

Research papers

A cognitive analytic framework for understanding and managing problematic frequent attendance in primary care

Deborah Pickvance

Clinical Lead Psychotherapist, Workplace Wellbeing Service, Psychological Health Sheffield, UK

Glenys Parry

Professor of Applied Psychological Therapies, University of Sheffield School of Health and Related Research, Sheffield, UK

Amanda Howe

Professor of Primary Care, School of Medicine, Health Policy and Practice, University of East Anglia, Norwich, UK

ABSTRACT

Aim To develop and demonstrate the use of a systematic approach to identifying and managing problematic frequent attendance in primary care.

Study type Phase I: development of intervention.

Setting Two urban primary care practices.

Method Patients were identified whose attendance at the practice was inappropriately frequent, using a statistical method adjusting for age and sex and an operational definition of 'problematic' attendance. Three in-depth interviews were conducted with a subsample of nine patients from these lists, to build up a profile of patterns of and reasons for inappropriate frequent attendance. Focus groups with members of the primary care teams were conducted to explore attitudes to and management of frequent attendance. A cognitive-analytic framework was applied to these qualitative data to identify 'reciprocal roles' in doctor–patient interaction for these patients. On this basis, a training and consultation intervention was developed which aimed to alert practitioners

to these patterns in order to alter their reciprocating role behaviour.

Results Three 'procedural sequences' were identified that characterise unhelpful but self-maintaining patterns of consulting. Feedback from the teams receiving the training intervention was positive, reporting increased understanding, team co-operation and changes in practice.

Conclusion Frequent attending can be understood as part of a pattern of interpersonal relating which unwittingly maintains or encourages the behaviour. After a brief training intervention, this framework can be used by primary care staff to become alert to these patterns and to understand and manage frequent attendance. The effectiveness of this intervention in reducing consultation rates requires formal evaluation through a phase II cluster randomised trial.

Keywords: cognitive analytic therapy, frequent attenders

Introduction

Concern about frequent attendance in primary care centres on three issues:

- 1 the question of whether frequent attenders have health needs that are not being met by the primary care team
- 2 the demands made by frequent attenders on primary care team members' time with resulting pressure and difficulties in workload and management of patient–professional relationships
- 3 the argument that it represents an ineffective use of primary care resources in health economics terms.

The definition of frequent attendance varies. Some authors define it as greater than a certain number of consultations per annum others in terms of a percentile cut-off in a practice population.¹ A distinction has been made between two patterns of frequent attendance in a given time period – regular, sustained high usage and short-term intensive consultation rates which then return to normal levels.² Because consultation rates increase with age, and women consult more than men at most stages of life, we developed an approach which initially corrects for different normative attendance rates in different age groups.³ This identifies those whose attendance pattern appears unusual.

Despite definitional uncertainty, there is a growing knowledge of the phenomenon. The characteristics and consulting patterns of frequent attenders have been described by many authors.^{4,5} Frequent attendance is associated with female gender, advancing age, co-morbidity, psychosocial problems, adverse life events, external locus of control, and social isolation. The workload generated by frequent attenders is considerable, but while many clinicians and patients recognise factors that may influence attendance, the 'case mix' of frequent attenders is very varied, and the ways in which dysfunctional patterns of service use might be altered remain unclear.^{5–7} In any case, evidence that very frequently attending patients are often significantly psychologically distressed makes reduced attendance as a goal in itself appear inappropriate: the issue is more one of recognition and evaluation.⁸ For example, patients with somatisation syndrome may benefit from frequent consultation with a small number of primary care clinicians who know the patient, and can avoid invasive medical procedures or surgery.⁹

Using practice-based data to define frequent attendance can be misleading. The consultation style of individual professionals and the way health services are organised influence attendance patterns,

and patterns of frequent attendance are not stable over time.¹⁰ In any case, statistical definitions alone do not capture the phenomenon. This is mainly because, within any study population identified statistically, some will be attending frequently for appropriate medical management of acute or chronic diseases.

Many studies do not differentiate between those attending frequently with chronic physical disease from those who have no apparent mental or physical health problem accounting for the consultation pattern. The latter group, which may include those presenting with psychosocial difficulties, medically unexplained symptoms, somatisation disorder and health anxiety, are the focus of this study.

Factors in the doctor–patient relationship (or relationship with another primary care professional) are likely to maintain frequent attendance. For example, doctors can unwittingly contribute to the exacerbation of medically unexplained symptoms through such reactions as overtreatment, multiple investigations and ineffective reassurance.¹¹ A negative doctor–patient interaction was found to be predictive of more frequent attendance in irritable bowel syndrome.¹²

Attempts to intervene in reducing inappropriate frequent attendance vary in complexity. A very simple intervention providing general practitioners (GPs) with detailed and accessible summaries of the patients' clinical records unfortunately had no impact on consultation rates.¹³ A small randomised trial obtained positive results for a three-day programme of guided written disclosure of stressful or traumatic experiences, which aimed to give patients more control over their trauma memories.¹⁴ Psychiatric consultation letters to primary care physicians have been found to be cost-effective in the management of patients with somatisation syndrome or its more extreme form, somatisation disorder, in terms of improved physical functioning rather than through reduction in primary care consultation.¹⁵

An example of a complex intervention was provided by a specialist multidisciplinary community team, which undertook a comprehensive biopsychosocial consultation followed by presentation of a reformulation which interweaved life history and symptoms in a new narrative. This was followed, if required, by short-term psychological therapy (ten sessions), pharmacotherapy for anxiety, depression or panic, and in some cases referral to specialist psychological treatment. Introducing this approach was found to reduce treatment costs substantially in an uncontrolled study, although a full economic evaluation examining costs and outcomes in a randomised trial is not yet available.¹⁶

The purpose of our current study was to develop a conceptual framework for understanding the

phenomenon in terms of the relationship between the patient and the doctor (or other primary care team member), using qualitative methods. We wished to use this framework as the basis for developing a team-based training intervention to help primary care teams manage frequent attendance more effectively. Preliminary information about the acceptability of this intervention was obtained.

Conceptual framework

We required a conceptual framework that would enable primary care teams to formulate the phenomenon of frequent attendance in a manner that would facilitate reflective practice, give greater insight and change attitudes and behaviour maintaining the phenomenon. We selected a method based on cognitive analytic therapy (CAT) because its therapeutic approach focuses on a diagnostic description of how the patient relates to others, and therefore can describe (formulate) problematic patterns of interpersonal relationships being maladaptively re-enacted in professional–client relationships.

CAT is an integrative model of psychopathology and psychotherapy developed in the UK over recent decades by Anthony Ryle and in recent years further extended both theoretically and clinically by others.^{17,18} The CAT model weaves together theoretical strands from child development, personality and psychopathology, and these have come to be underpinned by a radically social concept of self. CAT asserts the pervasively dialogic nature of the human world, where internalised self–other relationship patterns become the basis of reciprocal role procedures governing intrapersonal as well as interpersonal relationships. The CAT model is consistent with a range of other relational psychotherapeutic models which share this emphasis on problematic relationship patterns being re-enacted in patient–professional relationships.^{19,20}

According to cognitive analytic theory, relationships with others and intrapersonal self-management follow established patterns – these are described as *reciprocal role procedures*. They have their origins in childhood, form the basis for interpersonal interaction, and involve the prediction and elicitation of responses in others. The reciprocal roles enacted by two people interacting with one another can change in a dialogical sequence. A ‘role’ can elicit more than one reciprocal role in response. A *procedural sequence* is the enactment of a reciprocal role procedure; it consists of cognitive and affective processes and incorporates an aim, action, consequence and

appraisal. A problematic procedure is one which has a negative effect, not meeting the aims of the person enacting it, but which, despite this, is resistant to change. Procedures can be usefully represented in a diagrammatic form.

Despite this theoretical complexity, an attractive feature of CAT for our purpose was its emphasis on developing collaborative formulations of these problematic patterns in simple terms, easily understood by patients, or by NHS staff working with patients. These formulatory tools are increasingly used in consultation interventions with mental health staff and emergency departments.^{21–23} The use of the framework in primary care extends these applications, but in a way entirely consistent with long established traditions of mental health consultation to general practice.²⁴

Study design

The study, which was exploratory in nature, took place in two inner-city practices in different parts of Sheffield and had three phases. In the first phase computerised attendance data were used to draw up a list of frequent attenders for each practice: GPs and nurses then completed questionnaires in order to identify which frequent attenders were perceived as ‘problematic’. The second phase concentrated on gathering detailed information about patterns and causes of frequent attendance and methods of managing it within the practices, and involved consulting with both patients and the clinical teams. The third phase consisted of the design and delivery of a training intervention to each primary care team by cognitive analytic therapists and a preliminary evaluation of this intervention. The methods and results of each phase will be reported separately below.

Phase 1: identifying ‘problematic’ frequent attenders

Phase 1 method

This phase involved the identification of frequent attenders in the two practices, using a method we describe elsewhere.³ The routine computerised attendance data for each practice were interrogated in order to obtain a list of patients who had the highest 3% of number of attendances over a one-year period, compared with their practice population,

after correction for age and sex. The data included consultations with nurses and other team members as well as doctors. The GPs, nurses and practice counsellor then completed a questionnaire for each patient on this list. In this questionnaire, staff were asked to indicate whether there was a clear medical reason for a patient's frequent attendance, whether they perceived psychological factors to make a significant contribution in the pattern of attendance, and whether they thought the patient's pattern of attendance was 'appropriate' (or not) to their needs.

On the basis of these questionnaires a shorter list was drawn up of patients whose pattern of attendance was perceived as having a psychological component: as being potentially inappropriate; and for whom there were no specific reasons for exclusion from the study. Patients were selected for this list on the basis of at least one doctor or nurse assigning a maximum score for psychological factors, irrespective of concurrent physical healthcare needs. The patients were then ranked according to the extent to which their attendance pattern was perceived to link to their psychological rather than physical needs. Staff indicated whether there was any reason why a patient should be considered ineligible for the study.

Phase 1 results

In Practice 1, the primary care team of eight staff participated – five GPs, two nurses and the practice counsellor. The statistical method yielded 106 patients who were in the top 3% of attendance frequency for their sex and age group. Of these, 41 (39%) were rated by at least one staff member as having a major psychological component to their attendance pattern. Fourteen patients were considered ineligible for the study for one of the following reasons: a severe mental illness unlikely to be amenable to relational approaches; a recent trauma or bereavement, where the increase in attendance was new and explicable; and patients currently seeing a counsellor or other psychological therapist, where an intervention was already occurring. A total of 27 patients were finally identified and rank ordered. In Practice 2, the primary care team of seven staff participated – five GPs and two nurses. The statistical method yielded 79 patients who were in the top 3% of attendance frequency for their sex and age group. Of these, 33 (42%) were rated by at least one staff member as having a major psychological component to their attendance pattern. Fourteen patients were ineligible for the study for the same reasons as in Practice 1. A total of 19 patients were finally identified and rank ordered. The combined total from both practices was 46 patients who met criteria for problematic frequent attendance.

Phase 2: exploring relationship patterns in frequent attendance

Phase 2 participants

In the second phase of the study, in-depth interviews were conducted with a subsample of patients from the lists derived from the first phase, in order to build up a profile of patterns of and reasons for inappropriate frequent attendance. In the first practice the 18 patients ranked highest of the 27 were invited, by a posted letter signed by one of their GPs, to attend these interviews. Eleven patients declined or did not attend, and a further four did not complete all the interviews. In the second practice, the procedure for inviting patients to take part in the study was altered; marker cards were placed in the notes of all 19 shortlisted patients, and when the patient next attended surgery, the doctor or nurse would give the patient a letter inviting them to take part in the study. Using this method, six patients were recruited, making a total of nine patients across both practices completing all three interviews, and a further four providing partial information.

Ethical approval for the research was obtained from the LREC, and all patients gave informed consent after receiving an information sheet describing both the confidential way in which information gathered in the study would be used, and also what participation in the study would involve. Primary healthcare team members were bound by professional codes of practice and NHS clinical governance rules in relation to the confidentiality of identifiable material discussed in the focus groups and case discussion sessions.

Phase 2 method

Interviews with patients

The patients completed the General Health Questionnaire (GHQ-12) and the CORE outcome measure. In addition they were asked to complete a questionnaire used in cognitive analytic therapy to identify common problematic patterns in the management of feelings and relationships (this questionnaire, 'the psychotherapy file', is reproduced in full in Ryle, 1990 and Ryle and Kerr, 2003^{17,18}) and a questionnaire covering their health, the health of their family of origin, their family relationships in childhood, current family relationships and social activities. Each patient attended three interviews with a cognitive analytic therapist who was also an accredited trainer in the method (DP), in which they were asked about their symptoms, their reactions

and associations to illness, illness behaviour in their family, significant relationships in childhood and adulthood, their ways of dealing with emotion, their current work, social and domestic activities, and their perceptions of their general practice and relationships with primary care staff.

Focus groups with staff

To gather information about staff attitudes to and management of frequent attendance, two cognitive analytic therapists ran a focus group for the clinical staff in each practice. In these groups, the staff were asked to explore their views and feelings about frequent attenders, including whether they thought they contributed to patterns of frequent attendance, whether they reacted to different patients differently and if so, why. They were also asked to discuss the strategies that individual staff or clinical teams used to manage frequent attendance. The focus groups were audiotaped with the permission of the participants.

Using the results of these interviews and measures and the information gathered in the focus groups, cognitive analytic formulations of problematic frequent attendance were drawn up by one cognitive analytic therapist (DP), describing the roles and implicit expectations and behaviour adopted by frequently attending patients and their clinicians. The CAT formulation method, described by Ryle and Kerr, requires a trained practitioner with accredited competence.¹⁸ The CAT method has explicit and measurable criteria for competence, and has been validated against two other qualitative coding methods in psychotherapy research.^{25,26} In this study, as a further check on the integrity of the method, a second experienced cognitive analytic therapist and trainer (GP) compared the formulations with data from the interviews and questionnaires.

Phase 2 results

Some patients were surprised to learn that they attended the practice more frequently than other patients, and did not identify any concerns about the way in which they used the practice's services. Most patients had a positive view of the care they received in the practice. Patients gave positive feedback to practice staff about their involvement in the study.

Equally, doctors and other practice staff were also surprised at times to find a particular patient was a frequent attender. This showed that in some professional-patient relationships, frequent attendance for psychological reasons is not perceived by the doctor or the patient as problematic.

The focus groups, which were attended by all the GPs and practice nurses, revealed divergent attitudes towards frequent attenders among the doctors and nurses, some seeing consultations with problematic frequent attenders as an acceptable part of their work which was compatible with their holistic view of the purpose of general practice. Others sought to restrict the time given to these patients and cited ways of doing this, e.g. by giving definite dates or time intervals to patients who attended often, allocating one doctor to a family of frequent attenders. It appeared that doctor attitudes influenced patient consulting patterns, as some staff saw very few such patients, while others saw many more. Staff members were aware that they could reinforce frequent attending, and acknowledged difficulty in confronting patients.

The range of attitudes and approaches to frequent attenders is shown in the following quotations from doctors:

I don't have a problem with providing a service for someone to come and use me as a prop, someone to moan to, a shoulder to moan on, if they haven't got a neighbour or friend or somebody else they can use. OK, maybe it's not a very cost-effective use of my training, but I feel if it's providing them with something that's positive in their life, then I don't have a problem with providing that as a service. If it is manageable, once every six weeks or once a month, I think we can ride with a certain number of these.'

I must be the hard woman of the practice ... I don't have so many patients who just come and whinge.

I say, 'come back and see me if X, Y or Z occurs' or 'I don't need to see you unless such and such'. I bring back people who are depressed till they're OK again. I don't consider those to be inappropriate.'

After combining themes from the patient interviews with the focus group data, reciprocal roles between frequent attenders and doctors were derived using the CAT formulation method. These are summarised in Table 1.

A number of procedural sequences were also identified which patients enact both in their personal lives and in their relationships with primary care clinicians. On the basis of the data gathered in this phase three types of problematic frequent attendance were postulated:

The 'strong copier'

A frequent attender who is a strong copier in their family may have a dominant reciprocal role procedure of:

dependent, needy, seeking care ↔ responsible, caring.

The aim of the patient's procedural sequence is to seek acceptance and love by attending to the needs of others. This means that they adopt a responsible,

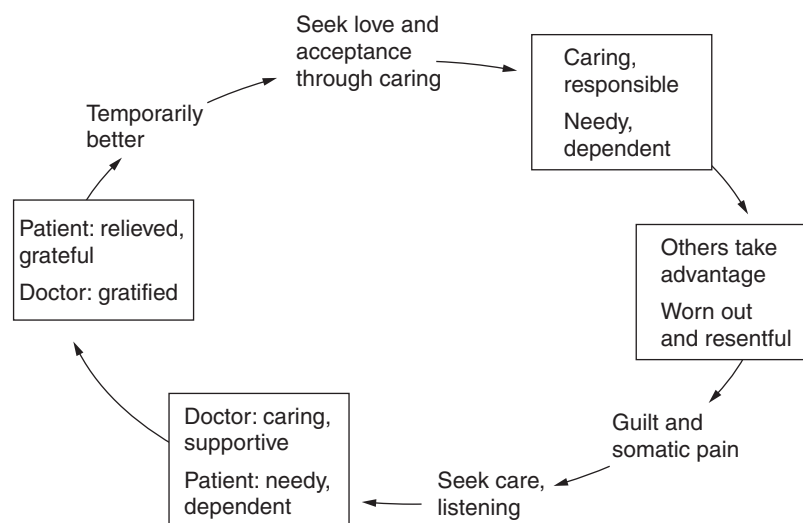
Table 1 Reciprocal roles between doctors and frequent attenders

Patient	Doctor
Insecure, seeking care, safety and protection	Powerfully caring, reassuring
Powerless, passive, stuck	Powerful, responsible, controlling
Powerless, passive, stuck	Defeated, overwhelmed, stuck
Dependent, needy, clinging, anxious	Dependable, 'OK', reassuring, guilty
Flattering, appreciative	Feel special, valued, seduced, want to carry on pleasing
Demanding, controlling, dominating	Anxiously striving to please
Demanding, controlling, dominating	Impotent, helpless, manipulated (into prescribing, referring)
Anxiously demanding help but rejecting it	Pressurised, helpless, frustrated
Seeking reassurance but rejecting it	Powerless, annoyed, frustrated

caring role, devote themselves to looking after others, and others become dependent on them. Within this role, they deny their own emotional needs and feel guilty about having them; the negative consequences that follow are that others take advantage and the patient feels resentful or worn down. The denial of and guilt about their own feelings and needs result in somatic pain. In the consultation with the doctor, the patient then swaps reciprocal roles, feels needy and seeks care from the doctor. Feeling cared for and reassured by the doctor the patient feels temporarily better, only to resume the caring role in the family once more. This is represented diagrammatically in Figure 1.

Difficulty in emotional awareness and communication

Some patients do not have the experience of having their feelings acknowledged by others and they do not expect their emotional experience to be understood. They may be alexithymic, i.e. unaware of their emotions as well as unable to express them. They may have had unresolved traumatic experiences in childhood or adulthood that have not been processed emotionally. They may ward off feelings and become tense, and then experience and communicate their distress in a bodily or somatic way. Their attention then focuses on the somatic pain and they seek reassurance for their somatic symptoms;

**Figure 1** The strong coper

however their tension is not relieved by a doctor's reassurance, as the cause of the pain is emotional not physical. The doctor can feel helpless and the patient dissatisfied, resulting in a reciprocal role procedure of:

anxiously seeking reassurance ↔ reassuring, but ineffective.

Figure 2 shows this procedural sequence.

Anxiety over illness

Some patients' anxious preoccupation with symptoms can result from a range of causes: parental anxiety about illness, chronic or serious illness in the family, a lack of normalisation of symptoms, or secondary gain from being ill. This leads to a reciprocal role procedure of:

anxious, seeking attention ↔ anxiously attentive.

The patient will thus seek an anxiously attentive response from the doctor e.g. through referral to a specialist, doing tests, asking the patient to return. When the doctor reassures the patient instead, the patient feels rejected and dismissed and may respond by becoming demanding:

Rejected, dismissed ↔ reassuring, but ineffective.

This can lead to a dysfunctional consultation when the doctor can feel trapped in any of a number of reciprocal roles:

anxiously demanding ↔ striving to please

anxiously demanding ↔ manipulated, pressurised

anxiously demanding ↔ frustrated, stuck.

Figure 3 shows this sequence.

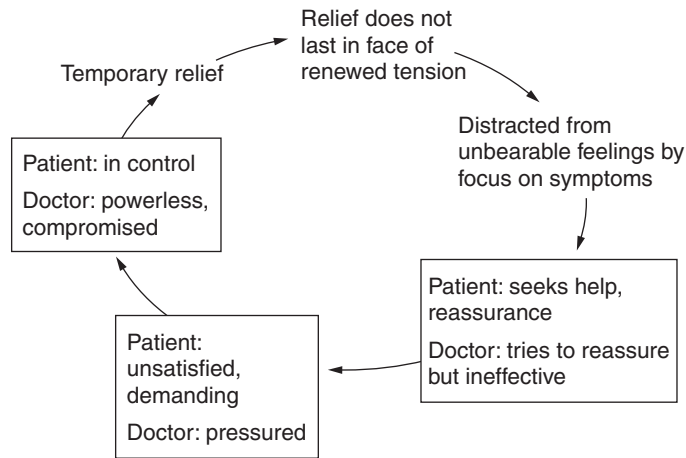


Figure 2 Difficulty in emotional awareness and communication

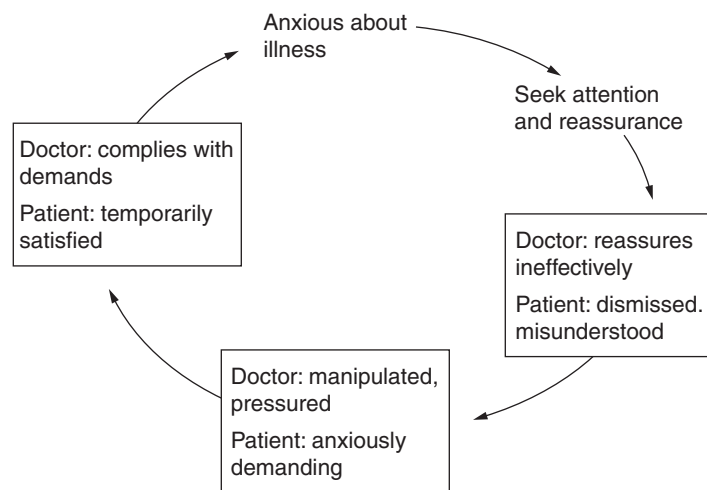


Figure 3 Anxiety about illness

Phase 3: the intervention

Phase 3 method

In this phase the training intervention was designed and delivered, and a preliminary evaluation was undertaken. The training package consisted of a training workshop for the primary care team followed by a series of six structured case discussions. At the end of the intervention, teams were consulted about their views of the approach by means of questionnaires and a focus group.

In the training workshop, two teams received presentations on the research evidence about frequent attenders and on a cognitive analytic approach to problematic patterns of primary care consulting. This approach was illustrated by videotaped, role-played doctor–patient consultations, demonstrating the three different types of presentation of frequent attendance described above. The formulations developed in the second phase provided the theoretical basis for these examples. They were used in the construction of the video case vignettes and in the discussion of these cases in the training workshop. Each doctor was given a copy of the list of reciprocal role procedures, which they could then refer to during or after surgeries.

The aim of the case discussions was to help the clinical team to understand the patterns of interpersonal relating which the patient was enacting in the consultation and to help them to avoid reciprocating the reciprocal role patterns which were leading to stuck, unproductive or unnecessary consultations. They were arranged at fortnightly intervals; the first ones focused on patients who had participated in the interviews in phase two of the project. Subsequent discussions looked at other cases selected by the doctors and nurses from the shortlist of problematic frequent attenders derived in the first phase of the project. The doctors and nurses selected cases on the basis of demands or challenges currently presented by patients to one or more members of staff. For each case, a reformulation of the patient's relationship patterns and their impact on the consultation was made, and on the basis of this, the team agreed a plan for managing their future attendance.

Phase 3 results

The feedback received from the primary care teams at the end of the intervention indicated that the discussions were valuable. They increased the awareness in the primary care team of underlying processes in consultations. The list of reciprocal role

procedures was particularly useful. Staff could readily identify the reciprocal roles that they and their patients were adopting. The discussions were most useful for staff who knew the patients under discussion and when there was adequate preparation of the information about the patients. Reported results of the intervention included: increased understanding e.g. that there were alternative ways of coping with the same patient, co-operation within the team, e.g. an offer by one doctor to see a patient who was making many demands on another doctor, and a change in practice (a nurse reduced the regular and very frequent appointments she offered a patient).

Time was a key issue; doctors in particular had difficulty in giving adequate time to the intervention. They found the case discussions time consuming and thought that a smaller number of discussions would be adequate to demonstrate the approach.

Discussion

This exploratory study demonstrates the use of a systematic approach to identifying and managing problematic frequent attendance in primary care. We used a statistical method that adjusts for age and sex, and an operational definition of 'problematic' or 'inappropriate' frequent attendance. A cognitive analytic framework was then used to identify 'reciprocal roles' in doctor–patient interaction for these patients. Three 'procedural sequences' were identified that characterise unhelpful but self-maintaining patterns of consulting. These were used to develop training materials. Two primary care teams received a training and consultation intervention that aimed to alert practitioners to these patterns in order to alter their reciprocating role behaviour. Feedback from the teams was positive, reporting increased understanding, team co-operation and changes in practice.

We found that frequent attending can be understood as part of a pattern of interpersonal relating which unwittingly maintains or encourages the behaviour. Three of these patterns were identified using the psychotherapeutic interview and CAT formulation method, supplemented by staff focus groups. Although this was conducted to appropriate standards for a clinical formulation, as a research method it has the drawback that it relies on clinical judgement. Because independent formulations were not obtained, it leaves open the question of whether a different interviewer and formulator would have derived different reciprocal roles. As a validation method, further research could use psychotherapy process research techniques with blind independent

raters to identify such patterns within patient consultations with their doctors.²⁶

Although the training intervention used was found to be helpful, the six consultation sessions afterwards demanded considerable time from the team, and many felt it would be possible to shorten this period.

Only some frequent attenders were found to be 'heartsink' patients. This term is itself descriptive of the experience of enacting some of the reciprocal roles outlined here, for example 'demanding, controlling, dominating' in relation to 'impotent, helpless, manipulated', or 'anxiously demanding but rejecting help' in relation to 'pressurised, helpless, frustrated'. However, other frequent attenders, while just as 'problematic' in our definition, may be enacting a different pattern of 'flattering, appreciative' in relation to 'special, valued, want to carry on pleasing'. Although this pattern is subjectively more pleasant for the health professional, it may still be preventing more appropriate care.

The extent to which the nine patients studied in depth were representative of the 46 identified as problematic frequent attenders is a key issue. A majority of those approached by letter in the first practice declined to participate, and this reluctance may have introduced a systematic bias. Although a personal invitation to participate from the GP had a much better result in the second practice, and is less open to response bias, it depended on the patient consulting the practice during the study period. However, in the case discussions the primary care professionals were able to recognise the patterns from the index patients in other patients from the full list. The interpersonal patterns identified from the 20% sample may not therefore be a comprehensive account of all such patterns, but are unlikely to be atypical of the group under study.

This study has a major limitation, in the lack of outcome measurement for the identified patients. However, it was conceived as 'exploratory', to develop and test the conceptual framework and the intervention, the first phase described in the Medical Research Council framework for the development and evaluation of randomised controlled trials for complex interventions.²⁷ The next step is a phase II cluster randomised trial to evaluate its clinical and cost-effectiveness. It will also be possible to make a controlled comparison between this method (which uses an indirect intervention focusing on changing the doctor-patient and team-patient interaction), and others that intervene directly with the patient, using formulary methods, guided written disclosure or a psychological therapy.

ACKNOWLEDGEMENTS

We should like to thank Brian Hockley for assistance in identifying frequent attenders using the statistical method, and Dr Tom Heller for assistance with preparing training materials, including videotapes of role-played consultations. We are grateful to the staff and patients in the two primary healthcare teams who participated in this study.

This work was supported by the NHS Priorities and Needs R&D programme through the Sheffield Health and Social Research Consortium.

REFERENCES

- 1 Freeborn DK, Pope CR, Mulloly JF and McFarlan BH. Consistently high users of medical care among the elderly. *Medical Care* 1990;28:527-40.
- 2 Ward AM, Underwood P, Fatovich B and Wood A. Stability of attendance in general practice. *Family Practice* 1994;11:431-7.
- 3 Howe A, Parry G and Pickvance D. Defining frequent attendance - evidence for routine age and sex correction in studies from primary care. *British Journal of General Practice* 2002;52:561-3.
- 4 Little P, Somerville J, Williamson I *et al.* Psychosocial, lifestyle and health status variables in predicting high attendance among adults. *British Journal of General Practice* 2001;51:987-93.
- 5 Neal RD, Heywood PL, Morley S, Clayden A and Dowell A. Frequency of patients' consulting in general practice and workload generated by frequent attenders: comparisons between practices. *British Journal of General Practice* 1998;48:895-8.
- 6 Baez K, Aiarzaguena JM, Grandes G *et al.* Understanding patient-initiated frequent attendance in primary care: a case control study. *British Journal of General Practice* 1998;48:1824-7.
- 7 Neal R, Heywood P, Morley S. 'I always seem to be there' - a qualitative study of frequent attenders. *British Journal of General Practice* 2000;50:716-23.
- 8 Katon W, Lin E, Von-Korff M *et al.* Somatization: a spectrum of severity. *American Journal of Psychiatry* 1991;148:34-40.
- 9 Kashner TM, Rost K, Cohen B, Anderson M and Smith GR. Enhancing the health of somatization disorder patients. *Psychosomatics* 1995;36:462-70.
- 10 Neal RD, Heywood PL and Morley S. Freight trains and supernovas: the use of a sorting task to determine patterns within longterm frequent attendance to GPs. *Primary Care and Mental Health* 2000; 1:39-50.
- 11 Page LA and Wessely S. Medically unexplained symptoms: exacerbating factors in the doctor-patient encounter. *Journal of the Royal Society of Medicine* 2003;96:223-7.
- 12 Owens G, Nelson D and Talley N. The irritable bowel syndrome: long term prognosis and the physician-patient interaction. *Annals of Internal Medicine* 1995;122:107-12.

- 13 Jiwa M. Frequent attenders in general practice: an attempt to reduce attendance. *Family Practice* 2000; 17:248–51.
- 14 Gidron Y, Duncan E, Lazar A *et al.* Effects of guided written disclosure of stressful experiences on clinic visits and symptoms in frequent clinic attenders. *Family Practice* 2002;19:161–6.
- 15 Smtih GR, Rost K and Kashner TM. A trial of the effect of a standardized psychiatric consultation on health outcomes and costs in somatizing patients. *Archives of General Psychiatry* 1995;52:238–43.
- 16 Matalon A, Nahmani T, Rabin S, Maoz B, Hart J. A short term intervention in a multidisciplinary referral clinic for primary care frequent attenders: description of the model, patient characteristics and their use of medical resources. *Family Practice* 2002;19:251–6.
- 17 Ryle A. *Cognitive Analytic Therapy: active participation in change*. Chichester: Wiley, 1990.
- 18 Ryle A and Kerr IB. *Introducing Cognitive Analytic Therapy*. Chichester: Wiley, 2002.
- 19 Schact TE, Binder JL and Strupp HH. *Psychotherapy in a New Key*. New York: Harper Collins, 1984.
- 20 Safran JD and Muran JC. *Negotiating the Therapeutic Alliance: a relational treatment guide*. New York: Guilford, 2000.
- 21 Dunn M and Parry G. A formulated care plan approach to caring for borderline personality disorder in a community mental health setting. *Clinical Psychology Forum* 1997;104:19–22.
- 22 Kerr IB. Cognitive analytic therapy for borderline personality disorder in the context of a community mental health team: individual and organisational psychodynamic implications. *British Journal of Psychotherapy* 1999;15:425–38.
- 23 Sheard T, Evans J, Cash D *et al.* A CAT-derived one to three session intervention for repeated deliberate self-harm: a description of the model and initial experience of trainee psychiatrists in using it. *British Journal of Medical Psychology* 2000;73:179–96.
- 24 Balint M, Ornstein PH and Balint E. *Focal Psychotherapy: An example of applied psychoanalysis*. London: Tavistock Publications, 1972.
- 25 Bennett D and Parry G. A measure of psychotherapeutic competence derived from cognitive analytic therapy (CCAT). *Psychotherapy Research* 2003.
- 26 Bennett D and Parry G. The accuracy of reformulation in cognitive analytic therapy: a validation study. *Psychotherapy Research* 1998;8:405–22.
- 27 Medical Research Council. *A framework for development and evaluation of RCTs for complex interventions to improve health*. London: Medical Research Council, 2000.

CONFLICTS OF INTEREST

None.

ADDRESS FOR CORRESPONDENCE

Deborah Pickvance, Clinical Lead Psychotherapist, Workplace Wellbeing Service, Psychological Health Sheffield, Sheffield Care Trust, 574 Barnsley Road, Sheffield S5 6UA, UK. Tel: +44 (0)114 226 1810; fax: +44 (0)114 226 1811; email: deborah.pickvance@sct.nhs.uk

Received
Accepted