# Management of neurotic problems in general practice

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SUMMARY. Very little is known of how general practitioners assess and treat psychological problems, which make up a substantial proportion of consultations. Sequential case histories were used as a basis for interviews with 20 experienced doctors. There was considerable agreement about diagnosis but wide variation in treatment. It is argued that clarification of precise strategies could be a basis for evaluation and improved care.

## Introduction

AT least 95 per cent of identified psychological problems are managed entirely within general practice, but there is a wide variation in individual approach and interest. Interviewing skills are stressed in training, but remarkably little is known of what doctors actually do to assess and manage problems, processes described by Shepherd (1972) as 'haphazard'. There can be no correct answers and, indeed, psychiatrists disagree alarmingly (Mayou, 1977). This paper argues that by examining what good general practitioners actually do, simple basic procedures may be identified and then defined which could be both evaluated and taught. In this way, it might be possible to achieve Shepherd's aim "to strengthen the therapeutic role of the general practitioner".

## Method

Twenty Oxfordshire general practitioners, with lists varying from 1,800 to over 3,000 patients, were chosen for their special interest in the practice and teaching of medicine. They were asked in an interview how they would deal with seven common newly presenting psychological problems in a normal surgery. Information (prepared from detailed case summaries) was provided sequentially in response to doctors' requests, with the interviewer, in effect, role playing the patient. Further questions were asked to clarify management.



The clinical problems were: acute anxiety in a student; endogenous depression presenting with headache; agoraphobia and neurotic depression in a middle-aged woman; overdose in a 19-year-old girl, and psychological disability three months after a heart attack. More structured general questions followed, covering other aspects of management including chronic neurosis.

## Results

The doctors differed considerably in their interest in psychological problems and their willingness to be closely involved in management. All gave thoughtful answers, and special attention was paid to the detection of the most serious and the most treatable problems. Some of the doctors were very precise in outlining strategies but others appeared more intuitive and less able to describe their standard procedures (Table 1). Consultation times varied from five to 15 minutes and only a minority suggested longer appointments outside normal surgery hours. Most doctors suggested that a follow-up appointment should be made at the end of a surgery or that double time should be allowed. A number said they had given up special times, finding normal surgery appointments simpler and more acceptable to patients.

### *Initial assessment*

The first interview was seen as covering the basic information needed for a provisional formulation. This included clarification of the presenting problem, questions about any other symptoms (including exclusion of physical illness and endogenous depression), and enquiries about stress, the patient's personality and background, and usually the patient's expectations of his consultation. At this stage, the doctors appeared to have made decisions about:

1. The need for further information (from the patient and others).
2. Whether encouragement and reassurance were likely to be adequate.
3. Other intervention (drugs, psychotherapy, referral).

**Table 1.** Assessment and therapy by 20 general practitioners.

| | | | |
|---|---|---|---|
| *Assessment strategy* | | *Sex therapy* | |
| clear | 16 | never | 2 |
| vague | 4 | simple advice | 9 |
| | | Masters and Johnson | 9 |
| | | *Relatives involved in follow up* | |
| *Other informants seen* | | rarely | 7 |
| frequently | 8 | sometimes | 9 |
| sometimes | 8 | usually | 4 |
| rarely | 4 | | |
| *Minor tranquillizers for acute problems* | | *Joint therapy* | |
| often | 6 | never | 4 |
| sometimes | 8 | occasionally | 10 |
| rarely | 6 | often | 6 |
| *Minor tranquillizers for chronic problems* | | *Behaviour therapy* | |
| sometimes | 5 | never/rarely | 3 |
| never/rarely | 15 | general advice | 13 |
| | | specific advice | 4 |
| *Antidepressant dosage* | | *Referral to psychiatrist* | |
| standard | 15 | rarely | 14 |
| low | 5 | sometimes | 5 |
| | | frequently | 1 |
| *Counselling/psychotherapy* | | *Use of other team members* | |
| occasionally | 6 | rarely | 5 |
| frequently | 14 | sometimes | 7 |
| | | frequently | 8 |
| *Supportive psychotherapy* | | | |
| rarely/never | 2 | | |
| occasionally | 7 | | |
| frequently | 11 | | |

4. Whether to arrange another appointment or to leave the decision with the patient.

Although not always made explicit, and varying greatly in style, a basic problem-orientated approach to assessment was recognizable. Those doctors most interested in psychological problems wanted more information, were more likely to want to speak to other informants, especially spouses, and suggested definite follow-up appointments. The less interested had a higher threshold for specific intervention and were more likely to suggest referral at an early stage. On the occasions when no further action followed the initial screening, patients were always asked to consult again if there was no improvement or recurrence.

Two obvious differences in assessment procedures were the emphasis on seeing relatives (answers ranged from "almost invariably" to "very rarely") and the marked reluctance of half of the general practitioners to consider a psychological cause for a severe atypical headache in a distressed, hopeless and cancerophobic 55-year-old man.

### *Management*

As expected from the selection of the doctors, the quality of care offered was high and in no way reflected the common criticism that general practitioners are 'haphazard', over-prescribe psychotropic medication, and neglect simple psychological treatments. In contrast to the similarities in assessment, approaches to therapy (Table 1) showed as wide a variation as has been previously reported for psychiatrists (Mayou, 1977):

1. *Advice and reassurance.* Reassurance about the commoness of the complaint, and simple practical advice and encouragement were regarded as essential. The benefits of self-help were stressed rather than the doubtful value and side-effects of medication.

2. *Prescribing tranquillizers.* Tranquillizers were believed to have a limited role, most especially in acute crises. Although several doctors admitted they were not always able to put their cautious beliefs into practice, all said that they gave very small supplies, emphasizing the dangers of longer usage. The majority discussed other ways in which the patient himself might more satisfactorily cope with his own symptoms. Dosage was modest, about a half preferring flexible use rather than a regular dosage schedule. Six doctors rarely use the minor tranquillizers even for crises.

3. *Prescribing antidepressants.* Similar caution was expressed about antidepressants, to the point in three instances of marked reluctance to use these drugs. Amitriptyline and imipramine were the most favoured drugs, and although there was some polypharmacy (with several drugs of the same therapeutic group) there was little interest in new antidepressants. There was a tendency to use rather low dosages (75 mg or less) compared with outpatient practice, and some doctors were reluctant to consider an increased prescription following failure to respond. All would stop medication very soon after recovery from depression.

4. *Discussion and psychotherapy.* Three doctors described a sophisticated interpretative psychotherapy, but the majority were willing to take on what could be termed 'brief counselling' of four or five sessions (or on occasion much more lengthy treatments) to clarify and solve problems. The procedures were varied, ranging from the directive to passive listening, and were not always clearly described. Most doctors were willing to continue discussion as long as it seemed to be of benefit to the patient, although a minority either referred patients to psychiatrists or terminated therapy. Several admitted that personal liking and sympathy for the patient determined the extent and nature of the treatment—this appeared implicit in most replies.

The components of the psychotherapy of chronic neurosis were rather unclear. There was a definite impression that doctors were discouraged when initial treatment was unsuccessful and became rather passive as patterns of chronic neurosis emerged. Although

repeat attenders were often seen as a burden to be suffered and controlled, half the doctors differentiated a more therapeutically active and valuable process of supportive psychotherapy, combining practical help, encouragement and listening.

It seemed that the general practitioners were, not unreasonably, uncertain as to how to manage perhaps the principal psychiatric burden of general practice (Shepherd, 1972).

5. *Joint therapy.* Fewer than half the general practitioners interviewed regularly involved relatives in therapy, and separate interviews were often preferred. There was little interest in joint therapy except in the case of sexual problems. The majority were tentative about their aims. In other than sexual problems all except six doctors normally left decisions about joint attendances to the couples themselves.

6. *Behaviour therapy.* Behavioural measures were often mentioned, but only in very general terms. Nine of the younger doctors referred by name to Masters and Johnson techniques for sex therapy. Two teach relaxation techniques, and three suggested desensitization for agoraphobia. All these doctors found the methods useful and easily adaptable to general practice.

7. *Practical help.* Practical measures to be taken by the patient himself were often suggested, both for their immediate benefits and as a demonstration of the scope for improving morale by self-help. Those doctors who involved social workers and health visitors saw this as their principal role.

8. *Referral.* Although none of the doctors regarded themselves as making great use of specialist services for neurotic problems, their practice appeared to vary from the very rare to frequent. The main reasons for referral were: specific specialist treatment (behaviour therapy and psychotherapy), admission to hospital of the severely ill, to provide a second opinion at the patient's request, failure to respond to therapy, and, rather less frequently, to provide fresh and detailed assessment. Three doctors had had experience of a psychiatric clinic within their practice and they and a number of the others preferred this model to the outpatient clinic. Only three doctors regularly referred directly to clinical psychologists.

9. *Use of other members of practice team.* Involvement of other therapists was seen variously as: (1) the best method of managing certain patients; (2) as an appropriate way of providing treatment in which the doctor was not greatly interested; and (3) as a second best to personal care by the busy general practitioner. In general, other therapists appeared to be most valued by those doctors who were themselves most active and interested in psychological difficulties.

The most successful working relationships always depended on the availability within the practice of someone who was felt to have the personal qualities and enthusiasm to work successfully with patients. Thus, liaison with the social work area team was found to be much less satisfactory than a specific attachment. Health visitors were usually thought to have a relatively narrow role confined to families with young children. Individual doctors mentioned the value of community nurses, marriage guidance counsellors and attached psychiatric nurses.

## Discussion

Questioning about clinical problems is artificial, depriving the doctor of his real life knowledge of previous history, behaviour and personality, family background, and relationship with the patient. Even so, the method is justified as a way of finding out what experienced doctors regard both as good medicine and as feasible in their own work. It is, of course, a highly selective view of general practice. The high standards of assessment and treatment are encouraging, more encouraging than a previous study of psychiatrists (Mayou, 1977).

A very wide variety of treatment methods and strategies was described by the group as a whole. Individual doctors tended to use a somewhat restricted number of techniques and were tentative about detailed application. The variation did not appear to be adequately explained by differences in personality and style. More probably it reflected the lack of specific training and the uncertainties within specialist psychiatry. This would be most obviously true in the case of brief psychotherapy.

Comparison of the management of neurosis in general practice with specialist hospital-based experience and research must be guarded, since problems, circumstances and resources are totally different. Some comments are possible, however: there was little use of other informants in diagnosis and involvement of relatives in treatment; some unwillingness to use larger dosages of antidepressants and a tendency to stop them too early; lack of knowledge about behavioural principles; hesitancy about the techniques of brief psychotherapy and counselling; and uncertainty about the management of chronic neuroses.

It can be argued that the combination of up-to-date research findings and the experience of general practitioners could lead to the detailed definition of a wider range of treatment options. In fact, a process is needed similar to that of Lazare (1976) in emergency clinic psychiatry. He has shown how the classification of patient requests and of therapies (medical, behavioural, social and psychotherapeutic) has led to more eclectic, effective and efficient care. It is, moreover, a system of management which can be a basis for training—training which would, no doubt, be rather more beneficial for unselected doctors than for general practitioners as interested and enthusiastic as those surveyed.

The analysis of good treatment as practised by doctors of widely differing personality and interests could lead to treatment alternatives practicable in any practice. It would avoid commitment to any particular

approach (for instance, Balint psychotherapy), and recognize that general practitioners will vary in skills and interests. Some will wish to be enthusiastically involved, others will wish to supervise non-medical colleagues.

This small study supports the value of the approach. The next step is to extend the investigation in much greater detail with a larger number of doctors to define the components of management. Thereafter they can be evaluated and taught. Success would prompt extension of the methods to the work of the social worker, health visitor and other groups, whose roles are rather more uncertain than that of the general practitioner.

### References

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## Mild hypertension

The Australian National Blood Pressure Study was a controlled therapeutic trial of antihypertensive drug treatment in 3,427 men and women with mild hypertension. Subjects, who were aged 30 to 69 years, were free of clinical evidence of cardiovascular disease and, after randomization, were given either active or placebo tablets at special clinics for an average of four years. The results showed a significant reduction in mortality in the actively treated group, mainly due to a reduction by two thirds in deaths from cardiovascular disease. There was also a significant reduction in the incidence of non-fatal trial end-points. There were fewer cerebrovascular events in the actively treated group, but there was little overall difference in ischaemic heart disease events. There were fewer deaths from ischaemic heart disease in the active group, but the number was small and the difference just short of significance. Trial end-point rates correlated well with blood pressure levels throughout the trial irrespective of treatment regimens. The occurrence of trial end-points overall was low, reflecting the mild degree of hypertension and the absence of pre-existing cardiovascular disease.

**Reference**

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