Problem behaviour in primary health care

H. LAMBERTS, MD, PH.D
General Practitioner, Ommoord Health Centre, Rotterdam, The Netherlands

SUMMARY. Primary health care can be regarded as the boundary between society as a whole and the medical system. Many of the problems patients bring to doctors in primary care are concerned with their personalities and life situation, and can be considered together as problems of human behaviour.

On being questioned in a waiting room, 15 per cent of patients considered their problem "psychosocial only", and an additional 13 to 14 per cent "both somatic and psychosocial".

I believe that the concept of the primary health care team is particularly valuable in managing problems of behaviour, and non-doctor members of the team play a crucial role.

In my opinion it is questionable whether people's life problems should be channelled through primary health care, but in the meanwhile it seems clear that in most western societies the fact is they are.

Human beings are endlessly ingenious about promoting their own misery. Even in catastrophe mysterious barriers can isolate them, barriers of fear and suspicion and sheer stupid moral incompetence.

Iris Murdoch (1976).

Introduction

LIFE is not easy and often even rather painful. Sometimes people treat other people very badly indeed.

In many countries the medical system is the institutionalized outlet for people who are either unable or unwilling to cope with their lives. They do so by adopting the sick role, with all its attendant privileges and duties. The community accepts the physician as the approved instrument for resolving such conflicts. The physician usually accepts this and in doing so helps society to maintain its equilibrium.

© *Journal of the Royal College of General Practitioners*, 1979, **29**, 331-335.

Many have condemned this medicalization of the problems of life, especially when these problems are misnamed 'disease' (Illich, 1974). We have to be fully aware of the social consequences of giving a medical label to what is really a life problem. It constitutes a major health care dilemma in that a diagnostic label in psychiatric terms may in itself adversely affect therapy and prognosis. Szasz (1973) maintains that mental illness is a metaphorical disease: "Bodily illness stands in the same relation to mental illness as a defective television set stands to a bad television programme".

Primary health care

Primary health care can be seen as the boundary between the medical system and society. It is all too easy to label people's problems with medical terms like 'neurotic personality', 'neurasthenic reaction', and 'depression'. These labels are characteristic of the care provider as a member of a professional group, and a particular strategy or treatment (or indeed its absence) is inherent in each of them. By definition a 'psychiatric' diagnosis can never be a part of the frame of reference of the general practitioner.

Primary health care has a cultural function, which varies strongly between countries. This cultural function becomes clear when people without a somatic disease but with life problems, emotional problems, or various heterogeneous, vague, or 'functional' complaints enter the medical system.

Aim

I wish to describe the concept of problem behaviour as we see it in the Ommoord Health Centre near Rotterdam, to describe our findings, and to set them within a broader international context.

Ommoord Health Centre

We have had a multidisciplinary primary health care team for 10 years in our health centre in Ommoord and Figure 1 shows the composition of the team on 1 January 1978.

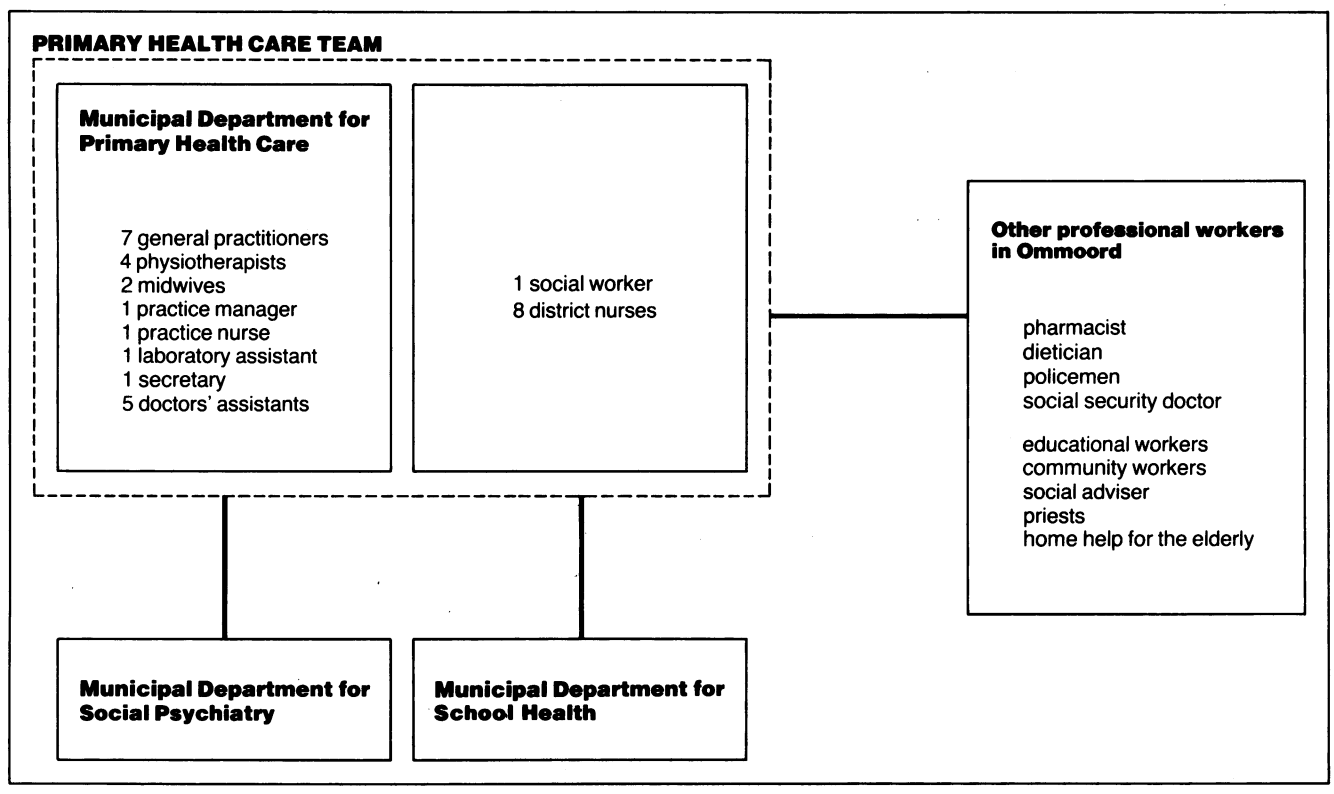

Figure 1. *Composition of the primary health care team at Ommoord Health Centre.*

Concept of problem behaviour

Problem behaviour can be differentiated from illness behaviour. It is well known that not all people with an illness or illness feeling show 'illness behaviour'. Illness behaviour relates to those occasions where someone, assuming he is suffering from an illness and is needing professional help, adopts the role of patient and seeks help from a professional. It is common knowledge that an impressive amount of illness behaviour cannot be explained on the basis of detectable disease. Figure 2 shows the overlap between the concepts of illness, illness feeling, illness behaviour, and problem behaviour.

Problem behaviour is the behaviour of the patient in his contact with a general practitioner (or other care provider) where it is clear to both of them that a life problem is being discussed which so far is differentiated from illness behaviour.

Results

What is the extent of problem behaviour in the daily content of primary health care? In 1972, four general practitioners diagnosed approximately 30,000 diseases, problems, or otherwise in their daily contacts with approximately 11,000 patients during that year (Table 1).

We tried to discern the form and the content of problem behaviour. Form has to do with anxiety, depression, and neurasthenic reactions, whereas content is focussed on the actual problem (Table 2).

The prevalence and presentation of psychosocial problems are summarized in Tables 3 and 4.

What does the patient think?

An important question which needed to be asked was whether the diagnosis 'problem behaviour' was accepted by the patient or not.

In 1976, 272 adult patients were interviewed in the waiting room, when they were asked: "What is the nature of the problem you are going to see your doctor about?" The same question was repeated after the consultation: "What actually was the nature of your problem?" The general practitioner was asked after the consultation: "What do you think the patient's answer will be?" The results are summarized in Table 5.

We also decided to estimate the relationship between several providers of psycho-therapeutic care per 1,000 patients of the practice population per year. The results are shown in Table 6.

Table 7 shows our findings from a follow-up of 400 patients with problem behaviour in 1972. Group A includes 100 randomly selected patients with problem behaviour from each of the four practices. Group B (50 from each practice, matched to group A for age and sex) consists of individuals without problem behaviour in 1972.

During the year before 1972 and the year after it we registered the percentages, showing problem behaviour in each period. There seems to be a hard core of people for whom life problems form a more or less continuous

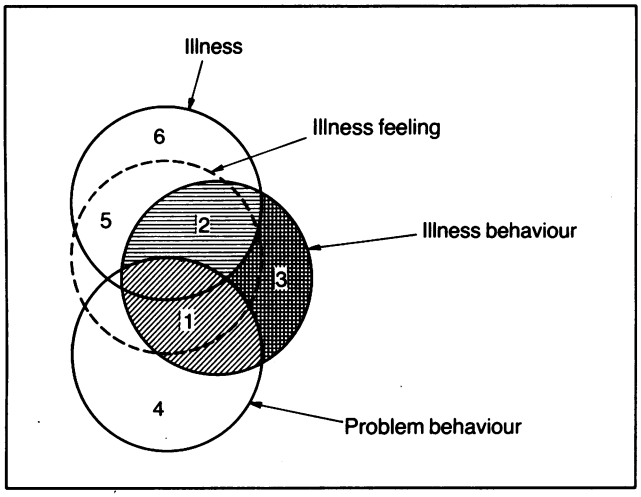

Figure 2. *Diagram showing relationship between illness, illness feeling, illness behaviour, and problem behaviour.*

1. Illness behaviour that is also problem behaviour.
2. Illness behaviour on the basis of illness; no problem behaviour.
3. Illness behaviour without illness; no problem behaviour.
4. Problem behaviour but no illness behaviour.
5. Illness and feeling ill, but not showing illness behaviour.
6. Illness without illness feeling and without illness behaviour.

Table 1. 30,000 classifications of problems in primary health care in 1972 (N = 10,794).

	Percentages
Clear, somatic diagnosis	*41*
Chronic impairment of daily life activities	*5*
Problem behaviour and psychological reactions	*31*
Reaction forms	*6*
Psychosomatic diseases	*6*
Clear problems of life	*7*
Functional complaints	*11*
Procedural	*10*
Vague, unclear	*18*

basis for frequent contacts with their general practitioner. In group A, 23 per cent showed problem behaviour in all four periods, and another 24 per cent during three periods. So in about half of the cases the patient and the general practitioner continued their shared problem behaviour for at least three years.

In addition, the content of problem behaviour did not change in about 80 per cent of people (no change in problem classification). It is not surprising that the idea of an 'umbilical cord syndrome' between doctor and patient was introduced, that is, the desire of the provider to counsel patients with certain problems, partially because of his own personal needs; over a longer period.

Table 2. Differentiation of life problems (per 1,000 patients per year) (N = 10,794).

Relationship problem	
'Man/wife' (not sexual)	33
Other family members (parents, parents in law)	7
'Man/wife' (sexual)	21
In the family (children/parents)	24
Work problem	31
School, emancipation, education	8
Crisis situations	17
Phase of life	8
Other well defined problems	30

Table 3. Comparison of prevalences.

	Prevalence per 1,000 persons per year		
	Ommoord 1972	Netherlands 1967	England 1971
Types of reaction	173	72	83
Life problems	183	5	±8
Problems about young children	33	—	—
'Psychosomatic'	144	101	133
'Functional disorders'	305	188	152
'True' psychiatry	7	5	8

Discussion

It is clear that our results as far as psychological symptoms are concerned cannot be considered exceptional, although the divergence in the figures presented is striking. The prevalence of life problems, however, in primary medical care appears to be relatively little known because it has been relatively little investigated.

It might be said that I am describing something which, although of great interest and like a self-fulfilling prophecy, has nothing to do with everyday reality. However, the occurrence of problem behaviour has some of the characteristics of a self-fulfilling prophecy both when its existence is ignored and when attention is focussed explicitly on its possible presence. Reality—or a diagnosis—is not entirely objective like a hard, unchangeable stone over which we can stumble: it is constituted in the contact between people.

The basic criterion for the diagnosis of problem behaviour is a meeting between someone with a problem and a professional care provider entitled by his specific frame of reference and also by his legal right to endow people and their problems with labels. Their open contact implies that the interchange of reactions and opinions between patient and doctor have the characteristics of negotiating about the problem and of exchanging mutual estimates of its importance.

Table 4. Prevalence of psychosocial problems in primary medical care.

	Men	Women	Total	Remarks
Lamberts, 1974, 1975 (Ommoord Netherlands)			18	All ages, entire practice population
Cooper *et al.*, 1969 (UK)	6	17		15 years and older
Hodgkin, 1973 (UK)			10	All ages, entire practice population
Johnstone and Goldberg, 1976 (UK)			32	Adults in waiting room
Martin *et al.*, 1957 (UK)			4	All ages, entire practice population
Morbidity Survey (RCGP *et al.*, 1974) (UK)			11	All ages, entire practice population
Oliemans, 1969 (Netherlands)			7	All ages, entire practice population
Stewart *et al.*, 1975 (USA)		22		Adult women
Wolfe and Badgley, 1972 (Canada)			20	Only patients with at least one contact

Table 5. "What is the nature of your problem?" (Percentages) (N = 272)

	Before (expectation)	After (experience)	General practitioner
Somatic only	*52*	*56*	*60*
Both somatic and psychosocial	*14*	*13*	*26*
Psychosocial only	*15*	*15*	*8*
No answer	*19*	*15*	*6*

Table 6. Estimate of psychotherapeutic relationship per 1,000 patients of the practice population per year between several providers.

General practitioner	180
Physiotherapists	50
Nurses—well baby clinics	20
—home care	15
Social worker	9
Mental health agencies, psychiatrists, mental hospitals	16

In some countries, such as UK and the Netherlands, open access is the hallmark of good general practice, particularly as it has strong connections with the cultural conditions in which primary care flourishes. In other countries, such as the USA, the characteristics of closed contact are not experienced as inherent contradictions for primary health care.

Outcome of problem behaviour

The diagnosis of problem behaviour implies a choice of three types of outcome:

1. Psychotherapy by someone in the team or someone else (referral).

2. Drug treatment, usually in conjunction with psychotherapy.

3. 'Doing nothing', that is, explaining to the patient that his problem does not fit into the socio-medical system and that he is much better off outside it.

There is no good reason to defend any particular psychotherapeutic technique in primary care on grounds other than those of personal preference of the provider. Truax and Carkhuff (1969) made it clear that whatever the technique used, three essential qualities were necessary: accurate empathy, non-possessive warmth, and genuineness. Within this approach it becomes clear that not only the general practitioner but all members of the primary care team can rightfully claim their share of responsibility for psychotherapeutic activities. In fact it is especially the concept of problem behaviour which forms a major incentive and lasting basis for team work (Table 6).

Outcome of psychotherapy

A vast literature describes the outcome of psychotherapy, all stemming from the classic work of Eysenck (1952). He stated that of all 'neurotic' complaints or 'neurotic' behaviour 70 per cent disappeared spontaneously within two years and 90 per cent in five.

After Eysenck many others, such as Truax and Carkhuff (1969), have come to the same conclusion: that there is no good evidence to show that psychotherapy is any better than the spontaneous remission rate.

More recent literature tries to differentiate between the numerous aspects of the structure, process, and various specified aspects of outcome. What specific intervention produces what change in what specific patient in what circumstances, and what was the original goal? Goal attainment scaling, regression towards the mean or the 'hello/goodbye' effect, the opinion of the patient, and the difference from that of the therapist, symptomatic changes, short instead of long therapy, and the making of a contract are all aspects of this development.

Table 7. Follow-up of 400 patients with problem behaviour in 1972. (Percentages.)

	1971	1972	1973	1974
Group A—total	*60*	*100*	*46*	*39*
—Doctor A	*52*	*100*	*43*	*42*
—Doctor B	*61*	*100*	*36*	*36*
—Doctor C	*74*	*100*	*51*	*33*
—Doctor D	*60*	*100*	*53*	*47*
Group B—total (control)	*17*	*0*	*9*	*13*

Conclusion

Problem behaviour is one of the major 'form factors' of primary health care because it is the strongest single predictor of primary care use and because it makes the cultural function of primary care clear.

Furthermore it has been shown that a part of illness behaviour where no illness can be detected can be defined and managed in such a way that it forms an essential part of the professional frame of reference for primary care providers. It is particularly important for the team concept of care, for the aspirations to fight medicalization of society, over-professionalization, and over-specialization to discern problem behaviour as an essential entity.

If we are to succeed in our aim of containing problem behaviour within the limits of primary medical care, we must adopt a much less negative approach towards people with psychosocial problems and devious behaviour.

The lack of clear evidence of proven positive outcome of psychotherapy in general, the sometimes negative or harmful aspects of mental health care, the impact on the patient of labelling, the lack of specificity of therapies, and the painful aspects of intake procedures represent just some of the negative aspects of organized mental health care.

I do not want to deny an important part of the care to people with problems and obvious psychiatric diseases by organized mental health care and psychiatrists. But psychiatric care should be undertaken only when the possibilities and the opportunities in primary care have been explicitly exhausted.

However, it is questionable whether life problems should be channelled in the primary health care setting in the first place. Primary health care is, or should be, the boundary or entry point between medical system and society. It should be the place where both powerful systems are linked in the first instance and where they can move in relation to each other. Problem behaviour can be one of the main lubricants of this joint.

It is a moral, political, cultural, and finally a medical question in what way society wishes to cope with the sorrow and pain of its members. For this reason important international differences in general practice and primary health care are to be expected. But however extensive these differences, an essential notion exists as to what is good general practice, whatever the cultural context, and what is not.

References

Cooper, B., Fry, J. & Kalton, G. (1969). A longitudinal study of psychiatric morbidity in a general practice population. *British Journal of Preventive Social Medicine,* **23**, 210-217.

Eysenck, H. J. (1952). The effects of psychotherapy: an evaluation. *Journal of Consulting Psychology,* **16**, 319-324.

Hodgkin, K. (1973). *Towards Earlier Diagnosis.* (3rd edn). London: Churchill Livingstone.

Illich, I. (1974). *Medical Nemesis.* London: Calder and Boyars.

Johnstone, A. & Goldberg, D. (1976). Psychiatric screening in general practice. *Lancet,* **1**, 605-608.

Lamberts, H. (1974, 1975). De morbiditeitsanalyse—1972 door de groepspraktijk Ommoord: een nieuwe ordening van ziekte—en probleemgedrag voor de huisartsgeneeskunde. *Huisarts en Wetenschap,* **17**, 455-473, **18**, 7-39, **18**, 61-73.

Martin, F. M., Brotherstone, S. P. W. & Chave, S. P. W. (1957). *British Journal of Preventive Social Medicine,* **11**, 196-000.

Murdoch, I. (1976). *Henry and Cato.* London: Chatto and Windus.

Oliemans, A. P. (1969). *Morbiditeit in de Huisartspraktijk.* (Morbidity in general practice). Leiden: N. E. Stenfert Kroese. N.V.

Royal College of General Practitioners, Office of Population Censuses and Surveys and Department of Health and Social Security (1974). *Morbidity Statistics from General Practice. Second National Study 1970-71.* London: HMSO.

Stewart, M. A., McWhinney, J. R. & Buck, C. W. (1975). How illness presents: a study of patient behaviour. *Journal of Family Practice,* **2**, 411-414.

Szasz, T. S. (1973). Mental illness as a metaphor. *Nature,* **242**, 305-307.

Truax, C. B. & Carkhuff, R. R. (1969). *Towards Effective Counselling and Psychotherapy.* Chicago: Aldine Publishing Co.

Wolfe, S. & Badgley, R. F. (1972). The family doctor. *Milbank Memorial Fund Quarterly,* **50**, 1-201.

Addendum

This article is a modified and edited version of a paper delivered by Dr Lamberts at the World Conference on Family Medicine at Montreux in May 1978.

Declining incidence of stroke

A major decline in the incidence of stroke occurred in the population of Rochester, Minnesota, during the period 1945 to 1974. For every 100 first episodes of stroke that occurred per unit of population during the period 1945 to 1949, only 55 occurred in the period 1970 to 1974. Although the decline was present in both sexes and in all age groups, the reduction in rates was more pronounced in the elderly. There was no major change in age at onset. Analysis of cohorts born during successive five-year periods from 1865 to 1915 confirmed the decreasing incidence rate in all age groups.

Reference

Garraway, W. M., Whisnant, J. P., Furlan, A. J. *et al.* (1979). The declining incidence of stroke. *New England Journal of Medicine,* **300**, 449-452.