

PSYCHOLOGICAL MANAGEMENT IN
ROUTINE FAMILY PRACTICE

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ABSTRACT

Background: Little is known about the provision of psychological management in routine primary care. This study examines patient demographic and clinical characteristics which predict who receives psychological management at three university affiliated family medicine practices.

Methods: Primary care patients (N=937) completed a mental health screening form immediately prior to their medical visit. Results were withheld from their physicians (N=7). Following the visit, the physicians were asked to classify the range of psychological interventions they used to manage their patients' emotional problems during the visit. A structured psychiatric diagnostic interview was subsequently administered to a subgroup of the patients (N=288).

Results: At least one psychological intervention was provided to nearly a quarter (24.1%) of the patients. The interventions included listening to the patient's emotional problems (22.4%), providing advice (19.0%), discussing the patient's mental disorder diagnosis (11.4%), and providing individual counseling (8.4%) or family counseling (0.6%). Two thirds (66.7%) of the patients who reported that their emotional health was poor received at least one of these psychological interventions. In a multivariate model, the likelihood of receiving a psychological intervention was increased for patients who were separated or divorced; between 45 and 59 years of age; had less than a college education; received disability payments; reported poor emotional health; or had a positive SDDS-PC screen for panic disorder, major depressive disorder, or obsessive-compulsive disorder.

Conclusion: Primary care physicians may be far more extensively involved in providing psychological interventions than is commonly assumed. Individual determinants of who receives psychological interventions included measures of clinical need and predisposing sociodemographic characteristics.

Considerable attention has been devoted to the role of primary care physicians in the provision of ambulatory mental health care. Interest in this area has been fuelled by the observation that more patients with mental disorders are cared for in the general medical sector than in the mental health sector (1,2). While researchers have devoted considerable effort to measuring the extent of psychopathology in primary care (3-5) and to assessing the diagnostic skills (6-8) and prescribing practices (9-11) of primary care physicians, less attention has been given to the routine psychological management of mental disorders in primary care. Important gaps remain in our understanding of the extent, range, and appropriateness of psychological interventions provided by primary care physicians.

A common stereotype of the primary care physician is a harried and overworked practitioner who focuses more on the pharmacologic than the psychologic dimensions of patient care (12). Support for this generalization comes from the finding that, as compared with psychiatrists, primary care physicians spend considerably less time with their mentally ill patients and write more prescriptions for psychotropic medications per patient visit (13,14).

In office-based practice, primary care physicians are more than twice as likely to prescribe a psychotropic medication than to provide psychotherapy for emotional problems (15). A national household survey revealed that only 4.7% of psychotherapy visits are provided by nonpsychiatrist physicians (16). However, because these studies focused on psychotherapy, they may have missed a range of other psychological interventions which are often provided in primary care practice. Primary care physicians may commonly rely on a variety of less formal verbal interventions, such as providing practical advice, offering reassurance, and teaching patients that their current symptoms are a reaction to a stressful life event (17).

According to a national survey, family physicians report using some type of psychological intervention in roughly two-thirds of the cases who they believe have a significant psychiatric disorder (18). This therapy consists almost exclusively of supportive problem solving, advice, and reassurance, rather than formal psychotherapy (18). These survey results suggest that psychological interventions may be far more common in primary care than is generally assumed. In support of this view, primary care physicians also report spending a bit more time with their depressed patients than they do with their other patients (14).

In the current study, we describe the extent to which a variety of informal psychological interventions, such as listening to emotional problems and offering advice, are provided during the course of routine practice. We also examine patient sociodemographic as well as functional and clinical characteristics which predict who receives these psychological interventions.

METHOD

General

The study was conducted during the Spring and Summer of 1992 at three private primary care practices in cooperation with the Brown University School of Medicine Departments of Family Medicine and Psychiatry. One of the practices has the equivalent of 2.5 full-time physicians, one has two full-time physicians, and one has two full-time physicians and two nurse practitioners. None of the practices were engaged in on site teaching of medical students or interns and residents at the time of the study and all of the physicians were board certified in Family Practice.

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The data were collected as part of a study to validate a screening and diagnostic system

for mental disorders in primary care: the DSM-III-R Symptom-Driven Diagnostic System for Primary Care (SDDS-PC) (The Upjohn Co, Kalamzoo, Mich). The methods, primary objectives, and general characteristics of the patient population are described elsewhere (19).

Patients

Consecutive new and continuing patients, between 18 and 70 years of age, who could read and write English were invited to participate in the study. Patients who were coming for prenatal visits and those who were not scheduled to have face-to-face contact with their physician were excluded.

Of 2,262 patients who met initial criteria for inclusion in the study, 1,360 were approached to participate in the study. The remainder were excluded because of rapid patient flow (N=709) or because they left before being seen (N=193). Of the 1,360 patients who were asked to participate, 940 (69.1%) consented and completed the screening form. Physician questionnaires were completed for 937 of these patients.

Patient Screen Form

While waiting to see their physician, patients were asked by a research assistant to complete a questionnaire which probed basic sociodemographic data, role functioning, and mental health symptoms. The mental health symptoms included an abbreviated 18-item version of the Center for Epidemiology Studies Depression Scale (CES-D) (20) and the SDDS-PC screen for multiple mental disorders (19). The SDDS-PC screen is a sensitive and valid first step to the recognition of several common mental disorders in primary care.

Information was also collected on each patient's use of mental health services during the past month, psychotropic medications, medical services, as well as physical and emotional health.

Physician Questionnaire

Following completion of the screening form, each patient was provided with routine medical care by his or her primary care physician. At the end of the visit, the physician was asked to complete a brief questionnaire. This questionnaire asked the physician to assess the patient's overall emotional health, whether the patient had an emotional problem, and if so what kind. When the physician thought the patient had an emotional problem, the physician was asked to select from a list those interventions he or she provided to manage the emotional problem. This list included five types of psychological intervention (listening to emotional problems, providing advice about emotional problems, discussing a possible mental disorder diagnoses with the patient, counseling the patient, and counseling the patient's family), five types of referral for specialty care (psychiatrist, psychologist, neurologist, substance abuse program, and other) and three types of psychotropic medication (minor tranquilizers and hypnotics, antidepressants, and other psychotropic medications).

Diagnostic Criteria

A subset of consenting patients received a face-to-face structured diagnostic interview to determine whether they met criteria for five mental disorders defined in the Diagnostic and Statistical Manual for Psychiatric Disorders, Revised Third Edition (DSM-III-R) (21). This

interview, the Structured Clinical Interview for DSM-III-R, version P (SCID-P) (22,23), was administered by trained mental health professionals (19). The interviews were scheduled for no later than 2 weeks following the medical visit. A comparison of patients who received and did not receive the SCID-P revealed no significant differences in age, gender, or education. However, nonwhites (27%) were significantly less likely to be interviewed than whites (40%) ($P=0.007$). In addition, single persons were less likely to receive a SCID-P interview (34%) than married persons (43%) ($P=0.03$) (19).

Statistical Methods

Between group comparisons on categorical variables were made with the χ^2 -test. The strength of linear relationships between pairs of variables was assessed with the Pearson product-moment correlation (r) and comparisons between correlation coefficients was made with Fisher's r -to- z transformation. A logistic regression was conducted to examine the strength of the association between various demographic and clinical variables and receipt of psychological management. Statistical significance was defined as a two-tailed alpha of 0.05.

RESULTS

Mental Health Interventions

Table 1 presents the frequencies with which the physicians provided a range of interventions to manage emotional problems during the index medical visit. Patients were more than four times as likely to receive some form of psychological management (24.1%) than a psychotropic medication (5.1%) and more than six times as likely to receive psychological

management than a referral for specialty care (3.5%). In a separate analysis, it was revealed that 13.7% of the patients who received psychological management also received a psychotropic medication and 14.2% of those receiving psychological management were also referred for specialty care.

Sociodemographic Characteristics

Table 2 presents the rate of psychological management among various sociodemographic groups. Psychological management was significantly more commonly provided to separated or divorced patients as compared with married, never married, or widowed patients ($\chi^2=8.8$, $df=1$, $p=0.003$), those who had not graduated college ($\chi^2=18.9$, $df=1$, $p<0.0001$), and patients who were 45 to 59 years of age ($\chi^2=7.2$, $df=1$, $p=0.007$). No significant differences in the rate of psychological management were observed between male and female patients or between whites and nonwhites.

Role Functioning & Treatment History

Increased rates of psychological management were found across a range of measures of impaired patient functioning. The likelihood of receiving psychological management was significantly increased among patients who reported having missed work or school because of a mental health problem during the month prior to the medical visit (Table 3). Provision of psychological management was also increased among patients who reported that they did not get along well their spouse or partner and those who stated that they did not have enough money to care for themselves (Table 3). Approximately half (53.6%) of the patients who received disability benefits and fully two-thirds (66.7%) who reported that their emotional health was

poor received psychological management from their primary care physician during the index medical visit.

Previous mental health treatment was also associated with increased rates of psychological management. Provision of psychological interventions was increased among patients who reported that they had been previously hospitalized for a mental health or substance abuse problem, reported recent visits to mental health specialist, or had taken a prescribed psychotropic medication during the past month (Table 3).

Psychiatric Disorder

Approximately half of the patients who received the SCID-P and met DSM-III-R criteria for major depressive disorder or obsessive-compulsive disorder and two-thirds of those who met alcohol abuse/dependence or panic disorder criteria received psychological management (Table 4). The rate of psychological management was also significantly increased among patients who were positive for these four conditions on the SDDS-PC screening questionnaire. A SCID-P diagnosis of generalized anxiety disorder was not associated with psychological management.

In previous research, a score of 16 or above on the full 20-item CES-D has been used to screen for depressive disorder in community samples (24). In the current study, patients who scored 16 or higher on the 18 item CES-D (N=143) were more likely to receive a psychological intervention (45.5%) than those who had lower scores (20.0%) ($\chi^2=42.2$, $df=1$, $p<0.0001$).

Assessments of Emotional Health

Most of the patients reported that their emotional health was either excellent (28.9%) or good (47.7%), rather than fair (19.5%) or poor (3.9%). Approximately two-thirds of the

patients who rated themselves as in poor emotional health were judged to be in either fair (35.3%) or poor (32.4%) emotional health by their physicians.

The correlation between the physician's and patient's rating of patient emotional health was significantly higher among the group who received ($r=.419$) than among the group who did not receive ($r=.197$) psychological management ($z=3.22$, $P<0.001$).

An Explanatory Model of Psychological Management

A logistic regression analysis was conducted to examine the association between provision of psychological management and patient demographic characteristics, role functioning, and clinical symptoms (Table 5). The hypothesized explanatory variables included patient age, gender, race, marital status, education, missing work for emotional reasons, problems getting along with partner, visits with family or friends during the past month, disability payments, overall emotional health, and SDDS-PC screen positive for major depression, panic disorder, alcohol abuse/dependence, or obsessive-compulsive disorder. In this model, the likelihood of receiving some form of psychological management was significantly related to patient age between 40 and 59 years, separated or divorced marital status, less than a college education, receiving disability payments, poor perceived emotional health, and screening positive for panic disorder, major depressive disorder, or obsessive compulsive disorder. The measures of marital distress and impaired occupational functioning were not significantly associated with utilization of a psychological intervention.

DISCUSSION

In the current report, psychological management was the most common form of primary

care treatment for emotional problems. More than four times as many patients received a verbal intervention than a psychotropic medication. Similar results have been reported from a national survey of family practitioners (16). In that survey, more than half (58%) of the physicians reported providing a psychological intervention to a majority of their patients with significant psychiatric problems, while only 10% of physicians reported providing drug treatment this frequently to their affected patients.

In evaluating the high prevalence of psychological interventions in primary care, it is important to consider the degree to which these interventions are matched to patient needs. We found that the likelihood of receiving a verbal intervention was closely tied to the patients' independent assessment of their own emotional health. Fully two thirds of the patients who rated themselves as in poor emotional health received a psychological intervention from their primary care physician. In the subset of our sample who received a structured psychiatric diagnostic interview following the medical visit, two thirds who met criteria for panic disorder or alcohol abuse/dependence and approximately half who met criteria for major depressive disorder or obsessive-compulsive disorder received some type of psychological intervention. Increased rates of psychological intervention were also associated with several measures of functional impairment and patient sociodemographic characteristics (age, marital status, and educational achievement) which may predispose physicians to providing such care.

These findings suggest that the patients who were selected for psychological interventions were under significant psychological distress. At the same time, significant numbers of patients who reported met diagnostic criteria for a psychiatric disorder did not receive a psychological intervention. In evaluating these findings, it is important to bear in mind that the specific clinical indications for brief psychological treatments have not been well established. For this

reason, it is not possible to assess the appropriateness of the care that was actually provided.

For patients receiving a psychological intervention, there was close agreement between the physician's and patient's assessment of the patient's general emotional health. Physicians who take time to listen and respond to their patient's personal problems may have an opportunity to develop a more accurate assessment of their patient's emotional status. In previous research, physicians trained to probe psychological issues have been shown to uncover more psychiatric symptoms and make more accurate diagnoses than their colleagues who did not receive the training (25-27). In the current study, increased attention to psychological problems may help explain the association between physician intervention and improved assessment. Alternatively, when physicians understand their patients' emotional health, patients may be selected to receive a psychological intervention.

The question remains whether such extensive reliance on informal verbal interventions represents effective care. Unfortunately, very little is known about which brief psychological management strategies are effective for which patients. In general terms, some evidence indicates that teaching physicians better interviewing techniques reduces the psychiatric symptoms of their emotionally distressed patients (28,29). In one recent study, a majority of primary care patients recently prescribed an antidepressant reported that their physician used a cognitive behavioral technique (30). Recognition of these interactions was associated with greater adherence to the prescribed antidepressant (30).

Some data further suggest that "clinical management" which includes an assessment of psychiatric symptoms, encouragement, support and advice (31) may be helpful in the treatment of mild depressive disorders. In the NIMH Treatment of Depression Collaborative Research Program study, approximately half of the patients with mild but nonetheless diagnosable current

major depressive episodes recovered following four months of clinical management (32).

However, because there was no study group who did not receive clinical management, it is not possible to estimate the proportion of remissions which would have occurred spontaneously.

Reimbursement schedules that discourage extended patient visits tend to limit the amount of time primary care physicians have available to spend with individual patients. According to the 1992 National Ambulatory Medical Care Survey, the average duration of visits to office-based primary care physicians is just 16 minutes (33). The time intensive nature of more formal psychotherapy makes this mode of treatment simply infeasible in most primary care practices. For this reason, it is important to define and distinguish those conditions which have a high likelihood of responding to brief psychological treatments from those which require more time intensive specialized care. Stuart and Lieberman have developed a model for brief (15 minute) psychological intervention which involves asking questions concerning the patient's background state, affect, current troubles, and handling or management of these troubles together with empathic statements which express the physician's concern for the patient (17).

The current findings are constrained by several limitations in the data. The significant rate of patient refusal to participate raises the possibility that the study sample was not representative of the three practices with respect to mental health status and treatment. Specifically, recruitment may have been more efficient when the practices were less busy and the physicians had a greater opportunity to provide psychological interventions. Second, the inter-rater reliability of the various psychological interventions is unknown. For example, one physician might label "advice" what another physician would label "counseling." Third, because physicians were aware of the general purpose of the study, they may have been more likely to report that they provided a psychological intervention than they would be under typical

practice conditions. Fourth and perhaps most important, the study was conducted with a small number of university-affiliated physicians treating a rather affluent and well educated patient population who completed a mental health screening form immediately prior to the patient visit. It is not known whether similar results would have been obtained with a different patient population in a different treatment setting.

Beyond direct interventions from the primary care physician, several models have been developed for linking specialized mental health services to primary care practice (34-36). One approach relies on nurses who have been trained in interpersonal counseling (37). Under such an arrangement, the physician can refer those patients who do not respond to routine clinical management for more extensive psychological counseling within the primary care setting. A more complicated and ambitious strategy places an entire multidisciplinary mental health treatment team in the primary care practice (38).

Efficient integration of specialized services into primary care will require an understanding of the strengths and limitations of the psychological interventions routinely provided by primary care physicians. Research in this area is limited by measurement problems. Standard research methods need to be developed which reliably quantify the psychological interactions which occur between the physician and patient during routine visits. One interesting strategy scores videotaped interviews for various aspects of the physician's behavior including the types of questions asked, whether the physician interrupts the patient or uses gestures to facilitate information, the extent of eye contact between the physician and patient, and other aspects of interviewing style (26).

CONCLUSION

We report evidence that family physicians in three private practices provide some form of psychological management to approximately one quarter of their patients. The likelihood of receiving these interventions was closely tied to several measures of psychiatric symptoms and functional impairment. These findings suggest that primary care physicians may be far more commonly involved in the psychological dimensions of patient care than is generally assumed.

Much remains to be learned about the psychological management of mental and emotional problems in primary care. Research is needed to better understand the composition, quality, and quantity of psychological care that is provided in routine primary care practice. More importantly, work is needed to determine which simple psychological techniques help provide relief from the various mental conditions that commonly present in primary care.

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Table 2
Rates of Psychological Management for
Selected Sociodemographic Groups

Sociodemographic Group	No. of Patients in Group	No. Received Psychological Management	Rate of Psychological Management (%)	P*
Sex				
Female	673	159	23.6	.57
Male	264	67	25.4	
Age, year				
18-29	271	58	21.4	.029
30-44	369	89	24.1	
45-59	220	68	30.9	
60-70	76	16	21.1	
Race				
White	910	220	24.2	.52
Nonwhite	22	4	18.2	
Marital Status				
Never Married	210	41	19.5	.01
Married	611	145	23.7	
Separated/Divorced	76	29	38.2	
Widowed	29	9	31.0	
Education				
High school graduate or less	304	86	28.2	<.0001
Some college	228	71	31.1	
College graduate	387	66	17.1	

Psychological Management includes providing of advice, counseling patient or family, listening to emotional problems, and discussing possible mental disorder diagnosis with the patient. *P values obtained using the χ^2 test.

Table 3
Rate of Psychological Management by Patient
Self-Report Function & Treatment History

Measure	No. of Patients in Group*	No. Received Psychological Management	Rate of Psychological Management (%)	P*
Function				
Missed work due to mental health problem (past month)	96	42	43.8	<.0001
Got along not well or poorly with spouse or partner (past month)	62	21	33.9	.04
No visits with friends or relatives (past month)	26	10	38.5	.08
Not enough money to care for self & family (past month)	148	46	31.1	.03
Receiving financial disability payments (current)	28	15	53.6	.0002
Self-assessed poor emotional health (past month)	39	26	66.7	<.0001
Treatment History				
Mental health specialist visit (past month)	100	50	50.0	<.0001
Mental health/substance abuse inpatient admission (lifetime)	47	23	48.9	<.0001
Taken prescribed psychotropic medications (past month)	107	49	45.8	<.0001

Psychological Management includes providing advice, counseling patient or family, listening to emotional problems, and discussing possible mental disorder diagnosis with the patient. Total N varies from 937 to 925, except for spouse item where total N was 774.

*P values obtained using the χ^2 test.

Table 4
Rate of Psychological Management by SCID-P
Diagnosis and SDDS-PC Screening Status*

Measure	No. of Patients with Condition	No. Received Psychological Management	Rate of Psychological Management (%)	P
SCID-P Diagnosis (N=388)				
Alcohol abuse or dependence	12	8	66.7	.001
Generalized anxiety disorder	12	3	25.0	.94
Major depressive disorder	61	32	52.5	<.0001
Obsessive-compulsive disorder	9	5	55.6	.04
Panic disorder	27	18	66.7	<.0001
SDDS-PC Screen Status (N=937)				
Alcohol abuse or dependence	34	16	47.1	.001
Generalized anxiety disorder	443	148	33.4	<.0001
Major depressive disorder	299	112	37.5	<.0001
Obsessive-compulsive disorder	262	94	35.9	<.0001
Panic Disorder	218	91	41.7	<.0001

Psychological Management includes providing advice, counseling patient or family, listening to emotional problems, and discussing possible mental disorder diagnosis with the patient. SDDS-PC (The Upjohn Co, Kalamazoo, Mich.) indicates Symptom-Driven Diagnostic System for Primary Care and SCID-P, Structured Diagnostic Interview for the Diagnostic and Statistical Manual of Mental Disorders, Revised Third Edition.

*P values obtained using the χ^2 test.

Table 5
Selected Risk Factors for
Provision of Psychological
Management in Primary Care

Risk Factor	Odds Ratio (95% CI)
Demographic Variables	
Age of patient (40 to 59 years)	2.11 (1.43-3.10)*
Sex of patient (male)	1.32 (0.89-1.94)
Race of patient (white)	1.59 (0.47-5.39)
Marital status of patient (separated/divorced)	1.82 (1.02-3.26)*
Education of patient (less than college)	1.92 (1.33-2.78)*
Role functioning	
Missed work for emotional reasons (present)	1.55 (0.91-2.67)
Problems getting along with partner (present)	0.82 (0.48-1.41)
Visits with family and friends (absent)	0.74 (0.28-1.92)
Disability payments (present)	2.93 (1.17-7.33)*
Emotional health (poor)	2.95 (1.30-6.72)*
SDDS-PC Screen Status**	
Panic disorder screen (positive)	1.94 (1.28-2.94)*
Alcohol abuse/dependence screen (positive)	1.87 (0.84-4.36)
Obsessive-compulsive disorder screen (positive)	1.51 (1.01-2.25)*
Major depressive disorder screen (positive)	1.54 (1.02-2.32)*

Psychological Management includes providing advice, counseling patient or family, listening to emotional problems, and discussing possible mental disorder diagnosis with the patient.

CI denotes confidence interval. Reference group is presented in parentheses. *Lower bound of confidence interval exceeds 1.00. N=851, constant=-2.99.

**SDDS-PC (The Upjohn Co, Kalamazoo, Mich.) indicates Symptom-Driven Diagnostic System for Primary Care.