Doctors' views on anxiety management in general practice

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Keywords: general practice; anxiety management

Summary

Various guidelines have been issued to doctors concerning the treatment of anxiety in primary care and particularly on the use of benzodiazepines. Little has been reported about how this advice has influenced doctors' opinions and practice. This paper describes results of interviews with 15 general practitioners and 15 general practitioner trainees on their management of anxiety problems. Most respondents admitted prescribing benzodiazepines for anxiety but reported doing so only in cases of severe distress and for short periods of time. Trainees appeared more cautious in their use of benzodiazepines than the experienced practitioners. Most doctors agreed that counselling could be as effective as benzodiazepines in treating moderate anxiety but several respondents felt it too demanding of their time. Two-thirds of doctors were in favour of employing counsellors in general practice though many foresaw practical difficulties in doing so. Increased availability of clinical psychology services was the development which most respondents felt would improve their management of anxiety problems in primary care.

Introduction

General practitioners are frequently consulted by patients suffering anxiety[1]. Most general practitioners consider treatment of such problems part of their role[2] and fewer than 10% of cases are referred to psychiatric services[3].

In the past, benzodiazepines were widely used as the principal treatment for anxiety[4]. Following evidence of their addictiveness[5-7], however, there has been considerable debate about the use of these drugs. While some doctors have suggested banning use of benzodiazepines in treating anxiety[8-10] others have defended their role[11-13].

Recently, guidelines on the use of benzodiazepines have been issued by several professional bodies[14-16]. The Committee on the Review of Medicines[14] advised against using benzodiazepines in long-term management of anxiety because of lack of evidence that their efficacy as anxiolytics extended beyond 4 months. It was recommended that benzodiazepine therapy be short-term, carefully monitored and withdrawn gradually to minimize withdrawal symptoms.

Following evidence of the dependence-inducing potential of benzodiazepines, more recent guidelines have gone further. Both the Committee on the Safety of Medicines[15] and the Royal College of Psychiatrists[16] advised that benzodiazepines are indicated only for short-term relief of anxiety that is severe, disabling or causing a patient unacceptable distress. Furthermore, they stipulated that continuous benzodiazepine therapy should rarely extend beyond one month. They also noted that in cases of bereavement or other loss, psychological adjustment may actually be inhibited by benzodiazepines[16].

In addition to such recommendations, research has suggested that alternative methods of anxiety management may be equally effective to benzodiazepines. There is evidence that antidepressants may be superior to benzodiazepines in the treatment of many anxiety-related problems often seen in general practice[17,18]. Moreover, it has been claimed that non-pharmacological approaches may be as effective as pharmacological treatments for moderate anxiety[19].

Catalan *et al.*[19] compared the effectiveness of benzodiazepines with counselling by general practitioners in treating patients who would normally have been prescribed anxiolytics. Counselling consisted of simple listening, explanatory advice and reassurance. Improvements in the two treatment groups were similar in amount and parallel in course over 7 months suggesting that withholding benzodiazepines had not prolonged distress which might have been ameliorated by medication.

Counselling did not demand any more of doctors' time than did prescribing benzodiazepines, either at initial interview or in terms of subsequent consultations, and patients receiving counselling appeared more satisfied than those given benzodiazepines.

Catalan and Gath[20] later argued that for moderate anxiety the best treatment is brief counselling by a general practitioner or another professional working in the practice. For severe anxiety they advocated that counselling, benzodiazepines or both be tried initially but emphasized that drug therapy should be limited to 3 weeks while psychological or social intervention is organized.

Thus general practitioners have received various recommendations concerning management of anxiety problems. However, little has been reported on how this has influenced their opinions and practice[21,22]. The present study therefore sought to elicit the views of some general practitioners and general practitioner trainees on their treatment of anxiety.

Method

Samples

Semi-structured interviews were considered the most suitable mode of data collection and in the time available it was possible to conduct 30 interviews.

A random stratified sample of 15 general practitioners was drawn from a list of doctors (n=129) responsible to one Family Practitioners Committee in the West Midlands. Stratification was according to sex of doctor and length of experience in practice.

A sample of 15 general practitioner trainees was selected non-randomly, comprising a group of doctors under the guidance of a single GP Trainee Tutor.

0141-0768/92/020083-04/$02.00/0

Procedure

Between January and March 1989, data were collected by interviews conducted by the first author in the doctors' practices. To maximize comparability of results, each doctor was asked the same questions although prompts were used to encourage clarification and elaboration of answers when appropriate. Interviews lasted approximately 45 min (range 20-90 min). With respondents' permission, interviews were tape-recorded and transcribed for analysis. Many of the data gathered were in the form of definite responses to specific questions. Where data resulted from open questions an attempt was made to categorize responses although no co-rating was used.

Results

General information

Among the GPs, of whom four were female, the average length of experience in general practice was 12.2 years (range 3-32 years). Among the trainees, seven of whom were female, the average time since completion of their first medical degree was 5.9 years (range 4-13 years). The mean length of time spent working in general practice was 6.9 months (range 2-12 months).

The doctors were asked to estimate the average length of time of a surgery consultation and the maximum time they could allow for any patient. Mean duration of a consultation was 6.6 min (range 4-10 min) while the average maximum time specified was 22.7 min (range 10-30 min).

Incidence and perceived causes of anxiety problems

The estimated percentage of patients presenting each week primarily with anxiety problems was 9.9% (range 2-50%). Female trainees gave a higher estimate than males ($\overline{X}_{females}$=12.3% vs $\overline{X}_{males}$=6.3%; t=4.45, $P<0.001$) and this was also true for GPs ($\overline{X}_{females}$=16.8% vs $\overline{X}_{males}$=8.5%; t=3.9, $P<0.01$).

For the causes of anxiety, respondents most frequently cited intra-family relationship problems, work stress and financial difficulties as the main precipitants. Traumatic life events, eg bereavement and divorce, and concerns about health each accounted for just over a fifth of causes mentioned.

Frequency and kinds of medication prescribed for anxiety problems

Four respondents, three of them trainees, said they would only rarely prescribe medication to patients suffering anxiety but declined to give a numerical estimate. For the 26 doctors who did, the average estimated percentage of patients given medication was 44.1% (range 5-100%). However, GPs reported prescribing drugs to a higher percentage of anxiety patients than trainees ($\overline{X}_{GPs}$=48.8% vs $\overline{X}_{GPTs}$=39.4%; t=4.26, $P<0.001$).

Six (43%) trainees named benzodiazepines as the medication they would use most in treating anxiety but the majority claimed to use either antidepressants (n=5, 36%) or β-blockers (n=3, 21%) most often. One trainee said he would never prescribe benzodiazepines for anxiety. By contrast, a majority (n=9, 60%) of GPs reported that they most frequently prescribed benzodiazepines for anxiety.

Use of benzodiazepines in treating anxiety

None of the doctors was prepared to prescribe benzodiazepines for patients anxious about driving tests and only two would consider doing so for examination anxiety. In the former situation 60% of respondents said they might prescribe β-blockers while 44% were prepared to use this medication in the latter circumstance. The remainder reported that they would only offer reassurance in such cases.

Table 1. Maximum length of time doctors would issue a first prescription of benzodiazepines

	Total sample (n=30)	GPs		GP trainees	
		Males	Females	Males	Females
Up to 7 days	10 (33%)	2	2	3	3
8-14 days	14 (47%)	7	0	3	4
15-30 days	4 (13%)	2	2	0	0

A majority of doctors confirmed that they would prescribe benzodiazepines to someone who had suffered a bereavement (87%) or were going through a divorce/marital breakdown (70%). However, most emphasized their reluctance to do so and stipulated that they would use drugs only in cases of acute anxiety reactions and just in the short term.

For anxiety related to social isolation or unemployment, six doctors (20%) reported that they might prescribe benzodiazepines, although all stressed that they would do so only in cases of severe anxiety, for a limited period and would also try to intervene at a psychosocial level simultaneously.

Most (80%) doctors were prepared to issue a first prescription of benzodiazepines sufficient for only 14 days or less (Table 1). However, the average initial prescription length specified by GPs was longer than that of trainees ($\overline{X}_{GPs}$=16.1 days vs $\overline{X}_{GPTs}$=9.85 days; t=6.1, $P<0.001$).

A third of trainees said they would not prescribe benzodiazepines continuously to any patient for more than 3 weeks although none of the GPs specified such a short time limit. While four GPs did stipulate a limit of 4 weeks, most said they would make a judgement on treatment duration for each patient individually. A third of the trainees expressed the same view.

Views on counselling in anxiety management

All the trainees and most (n=13, 87%) GPs agreed that counselling by a general practitioner could be equally effective to benzodiazepines in treating moderate anxiety. Three respondents said they believed counselling would be more effective and a further three reported receiving positive feedback from patients whom they had counselled. However, several other doctors argued that counselling is more time consuming and represents a constraint to adopting that method. Nevertheless, all respondents agreed that counselling is part of a general practitioner's role and most said they felt comfortable doing it. However, six (40%) trainees admitted feeling inadequate in counselling patients and three attributed this to lack of appropriate training during their medical education.

Three GPs were convinced that general practitioners do not have time to listen to patients' emotional problems. Four trainees (27%) and seven GPs (47%) also felt that lack of time is a constraint but is not always an insurmountable barrier to providing counselling. However, most trainees (n=10, 67%) and

a third of GPs rejected the claim that pressure of time should limit a doctor's willingness to listen to patients' concerns. They argued strongly that GPs can devote time to fulfil this function if necessary.

Two-thirds of respondents favoured employing counsellors within practices. They felt that such a development would benefit patients and be advantageous for GPs in terms of reducing workload, increasing time for other duties and by providing a readily accessible alternative treatment to medication. However, many respondents doubted the financial feasibility of employing counsellors. Others expressed concern about losing valuable contact with patients receiving counselling, while two respondents thought patients might prefer to see their doctor even if a counsellor was available. About a third of doctors were actually against the suggestion. Some iterated the same concerns outlined above, while others felt that GPs ought to undertake any counselling required and refer to other professionals if necessary.

Developments that would enable GPs to treat anxiety optimally

Over half the doctors thought increased access to clinical psychology services would be a valuable development in managing anxiety problems more effectively in primary care. Eight (28%) respondents wished for more time to devote to patients with such problems, while a fifth of doctors thought the employment of counsellors in general practice would be beneficial. Better training for doctors in non-pharmacological treatment techniques was advocated by seven (24%) of those interviewed.

Discussion

Given the smallness and mode of selection of samples involved, these findings clearly cannot necessarily be assumed to reflect the views or practice of primary care doctors in general. Moreover, the validity of the data depends on the accuracy and veracity of the reports given by the interviewees. Since the use of benzodiazepines has become controversial it may be that some of their responses were influenced by this, although an assurance of confidentiality was given and the doctors seemed keen to discuss candidly the dilemmas they face in this area of practice. That the interviewer was a psychologist represents another possible source of bias perhaps especially when respondents expressed opinions on clinical psychology services.

However, studies of this kind are rarely carried out and, despite the possible limitations noted, the results do provide an insight into the opinions of some primary care doctors on a difficult area of practice.

There was a wide variation in estimates of the incidence of anxiety problems among patients, with a tendency for female practitioners to give higher estimates. This is consistent with previous studies[23,24] which suggest that general practitioners differ in their diagnosis of anxiety disorders, although the reasons for this variability are not clear.

There was, however, more consensus about the main causes of anxiety, with difficulties in interpersonal relationships and social structural factors, eg work pressures, perceived as major precipitants of anxiety. This confirms the view of Gabe and Lipshitz-Phillips[21] that general practitioners do not operate with any simple unicausal model of anxiety nor do they attribute the source of problems exclusively to intra-personal factors.

Yet, despite awareness of extra-individual influences in the causation of anxiety, many doctors admitted to prescribing medication to a high proportion of patients with such problems. There were, however, some indications that trainees were less inclined to offer prescriptions for anxiety and were more likely than the general practitioners to use medications other than benzodiazepines. This may reflect a tendency among those entering primary care toward greater use of alternatives to medication in managing anxiety coupled with a reticence about using benzodiazepines as anxiolytics.

Most respondents appeared to be using benzodiazepines broadly in accordance with recent guidelines. A majority of doctors stressed that they prescribe benzodiazepines only for acute, severe distress and most claimed to give an initial prescription for only 2 weeks or less. That trainees were generally inclined to give a shorter first course is again perhaps indicative of a more cautious approach in using these drugs. Moreover, five trainees were not prepared to prescribe benzodiazepines for more than 3 weeks which is the maximum period for benzodiazepine therapy recommended by Catalan and Gath[20]. By contrast, none of the general practitioners specified a time limit as brief as 3 weeks and many placed no explicit limitation on continuous prescribing.

There was greater agreement among interviewees about when they might prescribe benzodiazepines. The majority considered benzodiazepines inappropriate for anxiety related to driving tests or examinations. There was also an obvious reluctance to prescribe such medication for patients with potentially long-term problems such as unemployment or social isolation; there was no indication that benzodiazepines would now be widely used as long-term palliatives in these situations.

The doctors seemed most prepared to use benzodiazepines in response to anxiety related to traumatic life-events like bereavement or divorce. This is consistent with findings of a recent questionnaire survey[22]. Thus, despite warnings that benzodiazepines may inhibit psychological adjustment in such loss situations, it appears that many doctors remain convinced that their use here is justified. However, most doctors emphasized that they preferred to manage such situations with counselling alone and would provide short-term treatment with benzodiazepines only in instances of extreme distress.

The place of counselling in general practice and the question of who should provide it has long been a source of debate[25-27]. Almost all the respondents seemed convinced by the claim that counselling by general practitioners can be as effective as benzodiazepines in treating moderate anxiety[19]. However, many general practitioners and a third of trainees believed counselling would demand more time than they could afford. This is perhaps surprising since Catalan *et al.*[19] found that the mean initial consultation time for patients given counselling was only 12 min with a range of 3-25 min. This time period is well within the maximum time which most interviewees here said they could allow a patient in a normal surgery.

Part of the confusion may arise from the lack of a clear definition of counselling. Rowland *et al.*[26] usefully distinguished between counselling skills (eg listening, empathizing etc.) and the process of counselling. They further argued that while GPs

might benefit from improving their use of specific skills there are many constraints to doctors routinely fulfilling a formal counselling role. Certainly, the study by Catalan *et al.*[19] would appear to suggest that increased use of basic counselling skills by doctors is worthwhile, and achievement of this level of competence by GPs would seem feasible.

As Corney[26] pointed out, however, the value of counselling in general practice has proved difficult to research and remains poorly evaluated. Our results therefore perhaps merely underline the confusion felt by GPs about what level of counselling is likely to be appropriate for their patients. It is possibly significant that six (40%) trainees reported feeling inadequate in counselling patients, with three mentioning lack of preparation in medical training as the reason. Although appeals for such training date back to the mid-seventies[28] it seems that some doctors are still entering general practice feeling uncertain about how best to offer counselling to patients.

Employing counsellors in general practice received support from most respondents even though evaluation studies have provided equivocal results about their efficacy[27]. However, although many doctors envisaged benefits for themselves and patients in such a development, a variety of problems were identified. Moreover, a third of doctors were against employing counsellors, particularly those who thought that they should offer any basic counselling themselves and refer on to other professionals when necessary.

Interestingly, most of the developments which doctors felt would enhance their treatment of anxiety concerned non-pharmacological measures. Nearly all the respondents thought that clinical psychologists have an important role in treating anxiety problems in primary care but many complained of the lengthy waiting lists for services due to lack of numbers. Also highlighted was a desire for improved training in non-pharmacological techniques of anxiety management for doctors. Perhaps most significant of all, however, was that only two doctors expressed a hope for the future development of further, albeit safer anxiolytic medications.

The results of the present study suggest that recent concerns about benzodiazepines may have encouraged a more cautious attitude to their use as anxiolytics. However, although most of the doctors interviewed were favourably disposed to non-pharmacological interventions as an alternative there was obvious uncertainty about which means are effective. This is understandable in view of the dearth of research in this area[27] but highlights two important conclusions. First, if GPs are to be persuaded to use alternatives to benzodiazepines, and particularly non-pharmacological alternatives, more convincing evidence of their efficacy is needed. Second, if GPs themselves are being advised to alter their approach to relating to patients in some way, appropriate undergraduate and postgraduate training is required.

Acknowledgments: We wish to thank the 30 doctors who participated in this study. Our thanks are also due to Professor Raymond Cochrane.

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(Accepted 31 May 1991)