Family physicians' approach to psychotherapy and counseling

Perceptions and practices

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SUMMARY

To determine how family physicians perceive the support they get for psychotherapy and counseling, we surveyed a random sample of Ontario College of Family Physicians members. Of 100 physicians who had family medicine residency training with psychotherapy experience, 43% indicated that such training was inadequate for their current needs. Because family physicians often provide psychotherapy and counseling, their training should reflect the needs found in practice.

RÉSUMÉ

Afin de déterminer comment les médecins de famille perçoivent le soutien qu'ils ont reçu dans les domaines de la psychothérapie et du counselling, nous avons effectué une enquête auprès d'un échantillon aléatoire de membres du Collège des médecins de famille de l'Ontario. Parmi les 100 médecins formés dans un programme de résidence en médecine familiale offrant une expérience en psychothérapie, 43% ont indiqué que cette formation était inadéquate pour répondre à leurs besoins actuels. Puisque les médecins de famille sont souvent appelés à dispenser des soins de psychothérapie et de counselling, leur formation devrait refléter les besoins de la pratique.

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FAMILY PRACTITIONERS OFTEN support patients and their families through emotional and physical illness with empathy, understanding, and careful advice. Data from the Ontario Health Insurance Plan (OHIP) indicate that family physicians billed the plan for 96% of the psychotherapy (*Table 1*) and 91% of the counseling performed in 1981 and 1982. Reports from OHIP show that the amounts billed for therapy and counseling have increased in subsequent years (personal communication from E. Murray). Heseltine[1] reports that 80% to 90% of psychiatric cases are managed by family physicians alone without psychiatric consultation and postulates that OHIP figures underestimate the time spent in therapy.

Family medicine residency programs have tried to enhance the psychotherapy training for medical graduates to better prepare them for the demands of practice. However, not all family physicians have been involved with residency programs. This paper reports the results of a survey designed to determine whether family physicians think they receive enough support from their training programs, the OHIP fee schedule, and their colleagues in psychiatry.

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METHODS

The survey instrument was a 28-item questionnaire that collected demographic data and asked about views on the use of counseling and psychotherapy in practice. It was pre-tested on members of the Board of Directors of the Ontario College of Family Physicians and on family physicians in Burlington, Ont. A modified version of the questionnaire was then sent to 305 members of the College who were randomly selected by computer from the membership list. A second mailing was sent 3 weeks later to those who had not responded. Data were tabulated and analyzed on the Statistical Package for the Social Sciences (SPSS) program at the Ontario Institute of Studies in Education in Toronto and on STATISTIX 3.1 (Analytical Software, St Paul, Minn). Where dichotomous groups were discovered, their characteristics were compared by the continuity-corrected χ^2 method. No

attempt was made to validate the reported information with actual practice patterns.

RESULTS

Sample description

We mailed 305 questionnaires; 201 (65.9%) were returned after two mailings; 198 responses could be used. Of the respondents, 44 (22.2%) were women, 139 (70.2%) were certificated, and 100 (50.5%) were residency trained. One hundred forty-seven (74.2%) were graduates of Ontario medical schools; 17 (8.5%) were trained at other Canadian universities; 18 (9.0%) were trained in the United Kingdom; and 16 (8.0%) were trained in other countries. Respondents' years of graduation ranged from 1928 to 1983, and their ages ranged from 24 to 79 years.

It was statistically significant that more respondents than nonrespondents were certificated ($P = 0.003$), but the groups were comparable in male to female ratio. The geographic distribution by postal code among respondents and nonrespondents was similar.

Table 1. **Definitions according to the Ontario Health Insurance Plan**

Psychotherapy: Any form of treatment for mental illness, behavioural maladaptations, or other problems that are assumed to be of an emotional nature, in which a physician deliberately establishes a professional relationship with a patient for the purposes of removing, modifying, or retarding existing symptoms, or attenuating or reversing disturbed patterns of behaviour and of promoting positive personality growth and development is psychotherapy. The minimum period for psychotherapy (to be claimed as such) is 20 minutes.

Counseling: Counseling is distinct from psychotherapy and is that form of activity in which the physician engages in an educational dialogue with the patient, on an individual or group basis, wherein the goal of the physician and patient is to become aware of the patient's problems or situation and of modalities for prevention or treatment. If the counseling session is less than 20 minutes, the appropriate assessment fee should be claimed.

Amount and type of therapy

The amount of psychotherapy being done was unrelated to sex, residency training, or certification status. *Table 2* divides respondents by the number of half-hour sessions of psychotherapy and counseling done each week. Most physicians performed one to five sessions of psychotherapy and counseling each week. Not included in this table are sessions that did not last a full 20 minutes; they cannot be billed to OHIP as psychotherapy or counseling. Such sessions were performed at least once each week by 135 (68.5%) and 125 (63.1%) respondents for psychotherapy and counseling, respectively. Sixty-one (30.8%) and 55 (27.7%) respondents performed psychotherapy and counseling, respectively, more than 10 times each week in sessions lasting less than 20 minutes. A great variety of techniques were used for psychotherapy (*Table 3*); supportive psychotherapy was used most frequently.

Although 63 (31.8%) respondents thought that neither counseling nor psychotherapy was precluded in practice, 110 (55.6%) thought that the demands of other parts of practice interfered with their ability to do psychotherapy (*Table 4*).

Perceived needs of patients

The percentages of patients per practice who were perceived to have problems that required psychotherapy or counseling are presented in *Table 5*. Fifty-eight physicians (29.2%) perceived that more than 30% of their patients had problems that required psychotherapeutic intervention; 65 (32.8%) indicated that more than 30% of their patients had problems requiring counseling.

In general, those respondents who perceived more of their patients as needing psychotherapy reported doing more psychotherapy ($P = 0.001$). Yet some respondents, who identified that more than 50% of their patients needed psychotherapeutic intervention, did five or fewer sessions per week.

Psychotherapy training

Of the 100 family practice residency graduates, 42 (42.0%) reported that they had had psychotherapy training in their residencies that met their current practice needs; 43 (43.0%) indicated that, although they had had psychotherapy training in their residencies, it was inadequate for their current requirements. Nine residency

graduates (9.0%) denied any psychotherapy training in residency, and six (6.0%) reported training but did not respond regarding its adequacy.

Seventy (75.2% of the 93 who answered the question) family practice residency program graduates had not been involved in any psychotherapy training beyond their residency. Twenty-three (24.7%) had undertaken psychotherapy training beyond residency. Twenty-seven (30.6%) respondents who were not family practice residency graduates had taken further psychotherapy training and 61 (69.3%) had not.

Of the 42 graduates of residency programs who thought that their psychotherapy training had been adequate for their current needs, five (11.9%) had done further training. But 15 (34.9%) of the 43 who thought that they had received inadequate training had done further training ($P = 0.02$).

Availability of psychiatric backup

Of the whole sample, 33 (16.6%) had no psychiatrists available in their community, 69 (34.8%) had one to five psychiatrists available, 16 (8.0%) had five to 10, and 79 (39.9%) had more than 10 psychiatrists available. For an acute psychiatric problem, a consultation was available within 24 hours for 147 (74.2%), after 2 days for 21 (10.6%), and after more than 2 days for 27 (13.6%). Consultation for a chronic problem was available after more than 2 days but within 2 weeks for 77 (38.9%), and after more than 2 weeks but within 2 months for 107 (54.0%) respondents.

Other referral services that were used included (in descending order of frequency): patient-paid psychologists, agency-paid psychologists, patient-paid social workers, agency-paid social workers, sociologists, clergy, community health centres, public health nurses, and hospital-based services. Although relative frequencies were recorded, the actual frequency of using these services was not determined.

DISCUSSION

Training programs

Family practice residency programs need to evaluate more closely the requirements of physicians in practice and to assess how well they train residents in psychotherapy and counseling. This survey found that only 42% of family physicians who had had a residency training program thought that the training was adequate for their

Table 2. **Number of half-hour sessions per week of psychotherapy or counseling**

NO. OF SESSIONS PER WEEK	NO. OF RESPONDENTS N = 198 PSYCHOTHERAPY (%)	COUNSELING (%)
0	16 (8)	18 (9)
1-5	117 (59)	114 (58)
6-10	43 (22)	45 (23)
11-15	8 (4)	8 (4)
16-20	7 (4)	4 (2)
No response	7 (4)	9 (5)

Table 3. **Reported frequency of various therapeutic techniques**

TYPE OF THERAPY	NEVER (%)	INFREQUENTLY (%)	OCCASIONALLY (%)	FREQUENTLY (%)	NO RESPONSE (%)
Formal psychotherapy	57.1	8.5	5.6	5.6	23.3
Transactional analysis	42.9	20.2	9.6	6.1	21.2
Hypnotherapy	58.6	8.1	6.6	3.6	23.4
Relaxation therapy	25.3	20.7	27.3	8.1	18.7
Balint groups	54.0	3.5	6.1	5.1	31.3
Neurolinguistics	61.6	6.1	1.5	0.5	30.3
Supportive psychotherapy	3.0	5.1	13.1	71.7	7.1

needs in practice. Residents' perceptions of training adequacy have been reported in other studies. Brown and Weston[2] reported a survey of family medicine graduates from the residency program at the University of Western Ontario. All respondents were providing supportive psychotherapy, yet fewer than 50% of the residents felt satisfied with their psychosocial skills. Brown and Weston suggested that recent graduates feel inadequate in dealing "with the varied organic problems common in family medicine but uncommon in their experience as medical students." They add, "Perhaps only after they feel comfortable with their basic medical skills are they secure enough to tackle patients' personal problems."

Table 4. **Reasons for not doing psychotherapy or counseling (respondents could indicate more than one reason)**

REASON	NO OF RESPONDENTS N = 198 PSYCHOTHERAPY	COUNSELING
No reason	63	63
Inflexible slots	49	57
Inadequate fees	41	39
Lack of training	50	21
Demands of practice	110	96
Other	5	6

It would be interesting to compare recent graduates' perceptions of the training they have received in treating organic and psychosocial problems. Has enhanced training in psychotherapy made any difference? Those who believed themselves least adequately trained would intuitively be expected to have sought the most postresidency training.

The most common therapy provided by respondents was supportive psychotherapy. Family physicians treat traditional psychiatric problems, such as depression, psychosis, generalized anxiety disorder, and personality disorder, as well as more common problems, such as unemployment, grief, insomnia, drug abuse, violence, anxiety, chronic illness, life-threatening situations, and chronic pain. Formal psychotherapy is not required for many of these problems, but hours are spent helping patients deal with them. Whether these issues present as part of a physical symptom complex or are identified as problems in themselves, family physicians must be able to recognize and deal with them initially and often must provide ongoing therapy. Supportive psychotherapy is an important aspect of treating the whole person. Feightner and Worrall[3] in their review of depression, reported that 50% of patients with nonpsychologic complaints who met the standard clinical criteria of depression were not recognized as being depressed. Ford[4] reported similar findings

The OHIP fee schedule

Data from OHIP cannot be used to determine the amount of psychotherapy and counseling family physicians provide. Sixty-one (31%) respondents reported that more than 10 sessions each week were mainly psychotherapeutic but could not be billed to OHIP as such because they did not last for the required 20 minutes. Similarly, counseling was frequently billed as other than "counseling" by the OHIP definition because less than 20 minutes were spent in therapy.

Sessions that last 5 to 30 minutes have been reported effective for helping patients become symptom free.[5] Collyer[6] calculated the mean time spent in psychotherapy as 18.4 minutes. The 20-minute rule is an arbitrary marker for billing purposes. The inflexibility of 20-minute billing slots was the second most common reason given for not spending time in psychotherapy (*Table 4*). Some physicians dealt with the problems imposed by time-limited billing definitions with other billing strategies. Low fees as a limiting factor was noted by 41 (20.7%) respondents.

Support from psychiatrist colleagues

When support of a psychiatrist was necessary, 75% of the respondents were able to arrange an acute psychiatric consultation within 24 hours. Chronic problems were less well supported. More than 50% had to wait for up to 2 months for help with a chronic problem. (This survey did not ask whether the waiting period for a consultation for a chronic problem was considered appropriate.) In

the meantime, family physicians had to deal with these psychiatric illnesses. Fortunately, other services are often available to help family physicians who are beyond their capabilities in training or time.

Emotional and psychiatric illnesses make up a large part of the patient problems seen in practice. Collyer,[6] in reviewing his practice, found that he spent 30% of his office time in formal psychotherapy and approximately half of his time dealing with emotional illnesses. Fisher,[7] in his review article, states that 18% of visits involve counseling or psychotherapy. Commonly, 20% to 25% of patients attending primary care facilities have emotional factors contributing to their illness.[8-10] This survey reported perceived needs for psychotherapy or counseling that are consistent with the prevalence of psychosocial problems found elsewhere. Similarly, the amount of psychotherapy being done was comparable to what others have found.[11,12]

"Demands of other parts of practice" was the most frequently cited factor for not doing psychotherapy. This might indicate that the physicians surveyed consider organic illness a greater priority than psychosocial problems, or that they prefer dealing with the less emotionally taxing organic illnesses. Lack of training was also listed as a common reason for not performing counseling or psychotherapy. (Lack of training in psychotherapy was considered a problem by more physicians than lack of training in counseling.) Residency training programs should change this perspective by providing training that gives family physicians greater comfort and facility in dealing with this important part of patient care.

The survey was one of self-reported work experience, and therefore is subject to the "obsequiousness bias"[13] where respondents overestimate "good" characteristics and underreport "undesirable" characteristics. As this was a survey about psychotherapy and counseling, respondents might overreport the therapy they perform and the patient need that they perceive. Battista[14] reported a 10% overestimate of what preventive procedures physicians reported compared with the number of procedures they did, measured by billings to the insurance plan.

CONCLUSION

The results of this survey suggest further questions. What are the needs of practising physicians for training in counseling and psychotherapy? How are they best taught? What are the characteristics of those residency-trained physicians who believed they were adequately trained?

Family physicians are important providers of emotional and psychotherapeutic support to patients. They need to be encouraged to continue their efforts to treat patients as whole people, and not to ignore the person for the illness. ■

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Table 5. **Family physicians' perceptions of the proportion of their patients that require psychotherapy or counseling**

	NO. OF RESPONDENTS N = 198	
PATIENTS (%)	PSYCHOTHERAPY (%)	COUNSELING (%)
<10	39 (19.6)	30 (15.1)
10-30	97 (48.9)	95 (47.9)
30-50	49 (24.7)	45 (22.7)
>50	9 (4.5)	20 (10.1)
No response	4 (2.0)	8 (4.0)

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