The clinical psychologist in general practice: a six-year study of consulting patterns for psychosocial problems

GEORGE K. FREEMAN, MRCP, MRCGP
Senior Lecturer in Primary Medical Care, University of Southampton

ERIC J. BUTTON, B.SC, PH.D
Lecturer in Clinical Psychology, University of Southampton

SUMMARY. Three quarters of the patients in a group practice referred to a clinical psychologist during a three-year period showed marked reductions in the consulting and psychotropic drug prescription rates in the six months after treatment compared with the six months leading up to treatment. However, the rates for the whole practice revealed a general falling trend over the period of study. Furthermore, examination of the records of all patients with at least one psychosocial problem over a six-year period during which they were registered with the practice has shown that encounters for psychosocial problems tended to be concentrated in a relatively short period—the 'worst year'—rather than being evenly distributed over the whole six years. It is concluded that the natural history of most psychological disorders is one of crisis and remission and that no benefit has been demonstrated from individual therapy by clinical psychologists.

Introduction

AFTER a number of enthusiastic earlier reports, Earll and Kincey[1] presented the results of the first controlled trial of a clinical psychology service in general practice. Although patients in the treated group were highly satisfied with the service, comparison with a control group after an interval of seven months showed no significant difference in any of the outcome measures used, including prescriptions for psychotropic drugs and contacts with the general practitioner. It would be wrong to over-generalize from this one study involving 50 patients, but such findings suggest that we look critically at optimistic claims of the various professional groups—including counsellors,[2] social workers,[3] and psychotherapists[4]—who, along with clinical psychologists, aspire to help those with 'psychosocial' disorders in the community.

A clinical psychology service has been operating at Aldermoor Health Centre, Southampton, since February 1977. Initial evaluation produced an encouraging picture, similar to other reports;[5,6] three quarters of patients showed improvement and only a quarter remained unchanged or deteriorated as measured by the rates for consultations and psychotropic drug prescriptions. However, it became clear that the impact of the psychologist should be considered in relation to all patients who are 'at risk'.[7] The availability of a computerized recording system has enabled us to examine the natural history of a large group of patients consulting for psychosocial problems over a six-year period.

© *Journal of the Royal College of General Practitioners*, 1984, **34**, 377-380.

Method

Identifying patients at risk

Clinical psychology sessions began at Aldermoor Health Centre in February 1977 with at least one session weekly and sometimes two. Patients were referred by general practitioners, without strict criteria, for an initial interview with the psychologist after which any further appointments were made by mutual agreement. By January 1980 168 patients had been referred and in 131 (78 per cent) of these cases the doctor had recorded the presenting problems as either psychological or social, according to our classification (see below). The most common problems recorded were anxiety and depression in 75 patients (45 per cent) and problems of living including sexual and marital problems in 25 patients (15 per cent).

It was decided that any patient labelled as having either a psychological problem or a social problem could reasonably be said to be 'at risk' and suitable for referral to the clinical psychologist. A retrospective study was undertaken of the consultation patterns of a large group of such patients.

Practice record system

Such a study was made possible by the existence of a computer-assisted record system holding details of all encounters with patients in the practice for the six-year period from 1 January 1975 to 31 December 1980. The data was collected by doctors and paramedical staff, who completed an encounter form at every consultation for each problem. Each encounter was labelled with a problem statement and this was coded using a system specially designed to place the minimum constraint on doctors' use of diagnostic terms.[8] Thus, for example, the terms anxiety, recurrent anxiety, chronic anxiety, tension, stress reaction, anxious personality and inability to relax all had separate codes. As the validity of such fine distinctions seemed doubtful in the context of this study, it seemed preferable to combine all terms into the general classes

Table 1. Average number of encounters and psychotropic drug records per patient per year in the six-year cohort compared with the whole practice population.

	1975	1976	1977	1978	1979	1980	Percentage reduction from maximum to minimum rates
Six-year cohort—males ($n=520$)							
Encounters							
All problems	6.1	5.8	5.3	4.7	4.1	4.3	(−33)
Psychosocial	1.1	1.2	1.0	0.9	0.6	0.7	(−53)
Psychotropic drug records	1.1	1.2	0.9	0.8	0.5	0.6	(−56)
Six-year cohort—females ($n=857$)							
Encounters							
All problems	6.6	7.1	6.7	5.9	4.8	5.6	(−31)
Psychosocial	1.3	1.6	1.4	1.1	0.9	1.0	(−44)
Psychotropic drug records	1.0	1.3	1.1	0.8	0.6	0.7	(−53)
Whole practice—both sexes (average $n=8,094$)							
Encounters							
All problems	4.1	4.8	4.5	4.5	3.8	4.3	(−21)
Psychosocial	0.5	0.6	0.5	0.4	0.3	0.4	(−42)
Psychotropic drug records	0.4	0.5	0.4	0.3	0.3	0.3	(−47)

Table 2. Concentration of psychosocial encounters within a patient's worst year for the six-year cohort patients with at least 12 psychosocial encounters from 1975–80.

	Male	Female	Both sexes
Patients with at least half their psychosocial encounters in their worst year			
Observed	46	68	114
Expected*	2	3	5
Total patients with 12 or more psychosocial encounters	70	132	202

* Assuming random distribution of psychosocial encounters over 24 successive quarter-years.

'psychological' (including neuroses and psychoses) and 'social' (including problems of living and of relationships). All such problems were called 'psychosocial' problems. (Further details of the use of these terms are available from G.K.F.). The medical regimen at the time of each encounter was also recorded whether or not a new prescription was given. Thus drug records are referred to rather than prescriptions. However, repeat prescriptions where the patient was not seen were not included because there was no formal 'encounter'. Drug details were collected using the health centre's own coding system.[9]

Six-year cohort of patients

In order to study the natural history of psychosocial disorders over a long period the analysis was restricted to those patients registered with the practice continuously for six years (1975–80) for which there were records. There were 3,613 such patients (1,800 females and 1,813 males) and the average total list size over the six years was 8,094. Of the 3,613 patients continuously registered, 1,377 (38 per cent) had at least one psychosocial problem recorded during the six-year period and these 1,377 patients were called the 'six-year cohort'.

A computer printout of the six-year cohort was prepared, showing the numbers of psychosocial encounters, other encounters and psychotropic drug records for each patient over each quarter (three months). Thus trends in these parameters could be observed over 24 successive quarters.

Worst year of psychosocial encounters

When the printout was scanned by eye for these trends, it was soon realized that for many patients psychosocial problems were not evenly distributed over the 24 quarters but tended to be concentrated in a relatively short time. The printout was therefore examined to find each patient's 'worst year', that is for the four consecutive quarters with the most psychological encounters and the number of patients with at least half their psychosocial encounters occurring in their worst year were counted.

Results

General trends

Over the six-year period 1975–80 there was a general reduction in the three factors recorded—psychosocial encounters, other encounters and psychotropic drug records (Table 1). These reductions occurred more in the six-year cohort than in the practice population as a whole, and in males more than in females. Psychosocial encounters declined more than other encounters and the largest reductions occurred with psychotropic drug records.

Worst year for psychosocial encounters

There were 202 patients (15 per cent) within the six-year cohort who had at least 12 psychosocial encounters, which allowed study of the distribution of these encounters over time. Table 2 shows the number of such

Table 3. Six-year cohort patients ($n=81$) referred to clinical psychologist, classified by sex and number of psychosocial encounters.

Total number of psychosocial encounters over six years	Six-year cohort		Six-year cohort referred to clinical psychologist			
	Males no.	Females no.	Males no.	(%)	Females no.	(%)
1–11	450	725	13	*(3)*	14	*(2)*
12–29	57	91	11	*(19)*	20	*(22)*
30+*	13	41	3	*(23)*	20	*(49)*
Total	520	857	27	*(5)*	54	*(6)*

* Range of encounters: 30–127 for males; 30–112 for females.

patients who had at least half their psychosocial encounters in their worst year and also shows the number expected if the distribution of encounters were random. The difference between observed and predicted numbers was highly significant in statistical terms. Thus there was a marked tendency for these patients' psychosocial encounters to occur in relatively short-term episodes; this tendency was more likely in males than in females. Fifty-four (27 per cent) of these 202 patients had been referred to the clinical psychologist. There was no statistically significant association between referral to the psychologist and concentration of at least half the psychosocial encounters within a patient's worst year.

Six-year cohort patients referred to the clinical psychologist

Table 3 shows that referral was positively associated with higher numbers of psychosocial encounters. The excess of females referred to the psychologist came almost entirely from the group with more than 30 psychosocial encounters in six years. Only 14 of these 41 women had half or more of their psychosocial encounters in the 'worst year'; the remaining 27 women might be said to constitute the 'hard core' of chronic neurotic problems and 13 were referred.

No patient over the age of 65 years was referred, and there were only four referred patients aged under 15 years (ages on 1 January 1975).

Thus the clinical psychologist typically saw young adults, who were more likely to be female.

Discussion

Our results would seem to indicate that at the time of introduction of a clinical psychology service and for several years afterwards there was a general fall in the use of psychotropic drugs and the consultation rates for psychosocial problems and for all other problems. We also found that when a large cohort of patients with recorded psychosocial problems was followed up over six years, 57 per cent of the patients had more than half their psychosocial encounters in one 'worst year'. Thus in these patients any follow-up after the 'worst year' would show a dramatic reduction in rate of consultation for psychosocial problems. These findings mean that it may be difficult to interpret reductions in consulting and prescribing rates after referral to a psychologist or another therapist unless contemporary trends for the whole practice are known. Furthermore, we suggest that the natural history of psychological and social problems is one of crisis and resolution in the majority of patients although in some patients, particularly women, there may be a more chronic course and this group is likely to demand much consulting time over the years.

These conclusions seem sobering when compared with the evident enthusiasm of both patients and staff for our clinical psychology service. Even Earll and Kincey in their controlled study reported high satisfaction with the services of the psychologist,[1] and an indepth study in our own practice by a fourth-year medical student confirmed this finding in patients who had suffered from depression. The truth may be that distressed patients are always grateful for personal and sympathetic interest, whether or not their future behaviour is altered.

The impact which may be made on a practice by a psychologist offering one or two sessions of individual therapy per week seems small considering our finding that only 6 per cent of our 'six-year cohort' of patients with psychosocial problems had been referred by the end of the study period (admittedly the service had only been available for rather less than two thirds of this time). However, 49 per cent of women with high consultation rates for psychosocial problems were referred to the psychologist, and these patients were often well known to their general practitioners.

Educational role of clinical psychologists

Given the level of psychosocial morbidity in the community individual therapy would have to show dramatic results before the cost of general introduction of clinical psychologists into primary care teams[7] would be justified and it now seems unlikely that such evidence will be forthcoming. We would argue that the most important effect of the clinical psychologist at Aldermoor Health Centre has been an educational one. The introduction of an alternative to psychotropic drugs has been welcome at a time when increasing doubt has been expressed about the wisdom and efficacy of such prescriptions.[10] Anecdotal evidence suggests that the existence of the psychologist in our practice has sometimes enabled doctors to avoid prescribing benzodiazepines, while on other occasions the offer of referral may have satisfied the patient even if it was not taken up. Rather than referring patients to a specialist in this way, it would seem preferable for doctors to learn more about simple problem-orientated psychotherapeutic

PRESENT STATE AND FUTURE NEEDS IN GENERAL PRACTICE

The sixth edition of this well known book by John Fry gives numerous facts and figures about general practice and is a basic reference for all those interested in primary medical care.

Dr Fry has again summarized key information such as the average number of patients, patterns of allowances, and numbers of trainers and teaching practices in a series of tables and charts which are supported by a clear commentary. Particularly useful is the conversion of current rates for illness and services in relation to population units of 2,500 (about one general practitioner) and 10,000 (a typical group practice).

Present state and future needs in general practice has been published for the College by MTP Press Limited and is available from the Publications Sales Department, Royal College of General Practitioners, 8 Queen Street, Edinburgh EH2 1JE, price £5.50 including postage.

A HISTORY OF THE ROYAL COLLEGE OF GENERAL PRACTITIONERS
The First 25 Years

This book records early attempts to form a College, the birth of the College itself, and the story of its growth through childhood to maturity. Edited by three distinguished founder members, John Fry, Lord Hunt of Fawley and R.J.F.H. Pinsent, it is a fascinating tribute to the enthusiasm, persistence and dedication of the men who made the College.

Written by those who were actually involved in its development, the chapters describe not only the story of the structure and organization of the College as a whole but of each of its component parts. Thus its involvement with medical education, standards, research and literature is described as well as relationships with other bodies at home and abroad—and a glimpse into the future.

Undoubtedly a success story, this account of the first 25 years of the College is recommended to those interested not only in the College but in the evolvement of general practice itself. Copies can be obtained from the Publications Sales Office, Royal College of General Practitioners, 8 Queen Street, Edinburgh EH2 1JE, price £10 to members, £12 to non-members, including postage. Payment should be made with order.

skills,[11] and clinical psychologists may have an important contribution to make here.[12]

Some referral facility within the general practice setting may still be desirable even when doctors are better trained in psychosocial problems. It could be argued that only a small minority of our referred patients needed the specific skills of a clinical psychologist and it may be preferable as well as cheaper to explore further the use of counsellors (including volunteers) both for giving support with short-term problems of living and for help with longer term problems of dependence both on drugs and on doctors. Training of such counsellors might be a task for psychologists.

The minority of patients with long-term dependence present a special problem in general practice because they seem to take up a large part of a doctor's time and perhaps because they may have learned some of their behaviour from earlier experience with their medical advisers. Here is an opportunity for clinical psychologists to collaborate with general practitioners in research into the causation of these problems and the development and evaluation of new treatment strategies.

References

1. Earll L, Kincey J. Clinical psychology in general practice: a controlled trial evaluation. *J R Coll Gen Pract* 1982: **32:** 32-37.
2. Anderson S, Hasler JC. Counselling in general practice. *J R Coll Gen Pract* 1979; **29:** 352-356.
3. Cooper B, Harwin BG, Depla C, *et al.* Mental health care in the community: an evaluative study. *Psychol Med* 1975; **5:** 372-380.
4. Brook A, Temperley J. The contribution of a psychotherapist to general practice. *J R Coll Gen Pract* 1976; **26:** 86-94.
5. Ives G. Psychological treatment in general practice. *J R Coll Gen Pract* 1979; **29:** 343-351.
6. Koch HCH. Evaluation of behaviour therapy intervention in general practice. *J R Coll Gen Pract* 1979; **29:** 337-340.
7. McPherson I. Clinical psychology in primary health care. In: *Reconstructing psychological practice.* McPherson I, Sutton A (Eds). London: Croom Helm, 1981.
8. Clark EM. Disease coding in a problem orientated general practice. *J R Coll Gen Pract* 1974; **24:** 469-475.
9. Freeman GK. Analysis of primary care prescribing—a 'constructive' coding system for drugs. *J R Coll Gen Pract* 1978; **28:** 547-551.
10. Committee on the review of medicines. Systematic review of the benzodiazepines. *Br Med J* 1980; **280:** 910-912.
11. Lesser AL. Is training in psychiatry relevant for general practice? *J R Coll Gen Pract* 1983; **33:** 617-618.
12. Pendleton D, Schofield T, Tate P, *et al. The consultation: an approach to learning and teaching.* Chapter 7. Oxford University Press, 1984.

Acknowledgements

We are most grateful to Dr Clive Osmond for valuable statistical advice in the preparation and interpretation of Table 2, and to Dr David Jewell and Professor John Bain for constructive criticism of this paper.

Address for correspondence

Dr G. K. Freeman, Aldermoor Health Centre, Aldermoor Close, Southampton SO1 6ST.