Counselling in general practice

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SUMMARY. In 1976, a group practice in South Oxfordshire established a counselling service. The counsellor is available in the health centre for three half-day sessions per week, and we describe a survey of the subjective and objective effects of counselling on the first 80 patients who used this service. There was an improvement, as measured by the feelings of the patients and doctors, and by some reduction of psychotropic drugs and medical consultations. The majority of the patients who returned the questionnaires said they preferred to see the counsellor rather than the general practitioner for their problem.

Introduction

SINCE 1976 a counsellor has joined the community health team in South Oxfordshire. The practice is based at a health centre in Sonning Common and there are four partners and one trainee: three other partners practise from another centre at a village four miles away. In addition to the doctors, nurses, and health visitors, a dietician, family planning nurses, and a chiropodist are also available. The list size is about 7,800 and is composed largely of social classes 1, 2, and 3 living in a semi-rural area.

Aim

We tried to measure the effects of a counselling service based in general practice.

Method

The counsellor

The counsellor was first trained and worked as a nurse. Then, after taking a first degree, she took a one-year diploma course in guidance and counselling at the University of Reading. She has direct access to the medical notes and uses them to record a summary of her observations. Confidential information, with the patient's permission, is shared between the counsellor and the referring doctor.

Referrals

The counsellor works on three half-days a week with two sessions for individual interviews and the third for a group session. Most patients are referred by one of the doctors and the average waiting time for new consultations is between one and two weeks. Individual, marital, and family group counselling is offered. The first interview lasts one hour and subsequent ones usually for half an hour.

The reasons for referral fall into two broad categories. The first is commonly stress due to a new, or crisis situation which is often the result of marital or other relationships breaking up, bereavement, or difficulties in coping with sudden changes in personal circumstances. The second cause is stress which is the result of a long-term situation. Patients with this type of stress often have difficulty in coping with established relationships, or may not have been able to participate fully in their personal or social situations. This second category contrasts with the criteria recommended by Cohen (1977) who felt that those patients with short-term problems and good history were most suitable for counselling.

In the first interview, the needs and wishes of the patient are explored, and the counsellor and the patient decide between them on the form of their future meetings. The counsellor's main aim is to offer the patient support and insight. The patient is also given the chance to learn new skills, such as relaxation techniques, and audiotapes and books for these purposes are available for loan. Vocational guidance and aptitude testing can also be given.

A behavioural approach has been found useful in the management of phobias. Patients also have the chance of taking part in the weekly group meeting after individual counselling.

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The experience of being counselled can lead to the development of interpersonal skills for the patient and group experience can provide a living example of the help and support that is available in the local community.

Evaluation

The study was based upon information obtained from questionnaires sent to the first 80 patients using the counselling service, from separate questionnaires completed by their doctors, and information from the medical records. The patients' questionnaire was detailed: broadly, it asked for their personal views about the effects of counselling and group experience. In addition, it asked about any measurable changes that had occurred in sleep patterns, eating, alcohol and tobacco consumption, and in the use of psychotropic drugs, whereby it was hoped that a more objective means of assessment could be achieved.

The doctors' questionnaire was similar but shorter. It enquired about the doctors' feelings about the effectiveness of counselling with regard to their particular patient in order to see if there was any correlation with the patient's view. More objectively, it asked whether there had been any change in the patient's use of medical time and psychotropic drugs.

Additional information was obtained from the patients' medical records. These were used to confirm the changes in the use of psychotropic drugs and to assess the attendance patterns of the patients and their nearest relatives for three months before and after counselling to see if there had been any measurable change. The medical records were also used to provide information about the patients who did not return their questionnaires.

Results

The age and sex of the first 80 patients seen by the counsellor are shown in Table 1. Fifty-five patients (69 per cent) returned completed questionnaires and these patients had seen the counsellor an average of five times with a range of one to 12. Twenty-one of these patients were men and 34 were women. The group who did not reply had seen the counsellor an average of three times, and a higher proportion of women (34 out of 44) returned the questionnaires than men (21 out of 36). However, the age distribution of the two groups was similar and seven of the men who did not reply had relationships with women who did return questionnaires.

Table 1. Age and sex of 80 patients seen by the counsellor.

Age	Under 25	25 to 34	35 to 55	Over 55	Total
Male	4	10	20	2	36
Female	2	20	19	3	44

Table 2. Personal development in 55 patients.

	Yes	No	No answer
Has there been any improvement in the way you feel about yourself?	35	19	1
Has there been any improvement in your close personal relationships?	26	27	2
Has there been any improvement in your contacts with friends?	25	25	5
Has there been a change in the way you feel about your past experiences?	22	30	3
Has there been a change in the way you feel about your present situation?	38	15	2
Do you feel more capable of dealing with your change in mood?	39	13	3
Do you feel more self-confident?	27	25	3

Personal habits. Three questions asked about changes in food intake, sleep patterns, and the consumption of alcohol and tobacco. Ten people reported that they had achieved a desired gain or loss in weight, and 24 stated that they were sleeping better. A very small reduction was reported for tobacco and alcohol consumption.

Personal development. Table 2 shows reported changes in personal development. Attitudes to self-image, present situation, and ability to cope with mood changes seemed to show the biggest changes. Many of the patients answering 'no' or not answering qualified their response by saying that this aspect was not a personal problem.

Relaxation techniques. Twenty-four patients had learned relaxation methods and of these 20 had found them helpful.

Group sessions. Fifteen patients had attended or were attending the group sessions and their answers are shown in Table 3. Many of the people answering 'no' or not answering qualified their response by saying this aspect was not a personal problem. As can be seen from the table, opinion is mixed and the results seem less clear cut than those from individual sessions with the counsellor. Most patients felt that their difficulties were less serious than those of other members and also felt that they had learnt more about other people by attending the group meeting. Conversely, they did not feel that they had learnt new ways of coping with their own difficulties or that group experience had encouraged

Table 3. Attitudes and feelings of 15 attending group sessions.

	Yes	No	No answer
Did you find these group sessions to be a support?	7	6	2
Did you feel that your difficulties were less serious than those of other members?	9	4	2
Did you learn more about yourself?	6	7	2
Did you learn more about other people?	11	2	2
Did you learn new ways of coping with difficulties?	5	8	2
Did these sessions encourage you to mix/share more with people outside the group?	5	8	2
Were there any problems you were unable to discuss?	8	5	2

them to share or mix more with other people. These responses may be related to the fact that many patients had problems they were unable to share with a group of people who all came from a small community. Also, when the survey was made, the group was at an early stage. Eight of the original members attended for 10 or more sessions.

Attitudes to the service. Given the choice, 48 patients out of 55 said they would not have preferred to continue to see their own doctor about their problems. Their feelings about the service are shown in Table 4.

The doctors' questionnaire. The doctors felt that the majority of their patients had improved their ability to cope with their problems. In addition, unlike the patients, they felt that the majority had improved the quality of their close personal relationships. Despite the fact that most patients did not feel they would have preferred to see their doctor about their problems, the doctors did not feel the referral to a counsellor had changed their relationship with the patient. In some cases they felt that it had improved it.

Change in the use of psychotropic drugs. The prescribing of psychotropic drugs was investigated for all 80 patients. The total cost of drugs issued to patients for a three-month period before counselling was compared with a similar period after their counselling sessions had been completed. It was estimated that the reduction in drug costs for the total group was £76·92 (£62 for the group returning questionnaires, £14·92 for the group that did not.) This figure was based on the unit cost of 100 tablets or capsules in the prescribed strength calculated from the December 1977 issue of *MIMS.* The actual saving would have been much greater owing to the additional costs of dispensing fees, container allowances, and cost allowances. Twenty-eight patients (24 who replied, four who did not) had reduced or stopped their medication and the average length of time these patients had been taking psychotropic drugs intermittently or continuously was seven years. Over half the remaining patients had not been prescribed psychotropic drugs in the first place.

Table 4. Attitudes and feelings of the 55 patients counselled in general practice.

	Yes	No	No answer
Do you think that counselling is a service that should be available in general practice?	47	2	6
Would you use a counselling service again?	43	4	8
Would you recommend counselling to your relatives or friends?	46	3	6

These results should be treated with caution. On the one hand three months is too short a period to make a valid judgement about patients taking drugs intermittently and 12 patients were known to be taking some medication six months later. On the other hand, 10 who were known to have had no more drugs prescribed six to nine months later included three men who had taken medication virtually continuously for four, seven, and eight years respectively before counselling.

Table 5 shows the alteration in demand for medical services, established by analysis of the records. Some of these records and the relatives' notes were unavailable by the time this analysis was done. Comparisons were

Table 5. Changes in medical demand by patients and their relatives after counselling.

	Increased	Decreased	Same	Not known
Responders' use of medical attention	7	35	8	5
Use made by responders' relatives of medical attention	6	15	30	4
Non-responders' use of medical attention	3	11	5	6

made between consulting rates with the doctors during the three months preceding counselling and the three months after personal counselling (not group experience) was completed. Those replying to the questionnaire had an average of 3·3 consultations before and 1·1 after: for those not replying the figures were 3·5 and 1·6 respectively. Most patients reduced their use of medical time after counselling and this finding was confirmed by the subjective answers from the doctors' questionnaire. The number of contacts made by the majority of the close relatives remained the same. Because of the short length of time, these figures must be interpreted with caution.

Discussion

All general practitioners know that a great proportion of their work is spent dealing with patients whose problems are related to situations beyond the doctors' control. The doctors have several options: they may choose to ignore the problem, or they may attempt to help by damping down the patient's emotions with psychotropic drugs. Alternatively, they may refer patients to other agencies such as marriage guidance, social services, or psychiatrists. Some doctors offer a counselling approach themselves but this depends upon their personal interests, their relationship with the patient concerned, and the time available.

In this practice, having a counsellor as a member of the community health team seems to be the most logical approach, and this feeling has been described in several recent papers (Marsh and Barr, 1975; Meacher, 1976; Cohen, 1977; Cohen and Halpern, 1978). It is interesting, however, that most of this published work deals largely with marriage guidance or marriage guidance counsellors. In our practice, 107 patients were seen in the first year of the service compared with representatives of 21 marriages in a Stockton-on-Tees practice offering marriage guidance counselling (Marsh and Barr, 1975) and 30 patients in two years in a London practice (Cohen and Halpern, 1978).

The counselling service is in the setting where patients are accustomed to bringing their problems which makes referral to a counsellor easier than it would be to someone outside the practice, or an agency. Moreover, the counsellor possesses skills which most doctors do not have, but at the same time benefits from close contact with and support of the doctors and other members of the team, and also from access to the medical records. The doctors in turn are helped by the counsellor's insight and because close contact makes communication quick and easy.

Conclusion

The results of this small survey support the view, already shown, that counselling is a valuable service in general practice. It offers an alternative to the use of psychotropic drugs and enables some people to reduce or discontinue medication. In the short term, use of the service may be linked with a reduction in the demand for medical time, although it is not possible to say whether this would have happened in our practice without the counselling service. On the question of personal development, the majority of patients felt more capable of dealing with their changes in mood, their present situation, and generally felt better about themselves.

The results of group experience are very difficult to assess with a uniform questionnaire (Yalom, 1975). Group participants, Yalom suggests, should have an individual outcome scale, which may give clearer results. Most patients did not feel rejected by their doctor when they were referred to the counsellor and the relationship between the patient and the doctor seemed to be unchanged or even improved as a result of counselling.

We feel that, in general, a readily available and accessible counselling service has been an important development in the provision of primary care in this practice.

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Acknowledgements

We wish to thank Dr P. M. R. Hemphill, Dr T. I. Stewart, Dr H. C. McEwen, and Dr A. P. Hill, and the patients for completing questionnaires. We also wish to thank the lecturers and staff of the Guidance Unit, School of Education, University of Reading.

Sphygmomanometers: errors due to blocked vents

Inaccuracies in the performance of mercury sphygmomanometers are widely reported. Sources of error include design, operation, and maintenance. Despite reported inaccuracies few attempts have been made to measure the actual errors produced at different rates of fall of the mercury column. These errors occur when the chamois leather vents at the top of the glass tube and mercury reservoir become partially blocked. We have checked the performance characteristics of 32 ward sphygmomanometers in a teaching hospital.

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