

How much child psychiatry does a general practitioner do?

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SUMMARY. Eleven general practitioners recorded information on relevant psychological and social factors on 1,127 consecutive attendances of children and adolescents under the age of 18 years. The proportion of 'pure' psychological problems was low (3.5 per cent of all attendances), but in 25.7 per cent of attendances a psychological component to the presenting problem existed. Non-specific 'emotional' problems were the most frequent psychological symptoms noted, but management problems in infancy and early childhood were also common. There were significant differences between practitioners in the proportion of 'purely physical' diagnoses made and in action taken at the time of attendance. The findings suggest that paediatric training of general practitioners should contain a considerable child psychiatric component.

Introduction

ALTHOUGH the recently published report of the Child Health Services Committee (1976) expresses the view that general practitioners should receive training in child psychiatry, there is a lack of information about the proportion of this work currently undertaken by family doctors. Child psychiatric problems are common in the general population (Rutter *et al.*, 1970) and it is reasonable to expect that family doctors will deal with them. Relevant studies have been carried out with adults (Cooper, 1973), but not with children.

Aim

We attempted to determine the proportion of work with

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© *Journal of the Royal College of General Practitioners*, 1978, 28, 621-626.

children currently being undertaken by general practitioners which had a significant psychological component.

Method

Eleven general practitioners in a socially mixed area in West London were approached and all agreed to cooperate. Eight were general-practitioner trainers who met fortnightly to study training methods in general practice, and the other three were colleagues or partners also with several years' experience. Each general practitioner filled in a questionnaire on every child who had not yet reached his eighteenth birthday who had been seen in a period of one month (May to June 1976). This covered every consultation including baby clinics and home visits. The questionnaire was devised in consultation with the general practitioners before the study began.

The questionnaire, which was completed during or immediately after attendance, recorded the age and sex of each child, whether attending school or not, and the date of each attendance. The general practitioner was asked to tick all relevant question boxes and leave blank those which were not relevant. The first ten boxes covered general consultation categories ranging from 'pure' physical symptoms to 'pure' psychological problems with no physical symptoms, attendance for a routine measure such as inoculation, developmental assessment at a well baby clinic, contraception, or other procedure. The follow-up visit could also be recorded as such. In addition there was a category for those attending with what was rated a minimal problem (one for which medical or psychiatric attention did not seem indicated if the presenting complaint was taken at face value).

The general practitioner was asked to assess the importance of the psychological factors when physical symptoms were present by marking "no significant psychological factors," for example, otitis media; "possible significant psychological factors," such as wheezing possibly due to stress on occasion; or "definite psychological factors".

The next nine boxes covered specific symptoms relevant to psychological or management problems. These consisted of feeding problems (including anorexia and obesity), sleep problems, wetting, antisocial problems (such as stealing or aggressive behaviour), developmental problems (slow motor or language development but excluding soiling or wetting), educational problems (for example, learning problems or mental retardation), emotional problems not otherwise specified (for example, anxiety or depression), and suicidal attempt or gesture. The doctor was also asked whether the mother or the family were known to have psychological problems, and if so then these were required to be specified.

In the next section of 15 questions the action taken by the general practitioner was noted. Drug therapy was recorded separately for mother and for child. Attempts to help by psychological means were divided into four categories: reassurance (suggest no cause for worry); opportunity to ventilate problem; advice to mother (telling her what to do); and psychotherapy, defined as an attempt to make patient or mother aware of motivation of which she was previously unaware. Referrals to paediatrician, child psychiatrist, social services department, health visitor, practice nurse, adult psychiatrist, or other health professional were recorded. Making a further appointment and any other form of treatment could also be recorded.

A record was kept of whether the child attended alone, with mother, with both parents, or with another relative or friend. Finally, ethnic group was categorized in five sections as indigenous, Irish, West Indian, Indian, and other.

Before the main study began there were discussions and piloting of forms with the general practitioners taking part to ensure uniformity of use of the questionnaire. One of the authors (V.B.) was available for discussion of rating problems as the study proceeded.

Table 1. Frequencies of diagnostic categories as recorded by general practitioners.

Diagnosis	Number of times recorded	Percentage of total consultations
Physical 1	650	57.7
2	183	16.2
3	74	6.6
Minimal problem	104	9.2
Follow-up	96	8.5
Developmental assessment	55	4.9
Inoculation	46	4.1
Psychological	40	3.5
Other	36	3.2
Contraception	5	0.4

Results

During the month, 981 children were seen in 1,127 consultations (Table 1). Of these, the majority (57.7 per cent) were consultations for physical symptoms with no important psychological factors (physical 1).

A minority consulted for routine measures—inoculation (4.1 per cent); developmental assessment (4.9 per cent); contraception (0.4 per cent); other (3.2 per cent); and follow-up when recovered (8.5 per cent).

In 3.5 per cent of consultations a 'pure' psychological problem was noted; physical symptoms with definite psychological factors (physical 3) in 6.6 per cent; physical symptoms with possible important psychological factors (physical 2) in 16.2 per cent; and a minimal problem (physical or psychological) in 9.2 per cent. More than one category was ticked in 152 cases—13.5 per cent of all consultations.

These categories can also be expressed in terms of cumulative loading of the psychological element (Table 2). 'Pure' psychological problems and physical symptoms with definite psychological factors together amounted to 9.8 per cent of consultations. When those with possible psychological factors were added, this amounted to 25.7 per cent of consultations. By including those with minimal problems the proportion rose to 31.6 per cent; and for those consultations where psychological problems in the mother or family were added, the cumulative frequency was 48.4 per cent.

The distribution by age and sex of the 1,127 consultations is shown in Figure 1. The attendance rate is highest in infancy, but an increasing attendance rate is noted in girls aged 15 to 17. The gradient of increase here was statistically significant ($p < 0.025$).

The initial diagnostic categories were then regrouped

Table 2. Consultations classified cumulatively in classes of decreasing psychological content.

Classification	Number of times recorded	Percentage of total consultations
Psychological	40	3.5
Psychological or physical 3	110	9.8
Psychological or physical 3 or physical 2	290	25.7
Psychological or physical 3 or physical 2 or minimal	356	31.6
Psychological or physical 3 or 2 or minimal or psycho-social problem in mother or family	546	48.4

into five main categories of reasons for attendance in order to make comparisons.

Those attending for routine measure or follow-up only were grouped together as a "routine" group; those with physical symptoms with no psychological factors and those with physical symptoms with possible psychological factors were grouped together and designated a "mainly physical" group; those with pure psychological problems or physical symptoms with definite psychological factors were designated a "mainly psychological" group; those with minimal problems alone or in combination with psychological, physical, or other categories were designated a "minimal" problem group; and a small group comprising combinations of routine follow-up, physical, or psychological problems was designated a "mixed group". Each consultation was classified in only one of the above five groups.

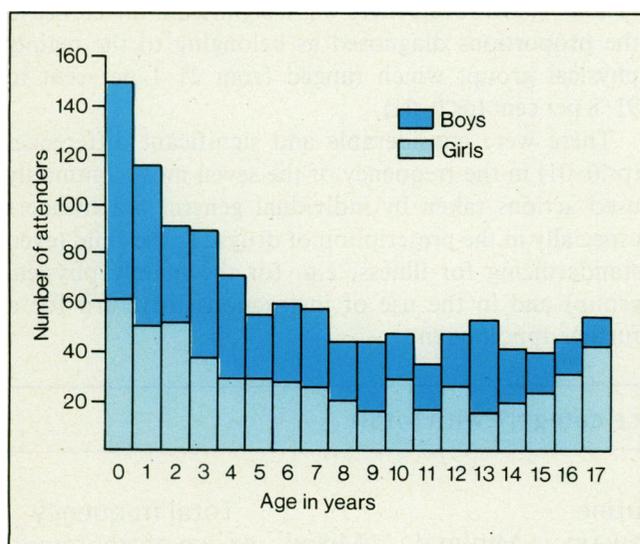


Figure 1. Distribution by age and sex of the 1,127 attenders.

Table 3. Consultations classified into five attendance categories (with sex ratio).

Attendance category	Number	Percentage of total consultations	Sex ratio % boys : % girls
Mainly physical	717	63.6	51 : 49
Mainly psychological	78	6.9	44 : 56
Routine	177	15.7	59 : 41
Minimal	104	9.2	52 : 48
Mixed	51	4.5	53 : 47
Total	1,127	100.0	52 : 48

Sex distributions do not differ significantly from expected.

It was found that there were no significant differences in sex distribution within the above groups. There were more girls than boys in the mainly psychological group, although this did not reach the five per cent level of significance (Table 3).

Compared with the overall total, a significantly higher proportion (76.9 per cent compared with 36.9 per cent; $p < 0.01$) of the mainly psychological group had psychological problems in the mother, or in the family, or in both. Those with minimal problems also had a higher proportion (67.3 per cent) of psychological problems noted ($p < 0.01$) than the attenders as a whole (Table 4) and in these there was a tendency for the psychological problem to be in the mother alone rather than in other members of the family.

Table 4. Psychosocial problems in mother or family.

Attendance category	Psychosocial problems	Total number in attendance category
Mainly physical	221 (30.8)	717
Mainly psychological	*60 (76.9)	78
Routine	45 (25.4)	177
Minimal	*70 (67.3)	104
Mixed	20 (39.2)	51
Total	416 (36.9)	1,127

* $p < 0.01$.

The proportion of each attendance category which exhibits psychosocial problems is given as a percentage.

Table 5. Frequency distribution of child psychiatric symptoms with sex ratio.

Symptom	Frequency as percentage of total attendances	Frequency	Sex ratio % boys : % girls
Emotional	9.1	103	*36 : 64
Feeding	4.1	46	54 : 46
Sleeping	3.7	42	55 : 45
Antisocial	2.2	25	72 : 28
Developmental	1.9	21	71 : 29
Educational	1.9	21	48 : 52
Wetting	1.6	18	67 : 33
Soiling	0.1	1	NA
Suicidal	0.1	1	NA

* $p < 0.01$.

Of the specific symptoms of psychological or management problems, the most commonly noted was a non-specific emotional problem. This occurred in 9.1 per cent of all consultations and was significantly more common in girls ($p < 0.01$; Table 5). Feeding problems occurred in 4.1 per cent of all consultations and sleeping difficulties in 3.7 per cent. Antisocial problems occurred in 2.2 per cent. Only one child was soiling and only 1.6 per cent wetting; educational and developmental problems occurred in 1.9 per cent in each case.

Recordings of school attendance were often omitted and it became clear that few general practitioners were aware of school attendance difficulties, especially truanting. It was also noteworthy that there were more consultations for pregnancy (11) than for contraceptive advice (five).

When the action taken was examined, it was found that drugs were prescribed for the child in 60.9 per cent of all consultations. Drugs were prescribed for 76.8 per cent of children in the mainly physical group and for 46.2 per cent of those in the mainly psychological group (Table 6). Reassurance was used more often for those with minimal problems (45.2 per cent) than for those in other categories ($p < 0.01$).

Opportunity to ventilate the problem was more commonly used for the psychological group (55.1 per cent) and for those with minimal problems (34.6 per cent). Psychotherapy was used for 23.1 per cent of those with psychological problems but only for those

minimal problems where there was also a psychological problem.

The children referred elsewhere (7.6 per cent) included referrals for x-ray, pathology, pregnancy testing, and to antenatal clinics. Referral to a paediatrician occurred in 15 consultations (1.3 per cent of total consultations) and five consultations (0.4 per cent of the total) resulted in referral to a child psychiatrist. There were no referrals to an adult psychiatrist, one referral to a social services department, and 10 referrals (0.9 per cent) to a health visitor of which six were for mainly psychological problems. In 55.7 per cent of consultations more than one action was taken.

The distribution of a diagnostic category used by different general practitioners (or diagnostic profile) was found to be not significantly different in the proportion of patients placed in the mainly psychological group, although the proportion diagnosed as mainly psychological did range from nil to 11.8 per cent (Table 7). However, there was a significant difference in the proportions diagnosed as belonging to the mainly physical group, which ranged from 21.1 per cent to 91.8 per cent ($p < 0.01$).

There were considerable and significant differences ($p < 0.01$) in the frequency of the seven most commonly used actions taken by individual general practitioners especially in the prescription of drugs for the child (even standardizing for illness, e.g. for the mainly physical group) and in the use of instructions to return for a further appointment.

Table 6. Frequency of treatments within each attendance category with totals.

Treatment	Mainly physical n = 717	Mainly psycho- logical n = 78	Routine follow-up n = 177	Minimal n = 104	Mixed n = 51	Total frequency of use of treatment n = 1,127
Drugs for child	551 (76.8)	36 (46.2)	19 (10.7)	52 (50.0)	28 (54.9)	686 (60.9)
Drugs for mother	7 (1.0)	5 (6.4)	0	2 (1.9)	0	14 (1.2)
Reassurance	117 (16.3)	14 (17.9)	14 (7.9)	*47 (45.2)	10 (19.6)	202 (17.9)
Ventilation	92 (12.8)	*43 (55.1)	21 (11.9)	*36 (34.6)	10 (19.6)	202 (17.9)
Advice to mother	136 (19.0)	21 (26.9)	21 (11.9)	28 (26.9)	9 (17.6)	215 (19.1)
Psychotherapy	9 (1.2)	18 (23.1)	2 (1.1)	16 (15.4)	2 (3.9)	47 (4.1)
<i>Referred</i>						
Paediatrics	10 (1.4)	4 (5.1)	0	0	1 (2.0)	15 (1.3)
Child psychiatry	1 (0.1)	3 (3.8)	0	1 (1.0)	0	5 (0.4)
Adult psychiatry	0	0	0	0	0	0
Social services	0	1 (1.3)	0	0	0	1 (0.1)
Health visitor	3 (0.4)	6 (7.7)	0	1 (1.0)	0	10 (0.9)
Nurse	1 (0.1)	0	0	0	0	1 (0.1)
Other	53 (7.4)	12 (15.4)	6 (3.4)	7 (6.7)	8 (15.7)	86 (7.6)
Follow-up appointment	169 (23.6)	25 (32.1)	79 (44.6)	24 (23.1)	22 (43.1)	319 (28.3)
Other treatment	18 (2.5)	4 (5.1)	5 (2.8)	5 (4.8)	1 (2.0)	33 (2.9)

* $p < 0.01$.

The proportions of children in each attendance category who were given a treatment appear as percentages of the total number of children in the attendance category. In the "total" column the percentages are based on the total number of consultations. In both cases the percentages add up to more than one hundred as some children are given more than one treatment.

Table 7. Profiles of the general practitioners—distribution of each general practitioner's total consultations over the five attendance categories (as percentages).

General practitioner	Mainly* physical	Mainly psychological	Routine	Minimal	Mixed	Total number of consultations
1	91.8	0.0	3.5	3.5	1.2	85
2	68.3	9.8	4.9	9.7	7.3	41
3	52.1	11.0	21.9	6.9	8.2	73
4	21.1	2.6	5.3	67.2	3.9	76
5	77.8	8.9	13.3	0.0	0.0	45
6	48.3	5.9	36.8	1.8	7.1	269
7	80.6	6.5	2.2	5.4	5.4	93
8	73.5	11.8	6.9	5.9	2.0	102
9	78.6	8.0	7.1	2.7	3.6	112
10	69.8	3.7	11.6	5.9	8.1	86
11	64.8	9.0	13.8	11.8	0.7	145

* $p < 0.01$.

Discussion

The main finding is the high proportion of child attendances in which psychological or social factors appear to be relevant. Although 'pure' psychological problems occurred in only 3.5 per cent of all consultations, when those with physical symptoms and possibly important psychological factors were added, the proportion was 25.7 per cent. If those with minimal problems are also considered to have a psychological aspect and are added, the proportion becomes 31.6 per cent; and if those not already included where there were psychological problems present in the mother or family were added, almost half (48.4 per cent) of all consultations had some sort of psychological or psychosocial aspect recognized and considered. This represents a considerable proportion of all child attendances.

There are, however, various problems in accepting these findings at face value. Although considerable efforts were made to ensure uniformity between doctors in filling in the forms, it was not possible to incorporate an independent check to assess how well this was achieved. It is likely that some variability did exist, particularly in categories such as "psychological problems in the mother" which were difficult to define. Furthermore, even if complete uniformity had been achieved, there remains the problem of knowing how valid is a standardized judgement of, for example, the relevance of psychological factors in a physical illness.

The variation between general practitioners in the way they used different diagnostic categories may have been due also to differences in their training, their diagnostic acumen or sensitivity, or to some degree of self-selection of patients for each general practitioner. There is presumably a degree of self-selection of patients which is partly due, perhaps, to the fact that patients learn from their doctors what symptoms they

find interesting and which symptoms give concern. In the absence of base-rates of childhood health problems for each general practitioner over the period in question, it is not possible to decide which of these explanations is most probable.

Although classification of child psychiatric disorders has recently been clarified and improved (Rutter *et al.*, 1975), there are particular difficulties in classification of disorders seen in general practice which are by no means peculiar to child psychiatry. While some patients present with clearly identifiable illnesses or mental health problems, others present with complaints which are relatively undefined and do not fit easily into those categories which are perhaps appropriate for a higher proportion of patients seen in hospital.

In this study the undefined complaints have been referred to as "minimal problems". This should not be taken to mean that they are thought trivial or unimportant, but merely that the presenting complaint alone did not provide sufficient grounds for a medical attendance. This concept is related to that referred to by others as, for example, "unorganized illness" (Balint, 1964), "undifferentiated illness" (Central Health Services Council, 1971), and "undiagnosed illness in the 'temporarily dependent patient'" (Thomas, 1974).

A "minimal problem" occurred in 9.2 per cent of all the consultations. In contrast to Thomas's observations of temporarily dependent patients in general practice who were not found to differ from a diagnosed group in psychosocial status, those with minimal problems in this study differ significantly ($p < 0.01$) from other consultations especially with regard to the high proportion (67.3 per cent) who have psychosocial problems noted in the mother or family. In this they resemble the mainly psychological group, of whom 76.9 per cent have psychosocial problems, rather than the mainly physical group of whom 30.8 per cent have psychosocial

problems noted in the mother or family. There was a tendency for the psychosocial problems to be found in the mother rather than in the family of those with minimal problems, which might imply that the mother is using the child as an admission ticket. Could this minimal group be considered as a group with incipient or borderline psychological problems? Certainly the action taken by the general practitioner was similar to that taken for the mainly psychological group in that ventilation of the problem was often used, and sometimes psychotherapy, but there was a difference in the high proportion (45.2 per cent) for whom reassurance was used. In any case, these findings support Balint's view that undifferentiated illness needs further exploration and that perhaps the focus should be on the psychological aspects of the problem.

Preventive medicine

It should also be noted that an important proportion of child attendance occurs for preventive reasons such as developmental screening or inoculations at well baby clinics. Such attendances provide the general practitioner with opportunities for counselling which has been claimed to be effective in the prevention of bedwetting (Brazelton, 1962) and other childhood behaviour problems (Cullen, 1976).

Studies of the prevalence of child psychological problems in the community have suggested that, in one year, this varies between five per cent and ten per cent of the population at risk (Child Health Services Committee, 1976). Only a minority of children are taken to family doctors and currently these visits are seen as variably helpful (Rutter *et al.*, 1970). Of course, appropriate management after attending the general practitioner may be most suitably carried out by referral to another agency, and it was therefore interesting to note how few such referrals occurred, and when this did happen, how often the health visitor, with whom the general practitioner has closest professional contact, is involved. It is uncertain whether the rarity of non-medical referrals, for instance to social service departments, is due to ignorance of the roles such agencies can play, to lack of knowledge of how to make referrals, or to experience that when referrals are made the outcome is not likely to be helpful to the patient.

Conclusion

We conclude that the pattern of paediatric work currently undertaken by general practitioners supports the view that the development of skills in coping with psychological problems in childhood should form an important component of training. This view is in accord with that expressed in a report of a Joint Working Party of the British Paediatric Association and the Royal College of General Practitioners (1976). Further work needs to be carried out to assess how to improve and evaluate the effectiveness of general-practitioner management of such problems.

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Acknowledgements

We thank Drs A. Bailey, D. Cowper, E. Dennys, A. Evans, M. Fraenkel, C. Myerson, A. Poteliakhoff, J. Scriven, D. Stayte, B. Tanner and S. Vakil who co-operated so willingly in the study, and also Mr J. Hartshorn who provided statistical and computer assistance.

Addendum

Copies of the questionnaire are available from Dr Bailey at the Department of Child Psychiatry, St George's Hospital, London SW17.

Collection of medicines by children

Concerted action by all retail pharmacists in their dealings with young children would bring to the attention of the general public the importance of keeping medicine away from children.

As stated in a letter from Mr Salim Jiwa (*Pharmaceutical Journal*, 1977, February 5, p. 90), it is a common situation for a mother to encourage her child to collect prescription medicines in the mother's presence. This situation is dealt with by handing the medicines only to the parent, and staff should be instructed to do the same. Prescription medicines (other than antibiotics) should not be handed out to young children—with or without their parents.

If the supply of medicine is urgent and the prescription is brought in by a young child, it can be delivered after closing the shop. This is an extremely rare occurrence, as our customers seem to have got the message that we do not sell, or hand over, medicines to children. If all pharmacists followed the same practice, there would be no problem with prescription medicines.

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