# Public Perceptions of Psychosocial Problems and Roles of the Family Physician

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Since its beginning as a specialty, family practice has embraced the biopsychosocial model of illness and has stressed the importance of integrating psychosocial factors in the everyday medical care of patients and their families. Concerted efforts have been made to develop behavioral science training in family practice residency programs with the assumption that there is both the need and the desire by the public for the family physician to take an active role in the recognition and management of a wide array of psychosocial problems. What has been missing, however, has been information on the attitudes and health-seeking behaviors of the public with respect to specific psychosocial problems.

Two papers in this issue of this journal provide enough new information on the subject to raise questions about the present content of behavioral science training in dealing with psychosocial problems. Kiraly, Coulton, and Graham[1] report the results of a study of the attitudes of 145 patients in an eastern urban family practice center with respect to care of their personal problems. They found that the family physician was strongly preferred for help when such problems were associated with physical symptoms, but that other providers were usually selected for help with predominantly social or emotional problems. Of interest, for example, is that only one sixth of this group would see the family physician for a marital problem. In another study of patient perceptions in a western city, Schwenk and his colleagues[2] asked over 300 patients in a family practice center to rank their desired level of involvement by the family physician for 45 psychosocial problems. Their findings corroborate those of Kiraly and her group. For example, no involvement was desired for divorce or marital problems; referral was expected for child school problems; concern and supportive care was expected for a wide range of other psychosocial problems usually involving physical complaints; definitive care was desired for physical illness and chronic pain.

Two other previous studies in other parts of the country have also raised questions about the extent of involvement by the family physician with some psychosocial problems. In a study of the attitudes of both family physicians and their patients in the Los Angeles area, Hyatt[3] noted that most patients do not expect the family physician to deal with emotional problems, marital problems, or with a difficult youngster. In another study examining utilization patterns of family practice patients in an urban southeastern teaching practice, Chatterton, Clapp, and Gehlbach[4] found that children with school problems and enuresis were taken by their parents principally to nonphysicians for care. Only 20 percent of men and 40 percent of women with

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sex or marital problems sought care from the family physician for these problems.

It can be argued that the public is not aware of the skills of residency-trained family physicians in the care of psychosocial problems, and that patients might more often seek out the family physician for the care of these problems were they so informed. There is some evidence, however, that residency training does not greatly influence utilization patterns for such problems. Cassata and Kirkman-Liff[5] recently surveyed a group of 116 graduates of family practice residency programs. Although the graduates reported one third of their encounters with patients to involve behavioral psychological diagnoses, and although 80 percent of the graduates felt at least adequately prepared by their training for short-term counseling and behavioral medicine, they reported only about ten individual counseling sessions per month.[5]

Against this background, it is useful to reassess the directions and content of current behavioral science training in family practice residencies. Jones and his colleagues[6] have done just that in a national survey, also reported in this issue. Their findings show a broad scope of content addressed by such training, including a number of areas for which public interest seems limited (eg, child abuse, marital counseling, behavioral problems of children).

What can be concluded from all of this? Although these studies do not together provide an entirely definitive picture of public expectations for mental health services by the family physician, and although the public may not be fully informed about the need, efficacy, and sources of the most appropriate management of psychosocial problems, there is now sufficient information available to re-evaluate the family physician's role in the care of these problems. The following conclusions seem warranted:

1. The family physician needs to be sensitive to the occurrence of psychosocial problems and to their relationship to organic illness, but the level of his or her involvement with the actual management of these problems may vary greatly. Thus an active role in diagnosis and management is clearly important for such problems as depression, anxiety, and somatizing illness. A more limited role, however, in the actual management of many other problems (eg, childhood behavioral problems, marital and family relationship problems) seems more consistent in most instances with both public expectations and the time constraints of a busy family practice.

2. It is now time to prioritize the present broad content areas of behavioral science training in family practice residencies along the lines suggested by Schwenk and his colleagues. The practicing family physician needs broad expertise in interpersonal skills and in recognition of psychosocial problems, but his domain of definitive management may be more limited (including, for example, crisis intervention and brief individual counseling, but usually excluding marital and family counseling).

3. For those psychosocial problems requiring management beyond the interests or skills of the family physician, he or she needs to be knowledgeable about other providers and community agencies and will serve these patients well by appropriate referral and follow-up. Some family practice groups may choose to involve a part-time or even full-time clinical psychologist or medical social worker as an active member of the group to provide these services.

These conclusions do not diminish the important role of behavioral science in family practice; rather, they represent a more realistic and effective approach to a broad area of training and roles requiring sharper definition.

**References**

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