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Letters to the Editor

Dear Editor,

Re: Sharp & Power (1998). Panic outcome ratings in primary care. *Behavioural and Cognitive Psychotherapy*, *26*, 13–27

We found Sharp and Power's article on treatments for panic disorder and agoraphobia in primary care interesting. We share their concern over the difference between statistical and clinical significance and agree entirely about the usefulness of global ratings.

The authors, however, hold that they are the first to use global ratings by psychologist, GP and patient for these disorders in this setting and that only one previous study (Power, 1990) had used GP ratings. They also report that the GP ratings differed significantly from those of the psychologists and patients and conclude that GPs may need prior training in research assessment methods.

In fact, we used global rating scales in a study reported in 1984 (Robson, France, & Bland, *BMJ*, *288*, pp. 1805–1808), for problems treated by clinical psychologists in primary care, including panic and agoraphobia. These rating scales were designed in co-operation with Professor Andrew Matthews and Dr Martin Bland of St George's Hospital. Three 9-point Likert scales were used to assess the problem as defined by the patient and the GP. Patient, significant other and GP rated the severity of the problem, effect on the sufferer and effect on the household. Every second point on each scale was labelled e.g. (0) no problem – (8) very severe. A cohort of index patients and controls was also rated by a blind assessor.

We found no significant difference between the ratings of the blind assessor and those of the patient's own GP. In addition, the GP ratings correlated well with those completed by the patient and the significant other. One other result that emerged, and surprised us, was that there was not significant difference between the GP ratings at the referral appointment and those of the psychologists at their initial appointment. This provides an interesting contrast with the current authors' concern about the efficiency of GP assessments. We should add that in our group of six GPs only one might have been considered to have had special mental health care or research experience. There are a number of other possible confounding factors that deserve further examination.

It was apparent to us that scales used by GPs and other primary care raters should be short, clear and simple. This was not so much because GPs were unable to use more complicated instruments but because the high number of patient contacts and lack of consultation time in primary care put brevity at a premium. We found the scales in our study were both statistically valid and subjectively relevant to primary care

patients. The latter were able to rate a problem in their own terms, thus avoiding some of the problems of construct validity mentioned by the current authors.

Yours sincerely,

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Reference

Robson, M. H., France, R., & Bland, M. (1984). Clinical psychologist in primary care: Controlled clinical and economic evaluation. *British Medical Journal*, *288*, 1805–1808.

Dear Editor,

Re: Letter from Drs Robson and France regarding Sharp & Power (1998). Panic outcome ratings in primary care. *Behavioural and Cognitive Psychotherapy*, *26*, 13–27

We find the comments of Drs Robson and France on the above paper interesting. The reason we did not include a reference to their work (Robson, France, & Bland, 1984) in our paper was that we did not see it as directly relevant to our discussion for a number of reasons. In particular, our comments were directed towards controlled treatment studies that focused on specific anxiety disorders, namely panic disorder and generalized anxiety disorder. The Robson et al. (1984) study was conducted on a mixed sample of patients who were not classified according to an internationally recognized diagnostic system, and only 51% of whom suffered from what was described by the authors as "anxiety/stress". Also, treatments in the Robson et al. study were not standardized to the same degree as treatments given in controlled comparative outcome studies such as we were discussing (Power, Simpson, Swanson, & Wallace, 1990; Sharp et al., 1996). The measure of severity employed by Robson et al. (1984) differed from the scales used in our studies and more recent studies. We used the Clinical Global Intensity and Clinical Global Improvement scales (Guy, 1976) designed for use in psychopharmacological treatment outcome studies. Furthermore, we have some reservations as to whether the measure used by Robson et al., namely an agreement between patient and doctor as to the nature of the main problem, will always constitute a truly global measure.

We have some data suggesting that when asked to identify their main problem some patients will identify highly circumscribed and individual problems or indeed social circumstances, which may not concur with a global measure of outcome.

It was not our intention to suggest that no previous research had taken ratings of outcome from general practitioners; the Robson et al. study is indeed an example of such work. Our discussion, however, focused on the use of recognized global rating scales (Guy, 1976) in controlled treatment outcome studies conducted on specific patient populations (GAD and panic disorder), defined according to standardized criteria (DSM III, DSM III-R). It was simply for these reasons that we did not include the Robson et al. study in our discussion. Our omission implies no criticism, and we regard their work as an interesting early example of the importance of involving referral agents such as GPs in the assessment of treatment outcome.

Yours sincerely,

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