Chronic neurotic patients in general practice

A pilot study

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A RECENT morbidity survey of 46 practices in London confirmed the view that neurotic illness constitutes a large problem for the general practitioner. Referral to a psychiatrist was initiated in only a small minority of cases, influenced by such factors as the general practitioner's training, orientation towards psychiatry, relationship with and past experience of local psychiatric services (Shepherd *et al.* 1966). For most general practitioners, even those who use their local services freely, there remains a sizeable number of patients whose condition does not appear to warrant referral, but who are characterized by very frequent attendance at surgery for conditions in which organic symptomatology plays only a small part, or is inextricably overlaid by social and emotional factors. About half such cases are chronic: indeed, psychiatric cases whose symptoms have not remitted by the end of one year tend to have illnesses which continue for many years (Kedward 1968).

The general practitioner is thus faced with the management of apparently intractable conditions whose chronicity is a measure of their failure to respond to those methods of treatment available to him, mainly advice, support and symptomatic treatment. Referral to already overworked psychiatric departments may not be the most suitable course in dealing with these patients. It is perhaps time to see whether the extent of the problem they present to the medical services could be reduced by alternative means. A shift of focus from psychiatric symptoms to the social problems with which, in many cases, they are associated might prove a more effective approach.

Detailed examination and treatment of social problems is often time-consuming and complex and may require skills tangential to those acquired during medical training. Even general practitioners whose view of their rôle is essentially holistic often find themselves unable to devote as much time as they would wish to the social aspects of illness. Alternative means of treating the 'social pathology' of patients are being explored, and there is currently a great deal of interest in the development of social casework in general practice. Collins (1966) and Forman and Fairbairn (1968), for example, have reported favourably on the attachment of medical social workers to practices to deal with patients' social difficulties.

Before such procedures can be recommended on a large scale, investigation of the nature and extent of social problems among chronic neurotic patients must be made and the therapeutic effectiveness of social intervention evaluated.

The pilot study described in this paper is in preparation for a larger study of this question being undertaken in a number of London practices. The first, or observational, phase will examine whether chronic neurotic patients in general practice experience more social difficulty than other demographically comparable surgery attenders. Psychiatric state and social adjustment will be measured on clinical and social rating scales which

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have been developed for the purpose, and comparison made of the range of social problems and need for social help experienced by the two groups. In a later controlled therapeutic phase it is hoped to implement recommendations for social intervention where possible and evaluate the therapeutic efficacy of social action.

Aims of the pilot study

The pilot study was undertaken to make preliminary examination of the case material to be found in general practice and to test the practicability of the design and methods proposed for the first phase of the main study. It was hoped that the study would indicate the extent of social problems among chronic neurotic patients and would demonstrate, by comparison with a non-neurotic control group, whether the difficulties of the neurotics exceeded or differed in quality or severity from those of other surgery attenders. Assessment of the neurotics' need for help with social problems could then be made, and the practicability, probable effectiveness and most suitable type of social intervention considered in individual cases.

At the pilot stage, examination of the duration and severity of illness and the frequency of demands made by chronic neurotic patients on the medical services would help to define the clinical and administrative criteria necessary for the selection of patients in the study proper. The proposed method of identifying cases, selecting controls and making contact with both groups had to be tested, and the instruments which had been developed to measure psychiatric disorder and social dysfunction required a full trial in a general practice setting.

Design of the study

The social functioning and psychiatric state of a group of 20 general-practice patients defined as chronic neurotics were measured and compared with those of a matched control group. As it was essential for the social and psychiatric assessments to be independent of each other they were made by different persons on different occasions: the social interviewer had no knowledge of the patient's psychiatric state and the clinical assessment did not involve consideration of social functioning.

The control group, drawn from the same practice as the index cases, consisted of patients ideally resembling the neurotics in all respects other than psychiatric disorder. Since demographic characteristics determine to a significant extent the kind of social difficulties which may be experienced, close matching on as many demographic variables as possible was essential so that index and control patients could be shown to be exposed to approximately the same hazards to social functioning. Differences in the extent of social problems could not then be attributed simply to demographic dissimilarity. So many different factors appear to bear on the individual's ability to function satisfactorily that exact matching of all relevant characteristics could not be expected. Eight major demographic variables—age, sex, marital status, employment status, social class, number in household and number of children—were selected as probably the most significant items on which matching could be attempted.

Method

During the study period of one month, the general practitioner kept a daybook in which he recorded details of all patients seen. The research team of two psychiatrists and a social research worker were given the names of surgery attenders whom he regarded as suffering from neurotic illness, and whose condition had persisted for at least a year prior to the beginning of the study period. The medical records of these patients were scrutinized and the reason for and number of their consultations during the previous year were noted. Consent having first been obtained by the general practitioner, the patients were then interviewed. Social functioning was assessed during a home interview carried out by the social research worker without reference to the patient's illness. An

independent assessment of the patient's psychiatric condition was subsequently made by one of the psychiatrists in a separate clinical interview, which did not touch on social functioning. Control patients, matched with index cases for the demographic variables described above were then selected from current surgery attenders, screened to ensure freedom from psychiatric disorder and interviewed in the same way.

The instruments

The indices of psychiatric disorder and social dysfunction were measured by two separate instruments, a clinical and social interview schedule.

The clinical schedule consisted of a psychiatric interview administered by a trained psychiatrist. The interview is divided into two sections: the first is unstructured and deals with the patient's present illness and past history, while the second is semi-structured and deals with symptoms the patient has noticed in the previous week. The ten symptom areas were intended to cover the commonly encountered phenomena of psychiatric illness. In addition to somatic symptoms clearly related to psychological phenomena, the psychiatrist rates fatigue, sleep disturbance, irritability, lack of concentration, depression, anxiety, phobias, obsessions and compulsions and depersonalization. At the end of the interview, a further set of 12 ratings are made of manifest abnormalities observed by the psychiatrist. These are rather more comprehensive than the symptom ratings, and range from such commonly encountered abnormalities as depression and morbid anxiety to relatively less common features such as delusions, hallucinations and intellectual impairment.

The clinical schedule was specially developed for use in a general-practice setting but has been tested in a whole range of clinical situations from general-practice patients to inpatients in mental hospitals. The inter-rater reliability of the ten ratings of reported symptoms has been shown to be +0.95, while that for the manifest abnormalities has been shown to be +0.82.

In the present study the psychiatrist made an overall clinical assessment in addition to the detailed ratings described above. This assessment was on a 5-point severity scale, and ranged from 'normal' (rating 0) through all minor abnormalities stopping short of clinical significance (rating 1) to three degrees (ratings 2, 3 and 4) of clinically significant psychiatric disturbance. These three degrees were called mild, moderate and severe illness respectively, and covered a spectrum ranging from cases that were just over the threshold of clinical disturbance to those whose illness was such that they might reasonably have been referred for inpatient psychiatric treatment.

Independent assessment of social functioning was made by the social research worker using the social schedule. This was a semi-structured interview with the patient and an informant, preferably the spouse or a close relative, whose presence was intended to correct any bias due to illness in the patient's reporting of objective factors.

Measurement was made of the patient's social circumstances, functioning and adjustment by ratings of a number of social areas: housing, work, finance, leisure, social contacts, marriage and family life. Each item was rated on a 4-point scale ranging from 'satisfactory, no difficulties' (rating 0) to 'severe difficulties or dissatisfaction' (rating 3), and was assigned to one of three categories in which analysis of the data was to be made. These were:

1. 'Material conditions', which consisted of objective features such as housing conditions and income level.
2. 'Social functioning', concerned with the patient's ability to manage his social affairs and personal relationships, e.g., marital adjustment, interaction with neighbours, child management.
3. 'Satisfaction', evaluation of the patient's attitude towards such aspects of his situation as housing, occupation, social rôle, i.e. as retired person, housewife.

This tripartite division, it was hoped, would localize and clarify the patient's social

difficulties and indicate the most appropriate form that social intervention should take.

An inter-rater reliability study was carried out with the schedule and the agreement between raters was satisfactory ($r = 0.9$).

A more detailed account of the social schedule is in preparation.

The practice

The pilot study was carried out in a single-handed practice with a full list in South-east London. The majority of patients were drawn from the area immediately surrounding the doctor's surgery, a district of suburban lower-middle class housing and some light industry, traversed by an arterial road. The general practitioner's knowledge of his patients is extensive and longstanding, and is supplemented by that of his wife, who acts as his receptionist. He is held in universally high regard by his patients, and this proved invaluable in securing their co-operation, while his familiarity with the social background of each patient greatly facilitated the process of matching controls.

Results

Demographic features and problems of matching

Both index and control groups consisted of 15 women and five men. The preponderance of women reflects the findings of many other workers in this field. The age distribution of the women was representative of that of the general population while the small group of men were all under forty. Index patients were matched for age with controls within five years in four fifths of the cases, within six years in three and nine years in one. Eleven index patients were married and four single, three were widowed and two cohabiting. The first four groups were matched with controls of the same status and the separated woman was matched with a widow.

TABLE I

AGE, SEX AND MARITAL STATUS OF THE INDEX GROUP

Age	*Male*	*Female*	*Total*
Under 20	1	1	2
20–29	2	3	5
30–39	2	2	4
40–49	–	3	3
50–59	–	1	1
60–69	–	1	1
70–79	–	3	3
80–89	–	1	1

Marital status	*Male*	*Female*	*Total*
Single ..	2	2	4
Married ..	3	8	11
Widowed ..	0	3	3
Other ..	0	2	2

The great majority of patients was drawn from the Registrar General's Social Class III; two were in Class II and there was a small group of elderly widows who remained unclassified. All male patients, with the exception of one index case, who were undergoing a rehabilitation course at a training centre, were in full-time employment. Only one index and one control among the women were employed full-time. Two index and two control women were in part-time employment. Exact matching for the number in the patient's household was possible in only half the sample. Households of up to seven people were represented, but the largest single group of index patients (seven cases)

lived in households consisting of four people, usually their spouse and two children. Three patients lived alone and they were successfully matched with controls in the same situation.

Exact matching for number of children was possible in 12 cases, which included the four unmarried, childless patients. The woman with the largest family had had eight children, only half of whom were still at home. She was matched with a control with fewer children: exact matching was not considered essential where children had grown up and left home, except in the case of certain vulnerable groups such as elderly widows living alone, whose situation was thought to have important implications for the social services.

Clinical features

The psychiatric state of both groups was examined and the following diagnoses were made of patients in the chronic psychiatric group: Anxiety state (6); depression (5); phobic state (2); neurosis with somatic symptoms (2); neurosis—other (2); personality disorder (3). None were psychotic. Each patient was given an overall rating of severity of symptoms on the 5-point severity scale. All cases were of mild or moderate severity (ratings 2 and 3). One patient received a rating of 4, but this woman, who was severely depressed, had to be rejected from the study as it proved impossible to find a suitably matching control.

TABLE II

DIAGNOSIS AND RATINGS OF CLINICAL SEVERITY IN THE CHRONIC NEUROTIC GROUP
(The figures are for women, unless otherwise specified)

Severity ratings	*Diagnosis*					
	Anxiety state	*Depression*	*Personality disorder*	*Phobic state*	*Neurosis + somatic symptoms*	*Neurosis (other)*
2 (mild)	6 (1 male)	3	1 (male)	–	1	1 (male)
3 (moderate)	–	2	2 (1 male)	2 (1 male)	1	1

All index patients had been ill for at least a year, during which they had consulted the general practitioner on average 13 times. This was a minimum estimate as cards were missing from the records of two patients. The highest number of consultations by an individual patient was twenty-eight. Seventeen patients were currently receiving medication from the general practitioner, tranquillizers, anti-depressants or sedatives. None were under specialist treatment at the time of the study: four of the five men had previously been referred to psychiatrists while only three of the 15 women had ever received specialist treatment.

All the controls were adjudged free from psychiatric symptoms: two who were not accepted as controls and substitutes had to be selected. A further two were considered to be suffering from minor emotional disturbance falling short of psychiatric disorder. They were given a severity rating of 1 (minor disturbance within normal range). The remaining 18 controls received a rating of 0 (normal).

Social findings

The social circumstances, functioning and adjustment of the index and control groups were examined. The comparison revealed an excess of social problems among the chronic neurotic patients. Their material circumstances were inferior; they were functioning markedly less well than the controls and were more dissatisfied with their

situation. The total number of adverse ratings for items on the social schedule was greater for index than control patients and the index group received a larger proportion of the higher, more 'severe' ratings of 2 and 3. Rating 1 (minor difficulties) was fairly evenly distributed between the two groups, and the controls had a markedly greater number of 0 ratings (satisfactory, no difficulties).

TABLE III

RATINGS OF SOCIAL DYSFUNCTION

TOTAL NUMBER OF ADVERSE RATINGS (RATINGS 1–3) FOR INDEX AND CONTROL PATIENTS ACCORDING TO CATEGORY OF SOCIAL PROBLEM

Category	*Index cases*			*Control cases*		
	Male	*Female*	*Total*	*Male*	*Female*	*Total*
Material conditions ..	9	42	51	13	31	44
Social functioning ..	20	47	67	14	27	41
Satisfaction	5	27	32	9	13	22
Totals	34	116	150	36	71	107

TABLE IV

DISTRIBUTION OF RATINGS OF ITEMS ON THE SOCIAL SCHEDULE ACCORDING TO SEVERITY OF SOCIAL DYSFUNCTION

Severity rating	*Index cases*			*Control cases*		
	Male	*Female*	*Total*	*Male*	*Female*	*Total*
0	48	123	171	49	167	216
1	22	57	79	19	54	73
2	11	34	45	14	13	27
3	1	25	26	3	4	7

The differences were, however, entirely due to the excess of social problems experienced by the women. One of the most striking findings of the social analysis was the apparently different trends demonstrated by the male and female index cases when compared with controls of the same sex. The index males received a smaller number of adverse ratings in each of the three categories: that is, their material conditions were adjudged better, they functioned better and were more satisfied than the controls. The smallness of the male sample makes it difficult to comment on this finding. The figures given below refer only to the females.

Statistical significance was found in the differences between the total number of adverse ratings for female index and control groups. ($\chi^2 = 31.965$; d.f. 3; p 01) and the totals for the categories of Social Functioning and Satisfaction were significant at one per cent level. The index group also had a greater number of adverse ratings of material conditions, but these were not significant. Over all categories the higher ratings (2 and 3) were significantly concentrated in the index group.

Certain individual items on the social schedule discriminated between the groups to a statistically significant level. These were housing conditions, satisfaction with housing, interaction with neighbours and with relatives, opportunities for leisure and social activities, extent of leisure activities, satisfaction with leisure and satisfaction with

the rôle of housewife. There was a positive correlation between these items ($r = .45$), so that a dissatisfied housewife tended to have highly adverse ratings on the other items, half of which were of particular relevance to persons leading a predominantly house-centred existence.

Degree of social dysfunction, demonstrated by the sum of adverse ratings for each patient, was shown to be positively correlated with severity of psychiatric condition ($r = 0.56$).

Discussion

Independent clinical and social assessments found the index group to be suffering from a variety of neurotic disorders, accompanied in many cases by difficulties in the social field. The study, therefore, though small, pointed towards confirmation of the view that social difficulties are significantly correlated with chronic neurotic illness, though it must be stressed that examination of the chronological development or relationship between the two was not undertaken.

Materially, the circumstances of the index patients were somewhat inferior to those of the controls: though few families reported financial difficulties, they were worse housed and experienced more objective restrictions—from environmental factors, work or family commitments—on their opportunities to develop social contacts or leisure interests. Dysfunction in the group was amply demonstrated by limited or conflict-ridden relationships with neighbours, relatives and workmates, and an excess of problems with husbands and children. Satisfactory adjustment to life situation, measured by ratings of satisfaction or dissatisfaction with several of its important aspects such as housing, occupation and social rôle, was correspondingly less frequent among the psychiatric patients.

Although these remarks are borne out by the overall figures for both sexes, it will be seen that when the sexes are separated, they apply to the women only. The men's social functioning did not reflect their psychiatric disturbance, while the women were beset by social problems in all areas. The women, however, tended to have high scores on items which did not apply to the men, notably ' satisfaction with the rôle of housewife', or which, being concerned with the home, might be expected to have a greater effect on their day-to-day functioning than on that of the men. The discontented housewife was well represented in the sample and, as correlations between this and other items on the social schedule were made and found to be positive, appeared to present what might be termed a 'social syndrome', conforming in many respects to the type of 'suburban neurosis' described 30 years ago by Lord Taylor (Taylor 1938). The patient, discontented with her domestic lot, dissatisfied with her house, with poor or non-existent relationships with her neighbours and frequent tension with family members, led a restricted and unsatisfying life with few social contacts or outside interests. Eight of the 11 index housewives presented this picture with little variation in detail. It is interesting that two of the three index women who described themselves as satisfied housewives were over 70.

The discovery of a significant amount of social difficulties among the chronic neurotic patients does not inevitably imply that we consider that the social services should be mobilized in every case or that such action would unfailingly ameliorate symptoms which years of medical treatment had failed to improve. Some social problems, it is recognized, are intractable, others beyond the resources of society to deal with. However, this study is orientated towards the optimal deployment of medical and paramedical resources and the reduction of demands on the medical services which could more appropriately be met by the social services, a medical social worker or a joint sociomedical team. The index group, identified by the general practitioner and confirmed as neurotic by the psychiatric interview, had been ill for at least a year, some for many years, and their surgery attendances had been all too frequent. Although

some had improved after specialist or general-practitioner treatment, none were symptom-free at the time of interview, and almost all required continuous medication to keep their symptoms in check. These factors, together with the suggested association between the severity of symptoms and the extent of social disability, appear to justify the exploration of alternative forms of therapy and a shift of focus in management from the medical to the social.

Social problems and difficulties of adjustment having been located in the index group, our next task was to consider what proportion seemed likely to respond to social measures. Each case was re-examined by the research team to determine its suitability for social intervention and the most appropriate form that such help might take. At the pilot stage this was a hypothetical exercise only, as the research team was not in a position to implement its own recommendations; nevertheless, it was hoped to provide useful indications for future therapeutic and evaluative studies.

In just over half the index cases (12 patients) social intervention seemed likely to prove beneficial, and half of these were judged to be of some urgency where marked deterioration in psychiatric condition or possible family breakdown appeared imminent in the absence of social help. This, in fact, occurred in one case within a few weeks. In six cases, it was thought that the intervention of a medical social worker attached to the practice could have proved helpful to discuss the situation fully with the patient, allow the ventilation of worries and offer advice and continuing reassurance and support. This is not to imply usurpation of what many may regard as the traditional rôle of the general practitioner: this is neither desirable nor is it likely to be welcomed by the majority of patients. It involves rather the reconsideration from a fresh standpoint of problems which must in many cases have become old news to the general practitioner, their outlines blurred by over-familiarity, their chronicity apparently entrenched and unassailable. It must be remembered that for many patients the doctor represents the only professional person to whom they have ready—and economic—access. Thus, problems with which they are unable to cope unaided or are unwilling to discuss with friends or relatives are likely to be brought to him, but the context of the doctor-patient relationship may lead many to cloak social and domestic problems with medically respectable symptoms and requests for medication. The introduction of a social worker into the practice might permit social problems to be recognized as such, minimize lengthy temporizing and offer patients immediate access to sources of help more appropriate to their needs.

A combination of casework and practical help was recommended for six other patients. This included direction to appropriate social agencies, advice on employment, guidance with marital or child management problems, help with elderly relatives, etc. Recommendations for material help such as rehousing or supplementing income—which in the light of current resources must always be sparing—were only tentative. Although the index cases achieved a greater number of adverse ratings for housing conditions than the controls, in only two cases were conditions sufficiently extreme to justify rehousing. In both cases, and in several others where conditions left much to be desired, the problem of poor housing was secondary to other difficulties which seemed unlikely to be resolved by rehousing alone.

It did appear, however, that problems of relationship and adjustment constituted the greater proportion of the social difficulties of the chronic neurotic group, and it is these which, once established, are most difficult to modify without the expenditure of a great deal of time and effort by someone with special skills in the field of human relations. Even then success can hardly be guaranteed. Though the general practitioner has the advantage of wide experience, and in many cases, a comprehensive knowledge of the patient and his family extending over a number of years, the enforced brevity of their meetings in the surgery context precludes the use of this knowledge other than to inform

his judgment of the complaint, and reassure the patient of his continuing personal interest. Allied to the skills of the trained social worker with more time at her disposal and readier access to social service resources, this knowledge could be deployed to better therapeutic effect.

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The medical services of the future. Report by the East of Ireland Faculty of the Royal College of General Practitioners. *J. Irish med. Ass.* 1968. **61**, 382.

This report expresses concern "lest the tendency for health services to be divided into three separate parts, specialist and hospital services, public health services, and general practice, should continue because we believe that the best use of our resources depends on the reintegration of these separate parts: on teamwork based on mutual knowledge and respect".

The needs of the community and possible modifications of the various branches of the health service so as to provide for this rationalization are discussed in detail. A special plea is made for more group practice—a rarity in Ireland where professional isolation is still an unfortunate feature of general practice. The reasons for this are partly economic and partly geographical.

Drug defaulting in a general practice. A. M. W. PORTER, M.D., D.Obst.R.C.O.G. *Brit. med. J.* 1969. **1**, 218.

Four different groups of patients were observed closely to assess their adherence to drug schedules. These were—those taking part in a short-term drug trial, those taking courses of antibiotics in tablet form, those on long-term treatment and antenatal patients on oral iron.

The first three groups had a relatively small incidence of defaulting but this was higher in the antenatal group who were taking oral iron in divided doses daily. A subgroup of antenatal patients taking iron in a one dose daily form (Ferro-gadumet) were far more compliant.

Defaulting is more likely in socially isolated patients and those of poor education. The extent of this problem and its practical consequences are still not fully appreciated.