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WHAT DOES A DOCTOR DO WITH PSYCHOSOCIAL PROBLEMS IN PRIMARY CARE?

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ABSTRACT

Though a lot has been published on the prevalence of psychosocial disorders in primary care, less is known about the actual treatment, given by primary care providers. This article describes treatment given to complaints which are considered by the physician as being psychosocial by nature. Treatment has been assessed by means of observation. A database of approximately 1500 videotaped consultations, sampled from thirty general practitioners has been used for this purpose. The possibilities and limitations of (generalist) psychosocial treatment in primary care are discussed.

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Key Words: general practitioner, primary health care, psychosocial problems, treatment.

What mental health care is being delivered in primary care? To answer this question we need an understanding of the way primary care providers actually treat the psychosocial problems which are presented to them.[1] This understanding is lacking at the moment. Though a lot of research has been done

[1] For the sake of convenience we use the term "psychosocial problems" to indicate all not purely physical problems. In this way the term designates psychiatric as well as milder psychoneurotic and social problems; they might be presented as mental complaints as well as co-existent with somatic complaints.

METHOD

To study doctors' treatment of psychosocial problems a research was conducted among thirty Dutch general practitioners. The data consisted of 1569 videotaped doctor-patient consultations, and a questionnaire about each contact filled in by the GP. The reason for visit, as put forward by the patient, was derived by observing and coding the encounter by means of the Reason for Encounter classification, RFE [12], a predecessor of the ICPC, the International Classification of Primary Care [13]. The physicians' assessment of the psychosocial character of the RFE was based on a four-point scale, containing the following categories:

1. strictly somatic,
2. somatic with psychosocial side-effects,
3. somatic presentation, with a suspected psychosocial background,
4. mainly psychosocial

This categorization is derived from McWhinney in a slightly adapted form [14]. Goldberg and Bridges mention a categorization which similarly tries to do justice to the fact that many complaints are presented somatically (and accordingly have a somatic RFE) while there is a suspicion of a psychosocial background [15].

The consultations were sampled by videotaping all doctor-patient encounters of thirty Dutch general practitioners until sixty recordings had been made. About 15 percent of the patients refused to participate, 16 percent of these patients had psychosocial problems. The sample of thirty GP's appeared to be slightly more oriented towards general-medicine, as opposed to specialist medicine, and had attended more post-graduate training courses on applied medical-psychology than the average Dutch GP [16]. An implication of this sample characteristic could be a psychosocial bias in the sense that the selected GP's show a greater tendency to focus on the psychosocial aspects than more clinically oriented colleagues.

The treatment of psychosocial problems was coded by the observers[2] with the following categories:

- prescribing psychotropic drugs,
- passive counseling (encouraging, comforting, listening),
- active counseling (exploring, giving insight),
- referral to somatic specialists,
- referral to mental health agencies,
- advice.

[2] For a more detailed description of the complete observation procedure, consult [16].

Table 3. Assessment of 1999 Complaints Presented to Thirty GPs Broken Down by Age

	Patients < 40		*Patients > 40*		
Assessment	*N*	*(Percent)*	*N*	*(Percent)*	*Total*
1. Strictly somatic	594	57	461	48	1055
2. Somatic with psychosocial side effects	156	15	197	21	353
3. Somatic with psychosocial background	164	16	162	17	326
4. Mainly psychosocial	128	12	137	14	265
Total	1042		957		1999

$\chi^2 = 30.1; p = 0{,}001$

relationship between the sex of the patient and the assessment of the complaint we turn to the influence of the "age" variable.

There is a greater difference in age groups. Most detected psychosocial problems are presented by middle-aged patients (40 to 59 years). The somatic-psychosocial ratio decreases with an increase of age, i.e., the average doctor encounters more psychosocial problems in the older age-groups. The data seem to suggest a tendency to perceive more somatic problems when dealing with younger patients and more psychosocial problems when dealing with older patients. This difference in assessment might also be due to a greater number of psychosocial complaints being presented by older patients. We will enlarge on this issue later on when discussing the actual treatment given. Now we will turn our attention to what could be called the crucial issue in the doctor-patient relationship, that is the degree of consonance between the-complaint-presented and the-complaint-perceived. In other words: do patient and doctor agree upon the nature of the problem (Table 4).

Table 4 shows that of all 2001 complaints a mere 8.7 percent were presented as psychosocial problems. A much larger percentage, however, was perceived as one. This could mean that the average general practitioner is well aware of psychosocial comorbidity, it does not mean that he actually treats the psychosocial aspect; this rather vital difference will be discussed later on. Although one might conclude that on the whole doctors and patients seem to agree, their agreement is restricted to the purely somatic cases. Doctor and patient do seem to agree on the true nature of these complaints. There appears to be however an interesting difference of opinion concerning the comorbidity cases (values 2, 3 and 4 in the first column). Especially noteworthy are the 6 percent somatic RFEs which were assessed as mainly psychosocial. Whereas the table shows 8.7 percent psychosocial RFEs (the *patients'* presentation), from the point of view of the *physician* a substantial 47 percent of the problems had a psychosocial aspect to them.

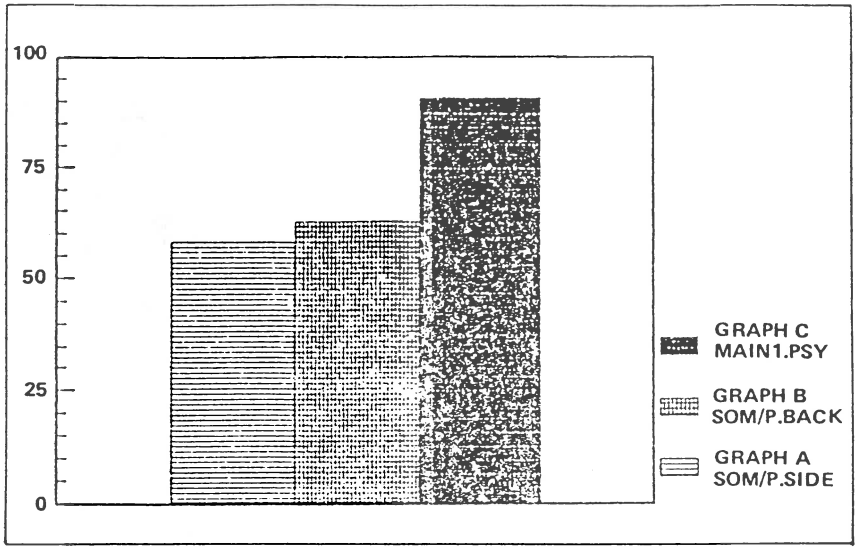

Figure 1. Proportion reactions to complaints assessed as A: somatic/ps.socs side-effects; B: somatic/possible ps.soc background; C: mainly psychosocial.

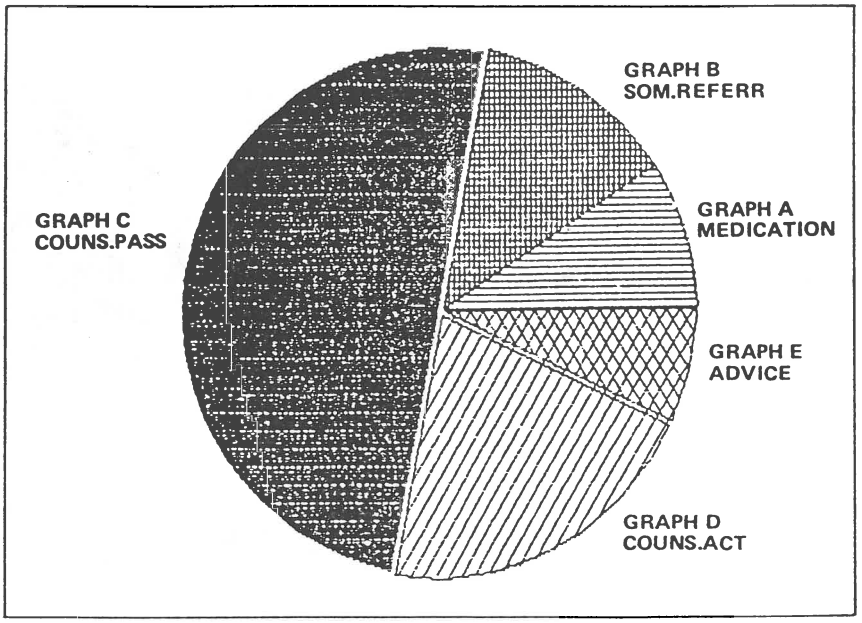

Figure 2. Treatment when complaint is "somatic with psychosocial side-effects."

i.e., more response was observed in the younger age groups. Treatment consists in the younger categories less often in medication, more often in counseling. The counseling itself has a more active nature when the patient is younger.

DISCUSSION

We can summarize the findings of our research as follows. Psychosocial complaints in primary care cover a greater area then one would suspect from the number of psychosocial reasons for encounter, put forward by the patient. The data direct our attention to two related phenomena typical of the average primary care situation. In the first place the doctor perceives more problems as being psychosocial by nature than are actually presented as such. In the second place much of his time is devoted to treating comorbidity. These findings are in accord with the reported prevalence rates for mental illness, measured by screening-instruments; these rates are higher than the number of psychosocial reason for visit a physician reports [1]. They are also in accord with Jencks' findings which showed that a lot of therapeutic listening and psychotopic drugs prescribing occurs without a psychiatric diagnosis. Schurman et al. [2] have pointed to a sharp contrast between the caseload of non-psychiatric agencies and psychiatric agencies: 27.8 percent psychosocial complaints as compared to 72.2 percent. Goldberg and Bridges [15] find 26 percent not entirely physical illnesses among 590 consecutive new patients in general practice, of which only 5 percent are entirely psychiatric illnesses, while 21 percent are labeled "physical illness with secondary psychiatric illness," "unrelated physical and psychiatric illness," and "psychiatric illness with somatic symptoms."

Our findings underline the problematic character of this average-GP-caseload and highlight the unclear situation in which he has to practice his art.

Contrary to the psychiatrist who may devote himself to clear cut psychiatric problems, the primary care physician has to deal with comorbidity. Furthermore it seems to be the case that doctor and patient often start their encounter with rather different views of the nature of the problem.

Purely psychosocial complaints seldom appear to be totally neglected; at least 90 percent got attention. On the other hand, the limitations of primary care became quite clear also: the main focus of treatment is directed to consolation, comfort or reassurance. Results which are in accord with the differences Schurman et al. found between non-psychiatrist and psychiatrist treatment [2]. Non-psychiatrists restrict themselves much more than psychiatrists do, to counseling and prescribing drugs. Psychotherapy in the strict sense of the word was hardly observed. One remarkable finding was the rare occasion that a patient was referred to a psychiatrist or psychotherapist. Detailed analysis showed that many patients with complaints like depression and anxiety were very reluctant to get more specialized help [18]; they considered mental health

To determine the actual effects of the treatment given, a longitudinal study is being conducted at this moment. In this research project the doctor-patient relationship is considered to be a negotiation in which both partners have to reach common objectives: diagnosis, treatment, prescription etc. Videotaped consultations will be analyzed to determine the influence of doctors' interactional style, patients' assertiveness and the nature of the complaint on the success of the treatment. To analyze these consultations additional data are being collected:

- registration by sixteen GPs of all consultations with a sample of 100 patients with psychosocial problems during one year,
- a follow-up study to determine the mental health, attitudes and beliefs of the patient sample.

From this study we hope to deduce possible strategies for the general practitioner to cope with the treatment of psychosocial problems, be they accompanied by somatic comorbidity or not.

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