider context. The shift of focus from the idea of families as a source of problems to families as resilient with strengths is also pertinent to primary care. Being a non-stigmatizing setting, it has great potential for preventative work. Given that very brief interventions are typically offered in primary care, drawing on the positive qualities of their families can be a useful resource for clients in maximizing and maintaining the benefits gained. Although empirical data about the efficacy of family therapy for adult-focused problems (Carr, 2000, 2009) may not automatically translate from other settings to primary care due to differences in client populations, levels of the severity of their problems and the length of intervention offered, in the absence of direct data it is reasonable to assume that similar outcomes would be found for adults treated in primary care.

Given the above, it is striking that couple and family therapy have not been more closely associated with general practice. Some innovative services specifically drawing on ideas from family therapy have developed (Denton and Michie, 2006; Deys et al., 1989; Senior, 1994). All PCPTs, whatever their orientation and training, have the potential to ‘think family’ and some do offer couple and family work, so seeing families is clearly feasible. However, most UK adult PCPTs offer only individual therapy. PCPTs draw on a range of models but a systemic and family therapy therapeutic orientation is rare: person-centred, integrative and cognitive behavioural therapies (CBT) are offered by over 60 per cent while systemic and family therapy is offered by less
than 20 per cent of UK primary care adult mental health services (Barnes et al., 2008). Unpublished audit data collected over more than a decade about the current author’s primary care psychology and counselling service show that between 96 and 98 per cent of interventions offered were individual, although between 20 per cent and 25 per cent of clients’ presenting problems were categorized as ‘interpersonal’ (Lewisham Primary Care Psychology and Counselling Service, Annual Reports, 1995–2009, unpublished).

It could be argued that aspects of the primary care context, such as high referral rates, brief interventions and rapid throughput, the physical environment and the minimal opportunity for collaborating with colleagues militate against seeing family members together. The current political context may also be influencing PCPTs who are under pressure to use interventions that have a strong evidence base. Many PCPT services are being restructured as Improving Access to Psychological Therapies (IAPT) (Department of Health, 2007) services. IAPT seeks to broaden access to National Institute for Clinical Excellence (NICE)-compliant psychological therapy. Although the NICE guidelines for depression (NICE, 2004, 2009) recommend other therapies, including couple therapy, it is particularly the capacity for CBT that is being increased. This may intensify the dominance of CBT over approaches with a less robust evidence base, such as couple and family (or systemic individual) therapy.

The factors outlined above might influence how much couple and family work takes place but they do not throw light on whether PCPTs offering services to adults consider or involve families in their clinical work. There is no published research investigating this issue despite the relevance of family therapy to primary care. Clients are entitled to have access to a choice of evidence-based treatments and their individual treatment would be enhanced if PCPTs held a family and systems perspective: if factors that inhibit or support ‘thinking family’ could be identified this might enable therapists and services to take steps to facilitate the latter.

This study aimed to explore in what ways PCPTs with a range of therapeutic orientations and professional backgrounds incorporate thinking about families and use this in their work. Since PCPTs with family therapy qualifications were excluded, it was unclear whether participants would consider or involve families, and the term ‘thinking family’ was therefore deliberately loosely defined: it referred to consideration in therapy of the clients’ current and past relationship contexts from the perspective of the PCPT’s preferred therapeutic
model(s). If PCPTs offered systemically oriented therapy, ‘thinking family’ could include direct exploration of relationship dynamics, seeking multiple perspectives, an emphasis on understanding contexts and a focus on strengths as well as routinely seeing family members together. This exploratory, qualitative pilot study thus aimed to:

1. investigate the experiences and views of PCPTs regarding the place of families in their clinical work.
2. identify factors that support or present barriers to the use of the therapists’ thinking about families in their clinical work.

The study is briefly described below. The discussion explores its implications in the context of the development of IAPT services. As an experienced PCPT who draws on systemic, CBT and psychodynamic models, and who is trained as a family therapist and clinical psychologist, I have experienced the advantages and challenges of seeing couples and families in primary care. Since the study was completed, my psychological therapy service has been restructured as an IAPT service. I am one of its team leaders.

Method

A purposeful sampling (Creswell, 1998) strategy was adopted covering central aspects relating to PCPTs, such as the variety of professionals, both on site therapists and those working from a central base. To be included therapists had to be professionally qualified and work in primary care. Family therapists trained to certificate or masters level were excluded.

Twelve PCPTs from two inner city services were invited to participate. Seven were interviewed (two declined, one was on long-term sick leave and two did not respond). All were psychologists (four clinical and three counselling) and all but one were women. They ranged from being newly qualified (4 months) to being very experienced (16 years). Their experience in primary care ranged from 4 months to 15 years. The main therapeutic orientation of five of the participants was CBT, one was integrative and one was psychodynamic. Two participants used only CBT while the others used a range of approaches. Training in working with couples and families as part of core professional training was limited and none had post-qualification training.

Individual semi-structured interviews were conducted. Two pilot interviews, not included in the sample, led to amendments in the
interview schedule. Interpretative phenomenological analysis (IPA) was chosen as the analytical tool. The distinctive feature of this method is its commitment to a detailed interpretative account which can be done only with a very small sample, six being considered reasonable (Smith and Osborn, 2008). Peer feedback on the credibility of themes identified led to the addition of sub-themes to the theme ‘therapy factors’.

Results

IPA resulted in two superordinate themes, ‘thinking family’ and ‘seeing family members together’ with sub-themes (see Table 1).

‘Thinking family’

*Therapists’ conceptualization*

All participants described asking questions about clients’ families. They enquired about the client’s current and past relationships and the influence of their childhood on the present. Asking about clients’ families was believed to aid assessment and engagement, deepen the therapists’ understanding of the therapeutic relationship and provide them with information about their clients’ support networks. Questions about the family appeared to be used primarily during assessment and were asked in order to help the therapists understand clients and to develop a formulation, rather than as interventions in themselves (Tomm, 1988).

**TABLE 1 Superordinate themes and sub-themes**

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The participants varied in whether they viewed their questions about families as a way of developing an individual/problem focused formulation of the client’s difficulties or as a reflection of their contextual understanding of the client’s difficulties. Those with a more individual/problem focus said they viewed this exploration of family relationships as relevant only if the client portrayed their family as particularly close or highlighted relationship difficulties:

If it’s very clear that the relationship is very close, in either a positive way or a way that the person finds unhelpful, then I probably would, but generally, if somebody isn’t talking very much about their family, I wouldn’t pursue it. (Participant 2)

Participants who used CBT asked questions about the family to identify the clients’ core beliefs and address the maintenance of the problem, for example, to find out if family members might be maintaining anxiety by offering reassurance. Some participants appeared to be drawing on psychodynamic ideas such as transference when ‘thinking family’: they reflected on whether the client might relate to them in a way that seemed to mirror the client’s relationship with members of their family.

Participants expressing a more family/context focus routinely asked questions about the family. They highlighted the value of holding in mind that the client was part of a family and wider social network:

I don’t think the problem ever is in isolation in a family, or whoever’s around, whatever that context is. (Participant 4)

Concepts and techniques from family therapy were hardly ever mentioned explicitly: two participants used geneograms (as a way to collect information rather than collaboratively with clients for therapeutic purposes) and one described being influenced by narrative ideas – particularly valuing the destigmatizing possibilities of externalization (White, 1989). Other concepts were mentioned (for example, circularity, intergenerational influences and the importance of context) but they were not attributed to family therapy.

Impact of the client’s family on process of therapy

The participants saw the current family as both a potential source of pathology that was undermining the client and therapy, and as a resource. If they took the latter view, they considered ways in which, usually without seeing family members together, they could involve
the family to help the client, for example, by suggesting that their clients seek help from family members with homework assignments.

**Seeing family members together**

Participants either never or extremely rarely saw family members together. The issue of whether to do so elicited negative beliefs about therapists’ competence and family therapy. Limitations attributed to the primary care setting and the absence of support were also highlighted.

**Therapist factors**

*Perceived competence.* All the participants expressed doubts about their competence to work with more than one family member at a time in comparison to their skills in individual therapy. They pointed to their limited training and negative experiences when they had seen family members together or tried to do so:

> People have never brought their partner back . . . I could benefit from more training on that. (Participant 3)

*Beliefs about family work and therapy.* Participants held negative beliefs that couple and family work is more demanding and time-consuming than individual therapy:

> You know, we see a lot of clients with problems that are reactive to somebody else and that’s really difficult to deal with . . . and it’s lengthier. I think if there’s two people with problems, it’s going to take twice as long, really. (Participant 5)

**Therapy factors**

The participants frequently emphasized the problems of seeing family members together and rarely identified the potential advantages of doing so.

*Process issues.* Dilemmas about confidentiality and neutrality were used as reasons for excluding family members. Some described the importance of seeing clients individually, arguing that seeing clients with a family member would impede the client accessing their feelings, ‘having a voice’ or talking of important issues for example, sexuality or drug misuse:
You get the hot thoughts, if they burst into tears in a session, and I might . . . actually linger on a painful bit to encourage them to cry; to let down their defences, to give me some good stuff. Whereas a mother would instantly say, ‘Oh no! Don’t! Stop!’ . . . they’d impede the work. (Participant 5)

On the rare occasions when family members were referred simultaneously to a team, this was not viewed as an opportunity to see them together but as a problem of confidentiality; that is, how to maintain a boundary between what each therapist knew.

**Presenting problem.** Arguments for seeing clients with a family member were put forward only in the case of relationship and sexual problems, particularly if the client was keen to bring somebody with them.

**Contextual factors**

**Primary care setting.** Limitations attributed to working in primary care included the predominance of individual referrals, working alone, practicalities such as room size, the primary care culture and the emphasis on brief interventions and throughput:

> In primary care we . . . work on our own and now that’s not to say that we couldn’t do [family work] but . . . it’s how to do it without losing on throughput. (Participant 1)

**Support available.** The participants claimed they were professionally isolated and lacked specialist supervision, training, exposure to research evidence supporting family therapy or even family-oriented colleagues as influences on the likelihood of them seeing family members:

> So, even if it’s just before or after a session, to have a think through or to really think about the family in a more systemic way I think that would help . . . to have that access to some kind of more instant support or something. (Participant 6)

In IPA the researcher has to interpret people’s mental and emotional state on the basis of what they say. There were many dichotomies and contradictions in what the participants said. The contradictions and lack of coherence may have reflected the participants’ high levels of anxiety. Some anxiety may have been due to their perceptions of my bias towards a family focus or it may have been due to a fear of exposing their lack of training in and knowledge of couple and family therapy.
Several participants seemed pleased when they reflected that they thought about family more than they had previously realized. Anxiety for some appeared linked to conflict between their professional values and beliefs as therapists versus what they felt was expected of them by their colleagues, managers, profession or commissioners.

IPA is explicit about combining different levels of information and both the content of the interviews and the researcher’s attempt to understand the participants’ experience were combined to translate the themes into two narrative patterns (Smith et al., 1999). Examples from two participants illustrate each pattern.

**Pattern 1: conflicted**

Those with a family/context focus believed such a focus conflicted in some way with the ethos of the service for which they worked. This was because of differences in therapeutic orientation, pressures to maintain throughput and conflict with current service policy and developments. Thus, participant 3’s family/context focus conflicted with what she had read, her CBT training and her department’s culture:

This isn’t particularly CBT but I would always do a geneogram . . . I’ve been told on training programmes . . . people, and they’re pretty high up doing CBT, would just focus on the presenting problem, formulate that and then the maintenance cycle and . . . they [the senior staff offering CBT training] – it’s intrusive really to be making these enquiries [about family]. (Participant 3)

Participant 7’s family/context focus predated her training as a psychologist and her current professional identity generated conflict in her approach:

I started off very much thinking in systemic . . . then it changed. . . . I can actually remember it happening. . . . I always felt that I should, it’s kind of a ‘should’, that I should focus on the individual as opposed to the context that that person was in and I think the discipline of psychology is just very much about somebody’s inner world. (Participant 7)

The family/context-focused participants’ accounts were characterized by doubts and uncertainties but they showed interest in reflecting on how their practice or their services could change.

**Pattern 2: congruent**

The participants who held a more individual/problem focus appeared, despite their apparent anxiety, to have a different relation-
ship with their wider work context and to be less conflicted about their therapeutic stance. They described themselves as purely CBT in therapeutic orientation, expressed their opinions with more certainty, (although they sometimes held contradictory views) and demonstrated little interest in changing their practice:

I think, actually, families aren’t that relevant and although I don’t think that, I think, at some level in my head I must think actually treating people, um families, it is possible to treat people effectively without, in a lot of circumstances, going into a whole load of family stuff especially in primary care. (Participant 2)

Family relationships were seen as relevant only if they were problematic and highlighted by clients:

I’m not sure anything could [lead me to consider families more], because the 20 per cent where I don’t talk about families is because everything’s dandy . . . if it ain’t broke, don’t fix it . . . And then on top of that, maybe, 20 per cent of the reason is – I wouldn’t use it in a standard – I wouldn’t go through childhood in a standard assessment, because I don’t want to frighten people off. (Participant 5)

The current emphasis on CBT in the wider context and dominant ideas about the evidence base clearly impacted on participants at a local and individual level:

I think research evidence then determines the chapters written up . . . the recommendations for interventions and what research trials will focus on . . . [CBT research trials] are the only ones I’ve had contact with. (Participant 3)

Several emphasized that they chose training that was politically and pragmatically acceptable for their future career development, rather than what would have been most clinically useful:

[Family oriented supervision is unavailable] I think probably because . . . the drive for CBT and the NICE guidelines and the present climate is probably moving people more towards cognitive therapy diplomas and . . . everyone’s energies is going into IAPT. (Participant 7).

Discussion

Limitations of the study

It is not possible to generalize from the findings that may have been a consequence of sampling or researcher bias. Although the study aimed
to include a range of PCPTs, only psychologists participated, further restricting application of the findings. With a larger sample, the influence of experience, therapists' gender and professional group could be investigated. In retrospect, it would have been preferable to differentiate between asking about family versus ‘thinking family’ in a systemic sense. Although ‘thinking family’ was deliberately loosely defined the theoretical concepts underlying the participants’ consideration of families could have been explored in more depth in the interviews.

**Asking about family and seeing family members together**

Asking about and seeing family members together appeared to be distinct processes rather than the latter being a development or consequence of the former. All participants said they asked about clients’ families but some claimed this was not important or even desirable. Although seeing family members together in primary care is clearly feasible, this rarely happens. Some participants were willing to see couples and families but were more likely to suggest this if the clients volunteered an interest in doing so. The choice of whether to involve the family was left to the client rather than being something the therapist might routinely consider or offer.

Family/context-focused participants always asked about the client’s family. Individual/problem-focused participants did so in certain circumstances or for specific reasons. The questions that participants asked about their clients’ families generally appeared to reflect their individually oriented main therapeutic model rather than a systemic perspective. On the other hand, Tomm (1988) described how different assumptions and intentions can underlie the same question and the participants in this study may have thought and acted more systemically in practice than came across in the interviews. If some were using systemic concepts they may have found this difficult to articulate due to the anxieties discussed earlier. As a result, the participants may have felt more comfortable talking from the perspective of their main model and may have underplayed any attempts to work systemically. It was therefore difficult to assess whether or not the participants were thinking systemically when they asked questions about their clients’ families and involved families in their interventions.
Facilitating factors and barriers to ‘thinking family’ and seeing family members together

Limited training in working with families did not preclude the participants from ‘thinking family’ but many claimed that to see family members together they would need training and other forms of input. The participants were not optimistic that these would be provided in their work settings.

The external barriers mentioned included aspects of the primary care setting such as their lack of physical and thinking space, professional isolation, large caseloads and rapid throughput. In some situations the PCPT would have found it very difficult to see families even if they chose to, working alone as they did in medical rooms barely large enough for two, yet it is striking that where therapists were working from a team base they did not create opportunities to see couples and families or to work together. One of the factors driving the emphasis on individual work may be the training of PCPTs. It is, as mentioned earlier, unusual for PCPTs to have a systemic and family therapy orientation and most are trained primarily in individual therapy. Psychologists are trained to work with couples and families but the relative emphasis on modalities varies and most training is likely to be with individuals.

Some barriers were internal: participants expressed negative beliefs about seeing family members together such as situations when it would be problematic, its perceived difficulty and time-consuming nature. Seeing family members together can be inappropriate but what was striking was that the potential benefits of doing so were given comparatively little attention. The participants expressed taken-for-granted beliefs that seeing family members together would take longer, although when Crane (2008) compared the length of interventions in individual, family and mixed therapy, family therapy interventions were the briefest. All questioned their competence to see families yet, as psychologists, they were likely to have many of the skills needed. Although this training need was identified, some participants appeared not to be interested in further training or supervision because they believed that considering and involving the family was irrelevant and even intrusive.

Conflict with professional perspective and the wider context

Some participants were open to developing their skills but expressed conflicts between their professional perspective and the wider context.
It seemed as if they had internalized constraints. Without an explicit proscription against ‘thinking family’, some participants questioned their focus on the family. Several therapists doubted whether it was appropriate in the eyes of their colleagues and whether developing their skills in these areas was in their best interests in terms of their professional development. These ideas were justified with reference to the evidence base supporting CBT and service developments such as IAPT. Significantly, research evidence supporting the efficacy of family interventions was not mentioned. It was not that the participants raised questions about the comparative efficacy of different approaches or their ignorance of the literature when making references to research into systemic and family therapy; it was as if it did not exist.

If professional identities do not fit clinical realities or if therapists’ beliefs conflict with their assumptions about their responsibilities to their service or role, therapists can experience conflicts. This can constrain effective practice (Reder and Fredman, 1996). The open expression of support for a therapeutic orientation perceived to lack an evidence base might result in therapists feeling isolated, which is already a characteristic of primary care work and their fears that this might compromise career progression may be justified. Even if training was available, therapists might be prevented from accessing it, either by external dissuasion or internal doubts.

Drawing on Foucault’s (1980) ideas about power, White (1992) described a process in which individuals are incited in an insidious way to adopt dominant norms as truths. Individuals are recruited by the system of power to collaborate without being aware of it and participate by disciplining or policing their own lives. This process may be applicable to participants who questioned the appropriateness of their family-orientated practice without externally applied restrictions. Knowledge and power are intimately connected. Ideas may become dominant and difficult to question, to the detriment of other ideas, which become secondary and less influential (Boscolo and Bertrando, 1996). This could be a description of some aspects of the current political situation in the NHS in which CBT has become increasingly dominant in primary care psychological therapies services. Within the IAPT framework there is a risk that approaches other than CBT – such as family therapy – may be marginalized. The IAPT initiative presents both challenges and opportunities for couple and family therapy, some of which will now be discussed.
Challenges for couple and family therapy presented by IAPT

IAPT presents family therapy with multiple challenges, given that it focuses only on anxiety and depression, has privileged individual CBT to date, and IAPT services are offered at the primary care level.

**IAPT focus on anxiety and depression.** Although some primary care mental health services respond to the broad spectrum of need reflected in referrals with a range of therapeutic approaches, many – particularly those offered by psychologists – have privileged individual CBT for a limited number of disorders. Some prohibit therapists from seeing couples. IAPT high-intensity and low-intensity workers are trained to offer protocol-based CBT-oriented treatments for anxiety disorders and depression. In consequence, IAPT services may develop restricted criteria for suitable referrals. There is a risk that primary care psychological therapies services may become viewed and commissioned as services only for adults presenting with anxiety and depression. This may make it difficult for services offering a range of therapies (including systemically oriented therapies) to clients presenting with a variety of problems, including interpersonal difficulties, to continue to do so. It may also work against the development of couple and family work – except, perhaps, couple therapy for depression.

**Privileging CBT.** The strong evidence base for CBT is used to justify increases in funding for training and service provision in this type of therapy. While the aim is to improve the quality of psychological therapy services there is a risk that models with a strong research tradition, such as CBT, may be perceived as the only appropriate treatment. The evidence base for family therapy can be overlooked and family therapy’s professional bodies should promote its benefits more vigorously to commissioners and therapists. Carr (2009) observes that the NICE guidelines for panic disorder with agoraphobia do not reflect the potentially helpful role of family-based interventions. The efficacy of couple therapy for depression is frequently omitted when NICE guidance for depression is reported. Shedler (2010) comments on bias in the dissemination of research findings, leading to a lack of awareness of empirical evidence for psychodynamic therapy. Selectivity in the dissemination of research findings may have a parallel impact on perceptions about the effectiveness of couple and family therapy. It seems that, in addition to the fact that there is a smaller body of research supporting couple and family
therapy in comparison with CBT, there may be additional processes at play that make it more difficult for other therapies – including other NICE-compliant therapies – to receive equivalent attention and resources.

IAPT has had an impact on what training is deemed to be most relevant or acceptable both outside and within the IAPT programme. In part to prepare trainees for IAPT roles, clinical psychologists’ professional training has changed. From 2008, instead of being required to have an ability to implement therapeutic interventions based on knowledge and practice in at least two evidence-based models of formal psychological therapy, the course accreditation requirement has changed such that one of these models must now be CBT (British Psychological Society, 2008, p. 1). This study suggests that psychologists already emerge from training lacking confidence in seeing couples and families. If the above makes it harder for courses to allocate time for training in systemically oriented therapy, this situation is likely to persist.

Until recently IAPT has only centrally funded CBT training. Training in other NICE-compliant therapies, such as couple therapy for depression has now begun (see below). However, this is being provided only to qualified, experienced therapists with existing advanced competencies in couple therapy and on a much smaller scale than CBT training: it is far briefer (1 week plus supervision versus one year) and a much smaller cohort is being trained. (A foundation course for novice couple therapists may be introduced in the future).

Primary care. The culture of primary care mental health services is to see large volumes of clients as briefly as possible. There has always been a greater pressure on throughput in primary than in secondary and specialist services. Under IAPT this has intensified with challenging targets for waiting times, throughput and outcomes. Given this, and the added exposure of performance with the introduction of routine outcome monitoring in every session, there may be a tendency for services and PCPTs to stick with what is familiar and they feel competent to offer rather than exploring something new. PCPTs would need to be both motivated and supported by their service to ‘think family’ and offer more couple and family interventions as it would usually involve, or be perceived to involve, additional work and the taking of risks. PCPTs, especially those working on-site in GP practices, rarely have colleagues with whom
to collaborate. Clients are almost invariably referred as individuals: if referrals of couples were invited this would increase the already high referral rate. These factors may militate against IAPT services seeing couples and families.

**Opportunities for couple and family therapy presented by IAPT**

Despite the challenges, IAPT also offers opportunities for family therapy, given its focus on the mandatory routine collection of outcome data, NICE guidance for depression, improving access and the NHS choice agenda and the commitment to staff training and supervision.

_Routine outcome monitoring_. The evidence base for couple therapy for depression has led directly to the provision of funding for training and support for the development of services in this specific area. Evidence of effectiveness is increasingly likely to be required to persuade commissioners to purchase services and competition for resources will be particularly intense in the current financial climate. Couple and family therapy and systemic individual therapy need to be supported by high-quality research evidence, to be recommended by NICE, and more is needed.

An opportunity offered by IAPT is its emphasis on routine outcome monitoring. The huge volumes of outcome data being collected by IAPT services will enable pilot studies to be conducted that will provide useful practice-based evidence (Margison _et al._, 2000) about the effectiveness of different types and modes of therapy. This could facilitate funding for randomized controlled trials (RCTs) investigating couple and family therapy. Unfortunately, a caveat is that mandatory IAPT outcome measures focus on change in symptoms of anxiety and depression. They are more appropriate for measuring the effectiveness of CBT than couple and family therapy, which may seek to encourage a wider range of changes in people’s lives. More suitable measures such as SCORE (Stratton _et al._, 2010) are being developed but, if introduced alongside the mandatory measures used in every session, would place an additional burden on clients and therapists. There is a risk that, since the mandatory measures are very specifically tailored to measure symptom changes after CBT for anxiety and depression rather than broader outcomes after other therapies for a wider range of presenting problems, outcomes for CBT may appear more positive than those for other therapies and problems. If such a bias exists, couple and family therapy would be at a disadvantage in IAPT services when comparing
outcomes of different therapies. Shedler (2010) presents empirical evidence for this argument in relation to psychodynamic therapy.

**NICE guidance for depression.** As the most recent NICE (2009) guidance for depression recommends couple therapy, this is where there is greatest potential for service development. Behavioural couple therapy (BCT) (Jacobson et al., 1993) in particular is advocated because five of the six RCTs included were based on BCT. Leff et al.’s study (2000) comparing systemic couple therapy with other interventions, which was included in a previous NICE guidance for depression (2004), was omitted from the most recent guidance due to a high drop-out rate from the group receiving antidepressants. There was also a high drop-out rate from CBT, which led to this arm of the trial being discontinued.

BCT is a brief, integrative treatment for depression where there is relationship distress and depression in one or both partners. The model focuses on the relational aspects of depression and on factors that reduce stress and increase support within the couple, such as improving communication, managing feelings, changing behaviour and promoting acceptance. The Tavistock Centre for Couple Relationships has been commissioned to provide the IAPT training in BCT. The curriculum draws on a wider evidence base than the six studies in the NICE guidelines, in part because Jacobson himself disowned traditional BCT due to its poor effectiveness over time. It is based on a range of evidence-based approaches including interpersonal-marital, systemic, emotion-focused and insight-oriented approaches as well as behavioural couple therapy (Hewison, 2010; IAPT, 2010). Therapists are expected to draw on competencies from their existing model of couple therapy and integrate them with competencies specified for use with couples with depression and relationship distress.

**Choice and access.** Clients are entitled to have access to a range of evidence-based treatments and family therapy interventions should therefore be available in primary care for a range of problems. The IAPT programme is now at a stage when NICE-compliant therapies other than CBT are beginning to receive attention and, as IAPT services are becoming more established and embedded in their local contexts, some are showing interest in offering these.

One of the two IAPT pilot sites (Newham in London) has included a systemic therapy service since 2007 with positive outcomes (Kuhn, 2011). It is unfortunate that this service has not been more widely
publicized. My own service employs therapists who occasionally see couples and families and it offers a very limited couple therapy for depression service (one session per week). We plan to develop this by identifying couple therapy leads in each team and offering in-house training and supervision to staff. Given the very restricted resource, referring therapists meet individual clients with their partners before referral to discuss what they hope to gain from couple therapy. This improves referral quality and may give therapists confidence in seeing family members together. Some other IAPT services are offering couple therapy for depression but provision is very limited (usually only a few sessions per week), particularly in comparison with other types of therapy. It would be a positive step if all IAPT services offered couple therapy for depression and if this was a more substantial part of each service. Links between IAPT services offering couple therapy could usefully be established to share ideas and support service development.

One of the positive aspects of IAPT is its focus on increasing access to groups who may not use traditional mental health services. One element of this has been to develop links with voluntary agencies, including those serving black and minority ethnic (BME) communities. Our service has placed staff in voluntary agencies serving BME groups and gay and lesbian people. Sites outside primary care may be more suitable for family work. To develop trust and work effectively with some BME groups, many of which have a collectivist perspective and place emphasis on the family as a unit, it will sometimes be necessary to see clients with their families. Both factors might support the development of couple and family therapy in IAPT services.

Since IAPT is specifically intended to improve access to psychological therapy and since neither individual therapy nor CBT will meet the needs of all clients, it could be argued that PCPTs in IAPT services should be offered training, along with ongoing supervision and support, to develop their skills not only in CBT but also in couple and family therapy. If so, individual therapy of various kinds could be systemically informed and more couple and family therapy offered. This would increase client choice and broaden therapists’ skills repertoire, making services more accessible and adaptable to client need.

Training and supervision. There is evidence that training in family interventions should be integrated with services and change the culture in
which the trainees work (Burbach and Stanbridge, 2006; Fadden, 2006). This may be problematic in IAPT services, given the strong emphasis on individual CBT and the fact that in primary care teams are dispersed and therapists tend to work alone. On the other hand, IAPT services are becoming larger and more centralized, and there is a central commitment to training and supervision – albeit only for NICE-compliant therapies, such as BCT.

This study suggests that factors facilitating ‘thinking family’ include training and supervision in family therapy ideas. The model of training plus supervision to add on skills to existing advanced competencies, being used for IAPT training in BCT, could be applied more generally in IAPT services to promote ‘thinking family’. Encouraging systemically informed individual therapy might be more feasible and have a greater impact as a first step rather than encouraging staff to see couples and families, which generates anxiety and could be developed as a later step after skills development.

Most IAPT staff offer individual and CBT-based interventions and may be most readily able to apply systemic ideas to support the types of therapy in which they have advanced competencies. CBT and systemic therapy have areas of overlap, for example, in their joint emphasis on beliefs and the significance of interpersonal contingencies to understanding symptomatic behaviour (Bandura and Goldman, 1995) and the use of tasks and collaborative discussion of beliefs and their implications (Dallos and Draper, 2000). They have been successfully integrated (Crowe and Ridley, 2000; Williams, 2006). Family-based therapies are effective for depression and some anxiety disorders (agoraphobia with panic disorder and obsessive compulsive disorder) (Carr, 2009). IAPT low-intensity interventions support clients to use self-help materials, some of which take account of the impact of relationships on mood (Williams, 2006).

In my experience as a supervisor, a systemic perspective is of great value to IAPT staff, both to therapists offering high-intensity therapy such as CBT and counselling as well as psychological wellbeing practitioners offering low-intensity self-help interventions. For example, family members can usefully support individual therapy but may also inadvertently act in ways that maintain problems. Taking account of how clients’ behaviour is embedded in patterns of family interaction, expectations and beliefs can improve effectiveness. Introducing staff to systemic ideas in supervision enables them to reflect on and respond in new ways to commonly encountered clinical issues such as a client’s parent telephoning to express anxiety about their adult child
or a client reluctant to try a self-managed exposure programme, preferring to rely on a family member’s support. Demonstrating the value of systemic thinking and techniques has led to some IAPT staff wanting to learn more about family therapy ideas. Others prefer to continue working within their main model of therapy but have become more open to involving family members where this would enhance the effectiveness of interventions.

Clients would benefit if all PCPTs were supported to ‘think family’, whatever their therapeutic orientation. Developing the capacity to ‘think family’ when offering individual therapy might give PCPTs confidence, motivation and skills to see couples and families. Successful interventions involving more than one family member might be considered unique outcomes (White, 1989) that could challenge the negative beliefs and attitudes towards family therapy that were expressed by the participants in this study.

**Conclusion**

Eisler (2007) argued that the role of family members in treatment should be part of good practice since for many problems it improves engagement, outcomes and cost effectiveness. This article demonstrates that there are various opportunities within IAPT for at least couple therapy and, ideally, all types of systemic therapy, to be made more widely available. This could result in changed attitudes, not only among therapists but also in the wider system, especially if the routine outcome data collection integral to IAPT services demonstrates its effectiveness. Unfortunately, in the current context, funding for training and supervision in family therapy for all PCPTs outlined above is unlikely since IAPT resource provision is driven by NICE guidance for anxiety and depression. If couple and family therapy is offered on a very small scale, without staff training and supervision, and evaluated using inappropriate measures, it is doubtful how much impact it can make in the current context of CBT dominance.

It is important to remember that the barriers to couple and family therapy that currently appear to be so powerful, such as the dominance of CBT, cannot fully explain the distant relationship between couple and family therapy and primary care because for decades it has been rare for adult PCPTs to have a systemic perspective or do couple and family work. Since therapists in other adult mental health contexts and qualified family therapists in private practice also offer
predominantly individual therapy (Green, 1992), this is likely to reflect other influences in addition to those specific to PCPTs.

This pilot study tentatively suggests that PCPTs ‘think family’ from the perspective of their main therapeutic model when offering individual therapy. Both external and internal constraints may need to be addressed for them to more frequently see family members together.

IAPT is having a huge impact on primary care mental health services. It may either present a window of opportunity through which ‘thinking family’ and the provision of couple and family work can develop or it may make it even more marginalized than it is at present. The NHS choice agenda means that clients should be able to access a choice of evidence-based treatments including couple and family interventions in primary care. IAPT services should be supported to offer couple and family therapy, as they have been for CBT provision, with funding for increased capacity, training and ongoing supervision. All PCPTs should be offered training and supervision in family therapy ideas. More high-quality research into the effectiveness of couple and family therapy is needed and evidence already available should be disseminated within and beyond IAPT, as this is what drives funding. Without this, there is a risk that family-oriented individual therapy and couple and family interventions, the provision of which is already negligible, may become even more limited in the current political climate.

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