Do Patient Attitudes Influence Physician Recognition of Psychosocial Problems in Primary Care?

Mary-Jo DelVecchio Good, PhD, Byron J. Good, PhD, and Paul D. Cleary, PhD
Boston, Massachusetts

Research has yielded consistent evidence of high levels of psychiatric morbidity and psychosocial problems among primary care patients, and recent studies have focused on improving physician recognition. These studies are based on the unexamined assumption that patients want their physicians to treat psychosocial disorders; thus, underrecognition is examined by analyzing characteristics of physicians and medical settings. Patient characteristics, particularly attitudes about the appropriateness of seeking help for psychosocial problems in primary care, have not been examined in relationship to underrecognition. This study directly focuses on patient attitudes about appropriateness of requesting care for psychosocial difficulties, the extent to which patients discuss difficulties with their physicians, and the degree to which physician recognition is explained by these patient characteristics. The study sample of 883 adult patients was drawn from 23 primary care practices. Over 70 percent of patients find it appropriate to turn to their primary care physicians for help with emotional distress, family problems, life stress, behavioral problems, and sexual dysfunction; however, only one fifth to one third of patients who have experienced difficulties have discussed these problems with their primary care providers. Attitudes about appropriateness are significantly related to physician recognition of psychiatric symptoms and family difficulties but account for limited variance in levels of recognition.

During the two past decades, substantial research has been conducted on factors influencing the recognition and treatment of psychiatric disorders in primary care. Since the early 1960s, studies have found that a high proportion of patients being cared for by primary care physicians suffer psychological distress or psychiatric disorders.[1–5] For example, a study in Marshfield, Wisconsin, which used independent structured interviews to define caseness, found 27 percent of primary care patients met research diagnostic criteria for mental illness. Over one half of these patients suffered major, intermittent, or minor depression.[6–9] Special importance was lent to this research by the findings of Regier and colleagues[10,11] at the National Institute of Mental Health. They analyzed a variety of data on the treatment of mental illness and estimated that nearly 60 percent of all cases of mental illness are treated in primary care settings. They concluded that primary care constitutes a "de facto mental health system" in the United States and urged that priority be given to investigating the quality of psychiatric care in this domain.

Researchers have found that a large proportion of psychiatric problems of primary care patients are unrecognized and untreated.[12] Recent attention has focused on ways of improving recognition and quality of treatment, including screening for disorders, improving training, and modifying practice arrangements.[12,13]

Family physicians and other primary care specialists often express doubts about the validity and relevance of this research to their practice. They argue that their patients present with a mixture of physical complaints, medical illnesses, and psychosocial problems, and that the narrow focus on "mental illness" and its diagnosis provides a mistaken picture of the problems treated by primary care providers.[13] They also report that many of

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From the Department of Social Medicine and Health Policy, Harvard Medical School, Boston, Massachusetts. Requests for reprints should be addressed to Dr. Mary-Jo DelVecchio Good, Department of Social Medicine and Health Policy, Harvard Medical School, 25 Shattuck Street, Boston, MA 02115.

their patients resist medicalization of their psychological or psychosocial difficulties and that they hold a relatively restricted view of what problems are appropriate to present to their physician.

These objections raise a significant research issue. The majority of past studies of recognition are based on the unexamined assumption that patients *want* their physicians to treat the psychiatric disorders or psychological symptoms identified by the researchers. As a result, underrecognition is examined by analyzing characteristics of physicians and of medical practice. More recent research by Schwenk et al,[14] Frowick et al,[15] and Yaffe and Stewart[16] has sought to identify patient expectations and ideas of desirable levels of physician involvement in addressing psychosocial problems. However, patient characteristics, particularly patients' attitudes about the appropriateness of treating emotional and psychosocial problems in primary care, have seldom been studied in relationship to the problem of underrecognition.

This article examines these issues directly. Data from a study of primary care practices in rural California were used to focus on two sets of questions: (1) What proportion of patients believe it is appropriate to request care for psychosocial problems and psychological distress from their primary care providers? To what extent do patients report actually discussing such problems with their provider? What social, cultural, and health status variables are related to the psychosocial orientation of patients? (2) To what extent is level of physician recognition explained by patient attitudes about the appropriateness of discussing such issues with their physicians; that is, do patient attitudes account for those cases in which physicians fail to recognize their patients' psychosocial problems?

METHODS

The California Rural Primary Care Study was conducted from 1981 through 1983 in 26 primary care practices located in six rural communities in coastal, central valley, and mountain regions of northern California. Communities were selected to represent distinctive occupational and cultural regions. Participating clinicians included nine general practitioners, six physicians who completed family medicine residencies, three internists, three pediatricians, two family nurse practitioners, and two physician assistants. All physicians were in solo or small-group private practice; one nurse practitioner and one physician assistant practiced in a public health clinic.

The analyses reported in this article are based on data collected from a consecutive sample of 883 adult patients (69 percent women, 31 percent men). The sample reflects the demographic makeup of rural northern California; the majority of patients are white, married, and received high school diplomas. Nine percent were unemployed and looking for work. Two thirds of patients reported household incomes under $20,000.

Patients were interviewed in their physician's office prior to a medical visit. Previously validated, as well as newly created, self-report questions were used to assess patient distress levels, psychological symptoms, acute life stress, chronic problems in social functioning, problems associated with physical disability, treatment requests, and explanatory models of current illness.[17–20] Psychiatric symptom levels for adult patients were measured by the Brief Symptom Inventory (BSI), a nine-scale, 53-item measure derived from the Hopkins Symptom Checklist (SCL-90) developed by Derogatis.[21] At the conclusion of each patient's visit, the physician or primary care provider listed diagnoses and medications prescribed, rated the patient on psychosocial and psychiatric dimensions analogous to patient measures (including the SCL-90 analogue), and noted mode of treatment response.

The measure of "appropriateness" described in this article was based on a series of global questions developed to complement the psychometric instruments used in the study. Patients were asked whether during the past year they had experienced psychosocial distress in a number of specific domains: emotional distress, family dysfunction, stressful life events, work stress, sexual dysfunction, social problems or isolation, problems of eating, drinking or smoking, and functional disability. For each of these domains, patients were asked whether they had experienced the problem, how serious it was, whether they had discussed the problem with their physician, and how helpful their physician had been in managing the problem. For each domain, patients were asked whether they thought it appropriate to discuss such problems with a physician, regardless of whether they had experienced a problem of this type during the past year.

An appropriateness scale was constructed from seven of the appropriateness questions, and a mean score was obtained. Because 94 percent of all patients believed it appropriate to discuss functional disabilities with their physicians, this item did not improve the internal consistency of the scale and was excluded. The relationship between patient characteristics and attitudes about appropriateness of seeking psychosocial care was explored through analysis of variance of the scale scores.

In this study "physician recognition" is defined as concordance between physician and patient ratings of psychological symptoms or analogous psychosocial problems. Physicians were asked to judge whether patients had experienced emotional problems in the past year and to indicate level of current psychological symptoms on the SCL-90 analogue. Degree of provider and patient agreement and factors influencing agreement (including patient

TABLE 1. PSYCHOSOCIAL PROBLEMS EXPERIENCED BY PATIENTS IN THE PAST YEAR, DISCUSSION OF PROBLEM WITH PRIMARY CARE PHYSICIAN, AND ATTITUDES ABOUT APPROPRIATENESS OF DISCUSSING PROBLEMS WITH PHYSICIANS, BY SEX (n = 883)

	Percent of Patients Who Reported Problem			Percent of Patients With Problem Who Discussed With Primary Care Physician or Family Nurse Practitioner			Percent of All Patients Who Deem It Appropriate to Discuss Psychosocial Problems With Their Primary Care Physician or Family Nurse Practitioner		
Problem	Male	Female	Total	Male	Female	Total	Male	Female	Total
Disorders of mood	49	63	59*	25	36	33*	78	87	84***
Family difficulties	28	40	37***	20	34	30*	65	75	72**
Stressful events	36	45	42*	25	33	30*	73	83	79***
Addictive problems (smoking, overeating, substance abuse)	42	48	46	43	49	46	88	90	89
Difficulties functioning due to illness or disabilities	28	29	29	65	74	71	93	95	94
Sexual dysfunction	21	16	18	40	28	33	82	84	83
Work-related stress	24	21	22	14	23	20	50	56	54
Social isolation, loneliness, poor social support	16	23	21	14	9	10	46	52	50

*Significant differences between male and female responses: *P = .05; **P = .01; ***P = .001*

attitudes about appropriateness) were analyzed using analysis of variance and regression procedures.

RESULTS

The health status of the sampled population parallels other ambulatory care studies.[22,23] Diagnoses of cardiovascular (15 percent), musculoskeletal (15 percent), and respiratory (10 percent) disorders were reported most frequently. Few patients received diagnoses of psychiatric disorders (4 percent) or of "undetermined" signs and symptoms suggestive of somatization (4 percent). Most patients rated their health as good (53 percent) or excellent (23 percent); 19 percent indicated their health was fair, and 4 percent, poor.

Table 1 presents a summary of patient reports of psychosocial problems during the past year, whether these problems were discussed with their primary care provider, and judgments of whether it is appropriate to discuss this type of problem with a physician. The most commonly reported problems were mood disorder, problems with habits (eating, smoking, drinking, recreational drugs), stressful life events, and family dysfunction. Persons experiencing a problem were most likely to have discussed physical disability with their physician, followed by habit control, sexual dysfunction (for men), and mood disorders.

A majority of individuals believe it is appropriate to discuss psychosocial problems with a primary care physician. Over two thirds of patients believed it appropriate to discuss problems associated with mood, family life, stressful events, sexual dysfunction, habit control (or addiction), and physical disability. Fewer patients believed it appropriate to discuss difficulties at work or problems with social isolation, loneliness, or other difficulties of so-

TABLE 2. PATIENT ATTITUDES ABOUT THE APPROPRIATENESS OF SEEKING PSYCHOSOCIAL CARE BY HEALTH STATUS, DEMOGRAPHIC AND CULTURAL CHARACTERISTICS (n = 883)

Characteristic	Mean Appropriateness Score	Significance of F
Health Status		
Perceived health		NS
Excellent	.75	
Good	.72	
Fair	.73	
Poor	.74	
Distress level		NS
None	.71	
Little	.72	
Moderate	.74	
Quite a bit	.74	
Extreme	.76	
Nature of problem		NS
Health maintenance	.71	
Acute	.71	
Chronic	.75	
Uncertainty	.60	
Psychiatric symptoms anxiety scale of BSI*		**
High	.78	
Medium	.75	
Low	.69	
Demographic Characteristics		
Sex		***
Male	.68	
Female	.75	
Employment status		**
Employed full time or part time	.76	
Homemaker	.72	
Retired	.73	
Unemployed	.69	
Students	.57	
Health insurance		NS
Private	.74	
Public (Medicare or Medicaid)	.74	
None	.69	
Cultural and Lifestyle Characteristics		
Education		***
< High school	.67	
High school graduate	.72	
Some college	.77	
College graduate	.82	
Ethnic heritage		**
European, non-Hispanic	.74	
Hispanic/Mexican	.61	
Other	.61	
Region		***
Coastal alternative	.83	
Central valley, university	.80	
Coastal traditional	.77	
Mountain traditional	.69	
Central valley, traditional	.65	
Marital status		***
Single	.63	
Married	.73	
Widowed	.74	
Living with a partner	.79	
Divorced or separated	.83	

BSI, Brief Symptom Inventory
**P = .01*
***P = .001*

cial life. Additional analyses indicated that for each type of psychosocial distress, patients who reported having experienced distress in the past year were somewhat more likely to believe it appropriate to discuss the problem with their primary care provider. With the exception of problems of mood and social life, the differences are significant at the .05 level or better.

Patient Characteristics and Attitudes About Appropriateness

The relationship between patient characteristics and attitudes about appropriateness of seeking psychosocial care was examined using analysis of variance, with the appropriateness scale scores as the dependent variable. Patient characteristics were grouped into four categories: sociodemographic variables (age, sex, income, employment status, insurance coverage); current health status variables (perceived health status, level of distress, physician assessment of seriousness of disorder, diagnosis and nature of the problem); cultural and lifestyle variables (education, marital status, ethnicity, religion, political opinion, and geographic locale); and psychiatric symptom levels, derived from scale scores on the Brief Symptom Inventory of the SCL-90. Significant differences in mean scores between groups are noted in Table 2. The most important finding is that patient attitudes about the appropriateness of psychosocial treatment in primary care vary considerably by cultural characteristics, but relatively little by health status, level of psychiatric symptoms, or socioeconomic status.

Current health status variables, with the exception of psychiatric diagnosis and chief complaint, are not significantly associated with the psychosocial appropriateness score. There are weak relationships between appropriateness scores and anxiety symptom levels as measured by the Brief Symptom Inventory; other scale scores, including depression and the global symptom measure, are unrelated. The few patients with a psychiatric chief complaint or diagnosis have higher appropriateness scores than patients with other diagnoses or complaints, and mean scores for health maintenance patients are among the lowest.

Difference in the appropriateness scores for demographic categories were statistically significant only for sex and employment status. Women scored more highly than men, as was expected from the literature arguing that women are more expressive about their symptoms and, regardless of health status, are more psychosocially minded.[24] Unemployed adults scored significantly lower than did other adults; students, many of whom were still in high school, scored the lowest of all adult patients, as reflected in the analysis by age. Age, income, and medical insurance coverage are not significantly related to appropriateness, although patients aged 35 to 64 years have higher appropriateness scores than younger patients.

In contrast to the weak and indeterminate relationship to health status and socioeconomic variables, the most powerful and intriguing distinctions among groups on the measure of appropriateness of seeking psychosocial care were related to cultural and lifestyle variables. Level of education, ethnicity, and political orientation were significantly associated with variation in attitudes on appropriateness. Although not statistically significant in the analysis, it is notable that those patients raised in a health-promoting Protestant sect (Seventh Day Adventists, Mormons) and in Judaism scored higher on the scale than those raised in other religious traditions.

The cultural characteristics of the patients' communities correlated strongly with attitudes about appropriateness. Each region of the study had a wide mix of individuals, but there was a cultural style dominant in each community that influenced the practice and content of primary care medicine. Patients from the counterculture community (coastal alternative) scored highest on the appropriateness scale. Members of a central valley town near a university also scored high, whereas patients from the traditional and long-established central valley farm communities and from the mountain logging and ranching communities had lowest scores.

Marital status and household composition are indicators not only of conjugal status but also of lifestyle characteristics. Single parents living with children and patients who were separated, divorced, or living with a partner without a legal tie scored highest on the appropriateness scale. Young, single patients living with parents and married individuals who lived with spouse, children, and additional adults scored lowest. It appears that patients with family resources less often feel the need to turn to physicians for psychosocial support than those without such resources.

Physician Recognition of Psychosocial Problems and Patient Attitudes

The second set of analyses examined physician recognition of patient psychosocial problems and the relationship between recognition and patient attitudes about the appropriateness of discussing such problems. In Table 3 are reported the findings of analysis of variance of appropriateness scores by groups of patients with recognized or unrecognized mood disorders and family problems in the past year. Thirty-one percent of all patients had unrecognized mood disorders: they reported having experienced a difficulty with their mood, while their physicians reported the patient had no such difficulty or that they did not know whether the patient had experienced difficulties with mood. Twenty-two percent of patients had unrecognized family problems. Recognition is significantly related to appropriateness score in each case. Greater differences on appropriateness scores are found, however, between patients without mood disorders and with mood disorders than between recognized and unrecognized patients. This finding indicates that physician recognition of mood disorders is only mildly related to the patients' attitudes about appropriateness.

TABLE 3. PATIENT ATTITUDES ABOUT APPROPRIATENESS TO SEEK PSYCHOSOCIAL HELP AND PHYSICIAN RECOGNITION OF DISORDERS OF MOOD AND FAMILY DIFFICULTIES

Physician/Practitioner Recognition	Percent	Appropriateness Score
Mood Disorders		
Unrecognized*	31	.74
Disagreement		
MD yes/patient no	14	.69
Agreement, yes	28	.79
Agreement, no	17	.68
Family Difficulties		
Unrecognized**	22	.75
Disagreement		
MD yes/patient no	9	.72
Agreement, yes	13	.82
Agreement, no	24	.71

One-way analysis of variance of appropriateness mean scores by physician recognition of disorders of mood, $F = 3.3527$; significance of $F = .003$; $n = 837$

**One-way analysis of variance of appropriateness mean scores by physician recognition of family difficulties, $F = 2.7705$; significance of $F = .011$; $n = 832$*

Factors that influence concordance between physician and patient ratings of psychological symptoms on the Brief Symptom Inventory and the SCL-90 analogue were examined. It was hypothesized that physician recognition of psychological symptoms is enhanced by positive patient attitudes regarding appropriateness of discussing psychosocial problems with their physicians, by patient reports that they had discussed such problems with their physicians, and by frequency of visits by the patient during the past six months (an indication of how well the physician knew the patient). These hypotheses were tested using regression equations. The dependent variable was physician rating of depression on the SCL-90 analogue scale. Independent variables included patient scores on the depression subscale of the Brief Symptom Inventory and interaction terms that assessed the influence of the following factors on agreement between physician and patient ratings: (1) perceived appropriateness of discussing psychosocial problems (score on the appropriateness scale), (2) number of visits in the preceding six months, and (3) the sum of the psychosocial problems patients indicated they had discussed with their physician. A stepwise regression procedure was utilized, with depression scores entered first, followed by variables with the most significant regression coefficients.

TABLE 4. PHYSICIAN RECOGNITION OF SYMPTOMS OF DEPRESSION, ANXIETY, AND FAMILY DIFFICULTIES IN PRIMARY CARE PATIENTS: THREE REGRESSION MODELS

Independent Variable	Standardized Regression Coefficient
Symptoms of Depression	
Patient score on Brief Symptom Inventory depression scale	.01
Number of visits in past six months for health care times depression score	.17**
Appropriateness score times depression score	.14*
Age	.17***
Education	−.08**
R^2	.11
Symptoms of Anxiety	
Patient score on Brief Symptom Inventory anxiety scale	.09
Number of visits in past six months for health care times anxiety score	.15***
Age	.14***
Propensity to discuss psychosocial problems with physician times anxiety score	.15***
Education	−.10**
R^2	.10
Experience of Family Difficulties	
Patient rating of family difficulties	.10
Number of visits in past six months for health care times family difficulties	.03
Appropriateness score times family difficulties	.17*
R^2	.09

*Significance of variables in regression model: *.05; **.01; ***.001*

Results are presented in Table 4. The agreement between provider and patient ratings of depression is positively and significantly associated with patient scores on the appropriateness scale as well as with number of visits in the past six months and patient's age and education. These variables account for 11 percent of the variance of physician recognition of the patient's depression. Similar analyses were conducted to examine the relation of these variables to agreement about symptoms of anxiety and family problems. In each of these analyses, these same variables account for 9 to 11 percent of the variance in levels of recognition.

DISCUSSION

The purposes of this study were to examine levels of psychosocial problems among patients in primary medical care and factors that influence physician recognition of these problems. This study investigated whether patients think it is appropriate to discuss their psychosocial problems with their primary care physicians, whether they report actually having done so, and whether their attitudes about appropriateness—their psychosocial-mindedness—help account for physician underrecognition of psychosocial problems.

The findings indicate, first, that psychological symptoms and psychosocial problems are highly prevalent among primary care patients, with reports of emotional distress, family difficulties, behavioral problems (eating, smoking, drinking), and stressful life events being most common. These findings contrast with data indicating that psychiatric diagnoses, chief complaints, and treatment requests are among the least frequent in primary care. These results, as well as Jencks'[13] analysis of National Ambulatory Medical Care Survey data, suggest the importance of assessing the diagnostic and chief complaint process separately from psychosocial care-seeking and physician recognition.

Second, the results indicate that a high proportion of patients find it appropriate to turn to their primary care providers for help with such difficulties. Over 70 percent of patients believe it is appropriate to discuss emotional distress, family problems, life stress, behavioral problems, and sexual dysfunction with their physicians, and approximately one half believe it appropriate to discuss problems at work and in their social life.

While all groups of patients express positive attitudes about psychosocial treatment by primary care physicians, these attitudes seem to be shaped significantly by a patient's cultural milieu and aspects of lifestyle. The traditional farmers, loggers, and ranchers in the study were more conservative in their view of the role of physicians—as in other aspects of their lives—than were many of the urban-to-rural migrants and those pursuing an alternative lifestyle.

Complementary findings from the urban-based studies of Schwenk et al[14] and Frowick et al[15] suggest that attitudinal variations regarding appropriateness of physician involvement in treatment of psychosocial disorders can be understood better when levels of involvement (referral, concern, or expert help) and specific psychosocial problems are identified. This study subsumes types of physician involvement under "appropriate to discuss" and defines certain psychosocial problems in more general terms. However, it offers analysis of prevalence of actual psychosocial problems (rather than hypothetical situations) and reported discussion of these problems with physicians in relationship to patient attitudes on appropriateness and provider recognition. Additional research combining attention to problems actually experienced by patients and to desired levels of physician involvement is necessary to advance understanding of these issues.

Third, findings indicate that attitudes about the appropriateness of seeking psychosocial treatment in primary

care translate only partially into practice. Only one fifth to one third of patients who have experienced disorders of mood or family difficulties in the past year report actually having talked with their primary care physicians about these problems. Furthermore, providers failed to recognize emotional distress for approximately 30 percent of their patients and family difficulties for 22 percent of their patients.

Finally, the results indicate that while appropriateness attitudes are significantly related to practitioner recognition of psychiatric symptoms, patient attitudes account for only a small part of the variance in levels of recognition. Although patients vary in degree of psychological mindedness, failure to recognize and treat emotional distress cannot be accounted for by patients' lack of desire to discuss such issues. Any response to psychosocial problems, whether simple discussion, formal treatment, or referral, requires recognition and assessment of these problems. The findings of this study suggest, therefore, that efforts to enhance recognition of psychosocial problems in primary care through improving training, modifying practice arrangements and reimbursement policies, and empowering patients to press their treatment requests more successfully should be continued.

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