Beliefs That Foster Physician Avoidance of Psychosocial Aspects of Health Care

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Although training in family medicine emphasizes a biopsychosocial approach to patients, many residents experience difficulties in carrying out the appropriate psychosocial part of their diagnosis and treatment. Through teaching family medicine residents in a year-long Balint and Difficult Patient seminar, there has emerged a consistent set of core tacit beliefs which inhibit physicians from thinking psychosocially about their patients. These beliefs appear to be rigidly held but not examined or challenged.

This paper presents the major of these beliefs and for each a more realistic therapeutic reply. They are grouped into three categories: (1) beliefs concerning physician's role (eg, I must rule out organic disease; only then can I focus on psychosocial problems), (2) beliefs concerning what the patient supposedly wants or does not want (eg, my patients want me to rule out organic problems), and (3) physicians' fears about approaching patients as people (eg, if the patient has the same problem I do, how can I help if I have not helped myself).

By making overt these tacit assumptions, this paper attempts to highlight core barriers to the implementation of biopsychosocial care, increase understanding of effective alternatives, and challenge physicians to examine their hidden beliefs about patient care and their approach to patients.

A biopsychosocial approach to patients is an increasingly accepted standard to which family physicians aspire. Engel, Drossman, Szasz and Hollander, and Van Egeren and Fabrega are among the writers who have compellingly articulated this model.[1-5] Its value has been highlighted by research studies [6-8] which have corroborated what was "known" anecdotally: up to 50 percent of patient visits to primary care practitioners include a primary or secondary psychosocial complaint. Furthermore, Regier et al have demonstrated that most patients with mental illness are

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seen by primary care physicians, not psychiatrists.[9] It is also now well substantiated that patients with mental disorders utilize approximately twice as much nonpsychiatric medical care as patients without such problems.[10]

In response to this documented need, skills in psychosocial assessment, conducting psychotherapy, supportive counseling, and crisis intervention are increasingly being incorporated into the behavioral science curricula for family practice residents. In spite of the desire to care for the "whole person," in spite of recognition of the need, and in spite of the additional training, many residents experience difficulties in carrying out the appropriate psychosocial part of their diagnosis and treatment. Marks et al have shown that family physicians detect only one half of the psychosocial problems of their patients.[11]

In the course of teaching family medicine residents over the past three years, particularly through a year-long Balint and Difficult Patient seminar conducted weekly for third year residents, it has been possible to define some of the reasons for physicians' reluctance to enter the psychosocial dimensions of their patients' problems. The intent of this paper is to elucidate those core tacit beliefs that inhibit physicians from being involved with the psychosocial aspects of patient care. Beck and Ellis have described in their work on cognitive therapy how irrational beliefs held, but not examined, can powerfully influence thoughts, feelings, and behavior.[12,13] People enter experiences with preconceived notions (called cognitive schemata by Beck) through which they selectively screen out environmental stimuli. Recognition of these underlying (often covert) beliefs is the first step in one's ability to question and challenge them.[14]

For a number of reasons, chiefly related to unidimensional training in viewing illness through the lens of the biomedical model, physicians come to hold a rather consistent set of beliefs which tend to perpetuate their avoidance of the psychosocial aspects of patient care. Helfer's study[15] comparing the skills of freshman and senior medical students in interviewing mothers of ill children lends support to this view. He found that freshmen obtained significantly more interpersonal information (eg, the effect of the illness upon the child and his family) and asked fewer leading questions. Seniors obtained more biomedical factual information. Helfer concluded that as medical students moved through their training, a certain degree of their innate ability to communicate with mothers of ill children was altered by their desire to obtain biomedical information.

While there is truth in certain of these tacit physician beliefs for some patients at some times, it is the rigidity with which they are held and their tacit unexamined nature that prevents physicians from recognizing when they do not apply. In the following sections are listed what have been taken to be the major of these beliefs and for each of them is provided a more rational and practical therapeutic reply. They are grouped into three categories: (1) beliefs concerning the physician's role, (2) beliefs concerning what the patient supposedly wants or does not want, and (3) physicians' fears about approaching patients as people. By delineating them, the hope is that primary care physicians will examine their covert premises about patient care. Where they find that these beliefs in fact uncritically guide their decision making practices, then they will be encouraged to challenge these premises in the light of those that spring from a biopsychosocial model and that offer a rational guide to effective psychosocial care.

Beliefs Concerning Physician's Role

1. *I must rule out organic disease. After I do that, then I can focus on psychosocial problems.* *Response:* Since psychosocial problems occur in over 50 percent of patients seen in primary care settings, they should be investigated concurrently. Selective focus on organic disease may encourage patient somatization.

2. *If I do not completely rule out the organic possibilities, then the patient might die and/or my colleagues might laugh at me. I may get sued.* *Response:* This line of reasoning serves to perpetuate biomedical evaluation while the more frequent psychosocial problems are ignored. For example, depressed patients frequently present

with vegetative somatic complaints; strict adherence to the above belief often leads to misdiagnosis and at times iatrogenic harm secondary to unnecessary medication use, hospitalization, laboratory tests, and surgery.[16,17]

3. *Psychosocial issues have nothing to do with medical problems.*

Response: This belief flies in the face of well-documented evidence that mind and brain importantly influence physical disease and body perception. For example, the growing literature on psychosomatic medicine attests to the fact that psychophysiological interactions occur in virtually all disease processes and that disease is virtually never physical or psychological, but routinely physical and psychological.[18,19] Family theorists provide an additional source of data. For example, Minuchin et al have demonstrated the role of dysfunctional family patterns in exacerbations of diabetes, asthma, and anorexia nervosa.[20] Further evidence comes from the work on stress. Life changes, stressful work, and disrupted or dysfunctional interpersonal relationships, as well as economic strains, correlate with onset of sickness and/or seeking medical assistance.[21-25]

4. *I am too pressed for time. I cannot go into everything.*

Response: Each primary care physician needs to develop a set of screening questions for psychosocial information. After the screen, a decision may be made about whether to investigate further, refer, or leave the area alone, just as one would do with parts of the biomedical history. This approach can save both time and money by preventing unnecessary costly workups or tests by expeditious recognition and attention to psychosocial problems. Patients whose somatic complaints reflect underlying anxiety states, depression, or hypochondriasis fall into this category. Similarly, the physician who recognizes a patient's "addiction to medical care" can prevent time consuming, inappropriate use of the care system by scheduling frequent brief appointments.[26]

5. *I focus on organic disease because I cannot treat the psychosocial. If I open up this area, I will be compelled to treat this person for these problems.*

Response: Some patients will treat themselves once the problem is defined, some will require supportive listening and clarification, some will require referral, and others will want to deny and avoid the problem and its treatment. Still others will come back at a later time ready to discuss treatment possibilities in greater depth.

6. *If I deal with psychosocial problems with all my patients, I will be overwhelmed and will soon "burn out" because more will be asked than I can give.*

Response: Different categories of psychosocial problems require different specific treatments. These treatments include medications, emotional support, stress management, counseling, psychotherapy by the primary care physician, referral to a mental health specialist, and no treatment. Perhaps most importantly, diagnosing an emotional problem does not automatically place the responsibility for treatment on the physician.

Misconceptions About Patients: What They Want and What They Do Not Want

7. *My patients want me to rule out organic problems.*

Response: Patients often want relief from pain, and if that relief is to come through a psychosocial diagnosis, then many will accept it. If the physician is tentative in making the psychosocial diagnosis, the patient may be tentative in accepting it. The physician's role is to provide expert diagnosis and to advise; it is the patient's right to accept or reject these recommendations.

8. *I have no right to inquire into psychosocial areas. It is an invasion of privacy.*

Response: The medical bias against the biopsychosocial model of illness perpetuates the mind-body split implicit in this reason to avoid the psychological aspects of patient care. First, physicians must accept the relationship between illness and psychosocial problems. Then patients must be educated to this new model of care, since many of them also think of the physician in traditional biomedical terms. The physician must, of course, have reasonable suspicion that psychosocial problems are involved. Clues suggesting psychosocial involve-

ment include no discernable physical explanation, excessive emotional responses, recurrent interpersonal patterns within which the symptom has been embedded before (eg, each time her husband goes on a business trip, she comes to the physician's office), vegetative symptoms of depression and anxiety, and patient described associations between stress, emotional, and somatic complaints.

9. *Talking about psychological issues will inevitably inflict pain on the patient and me. I will feel guilty for having done this, and the patient might blame me.*
Response: Often emotional pain is just below patients' awareness and has been experienced by them previously, although not in direct connection to physical symptoms or the desire to seek medical attention. In the same way that the physical examination may elicit pain in order to make a diagnosis and define treatment, the psychosocial examination may elicit pain in order to better delineate the patient's difficulty.

10. *If I address psychosocial issues, patients will reject them and never return.*
Response: Some patients will reject a psychosocial diagnosis and never return. Some will reject the idea at first and return, having accepted the description and perhaps addressed the solution. Others will appreciate the validation of their unspoken belief that perhaps stress has contributed to the occurrence of the physical symptoms. The physician can play an important educational role in making a mind-body link for the patient, which may have been just below the surface of the patient's consciousness. As Balint pointed out,[27] one advantage of the primary care physician is that patients continue to seek medical help even when they have rejected or set aside emotional issues for discussion.

11. *If I define a psychosocial problem, patients will find unacceptable a psychological treatment.*
Response: As with any diagnosis, patient response will constitute a spectrum from acceptance to rejection of treatment. One obvious determinant is the manner in which the issues are discussed. An empathetic exploration between a physician and a patient with whom he or she has a trusting relationship is quite different from an irritated judgment of "it's all in your head" made after the fourth organic workup.

12. *Patients will become totally dependent on me if I open up psychosocial concerns.*
Response: Some will become very dependent without addressing psychosocial issues, some will become less dependent, some will handle the problem themselves once it is defined for them, and others will not change at all.

Beliefs Concerning Physicians' Reactions to Their Patients as People

13. *If the patient has the same problem I do, how can I help if I have not helped myself?*
Response: Perhaps if physicians' own difficulties will get in the way, then referral may be the better alternative. Similarity of difficulty does not mean, however, that the psychosocial diagnosis should not be offered. The greater problem may occur if physicians have a similar problem and are not aware of it. This lack of self-understanding may blind physicians to potential difficulties in patients in the same way that they do not attend to themselves. Alternatively, effective models of helping (notably Alcoholics Anonymous) are based on the similarities of problems of participants.

14. *If the patient is having a problem beyond my experience, how can I help?* (For example, how can I, as a young physician, presume to help someone old enough to be my grandparent?)
Response: Just as with a physical complaint, it is important and possible to clarify the parameters of that complaint for the patient. (The physician's objectivity may in fact be enhanced by lack of experience.) It is always appropriate to indicate to the patient one's lack of familiarity with a culture, time of life, event, issue, or symptom as an indication of interest and entree to explicit data collection from the patient.

15. *It is painful to face the emotional problems of others.*
Response: Yes, it is. Practice, experience, and the development of helpful methods and techniques reduce the emotional drain on physicians. Without allowing oneself practice and experience to develop effective methods, this desire to avoid the emotional turmoil of others will be perpetuated.

Comment

Although a biopsychosocial approach to health care is becoming the common parlance of medical educators, resistance to dealing with psychological and social issues of patients is still prevalent. The reasons for this avoidance are complex. While there is growing intellectual acceptance of an integrated model of health care, today's physician educators, as well as residents in training, all have been raised during an era in which the biomedical model was the major paradigm. It is not easy to integrate one set of teachings (the essentially univariate and physical approach of the biomedical model) with the contradictory message to embrace a more complex biopsychosocial approach to patients' health care.

Observations indicate that many physicians have dealt with this dilemma by adhering to an uncritically accepted and frequently inflexible set of "commonsense" beliefs. While these beliefs may be true some of the time, they inhibit physicians from accurately defining their patients' problems and viewing them in a fully human manner. The beliefs delineated in this paper tend to fall into the trap of extreme thinking. Thus, problems are "cognitively distorted"[28] in subtle ways: through overgeneralization (every patient who discloses emotional stress will become overly dependent on me), through polarization (a problem is either biomedical or psychosocial), through exaggeration (I will "burn out" if I have to deal with the psychosocial problems of all my patients). Like all common sense they are a vague blend of half-truths, biases, and undisciplined thinking. Just as biological understanding is uncommon sense about the biological world that can be rigorously applied by the physician, so too psychosocial understanding is uncommon sense about the psychological and social world that can provide the clinician with a more rigorous and disciplined guide to biopsychosocial care.

By making overt these strongly held but rarely challenged tacit assumptions and by discussing a more appropriate range of potential responses, the hope is to highlight core barriers to the implementation of biopsychosocial care, to increase understanding of an effective alternative, and to challenge physicians to examine their hidden beliefs about patient care and hence, their approach to patients.

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