General practitioner psychological management of common emotional problems (II): a research agenda for the development of evidence-based practice

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SUMMARY

The majority of patients with common emotional or psychological problems are treated solely by general practitioners (GPs). Such treatment frequently includes some form of psychological management within the consultation, whether limited to listening and discussion or involving more specific techniques. This paper sets out a research agenda for the development of effective approaches to GP psychological management. Evidence is reviewed on three core components of all psychological treatments: establishing a positive therapeutic relationship, developing a shared understanding of the problem, and promoting change in behaviour, thoughts or emotions. The application of these components in GP psychological management is outlined and methodological issues in the development and evaluation of GP management approaches are discussed. Since the number of patients with emotional problems seen by each GP is so large, the population effects of even small improvements in psychological management would be sizeable.

Keywords: *psychological problems; general practitioners; evidence-based.*

Introduction

The majority of patients with common emotional or psychological problems are treated solely by general practitioners (GPs), without referral to specialist psychiatric, psychological or counselling services.[1,2] Such treatment frequently includes some form of psychological management,[3,4] whether limited to listening and discussion or including more specific psychological approaches, such as counselling, problem-solving, and cognitive-behavioural techniques. Psychological management may be the only treatment provided or it may be combined with pharmacological treatment. In an earlier paper we reviewed literature on the frequency and effectiveness of psychological management strategies.[3] The present paper draws on this research and on evidence from the specialist psychological treatment literature to set out a research agenda for the development of evidence-based GP psychological management.

We aim to consider how the limited time that GPs can devote to patients with emotional problems can best be used. GPs are, by definition, generalists, having to manage their time between multiple competing demands,[5,6] and the time they are able to give to patients presenting emotional problems is accordingly limited. GPs also vary in their interest in psychological approaches. However, GPs do see large numbers of such patients[1,2,7,8] and it is known that their consultations with them are generally longer than average.[9,10] During these consultations, GPs currently listen, show understanding, support, reassure, advise, counsel, or in various ways attempt to influence the patient.[3,4,11-13] The research agenda is to provide evidence to help GPs make the most effective therapeutic use of this time.

The emphasis throughout is on psychological management where emotional problems are directly presented by the patient or are elicited by the GP, rather than on management of patients with emotional problems presenting primarily somatic symptoms.[14,15] Patients presenting somatic symptoms require an initial period of negotiation about the psychological nature of the problem before an explicitly psychological management approach can be adopted.[16,17]

Research agenda for GP evidence-based psychological management

Given the time that GPs spend with patients consulting with emotional problems, there is a need for brief, effective psychological management approaches that can easily be carried out within routine GP consultations. These approaches may have low clinical impact on individual patients, but, with the larger number of patients treated, population effects would be sizeable. Such population effects of brief behavioural interventions have been documented for GP advice about smoking and drinking.[18-20]

By management approaches we mean not only specific techniques, but also styles of listening and communicating with patients when they present their emotional problems. A major part of the research agenda is to identify whether certain styles of communication with patients in routine psychological consultations are more effective than others in facilitating therapeutic change. In so far as some aspects of communication and relationship are present in every consultation then if particular aspects should be found related to clinical outcome in general practice, as they have been in specialist psychological therapies,[21,22] the population effects of even minor changes in GPs' consultation styles would be significant.

Psychological management approaches for emotional problems developed for use by GPs to date have commonly been compressed versions of specialist psychological treatments, such as counselling, cognitive behaviour therapy, and problem-solving therapy.[23-25] There is evidence that such brief packages are teachable[24,25] and effective.[3,26,27] However, such brief treatment packages, being compressed, require a high level of skill to deliver

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and may not be appropriate for use in routine consultations,[27] or may require significant modification.[28] Even the briefest packages developed for either primary or secondary care require three to six treatment hours per patient.[26,27,29]

We suggest that an alternative approach is to consider the application in general practice of core components common to all specialist psychological treatments. The identification and emerging consensus on such core common components has been an achievement of empirical psychological treatment research of the past decade.[21,22,30,31] As these are common to a variety of psychological treatments, they will probably also be important in GP psychological management.

Core common components of psychological treatments

Three core components have been found to be important:

- establishing a positive therapeutic relationship,
- assisting the patient in developing an understanding of their problems, and
- promoting change in behaviour, thoughts or emotions.

Establishing a positive therapeutic relationship

The first common task is establishment of a positive therapeutic relationship in which patients feel free to discuss emotional problems and work towards their resolution. An association of positive therapeutic relationship (often referred to as therapeutic alliance) with clinical outcome is one of the most robust findings of psychological treatment research[22,32] and is equally as important in cognitive-behaviour therapy[33] as in psychodynamic and other psychotherapies.[22]

A positive therapeutic relationship is a joint product of what the patient contributes and what the doctor or psychological therapist contributes to the interaction.[22,32] Patient factors associated with a positive therapeutic relationship are: the capacity to form good interpersonal relationships, active participation, an absence of suspiciousness, and a willingness to work towards agreed therapeutic goals.[22] Therapist factors are: active listening, empathy, and a genuine concern for patients.[22,34]

General practice studies offer preliminary evidence of the impact of listening and empathy in consultations about emotional problems on both patient evaluations of their consultations and clinical change.[35,36] Doctors' listening is associated with patient satisfaction in consultations about physical as well as emotional problems.[37] However, patients with emotional and stress related problems are particularly likely to consider talking about their symptoms and problems as helpful.[38]

Developing a shared understanding of the problem

The second core component consists of developing with the patient a shared understanding of their psychological symptoms or presenting problems. Communication of a clear and appropriate conceptualisation of the patient's problems, which the patient can make use of, has been found to be associated with beneficial clinical outcome over a number of psychological treatments and conditions.[30,39,40]

Helping patients to define and clarify their emotional problems is a central skill taught to GPs in problem-based interview training[41] and has been found to be associated with improved clinical outcomes in two studies.[35,42] Explanations of psychological symptoms and problems likely to be useful to patients in general practice include biological factors, psychosocial stresses and difficulties, and explanation of feedback mechanisms between thoughts, emotions, and behaviour. It is important that any explanation is acceptable to the patient and leads to a shared understanding between doctor and patient.[43-45]

Developing a new understanding of psychological symptoms can lead to symptomatic change directly, as patients' inaccurate ideas about their problems frequently contribute to their symptoms (e.g. thoughts of 'going mad' or having a heart attack).[46] A new understanding or perspective on problems may also indirectly suggest new behaviours or actions not previously considered, which may in turn lead to clinical change.[47]

Promoting change in behaviour, thoughts or emotions

Promoting change in behaviour, thoughts or emotions is the third and most time-intensive element common to all specialist psychological treatments. Most incorporate a number of strategies to promote change, but there is also increasing research on the role of individual strategies. In order for an individual strategy for change to be helpful in routine general practice consultations, it is necessary that it can be clearly defined, taught to GPs, and communicated by GPs effectively to patients within the time constraints of a relatively brief consultation.
Some possibilities are:

- identification and evaluation of catastrophic thoughts in patients with panic disorder,[46,48-50]
- advice on graded exposure to anxiety in patients with phobic and obsessive-compulsive conditions,[23,49-51]
- advice on increasing pleasurable activities in patients with major depressive disorder,[23,49,50,52] and
- encouraging problem-solving regarding loss, role conflicts, and interpersonal difficulties in patients with major depressive disorder.[24,49,50,53]

Identification and evaluation of depressive thoughts in patients with major depressive disorder[25,54] should possibly be added to this list. However, this is a complex skill to learn and use in brief interventions[27,28] and may not therefore meet the suggested criterion of usability in routine GP consultations.

Use of self-help materials may be helpful in enhancing GPs' suggestions for change[55-59] and also, increasingly, computer self-help programs developed for use in primary care.[60]

Application to general practitioner psychological management

For GP psychological management in the routine care of patients with emotional problems, the question arises as to how these three components relate to existing skills in the GP's repertoire, to the time constraints of general practice consultations, and to the proviso that GPs are generalists and do not have the capacity, or necessarily interest, to devote to learning about new psychological management approaches.

Establishing a therapeutic relationship and attempting to understand the patient's problems are part of what most GPs undertake, although not necessarily explicitly, when a patient initially presents an emotional problem. The importance of the doctor–patient relationship is a key element in teaching about patient-centred medicine,[61,62] as is the importance of trying to understand the patient's problems in psychological, social, and physical terms,[63] and of reaching agreement with the patient about their problems.[43-45,62] An emphasis on promoting change is also common as GPs discuss patients' problems and counsel them on what they might consider doing differently.[3,11-13] These components are all in the existing repertoire of consultation skills of most GPs, although establishing a positive relationship and developing a shared understanding may not necessarily be perceived as having the potential to facilitate a therapeutic change.

The importance of the research agenda is to establish under what circumstances and through what specific GP behaviours these core components may have therapeutic effects.

The key difference between GP psychological management and specialist psychological treatment is not that these core components are present in specialist treatments and absent in GP management but in the time available to be devoted to them. The GP's generalist role places severe restrictions on the amount of time available and many patients presenting emotional problems may only be seen for a single consultation. Pragmatically, an incremental approach over time to psychological management — as in other areas of general practice — depending on the severity or intractability of the patient's problem is reasonable. The establishment of a therapeutic relationship and, where appropriate, an initial attempt to come to some understanding of the patient's problems is likely to be sufficient for an initial consultation. If the patient returns, then further exploration and attempts to develop new understanding of their problems may be relevant. If they then continue to attend, consideration of specific strategies to promote change may be appropriate in addition to continued focus on developing the patient's understanding of their difficulties. Where a patient does not respond, then specialist referral for psychological treatment might be considered.

The generalist role also places constraints on the degree of expertise that a GP can develop, compared with the extensive training that psychological therapists receive in establishing and maintaining a therapeutic relationship, and in ways of understanding and promoting change through specific psychological approaches. However, there is evidence that relatively brief training of GPs in basic psychological skills can be helpful,[35,42,65] although this may need to be supplemented with ongoing supervision and support.[66]

Methodological issues

The development and evaluation of GP psychological management approaches will require both naturalistic studies and controlled trials. Naturalistic studies — both small scale intensive studies of individual GP–patient consultations[44,67,68] and large cohort studies of groups of doctors and patients[69-71] — would be able to identify potentially important GP psychological management approaches. Controlled trials would then be necessary to confirm the effectiveness of particular GP management approaches. Cost-effectiveness comparisons are also important, as, if increased GP therapeutic effectiveness is at the cost of spending significantly greater time with patients with emotional problems, it may be more cost-effective for these patients to be seen by primary care counsellors, psychologists or trained nurses.

In both controlled trials and naturalistic studies, methodological difficulties peculiar to researching GP psychological management approaches need to be addressed. These include issues relating to diagnostic heterogeneity, somatic presentation, and matching interventions to severity/prognosis.

Psychological problems in general practice are heterogeneous and existing diagnostic systems have problems in accommodating this.[1,72-74] Depression and anxiety present as a continuum rather than as discrete disorders.[1,73,74] While studies of psychiatric populations usually focus on a single disorder (e.g. major depression), for GP psychological management there are advantages in including patients with the full range of common emotional problems.

Psychological problems often first present in general practice as somatic complaints.[14,15] Defining the beginning of GP psychological management is then difficult, as there needs to be an initial period of discussion with the patient to reach agreement that there is an emotional problem requiring acknowledgement and treatment.[16,17] Limiting studies of psychological management to patients who directly present emotional problems would exclude this more common scenario and hence exclude a large proportion of patients with significant psychological morbidity.

Much psychological disorder in general practice is self-limiting.[75-77] The GP's role, as for self-limiting physical illness, is to explain, ease distress, and act to speed recovery where possible.[78] Where problems are not self-limiting, more active intervention is necessary. A research agenda for GP psychological management needs to identify which patients will improve spontaneously, who will benefit from GP routine psychological management, and who will need more active psychological interventions by the GP or referral for specialist psychological therapy.

Controlled trials of psychological interventions in general practice have the particular methodological difficulties of both trials in general practice[79] and of trials of psychological interventions.[80,81] A detailed discussion of these is beyond the scope of this paper but adaptations to standard clinical trial designs are likely to be necessary.[82-84] Since the clinical impact of GP psychological management is likely to be modest, the number of patients and doctors in clinical trials of psychological management will need to be large.

Conclusions

Development of effective GP psychological management has the potential to impact beneficially on large numbers of patients, given the time already spent by GPs managing the burden of psychological morbidity in primary care. Current GP psychological management lacks an empirical evidence base, compared to specialist psychological treatments where there have been significant, well researched therapeutic developments. GPs may be interested in developing psychological management skills, but lack evidence-based knowledge about what skills they should develop. A research effort to develop evidence-based GP psychological interventions will require contributions from GPs, psychiatrists, psychologists, methodologists, and health economists. Both naturalistic studies of GP consultations to identify key therapeutic components and controlled trials of brief treatment packages tailored to the GP context will be needed. The logistical and methodological problems are considerable, but the potential benefits to patients and GPs over time are great.

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