Steps Toward Patient Acknowledgement of Psychosocial Factors

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Among the high percentage of primary care patients who have psychosocial problems are those who would increase their probability of symptom remission if they were to acknowledge these influences. Unfortunately, many physicians are reluctant to address psychosocial issues, in part because some of their patients appear to be antagonistic to these explanations. This paper describes a series of steps by which physicians may learn to address psychological and social issues with patients who might benefit from this awareness.

By choosing to see physicians, patients are indicating the belief that their symptoms are likely to have a biomedical origin. However, a great many of the patients seen in primary care settings are troubled by psychosocial difficulties that are directly related to their reasons for seeking help.[1,2] In fact, primary care medicine operates as the chief treatment branch of the de facto mental health system of the United States, since more than 50 percent of the mentally ill are seen in primary care settings.[3] Family physicians appear to have accepted the importance of the biopsychosocial model[4] but seem to require more practical guidelines in its direct application. In addition, primary care physicians seem to be reluctant to address psychiatric problems directly because they feel it would not be acceptable to the patient.[5]

This paper outlines a series of steps by which physicians may help patients to recognize and accept psychosocial influences: Physicians must (1) overcome their own reluctance to act upon psychosocial factors and (2) be alert to those signs that suggest significant psychosocial difficulty. Once psychosocial issues appear prominent, then physicians must (3) judge the value of the patient's acknowledgment of these influences and (4) determine the patient's willingness to do so. Often (5) the physician-patient relationship requires firming up in order to proceed into (6) psychosocial data gathering. Finally, (7) the offer of a diagnosis

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and treatment plan usually requires the elicitation of the patient's personal theory of disease and a negotiated compromise between physician and patient. With these steps in mind, physicians may be better equipped to confront the psychosocial difficulties of patients who would benefit from acknowledging them.

A Sequenced Approach

Physician Acknowledgement of Psychosocial Issues

Despite the intellectual acceptance of the biopsychosocial model, primary care physicians tend to miss psychiatric and psychosocial diagnoses.[6,7] One of the most commonly cited reasons is lack of time,[8-10] yet the most important influence is medical school itself. Students are selected on the basis of grades and test scores with relatively little emphasis upon potential clinical skills.[11] Training tends to be correlated with a decline in altruism,[12] apparently due to the emphasis upon reductive thinking and the acquisition of factual rather than personal information. The influence of teachers serves also to perpetuate the bias against psychosocial considerations. Illnesses are placed in hierarchies of importance, with recognizing rare biomedical disease paying higher rewards than making psychiatric diagnoses.[9] Students build up strong psychological defenses against many of their experiences (denial, isolation of affect, and intellectualization) and also develop pejorative attitudes against people with psychiatric illness.[8] Many medical students receive superficial psychiatric training and therefore fail to do psychosocial histories or mental status examinations.[8]

As a result, physicians have developed an uncritically accepted and frequently inflexible set of "commonsense" beliefs that inhibit them from accurately perceiving their patient's psychosocial problems.[10] These beliefs include the following: "I must rule out organic disease first; if I do not, the patient might die or my colleagues might ridicule me." "Psychosocial problems have nothing to do with medical problems. If I deal with psychosocial problems I will be overwhelmed." "My patients want me to focus only on the organic problems and do not want me to invade their privacy. If I address these issues my patients will never return because they will find psychiatric treatment unacceptable." "Emotional problems are too painful for me. How can I help someone if the problem is like the one I am having?"

Each of these statements is true in a limited number of instances. Unfortunately, they are taken as generally true and therefore impede physician attention toward psychosocial issues. To help patients become aware of their psychosocial difficulties, family physicians will be required to challenge these beliefs and place them in their proper perspective.

Indicators of Psychosocial Problems

A variety of clues should raise the physician's index of suspicion that patients are presenting with psychosocial difficulties. As these clues are being considered, physicians often experience discomfort in moving from the secure boundaries of biomedical diagnosis into the more ambiguous psychosocial arena. The transition may be less difficult if it is made with the notion that psychosocial problems are far more frequent than rare biomedical difficulties. For episodic anxiety attacks, panic attacks are more likely than pheochromocytoma, yet occasionally the latter will be the correct diagnosis, although clinicians tend to overdiagnose the latter and underdiagnose the former. For symptoms of lethargy, weight gain, and poor concentration, depression will be the most likely diagnosis although hypothyroidism will occasionally be the cause.

Anxiety and depression are the two most common presentations of psychosocial dysfunction. Anxiety is indicated by initial insomnia, hyperadrenergic symptoms and signs (tachycardia, diaphoresis, dry mouth, tachypnea, tingling in hands and feet), phobias, and panic attacks. Depression is suggested by crying, hopelessness, helplessness, feelings of worthlessness, loss of interest, difficulty concentrating, slowed thoughts, memory

loss, and guilt. The biological correlates of depression include early morning awakening, anorexia, weight loss, loss of libido and energy, psychomotor retardation, diurnal mood and energy variation, dry mouth, and constipation.[13] In chronic depression and anxiety states symptoms of pain, gastrointestinal disturbance, weakness, and a range of vague bodily symptoms may predominate.

Data gleaned from the history that suggests psychosocial dysfunction include a history of multiple, shifting somatic complaints, a symptom history incompatible with known pathoanatomical and pathophysiological processes, failure of usually successful treatments for specific disease entities (which may sometimes be explained by compliance problems or inadequate treatment regimens), and a history of multiple unsatisfactory relationships with physicians. A history of psychiatric treatment may also be a clue to current psychosocial difficulty, but this notion may sometimes too quickly be seized as an explanation before proceeding with other biomedical evaluations.

Findings concerned directly with symptoms themselves suggesting psychosocial dysfunction include pain in the absence of verifiable organic pathology, complaints or disabilities that are excessive relative to the degree of known pathophysiology, and symptom onset correlated in time with a serious psychosocial stressor, such as a major shift in work or interpersonal relationships, especially in the absence of adequate social support and with a history of a somatizing coping style.

In regard to patients' interaction with physicians, inappropriate interpersonal styles, shifts in interpersonal styles (eg, from straightforward to seductive or hostile), and failure to follow treatment recommendations may also indicate psychosocial dysfunction.

Gauging the Value of Patient Psychosocial Awareness

Once psychosocial problems are presumed to be significant, would the patient benefit from this knowledge? By the act of seeking a physician's help, most patients are implying that they believe their symptoms probably are being caused by organic dysfunction. Otherwise, they would have sought help elsewhere. A psychiatric diagnosis or psychosocial formulation may be at odds with patients' personal theories of disease. When should physicians attempt to convey psychosocial awareness, and when may patients be successfully treated without this awareness?

Patients' awareness of psychosocial influences on their presenting complaints may be useful under four conditions: (1) when there is a need for psychiatric or psychological consultation, (2) when there is a need for treatment by psychiatric medications (antidepressants, neuroleptics), (3) when awareness of patterns of psychosocial dysfunction increases the probability of symptom reduction (eg, when psychosocial distress is causing significant psychophysiologic symptoms such as asthma attacks or increased ulcer pain), and (4) when there is a need for psychotherapy. Each of these situations has exceptions under which psychosocial awareness may be unnecessary. Some patients will accept psychiatric or psychological consultation as simply as another expert opinion. Many will receive an antidepressant or neuroleptic from a family physician in the same way they would accept other types of medication. Physicians do psychotherapy of all sorts within what appears to be the standard medical interview without acknowledging directly with their patients that psychosocial issues are the main reason for their meeting. If the patient is to be referred for psychotherapy, then in most instances psychosocial awareness will be required to set the stage for psychological work.

Attempts to bring patients to accept the significance of psychosocial influences may be met with resistance when this idea clashes with their own explanatory models. Each patient's willingness to consider psychosocial influences must be brought into the decision about whether to proceed in this direction.

Patient Willingness to Acknowledge Psychosocial Influences

Some patients are fully prepared to accept the influences of psychosocial factors on their present-

ing complaints. An early attempt to address psychological factors may prove to be the most efficient course of treatment. For example, a 44-year-old woman drove three hours to a major medical center from her small town to receive a major workup for a relatively benign process for which she was receiving adequate treatment from her primary care physician. In addition to describing her complaints, she mentioned that she was disturbed because her treatment contacts were now being taken over by her physician's nurse practitioner. She liked her physician but did not like this nurse. The consulting physician inquired further into the nature of the primary care physician-patient relationship and discovered that the physician had responded to a previous simple request and generally had treated her well. The patient was satisfied with the consultant's recommendation that she request to be seen by her own physician rather than the nurse. She stated that she had not made this request because she "did not want to bother him."

Like the preceding patient, many patients will drop hints of their belief that psychosocial factors have played an important role in their seeking medical attention. Listening for these hints, as is suggested in the following example, may lead to effective treatment recommendations. A 28-year-old woman presented with complaints of fatigue, muscle weakness, and irritability. In the course of describing her symptoms, she mentioned that she was in the process of terminating a psychotherapy relationship. On further questioning, the patient said that the therapist had been given additional duties in her institution and could no longer see her. The patient was disturbed by this forced termination because therapy appeared just then to be having an important effect on her life. She had attempted to transfer to another therapist but was unable to find a satisfactory replacement. Since the physician knew the psychotherapist professionally, with the patient's permission, he called her and suggested that the patient's somatic symptoms were likely caused by the forced termination. The psychotherapist rearranged her schedule to permit therapy to proceed. The patient's presenting symptoms disappeared.

On the other hand, some patients will imply that psychosocial factors have nothing to do with their complaints, even though many previous physicians appear to have held that opinion. Members of certain groups may be predicted to resist any effort to discuss psychosocial factors. Some of these predictably resistant groups include the following:

1. Patients who seek a disability physical examination and need the physician's sanction not to work want a biomedical diagnosis. While psychophysiological information may in some way be valuable to such people, the fundamental importance of receiving a clear biomedical diagnosis for financial purposes often makes this information disagreeable to them, no matter how true.

2. Patients who have had long diagnostic workups and invested much time or money in pursuing the organic source of their complaints will have difficulty accepting psychosocial factors. Such patients have been told to believe that some cause will be found "if we keep looking." Also, having difficulty with psychosocial explanations are those who have long histories of symptomatic treatment by physicians who reinforced the belief in a biomedical cause. These patients are invested in a bodily complaint and often have a bodily explanation, no matter how fanciful or dangerous.

3. Patients who had a prior illness episode diagnosed as psychiatric or psychosocial who later were found to have a biomedical cause for their complaint will resist considering a psychosocial explanation once again. For example, hypothyroidism may have been diagnosed as depression. During subsequent psychosocial conflicts presenting with physical symptoms, such patients will have difficulty accepting a psychological explanation.

4. Those patients who have had unrewarding experiences with psychiatrists and other psychotherapists may reject any connection between mind and body because of resentment of previous psychological treatment.

5. Some people are extremely antagonistic to psychosocial causes of physical complaints on ideological grounds. To accept a psychological explanation may require that they accept more responsibility for their condition, since they may believe that they should have more control over their minds than their bodies. Psychological difficulty may represent a sign of unbearable weakness. Certain groups are predictably antagonistic to psychosocial explanations: working class people especially of Northern European background, religious fundamentalists, and some traditionally oriented ethnic groups.[14]

6. Many patients have little psychological awareness or language to express emotional difficulty[15] or have little training in self-expression.

7. Some patients appear to accept the importance of psychological and social factors but do not believe that physicians can diagnose or treat these problems. For perceived physical problems these people seek the care of a biomedically oriented physician. "If I had wanted psychiatric treatment, I would have seen a psychiatrist."

8. Some patients appear to be addicted to contact with physicians and are willing to do almost anything to maintain the medical relationship (Briquet's syndrome, factitious illness, Münchausen's syndrome). To accept psychosocial explanations of their care-seeking behaviors would destroy their self-deceptions and potentially remove their tickets to the patient-physician relationships. Many of these patients can be successfully treated by short, regularly scheduled meetings during which their symptoms are discussed in a biomedical fashion. The scheduling serves to supply them with the contact they appear to need without forcing them to present with acute complaints in order to receive medical attention.[16] This treatment plan is an example of psychosocial awareness on the part of the physician without psychosocial awareness by the patient.

9. Patients who chronically utilize somatization as a means of coping with interpersonal relationships (eg, who avoid sex or are dependent) will not give it up easily.

Strengthening the Working Relationship

Once the decision has been made to explore and understand psychosocial influences on the presenting symptoms, the working relationship must often be strengthened to provide an atmosphere within which such exploration can take place comfortably. The groundwork of this engagement phase is laid through standard biomedical approaches. The twofold purposes of the initial contact are to screen major problem areas and to establish the working relationship through the achievement of confidence and trust by the patient in the physician. Confidence is established through patient perception that the physician is competent and trustworthy. Competence may be demonstrated through the conveyance of specialized knowledge or the provision of some beneficial suggestion or treatment.[17] The ordering of laboratory tests, the description of a disease entity in terms that the patient can respect, the thorough physical examination, the offer of a treatment that works, and the reduction of unnecessary medications are a few of the many ways physicians gain the confidence of their patients. Sympathetic listening and empathic understanding may demonstrate physician concern as well as lead to greater trust and a firmer working relationship.

Psychiatric diagnoses may not require immediate patient awareness. Instead, physicians may offer antidepressants, for example, as treatment for "fatigue" and may embark upon a very gradual biomedical workup as the antidepressant begins to take effect. The success of pharmacological treatment makes some patients more receptive to discussing psychological aspects of their depression, whereas others respond sufficiently well that they need or want little such discussion. If necessary, the dexamethasone suppression test may provide a connecting link between biomedical and psychiatric illness through the correlation of nonsuppression with antidepressant response.[18] The Minnesota Multiphasic Personality Inventory may also serve as a connecting link by functioning as another laboratory assessment procedure for nonbiomedical difficulty. Biofeedback, relaxation exercises, and hypnosis can also provide links between psychological and physiological events.

Data Gathering

In addition to providing essential information, questions and listening provide an effective way to build the relationship. Physicians select from a variety of methods for gathering information. This information may be used to bolster physician certainty of psychosocial diagnoses and to open negotiation with patients. Some start with the symptom and work out, while others circle in by gathering peripheral information first. Physicians may integrate into these styles questions and

statements which suggest that work and social life play an important part in their evaluations. Engel has advocated[4] taking a history of symptoms in the context of events in the patient's life. Investigation into the context within which the symptom is likely to occur may reveal dramatic correlations. For example, a 40-year-old man with intermittent acute chest pain, when asked about the circumstances under which he felt the pain, reported that it occurred at very specific times: when he got out of his car to go into the house (a short walk on a level path) and after his wife called him at work. He was pain-free most of the other times. The temporal correlation between symptom and situation helped him to accept that he was having trouble in his relationship with his wife. Investigation into the psychological correlates of physical symptoms may also reveal critical links. For example, a 30-year-old accountant felt acute chest pain while driving his car. Preliminary workup was negative. When asked what he was thinking about at the time of the attack, he reported that he was anxious about an audit that was about to take place. He had just realized that he had made a serious error and was uncertain that he could correct it in time. The principle of finding temporal correlations between symptoms and other events is common to biomedical interviewing as well (eg, ingestion of certain foods and epigastric pain). Diaries may be useful in demonstrating key correlations between symptoms and other events. A chronological history of the symptoms may be paralleled by questions concerning life changes prior to the emergence of physical discomfort.[19]

Patients sometimes have symptoms that are very similar to those of an important other. The question, "did anyone else you know have problems like this" may reveal a model for current symptoms. Some patients develop pathological grief reactions resulting from unresolved mourning and actually develop some of the same symptoms as their deceased loved ones.[20] One example of this pathological grieving process concerned a 30-year-old man who, while eating dinner, complained of severe chest pain and became very anxious. The workup was negative. On the same day, one year earlier his father had had similar chest pains at dinner and died of a myocardial infarction five days later.

Somatic complaints may be attempts to communicate indirectly a variety of experiences. Psychosomatic symptoms in children may be attempts to communicate family difficulties.[21] These and other symptoms provide ways to manipulate and control others.[22] Symptoms may be the way to account for failure in job or love and may be a way to earn a livelihood through welfare payments or disability insurance. The communication aspects of symptoms may be understood by inquiring into the effect of the symptoms on the person's life. If some gain is perceptible as a result of the symptom, then possibly that gain is related to the maintenance of the complaint. This notion, however, has too frequently been taken to the extreme of blaming the patient for the problem. Patients who consciously manipulate various systems for gain (malingering) are relatively rare. Most somatizers are reacting without full awareness of how the symptoms serve their purposes. Physicians may not necessarily use these explanations of symptoms directly but they do provide working hypotheses about the nature and cause of problems from the psychological and social levels.[23]

As the interview proceeds, the indirect communications of the patient to the physician also deserve attention. Nonverbal responses that indicate distress serve for the psychosocial evaluation as do pain and tenderness for the physical examination. If through routine questioning the physician notices tears, anxiety, or other clear changes in mood or behavior, these may suggest further probing. For example, a 24-year-old woman sought a second opinion for her gastric pain. She wanted to know if she required an upper gastrointestinal examination. When asked about sleep, her eyes began to tear. When asked about this reaction, she talked about being depressed and how the intensity of her gastric pain had paralleled the disintegration of her relationship with her mother. She agreed to the suggestion of counseling with another professional and to treating her pain with antacids. At follow-up three weeks later, she had decided to move out of her mother's house and was symptomatically improved.

Patients bring to their physicians interpersonal patterns that they have used and will continue to use with physicians and other important figures. Some are very passive and dependent. Others are seductive or controlling. Others are demanding and belligerent. These interaction styles as they become manifest in the physician-patient interaction are transferred from other relationships and

may provide data about the nature of the patient's interpersonal difficulties.[24]

Marked shifts in social equilibria with family, professional helpers (other physicians or psychotherapists), and work are often associated with psychosocial difficulties. Because patients may be unwilling or unable to perceive the significance of these shifts, family members and friends may be asked to attend an interview to provide another perspective on the source of the presenting difficulties. A related content area concerns the biopsychosocial challenges associated with various positions on the human life cycle. Each age has its obstacles to overcome as well as its rewards (eg, adolescents are concerned with group identity and leaving home; young adults, with sex and intimacy; people in the late twenties and thirties, with marriage and family; people in their forties, with life without children; people in their fifties, with acceptance of their limited accomplishments; people in their sixties, with infirmity and death).

Diagnosis and Treatment Plan

In the absence of physical findings physicians may consider refraining from saying, "There is nothing wrong with you medically." This statement is confusing to patients because the term *medical* has two meanings, one specific and one general. The specific meaning, and the one that physicians are usually invoking when they make this statement, is biomedically—nothing wrong organically. However, since the physician is practicing medicine, the word medical also refers to any problem within the province of the physician. When the patient is told nothing is wrong medically, what does that mean? Something seems wrong to the patient. Physicians might validate instead the patient's experience of the symptom as real and emphasize the psychosocial diagnosis, which seems most prominent. The importance of a clear validation of a physical experience coupled with a firm statement that the patient has a problem was illustrated in the case of a 29-year-old carpenter who was severely anxious and feared that he would die. After a cardiac workup the patient was told that he had nothing wrong. He became even more anxious. During the next interview, the physician told him directly that indeed he had something wrong; he had multiple phobias and he needed treatment. During the follow-up interview, the patient profusely thanked the physician for telling him that something was truly wrong and putting a clear label on it.

Before formally making the diagnosis, physicians may consider defining the patient's explanatory model (personal theory of disease). Since symptoms have different meanings for patients, knowledge of the patient's understanding of the etiology, pathophysiology, expected course, and desired treatment may predict negative or positive reactions to diagnosis and treatment recommendations. The patient's explanatory model may be efficiently elicited by the following set of questions outlined by Kleinman et al[25]: (1) What do you think caused your problem, (2) why do you think it started when it did, (3) what does your illness do to you, (4) how severe is it, (5) what kind of treatment should you receive, (6) what results do you expect from your treatment, (7) what are the chief problems caused by your illness, and (8) what do you fear most about your illness? When asked for their explanations of their diseases, patients generally shrug their shoulders and make some reference to not being the doctor. They may be encouraged to offer their opinion by gently urging them to try. "After all, you do live in your body, and most people do come up with some sort of guess. I'm not expecting you to know for sure." The patient's explanatory model provides the point from which to begin negotiation between the physician's model and the patient's.

A useful outline for patient-physician negotiation around diagnosis and treatment has been described by Katon.[26] After the patient's explanatory model is elicited, the physician presents his or her own concept in terms the patient can understand. The pair then attempts to develop a mutually acceptable explanation. The physician may utilize information gathered from the interview that demonstrates the influences of psychosocial variables on the presenting symptoms (eg, temporal correlations, symbolic meanings, interpersonal dysfunctions) or describe research data which indicate that patients with certain symptom complexes respond to a suggested treatment. If a mutual understanding cannot be reached, the physician should offer a potentially acceptable

compromise. If an agreement cannot be reached, then referral to another physician is indicated.

Perhaps the most difficult recommendation for a biomedically oriented patient to accept is referral to a psychiatrist for consultation or treatment. Unfortunately, some physicians seem to offer the referral as a last resort or a way to absolve themselves of the responsibility for the patient without taking the sometimes considerable effort to help the patient understand and accept the reasons for the recommendation. Since patients may perceive referral as a rejection, physicians should consider follow-up appointments.

One very effective technique to gain patient acknowledgement of psychosocial factors is to prescribe a series of regular meetings to improve the rapport, gather more psychosocial data, and negotiate explanatory models. Through the comfort and appeal of the physician's time and concern, the patient may be gradually desensitized to the aversive notion of psychiatrists or psychosocial influences. This investment of time and energy may yield positive results relatively quickly, or the patient may take months to finally acknowledge the possibility. The attempt to help patients acknowledge the influence of psychosocial factors is not without danger and difficulty. Patients are often reluctant to change their personal theories of disease and are frightened by the prospect of psychological examination and treatment. During this process, patients have become quite angry and have threatened suicide because they feared the psychological confrontation.

Comment

Certain aspects of these steps require further clarification. Medical school training is in need of alteration to accommodate the well-substantiated fact that primary care patients are often beset with psychosocial difficulties. Physicians in practice require direct attention to altering the thought patterns that help them avoid psychosocial issues. Once these problems are recognized, clearer guidelines are required for defining which patients should be approached with efforts toward acknowledgment and which patients should not. The indications for psychotherapy by whom and of what type also need clarification.

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