Psychological treatment in general practice

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SUMMARY. A clinical psychologist was attached to two group practices in Sheffield for 1·5 sessions each per week. A total of 238 patients was seen during 26 months. Of those completing therapy, 72 per cent made satisfactory progress. In the three months after stopping treatment patients made significantly fewer (36 per cent) visits to the surgeries and received significantly fewer (50 per cent) prescriptions for psychotropic drugs than in the three months before referral. These changes were maintained one year later in the three-month period 12 to 15 months after discharge. The result has been to provide largely successful therapy for a population of patients for whom adequate treatment was previously unavailable. This suggests that it would be worthwhile to expand psychological services in general practice still further as advised by the Department of Health and Social Security.

Introduction

SINCE the reorganization of the National Health Service it has been the policy of the Department of Health and Social Security that general practitioners should have direct access to the services of clinical psychologists (Trethowan, 1977). This has yet to be widely implemented, but papers have been published which show that the two professions are beginning to make contact with each other. For example, Davidson (1977) reported the results of a survey which showed that among a sample of 76 general practitioners around Croydon, 80 per cent wished to have direct access to the services of a psychologist. Other studies (Shepherd *et al.*, 1966; McPherson and Feldman, 1977) have shown that a considerable proportion of general practitioner consultations are for problems of a predominantly psychological nature.

In 1974 a clinical psychologist was appointed for the first time as a full-time member of a primary health care team, and an account of this has been published by McAllister and Philip (1975). However, a full-time psychologist must be considered a luxury, since there are only about 500 psychologists in the NHS. Also, it is debatable whether a full-time commitment to a single practice constitutes the most efficient use of a psychologist's time.

Since May 1976, I have been able to devote three sessions per week to work in primary care and have found it most rewarding, as have the doctors and patients.

Method

Contact was made initially with the general practitioners through the Department of Community Medicine at the University of Sheffield. Professor E. Wilkes wrote to six practices telling them that a psychologist wanted to work in general practice and asking them to contact me if they felt they might co-operate. Two practices wished to take part. One has six general practitioners with a list of 18,000 patients of varied social backgrounds; the other has two full-time and one part-time general practitioners serving a population of 4,500 patients, most of whom live on a large council estate built in the 1930s, and are almost exclusively working class.

After initial discussions with the doctors I sat in on four surgeries, two at each practice, to observe the sort of problem with which patients presented. This confirmed published reports that psychological problems are presented fairly often to general practitioners. After this, I held one afternoon clinic per week in each of the surgeries, to which patients were referred. The remaining session was divided between the two practices to treat marital and sexual difficulties jointly with a marriage guidance counsellor.

At the beginning of the project, sessions lasted 45 minutes. However, after a few weeks, pressure of referrals led to a change to 30 minutes. Joint sessions for marital work were always one hour. During the early

stages of the project there was some apprehension from the doctors about which patients were suitable for psychological treatment. Discussion between us encouraged the doctors to produce a wide spectrum of patients.

Referral

Referral by the general practitioner consisted either of a letter setting out the patient's main problems, or a conversation with me. After referral, I held one or more interviews with the patient to discuss the problem as fully as possible, and then wrote to the referring general practitioner giving my opinion. The patient was either accepted for treatment, referred to someone else, or given no further appointment. Usually no further correspondence with the doctor was necessary, except on discharge.

Treatment methods

In addition to general counselling skills, clinical psychologists are equipped with rapid treatment methods which are effective in the common neurotic disorders. Improved therapy techniques, particularly those based on learning theory, have been developed during the past 15 years by extensive research programmes (Katz and Zlutnick, 1975).

Anxiety, by far the most common problem, was treated by programmes of anxiety management tailored to individual needs. First, a detailed history was taken to discover the precise nature of the symptoms and the factors responsible for their origin and continued presence.

At this stage, a wide variety of problems often became apparent, such as marital conflict, stress at work, and personality problems. Counselling helped the patients to deal appropriately with their difficulties, but this in itself was often not enough to remove the presenting symptoms. Where appropriate, patients were taught how to control their symptoms by relaxation, and when autonomic symptoms were prominent, to lower their autonomic arousal by using a small portable electronic biofeedback device (Serenometer; Budget Electronics, Sheffield). This produces a tone the frequency of which is proportional to skin resistance and hence to autonomic arousal.

Once some degree of control over the anxiety symptoms was achieved, patients were gradually taught to approach the feared situations in easy stages until the anxiety disappeared. In a few severe cases, supportive medication was requested to help at the beginning, but in most cases existing medication was withdrawn as soon as possible.

Patients presenting with interpersonal problems such as excessive shyness, difficulties with relations (usually parents), and poorly controlled aggression were treated by helping them to understand the origins of their difficulties and teaching them new social skills to enable them to cope more effectively with people.

Table 1. Outcome of 149 patients discharged.

	Dropped out	Therapeutic outcome			Total
		Nil	*	**	
Anxiety	11	7	20	21	59
Interpersonal problems	0	2	1	3	6
Personality disorders	3	3	3	7	16
Behaviour problems	5	6	7	7	25
Psychosomatic disorders	1	5	4	2	12
Marital difficulties	3	1	2	0	6
Sexual problems	1	1	1	0	3
Depression	1	4	1	2	8
Others	1	5	3	5	14
Total	26	34	42	47	149

** Patient free, or almost free, of presenting symptoms.
* Good progress, some residual symptoms, patient coping adequately.
Nil Little or no progress, patient retaining all or most of the presenting symptoms.

Marital problems were treated by counselling both partners together, where possible, and when sexual difficulties were prominent Masters' and Johnson's (1970) methods were employed using co-therapists, one of each sex. These patients were seen in separate marital clinics.

Psychological disorders in children were often reflections of wider family problems, and therapy therefore involved helping parents to understand their parts in generating their childrens' difficulties. The main exception to this was persistent nocturnal enuresis in the absence of other family problems, which responded well to treatment by buzzer and pad.

Medical activities

Subjective assessment of global improvement as shown in Table 1, particularly when done by the therapist himself, is notoriously subject to bias and other sources of error. Consequently, I sought more objective measures. Improvement in a patient's condition would be expected to be reflected by his or her behaviour with the doctor and accordingly, I counted, where possible, the number of doctor/patient contacts and the number of prescriptions issued for psychotropic drugs for each patient during the three months immediately preceding referral and the three months immediately after discharge. The same measures were also obtained, where possible, for the three-month period 12 to 15 months after discharge. Four patients were excluded because of chronic physical illness which necessitated frequent visits to the surgery. Tables 2 and 3 show these results.

Results

During the first 26 months 246 patients were referred, of whom 185 were accepted for treatment and eight are on a waiting list at the larger practice only. Thirty-one patients are being counselled or treated at the time of writing. Of those accepted for treatment, 26 (14 per cent) failed to keep more than the first one or two appointments. Seventy-two per cent of those who completed therapy made good progress, over half of them to the extent of being more or less symptom free. Table 1 classifies all discharged patients into groups according to diagnosis and summarizes outcome, and Figure 1 shows the outcome of all 246 referrals.

Eighty-eight males and 150 females (excluding those on the waiting list) were referred. Their average age was 34 years with a range of two to 71 years. Twenty-two patients were under 16 years old. The mean duration of treatment, excluding those seen once only, was five half-hour sessions per patient with a range of two to 20 sessions. Seventy per cent required five sessions or fewer. The smaller practice referred a significantly larger percentage of its patients than did the practice with six doctors (1·1 per cent/year and 0·36 per cent/year respectively; $\chi^2 = 32{\cdot}9$, $p<0{\cdot}001$). It is not possible to say whether this reflects differences in the populations themselves or in the referral patterns of the general practitioners. There were no significant dif-

Table 2. Comparison of doctor/patient contacts and number of prescriptions issued for psychotropic drugs between periods of three months each, before and after treatment.

	Three months before treatment	Three months after treatment	Change (per cent)
Doctor/patient contacts	385	246	*36**
Total prescriptions for psychotropic drugs	205	102	*50**

*$p < 0.00001$, two-tailed Wilcoxon test.
Numbers indicate totals of 109 patients as shown in Figure 1.

Table 3. Comparison of doctor/patient contacts and number of prescriptions issued for psychotropic drugs between periods of three months each, before and after treatment, for patients whose progress was followed up. Percentage changes from baseline (three months before) are given in brackets.

	Three months before treatment	Three months after treatment	12 to 15 months after treatment
Doctor/patient contacts	165	104 *(37)**	94 *(43)**
Total prescriptions for psychotropic drugs	81	39 *(52)**	45 *(44)**

*$p < 0.002$, two-tailed Wilcoxon test.
Numbers indicate totals of 49 patients for whom one-year follow-up figures were available.

ferences between the two practices in the types of problems referred ($\chi^2 = 1 \cdot 16$, with three degrees of freedom).

Case histories

Three brief case histories may serve to illustrate typical patients seen during the course of the project.

Patient 1. Miss A., aged 20, was referred with agoraphobia. Her difficulty had started 18 months previously when she had fainted in Sheffield market, which she found very embarrassing. Since then she had avoided buses, large shops, and the market. Three months before referral she had fallen from her boyfriend's motorcycle, and although unhurt had suffered an exacerbation of her anxiety. This prevented her from leaving the house unaccompanied and had forced her to leave her job as a shop assistant. No other problems in her life could be identified and her childhood was unremarkable. Diazepam had been prescribed, with little effect.

Miss A's anxiety centred on fainting when out, and indeed she had fainted on several occasions since puberty. Initially, she was unable to carry out any 'homework' assignments, so desensitization in imagination was used. This involved imagining the feared situation whilst deeply relaxed. She began to go out alone, first for very short walks, then longer ones, then to visit shops. When she could cope well with large stores, the diazepam, on which she still depended, was reduced, then withdrawn. The patient made a complete recovery and returned to work.

Patient 2. Mr B., aged 33, married with two children, had a long history of psychological problems. In the previous eight years he had been referred to psychiatrists on at least six occasions, and had been variously diagnosed as suffering from a personality disorder, early schizophrenia, a schizo-affective disorder, a depressive illness with psychotic features, chronic depression, and manic depressive illness. He had been prescribed at least 10 different psychotropic drugs. The present referral arose from marked mood swings, in the 'high' phase of which he became disinhibited and indulged in shop lifting.

His own description of his difficulties included identity problems, feelings of 'rootlessness', a fear of close relationships, a rich fantasy life, and religious problems. His wish was for time to talk to somebody able to help him understand his complex and conflicting patterns of thought and feelings. In the course of therapy he came to understand that relating to others can be rewarding rather than threatening. His relationship with his wife improved and he became more sociable. He came to accept himself more and felt less of an oddity and was also able to integrate his confused religious leanings into his strivings for increased emotional growth and adjustment. His mood stabilized, all medication was withdrawn, and he has been well for a year.

Patient 3. Mrs C., a 31-year-old woman with two children, was referred with a worsening agitated depression of three years' duration. It had been precipitated by the death of her father and seven other close friends and relatives in the space of a few months. She eventually found her office work too stressful and left.

It quickly became clear that she was a very insecure person with a negative self-image. This had developed in childhood from a rigid and 'Victorian' father, a butcher, who placed severe restrictions on his two daughters lest they should 'show him up'. Her husband had also had an insecure childhood and appeared to have ceased to mature emotionally following his father's death, when he was 12. He was unable to cope with his wife's problems. Therapy focussed mainly on the marital relationship, with the emphasis on both learning to express and accept positive and negative emotions. Some behavioural tasks were assigned to help her with specific anxieties. She ceased to relate to her husband as if he were her father, her symptoms disappeared, and she was able to return to work.

These three case histories illustrate the different approaches taken in different cases: the first case involves behaviour therapy, the second only counselling, whilst the third used elements of both approaches.

Discussion

This project has shown that, whilst psychological services are available to some general practitioners under the existing NHS arrangements, several advantages accrue from the psychologist's presence in the surgery. Feedback between the professions is more immediate, and difficult cases or doubtful referrals can be discussed on the spot. Referral is more acceptable both to the patient and to the doctor than would otherwise be the case. The doctors said that they often feel reluctant to refer to psychiatrists because of long waiting lists, possible stigma to the patient, and because treatment is often only by drugs which the doctor could prescribe himself. With a psychologist visiting the surgery, patients can be seen within a week or two in surroundings with which they are familiar.

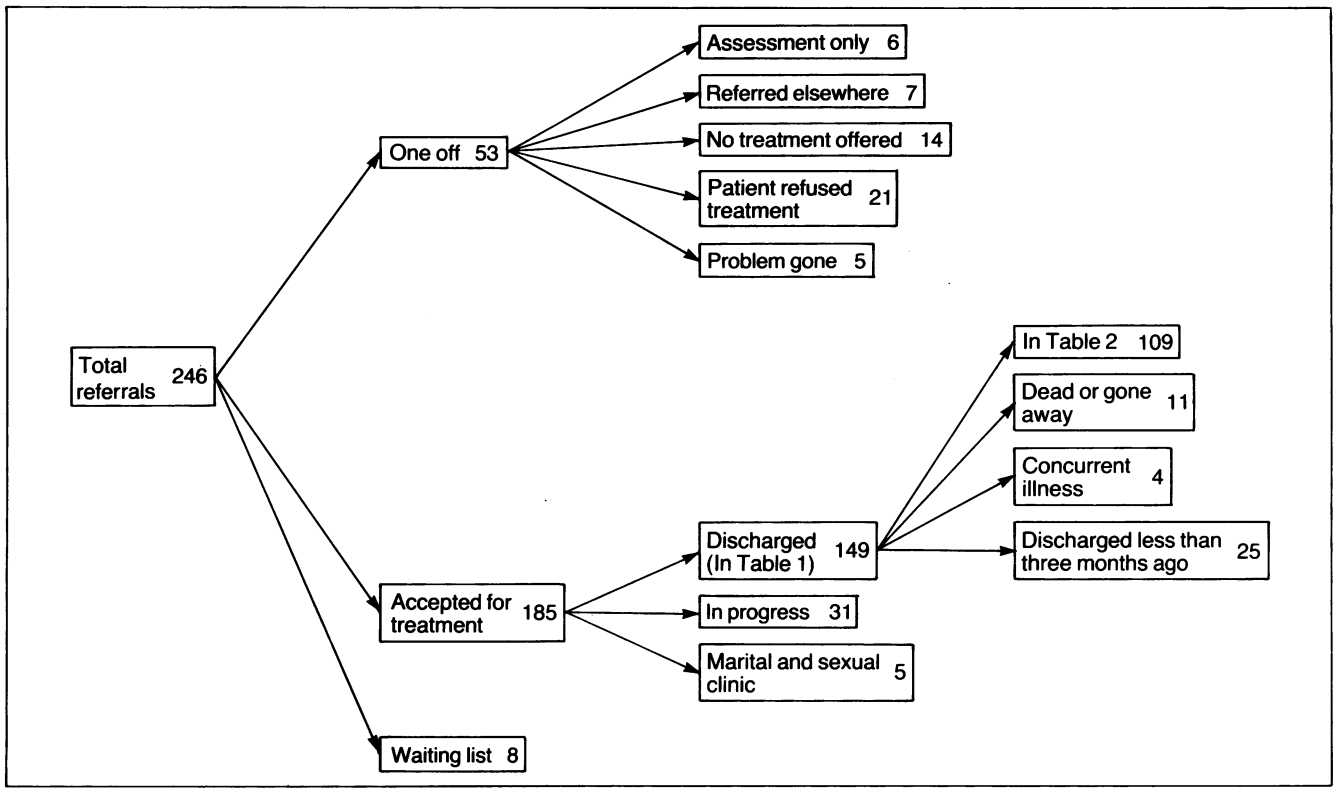

Figure 1. *Outcome of all referrals (N = 246).*

My presence at the surgery did not alter the rate of referral to psychiatrists, at least at the smaller practice for which figures were available. During the first five months of 1976 before the start of the project 1·40 patients per month were referred to psychiatrists; during the first seven months of the project 1·41 patients were referred per month, an insignificant change. As none of the doctors formerly referred to a psychologist, it seems that many of the patients seen during the course of this project would otherwise have received treatment only from their doctor, who often has neither the time nor the special skills with which to cope adequately with psychological problems.

It is encouraging that the reductions in visits and prescriptions issued were maintained after one year. It is worth noting that the small increase in prescriptions issued in the 12 to 15 month period resulted from a single patient receiving nine prescriptions during this time. Reduction in medication has cost benefits: a random sample of 30 prescriptions issued by the larger practice to patients in this study yielded a mean cost to the NHS of £1·19 per item.

The study I have described lacks an adequate control group, and therefore leaves open the question to what extent the observed changes are due to spontaneous remission. There is some evidence that this, at least, does not account for all of the observed change. Patients were referred whose problems lasted from a few months to 20 years. It would be expected that those with longstanding difficulties, often with a history of psychiatric intervention, would be less likely to remit spontaneously than those with problems of recent onset. If spontaneous remission were a large factor, it would be expected that there would be a negative correlation between duration of problem and outcome measures. In fact, no such correlation existed (minus 0·09 and plus 0·12 between duration and changes in prescription and changes in visits respectively; Spearman's rho; neither significant).

Future studies require an adequate control group. Doctors in a practice not having the services of a psychologist could be asked to indicate patients they would refer if they did, and such patients could be asked to participate in a study in which they would be assessed after the usual treatment by their general practitioner.

Besides the measures used in this study, individual indices of change for each patient are desirable. Ratings should be made by the therapist, the patient, a close relative, or friend, and if possible by an independent assessor who does not know whether the patient is from the treatment or control group. Outcome research in psychotherapy is fraught with difficulty (Bergin and Strupp, 1972).

A carefully designed study should be able to answer unequivocally the following questions:

To what extent can the presence of a clinical psychologist in the surgery prevent:

1. Future patient morbidity,
2. Use of the doctor's time,
3. Use of psychotropic drugs,
4. Referral to psychiatrists,
5. Admissions to psychiatric hospitals?

A more comprehensive outcome study extending over four years is planned which should answer these questions more clearly than the present pilot study.

Conclusion

McAllister and Philip (1975) saw 94 patients in a year of full-time work for six doctors serving a population of 10,500, while in the present project 233 patients (excluding those seen in the separate marital clinic) were seen in 26 months for nine doctors serving a population of 22,500, for two sessions per week. In terms of use of time for seeing patients this represents a six-fold increase in efficiency. Although McAllister and Philip did other work besides therapy, such as teaching other members of the primary health care team, they stated in their conclusion that pressure of referral had become such that they were considering the use of group treatment methods. My system is clearly able to cope with a much greater number of referrals.

These results suggest that 10 to 15 full-time psychologists would be able to serve the needs of a city the size of Sheffield, and that such a service, besides filling an important 'treatment gap', could materially reduce both the number of prescriptions issued for psychotropic drugs and the demands on the doctor's time. Such an expansion of psychological services into general practice appears to be not only greatly worthwhile but in line with current DHSS recommendations.

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Acknowledgements

I would like to thank Professor Eric Wilkes for his assistance in setting up and co-ordinating this project, and Drs K. G. Baldwin, S. L. Barley, E. G. Brown, P. E. Brown, S. Burgoyne, W. G. Cautley, H. J. Dooley, A. R. Evans, and J. Hopper for their continued interest.

Addendum

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