

General practitioner psychological management of common emotional problems (I): definitions and literature review

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SUMMARY

General practitioners' (GPs) treatment of patients with common emotional problems often includes some form of psychological management within the consultation. Such psychological management may be limited to listening and discussion or may also include more specific psychological approaches, such as use of counselling, problem-solving, or cognitive-behavioural techniques. This paper defines GP psychological management and reviews what is known about its frequency and effectiveness. MEDLINE and PsychLIT searches were undertaken of empirical studies of the psychological management of emotional problems by GPs in routine consultations published up to 1998. Thirty-six studies were identified. Most lacked details of the nature of the psychological management reported, making it difficult to compare studies. The frequency of use of psychological management by GPs was found to be generally less when rated by external observers than when assessed by GP self-report. There is preliminary evidence from a few studies of the clinical effectiveness of GP psychological management in routine consultations.

Keywords: *psychological management; emotional problems; general practice.*

Introduction

It is now well established that a high proportion of patients seen by general practitioners (GPs) have a significant psychological or psychiatric component to their presenting complaint.¹⁻³ The majority of these problems are managed solely in primary care, with only 5 to 10% being referred to secondary care mental health services.^{1,4} Within the primary care setting, an increasing number of practitioners with mental health skills, such as counsellors, psychologists, and community psychiatric nurses, are involved in seeing some of the remaining 90 to 95% of patients with psychological problems;⁵⁻⁷ however, a large majority of patients are still only seen by the GP.

Many of these patients have relatively minor or self-limiting episodes of anxiety or depression but a significant number are more severely affected or at risk of going on to a more chronic or relapsing course.⁸⁻¹⁰ In managing this range of emotional prob-

lems GPs will, in some cases, prescribe antidepressants or other medication¹¹⁻¹³ but they are also likely to use a variety of consultation or counselling skills.¹⁴ Although this is often termed the 'ordinary' GP consultation, the different ways in which GPs interact with their patients in such consultations may have therapeutic consequences.

In this paper we review what is known about how GPs interact psychologically with patients with emotional problems in 'ordinary' consultations and the effectiveness of such consultation behaviours. We use the term 'psychological management'¹⁴ to describe the variety of ways that a GP might interact psychologically with a patient presenting emotional problems, which may include listening, showing empathy, supporting, reassuring, advising, or influencing the patient to change. In some cases this may involve a consultation style and behaviours little different from those used by the GP in any routine consultation.^{15,16} In other instances such psychological management might involve a more conscious attempt by the GP to take more time, to listen more, or to use 'counselling skills'. Finally, in a minority of cases, psychological management might involve other more specific management strategies derived from the psychological therapies.

The term psychological management also implies that the way GPs interact psychologically with patients with emotional problems might have beneficial therapeutic effects. In an earlier era, Balint¹⁷ used the metaphor of the drug 'doctor' to convey a similar implication that the doctor's relationship with the patient should be considered to have analogous therapeutic effects to psychotropic medications. The mechanisms whereby relatively simple consultation behaviours and communication styles, such as listening and empathising, may have psychotherapeutic effects on emotional problems are discussed in the specialist literature and are summarised in a companion paper.¹⁸ For the present discussion, it is important to note that there is a continuity between everyday human communication and psychotherapeutic communication, in the same way that there is continuity between communication styles in everyday GP consultations and communication in consultations with patients presenting emotional problems.

GPs are commonly enjoined to consider all patients' problems in physical, social, and psychological terms.¹⁹ Psychological management — as we have defined it — can be viewed as how GPs may help with those aspects of a patient's problems that they have identified in psychological terms, whether presented by the patient purely as emotional or psychosocial problems or initially presented in physical terms. We do not consider how GPs might identify emotional problems, about which there is an extensive literature.²⁰⁻²² The focus of our review is on the management of patients whose emotional problems have been identified by the GP.

Psychological management approaches

The psychological management approaches used by GPs range from simple techniques, such as listening and non-directive interview styles, to management strategies derived from the specialist psychological therapies. In surveys GPs report themselves as using the more straightforward approaches of listening, discussion of problems, explanation of symptoms, and reassurance with

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the majority of their patients with emotional problems, while reporting a lower use of specific structured management strategies.²³⁻²⁶ The range of approaches used is partly owing to the variety of patient presentations, from disorders that are self-limiting and require little more than watchful waiting, to chronic and/or more severe disorders requiring active management strategies.

The following list summarises the most common approaches as reflected in the literature and in training programmes for GPs:^{27,28}

- education about symptoms;^{29,30}
- listening, non-directive interviewing, empathic understanding;³¹
- problem identification and defining skills;^{32,33}
- counselling skills;^{34,35}
- problem-solving techniques;³⁶
- behavioural techniques, e.g. relaxation, increasing pleasurable activities, stimulus control;³⁷
- cognitive techniques, e.g. challenging unrealistic thoughts;^{38,39}
- psychodynamic understanding of the doctor-patient relationship;^{17,40} and
- family and systemic approaches.^{41,42}

Literature review of research on GP psychological management

MEDLINE (1968–1998) and PsychLIT (1971–1998) searches were carried out to identify studies of psychological management by GPs. Searches were limited to English language texts. An initial sensitive search was carried out using a combination of MeSH headings (mental disorders combined with either family practice or primary care) and free text terms (variants of ‘psychological/anxiety/depression’, plus variants of ‘interventions’, plus variants of ‘primary care/general practice’). Original papers were examined where abstracts indicated they might meet inclusion criteria for the review, and reference lists of these papers were scanned for additional papers.

The inclusion criteria were:

- the study reported empirical findings on a series of patients with emotional problems treated by GPs,
- the treating GPs were aware that the patients had emotional problems, and
- the treating GPs were practising in their routine general practice context.

Studies that were specifically concerned with GP treatment of psychotic disorders, psychosexual disorders, or substance misuse were excluded. In other respects there was no restriction on the kinds of emotional problems that could be included or in how these may have been defined in a study in view of the problems of classification systems in general practice.⁴³⁻⁴⁵ Studies focusing on, or making extensive use of, written self-help material were not included as these have been separately reviewed.^{46,47}

Frequency of psychological management

Table 1 summarises studies that have examined frequency of use of psychological management approaches in a case series of patients. Frequency has been estimated either by doctor’s report of management approach used, by patient report, or by the report of an external observer (usually rating of audio or video-taped consultation).

General practitioners’ own reports of use of psychological management range from one-quarter to three-quarters of consultations about emotional problems (Table 1, first 19 studies). The

definitions and descriptions of what constitutes psychological management vary considerably between studies; it is not clear if the GPs were given any definition of terms such as ‘counselling’ in some studies. Accordingly, it is difficult to compare results between studies.

The two studies using patients’ reports of GPs’ behaviour^{64,65} have focused on structured management strategies and advice and suggest a high rate of use of such strategies. However, with the lack of anchoring descriptions given to patients in both studies it is unclear exactly what doctor behaviours patients would have included; for example, would a doctor’s statement, such as ‘look on the bright side’, be classified by patients as ‘taught positive thinking’? The five studies using independent observers of consultations⁶⁶⁻⁷⁰ give rather lower estimates of the frequency of psychological management than either GP or patient reports.

In summary, it is difficult to draw conclusions about the frequency of use of specific kinds of psychological management approach, given the lack of consistent definition between studies. However, GPs’ perceptions of their overall use of psychological management approaches generally appear to differ from that measured by external observers. This parallels findings on over-estimation by doctors of their delivery of preventive interventions in routine consultations.⁷¹⁻⁷³

Effectiveness of psychological management

Table 2 summarises studies on the effectiveness of psychological management approaches. Given the paucity of controlled trials of clinical outcome a broad range of both outcomes and designs have been included. Outcomes evaluated include patient-perceived impact and satisfaction as well as clinical outcome. Designs include correlational studies (naturalistic cohort studies in which patients’ exposure to a treatment is correlated with clinical outcome) and other non-controlled experimental designs. The inclusion criteria could have been broadened still further to include other outcomes^{74,75} and designs.^{76,77} For example, it could be argued that a positive therapeutic relationship is so sustaining as to constitute a sufficient outcome in itself, or that qualitative case studies of therapeutic interactions be included. In choosing the criteria set out above we sought a balance between excessive methodological purity and overinclusion.

The studies in Table 2 are classified under four headings relating to different broad intervention approaches: interview style, management techniques, counselling, and cognitive-behavioural techniques.

Interview style

Interview style was related to a measure of outcome in three of four studies. The first study⁷⁸ found that GPs who had been taught either problem-defining skills³² or emotional handling skills had better clinical outcomes with patients with emotional problems than control GPs. Problem-based interview skills were also associated with improved clinical outcomes in another study,⁷⁹ while the emotional handling skills of listening and empathy were associated with patient-perceived impact and satisfaction in a third study.⁶⁹ In the fourth study, limited to one GP, a non-directive interview style in patients presenting emotional problems was found to be unrelated to patient-reported benefit, while patients presenting with physical problems reported greater satisfaction with a directive interview style.⁸⁰

Table 1. Studies of prevalence of use of psychological management approaches by GPs.

Study	Country	Condition	Number of patients/GPs	Result
GP report				
Adeyemi (1998) ⁴⁸	UK	Emotional distress	173/7	67% counselling
Catalan (1984) ⁴⁹	UK	Minor affective disorder	91/? ^a	95% listening 59% explanation of symptoms 52% advice 34% reassurance
Chancellor (1977) ²⁴	Australia	Emotional problems	186/18	48% listening and counselling
Fink (1967) ⁵⁰	USA	All mental disorders	422/32	62% at least one discussion at length
Jencks (1985) ⁵¹	USA	Mental disorder	928/? ^a	24% psychotherapy/therapeutic listening
Li (1994) ⁵²	UK	All mental disorders	2304/21	66% counselling
Meredith (1996) ⁵³	USA	Depression	2460/349	55% counselled for more than 3 minutes
Olfson (1992) ⁵⁴	USA	Depression	854/? ^a	35% psychotherapy/ therapeutic listening
Olfson (1995) ¹⁴	USA	Poor emotional health	973/7	67% any psychological intervention 62% listening 53% advice 32% discussion of diagnosis 25% counselling
Ormel (1990) ⁵⁵	Netherlands	Psychological disorder	100/25	24% counselling
Schulberg (1997) ⁵⁶	USA	Depression	92/69	45% counselling
Schurman (1985) ⁵⁷	USA	Mental disorder	2093/? ^a	25% psychotherapy/ therapeutic listening
Shepherd (1981) ²³	UK	Emotional distress	2050/75	25% listening and discussion
Smith (1998) ⁵⁸	UK	Emotional distress	70/8	1% GP psychotherapy 34% long discussion about distress 59% short discussion about distress 52% discussion/counselling
Ustun (1995) ⁵⁹	Multinational	All mental disorders	?/473	65% counselling
van Os (1999) ⁶⁰	Netherlands	Depression	370/17	48% listening and reassurance
van Pasch (1998) ⁶¹	Netherlands	Psychosocial complaints	808/15	50% active counselling
Verhaak (1992) ⁶²	Netherlands	Psychosocial complaints	397/21	79% counselling
Williams (1999) ⁶³	USA	Depression	621/621	32% brief counselling (3–5 minutes) 40% counselling for more than 5 minutes
Patient report				
Harris (1996) ⁶⁴	Australia	Emotional distress	1732/117	39% advice about exercise 37% taught relaxation or meditation 30% taught positive thinking 5% told to keep diary
Robinson (1995) ⁶⁵	USA	Depression	164/? ^a	61% identify activities already doing to help feel better 40% plan pleasurable activities 34% solve life problems 31% identify and change thoughts 27% plan activities to boost confidence
Independent observer				
Brodaty (1982) ⁶⁶	Australia	Emotional problems	66/13	21% listening and counselling
Callahan (1996) ⁶⁷	USA	Depression	105/77	3% of consultation on average is counselling
Callahan (1998) ⁶⁸	USA	Emotional distress	80/? ^a	14% of consultation on average is counselling
Cape (1996) ⁶⁹	UK	Emotional distress	88/9	43% of consultation on average is psychological discussion
Verhaak (1990) ⁷⁰	Netherlands	GP 'mainly psychological'	150/30	31% active counselling 30% passive counselling 11% advice

^aQuestion mark indicates information unavailable in published paper.

Management techniques

Three studies found that approaches to managing somatising patients resulted in improved clinical outcomes and reduced health costs. In two studies from the same group of investigators^{81,82} an identical intervention was used whereby GPs were instructed in a management strategy that involved the making of regular brief appointments with patients who somatised and adopting a structured approach to the management of these patients' physical symptoms. The third study involved teaching GPs techniques to encourage patients to reattribute and relate their physical symptoms to psychosocial problems.^{83,84}

Counselling

The five studies of counselling by GPs show mixed results. Definitions of counselling varied between the studies and in most were only defined by whatever the study GPs considered counselling to involve. A study where patients who received counselling only from their GPs (defined in this study as listening, explanation, advice, and reassurance) did as well as patients receiving anxiolytic medication, is often cited in the UK literature as demonstrating the effectiveness of counselling; however, its benefits would have been clearer if there had been a control group receiving neither counselling nor medication.⁴⁹ A second

Table 2. Studies of effectiveness of GP psychological management approaches.

Study	Country	Condition	Number of patients/GPs	Design	Outcome ^b
Interview skills					
Cape (1996) ⁶⁹	UK	Emotional distress	88/9	Correlational	+
Gask (1993) ⁷⁹	UK	Minor affective illness	101/6	Case control	+
Roter (1995) ⁷⁸	USA	Emotional distress	648/69	Randomised controlled trial	+
Savage (1990) ⁸⁰	UK	Psychological problems	44/1	Randomised controlled trial	=
Management approach					
Morriss (1988) ^{83,84}	UK	Somatised mental disorder	112/8	Case series	+
Rost (1994) ⁸¹	USA	Somatisation disorder	73/59	Randomised controlled trial	+
Smith (1995) ⁸²	USA	Somatising patients	56/51	Randomised controlled trial	+
Counselling					
Brody (1990) ⁸⁵	USA	Emotional distress	102/60	Randomised controlled trial	=
Catalan (1984) ⁴⁹	UK	Minor affective disorder	91/6	Randomised controlled trial	+
Schulberg (1997) ⁵⁶	USA	Depression (MDD)	92/? ^a	Correlational	-
Sturm (1995) ⁸⁶	USA	Depression	424/? ^a	Correlational	+
Verhaak (1992) ⁶²	Netherlands	Psychosocial complaints	3197/21	Correlational	=
Cognitive behavioural					
Baillargeon (1997) ⁸⁸	Canada	Insomnia	24/6	Case series	+
Robinson (1995) ⁶⁵	USA	Depression	164/? ^a	Correlational	+

^aQuestion mark indicates information unavailable in published paper; ^boutcomes categorised as '+' (outcome favours intervention), '=' (no difference), and '-' (outcome worse with intervention).

controlled study found no outcome differences between patients whose doctors were given a protocol of how to counsel patients with high distress levels and patients whose doctors received only feedback about the distress levels of their patients and no counselling protocol.⁸⁵ Three studies using naturalistic correlational designs had varied outcomes. One found a poorer outcome for patients with depression receiving GP counselling only, when compared with patients receiving no treatment, medication only, or combined medication and counselling.⁵⁶ In the second there was no relationship between GP counselling and clinical outcome,⁶² while in the third counselling was associated with better outcomes.⁸⁶

Although not falling within the inclusion criteria of the review, and therefore not included in Table 2, three studies of unselected general practice patients with heterogeneous problems (i.e. not specifically emotional problems) have found a relationship between counselling by the GP, defined as a focus on the psychosocial concerns of the patient, and both patient satisfaction^{15,87} and clinical outcome.¹⁶

Cognitive-behavioural techniques

Studies of the effectiveness of cognitive-behavioural techniques by GPs in routine consultations are limited despite the increased interest in, and teaching of, such techniques.^{38,39} Patients who reported their GPs to be suggesting such techniques said, perhaps not surprisingly, that they themselves used these techniques subsequently more in the following four months.⁶⁵ Patients with chronic insomnia were helped by GPs trained to use behavioural techniques; however, there was a high dropout rate.⁸⁸ Controlled trials of both brief cognitive-behaviour therapy⁸⁹ and problem-solving therapy³⁶ in primary care have demonstrated that GPs can be trained to achieve clinically significant outcomes in contexts where they are acting as specialist therapists rather than in routine consultations, but the level of skill required is greater for brief treatment and it is unclear whether the results could be repeated in the context of usual practice.^{89,90}

Conclusions

The literature review identified relatively few empirical studies of the psychological management of patients with emotional problems by GPs in routine consultations. The studies identified were, on the whole, lacking in detail as to the nature of the psychological management reported. 'Counselling', 'therapeutic history', 'advice', 'problem-solving', 'cognitive-behaviour therapy', and other terms are generally used without clear definitions. This makes it difficult to compare studies.

The use of psychological management by GPs is found to be generally less when rated by external observers than when evaluated by GP self-report. One possible explanation is that GPs wish to undertake psychological management but, in practice, find it difficult given time constraints.

The preliminary evidence for the clinical effectiveness of GP psychological management in routine consultations is encouraging. While most such studies are methodologically weak, three controlled trials have shown positive results.^{78,81,82} It is also encouraging that only a relatively brief period of GP training was required in these studies.

Any literature review is limited by its selection criteria for inclusion of studies. We have used relatively relaxed criteria in terms of range of methods, range of definitions of emotional problems, and (for the effectiveness studies) range of outcomes included, but these will still have excluded many valuable case, qualitative, and small-scale studies. Different criteria, either tighter or looser, might have led to different conclusions.

Research on emotional problems in general practice can be seen as proceeding historically through three phases.⁹¹ Initial studies were concerned with studying the prevalence of emotional disorder in primary care. The second phase has focused on the GP's role in identification of emotional disorder. The third and most recent phase is research on GPs' management of psychological problems, both pharmacological and psychological. A companion paper¹⁸ will review research on specialist psychological treatments that may be of relevance to GP psychological management and will make recommendations as to how research on GP psychological management might move forward.

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