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postbus 1568
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MENTAL HEALTH AND PRIMARY CARE

Dutch and Israeli experience

Report on the Dutch-Israeli symposium on the interaction between mental health services and the primary care sector, held in Utrecht, the Netherlands, from 7 to 10 April 1986

Editors:

G.J. Visser
J.M. Bensing
B.P.R. Gersons
B. Maoz
C.Z. Margolis

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Netherlands institute of primary health care (NIVEL)
P.O. Box 1568, 3500 BN Utrecht, the Netherlands

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INTRODUCTION

The interaction between mental health services and the primary care sector is notoriously difficult. Many complaints can be heard. On the one hand the mental health sector is said to be inaccessible, to have long waiting lists, to work slowly and not too efficiently and to help only motivated people. On the other hand the primary care sector only concentrates on medical problem-solving and is insufficiently equipped even to notice its patients' many psychosocial problems, let alone to solve them.
How true are these common judgements? What is actually done in both sectors? And, most important: what can professionals in both sectors do in order to help each other, if needed, to help the patients?

The Dutch-Israeli symposium on the interaction between mental health services and the primary care sector, sponsored by the cultural treaty of 1984/1986, was organized in order to find the answer to these and other questions. Its aim was to provide its participants - nine of them being Israeli and seventeen Dutch, but all deeply involved in either the primary care or the mental health care in their respective countries - to meet each other, share experience and make plans for future cooperation and collaboration.

This book is a collection of most of the papers given, some, but not all, of them having been converted into more elaborate articles. Also, a summary of the discussions is given.

Like the symposium itself, the book is divided into four sections. In the first section a more or less detailed overview is given of the organization of primary care and mental health care in the Netherlands and in Israel and of some of the problems that arise in it. The second section depicts the family physician's concept of mental health and mental health services. The third section is the largest one: it deals with the training of primary care physicians, both students and practising general practitioners: consultation is the main topic in this respect. The final section gives some examples of the research done in the field: in addition to the interpretation and treatment of psychosocial complaints much

attention is given to the classification of disorders in primary care.

After having read the articles, the reader should judge for himself whether or not the participants of the symposium found any new answers to the difficult questions. For themselves, however, one thing is clear: the willingness to bridge the gap is as obvious a fact as the gap itself.

I. AN OVERVIEW OF SERVICES

1. MENTAL HEALTH AND PRIMARY CARE IN THE NETHERLANDS

J.M. Bensing

Twelve years ago, in 1974, the Dutch government published a White Paper called 'Structuurnota Gezondheidszorg' (Structuurnota, 1974), one of those ugly Dutch jargon terms, commonly used in health policy,this one meaning something like 'Health Care Structure Paper'. This White Paper deals with the structure and organization of the health care system and was written as a reaction to the intricate and disordered network of health care facilities that had been growing (and had been growing fast, especially after World War II) without an active central steering mechanism. Most countries in Western Europe had the same problem at that time.

In this White Paper three main principles were developed in terms of which the restructuring of the health care system (or non-system, as some cynical people used to say) had to take place:

1. the principle of 'echelonnering' or creating echelons;
2. the principle of 'regionalisering' or regionalizing;
3. the principle of 'integratie' or integration.

The first term is derived from the military world and refers to the common phenomenon that the troops (i.e. health care facilities) are arranged in such a way that the enemy (i.e. the patient) first meets the common troops, the ordinary soldiers (i.e. the first line or primary health care) and only after a major struggle succeeds in penetrating through to the second line (secondary care) where the specialist troops and the expensive equipment stand ready.

It was not mere chance, I think, that resulted in the use of military terminology; the first signs of the financial limits of the evergrowing health care system were clearly visible and asked for a firm action.

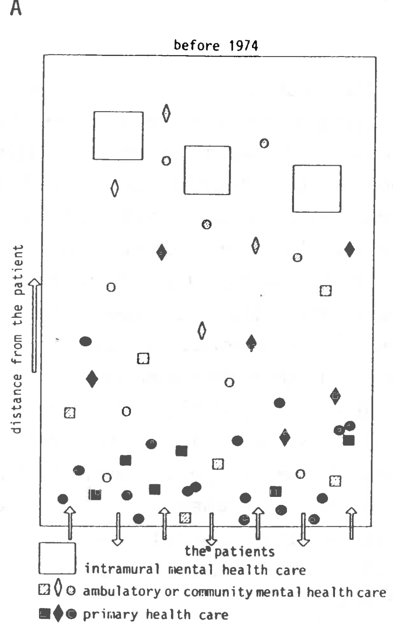
The second principle refers to the distribution of the health care facilities through the Dutch health care regions: each geographi-

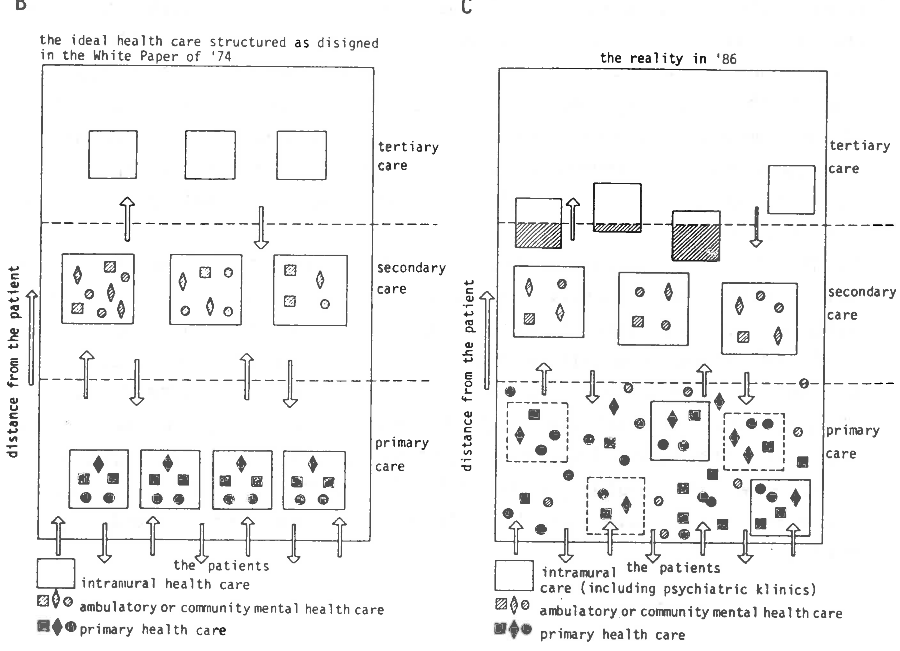
cal area had to have the total range of necessary health care facilities at its disposal, whereas until then some health care facilities were very unevenly distributed, especially in the field of mental health care.

The third principle refers to multidisciplinary cooperation within each subsystem of the health care system. In primary health care it is the multidisciplinary cooperation among general practitioners, district nurses, social workers, home helpers and many others, for instance in what are called 'health centers'. In ambulatory mental health care (or community mental health care) it is the integration of all kinds of different institutions - small and large, for children and adults, for the treatment of life problems and chronic psychiatric patients, for behaviour therapy and psychoanalysis and so on - into so called 'Regionale instituten voor ambulante geestelijke gezondheidszorg' ('Regional institutions of ambulatory mental health care; RIAGG's). The idea was to create comprehensive organizations with clear tasks and functions, easily recognizable for patients and other health care workers wanting to refer a patient. These new ambulatory mental health care facilities were - and still are - considered as secondary care: patients cannot refer themselves to the RIAGG directly (at least not officially) but need to be referred, preferably by their general practitioner. Furthermore, the RIAGG's were supposed to form a barrier between the patient and the primary health care system on the one hand and the mental hospitals on the other, the latter being considered (in this philosophy) as tertiary care.

In the White Paper all kinds of measures (financial, legislative, and so on) were planned to restructure the health care system in terms of these three guiding principles.
Nowadays, some twelve years later, we can see that an interesting development has taken place. The plan was that the intricate and disordered network of the health care system - as we have explained - should become a neat, surveyable whole comprising clearly recognizable institutions, but it has turned out to be - in 1986 - neither the one, nor the other (see figure 1).

Figure 1:
The Dutch health care system, as it looked before 1974 (A), as designed in the 1974 White Paper (B) and as it is in reality in 1986 (C)





The most important features of the actual situation are the following:

1. The restructuring of the existing ambulatory mental health care facilities has become a tremendous success. All the different services that used to exist with overlapping tasks and functions showing a colourful but chaotic and often incomprehensible pattern, have merged into neat regional offices (the RIAGG's) which are evenly distributed throughout the Netherlands. The fact that all these mental health care facilities have been brought together under one financial law, the 'Algemene Wet Bijzondere Ziektekosten' ('Exceptional Medical Expenses Act'; AWBZ) has been a strong force in this development.
2. The restructuring of primary health care is not such a success. Health centers did come, but not so many as people might have thought twelve years ago. At the beginning of 1986 we could still count no more than 140 health centers, employing or giving work to 7.2% of the general practitioners, 10.5% of the social workers, 9.3% of the district nurses and barely any home helpers (Boerma, in press).
In addition to these health centers there are many other forms of multidisciplinary cooperation with a less formal structure and no common premises, like home teams (391 in the beginning of 1986) and home teamlike organizations (129 at that time, together about 500) (Boerma, in press). But they are no answer to the old complaint that primary health care does not have a fixed address or phone number, a common voice or a general policy with regard to the referral or aftercare of patients, for instance. Although I must add that this is not the only or most important thing in the care for people.
3. The third striking feature is that although the **existing** mental health care facilities have been merged into these neat RIAGG's, at the same time during this restructuring process all kinds of other ambulatory health care facilities have sprung up. The mental hospitals or mental wards of general hospitals, for instance, have opened out-patient departments, forming ambulatory backyards and soon also front gardens for their clinical patients. After a while ambulatory patients for whom no clinical treatment was considered could also be referred to these out-patient departments.

Next, there was the fast growing phenomenon of the so called primary care psychologists, who opened (generally private) practices in towns or villages and sought close cooperation with nearby general practitioners.
Both these developments became a success, although the former more than the latter because of the difficult financial position of these primary care psychologists, who are not included in Dutch public insurance.

So, while in official policy an effort was made to restructure the existing mental health care facilities in terms of the principles of 'echelonnering', 'regionalisering' and 'integratie', we see that in the meantime all kinds of unforeseen processes have taken place causing the day-by-day reality to be all but successful. Evidently the new desk-made structure was not given a satisfactory assessment by the people who had to use them, which created a new market for new initiatives.

One possible explanation for this peculiar process might be the fact - obvious, but underestimated in its consequences - that primary health care is much more important for the RIAGG's than the RIAGG's are for workers in primary health care. This statement can be illustrated with some figures. In 1983 about 42% of the clients of the RIAGG came from general practitioners (Peters, 1984). That makes VIP's of the latter: very important persons, and asks for a close relationship between RIAGG's and general practioners with a special focus on this referral process. But, when the same kind of figure is presented from the point of view of the general practitioner, quite a different picture emerges.

Table 1: average referral figures in general practice

referral to	times a year in an average general practice	per thousand patients
medical specialists	575	231
physiotherapists	130	50
mental health care	16 à 17	6 à 7
(RIAGG	8	3)

Source: Peters, 1984.

As is shown in table 1, the average general practitioner refers only 16 or 17 times a year to a mental health care facility (about half of them to a RIAGG), as compared with no less than 575 referrals a year to medical specialists and about 130 referrals a year to physiotherapists, not to mention the many contacts with other disciplines in primary health care, like district nurses, home helpers and social workers. In this spectrum of professional contacts the RIAGG's form a minor part.

This difference in the relevance the relationship has for the different partners, does place a strain on it which has to be considered when developing strategic plans for improvement. I shall come back to this later. First another important point is to be made. These low referral figures do suggest that mental health problems form a minor part of the work in primary health care. However, nothing is less true.

In table 2 some figures are shown about the number of psychosocial problems presented to the four so called core disciplines in primary health care: the general practitioner, the social worker, the district nurse, and the home helper, as well as to the physiotherapist, another important health care worker in primary health care.

Table 2: psychosocial problems in primary health care

discipline	explicit psychosocial problems	obscured or mixed psychosocial problems	total amount of psychosocial problems
general practitioner	± 19%	± 43%	± 62%
social worker	± 50%	± 50%	± 100%
district nurse	?	?	3-63%
home helper	12%	46%	58%
physiotherapist	4%	± 50%	± 54%

Source: Bensing en Sluijs, 1984.

Measuring the amount of psychosocial problems is not an easy thing to do. Besides, great variations do exist between different health care workers, even of one-and-the-same discipline. The figures shown are - therefore - rough figures, just to give an idea. Those about the general practitioner result from the observation - in our institute - of about three thousand video-taped consultations, those about other disciplines from the records of the health care workers themselves.
The left column refers to those consultations in which the patient formulates a clear psychosocial problem. The right column refers both to those consultations (or visits) in which the health care worker knows or thinks that psychosocial problems are involved but does not discuss them during this particular consultation, and to those consultations (or visits) in which complex problems are presented of which psychosocial problems form a part. This latter might be the case with psychosomatic complaints presented to a general practitioner or a physiotherapist or with demands for domestic aid by home help in which psychosocial, psychiatric or psychogeriatric problems might play a part.
These figures have even more significance when translated into yearly contact rates, as is done - for the general practitioners - in table 3.

Table 3: psychosocial problems in general practice and RIAGG

	1982 general practitioner	1983 RIAGG
number of professionals	± 5,600	± 2,600
number of patients in care	± 11,000,000	± 154,000))
number of contacts	± 50,000,000	± 1,556,000
number of contacts with explicit psychosocial problems	± 9,500,000	
number of contacts with psychosocial problems	± 21,500,000	1,556,000
total number of contacts with psychosocial problems	± 31,000,000	

))client or client system

Source: Bensing en Sluijs, 1984; De Haen en Van Lieshout, 1985.

In 1982 about 5,600 general practitioners saw about 11 million different patients (about 77% of the Dutch population), with whom they had about 50 million contacts. Out of these 50 million contacts, in about 31 million contacts explicit or hidden or mixed psychosocial problems were presented (Bensing en Sluijs, 1984)

In comparison with these figures, in 1983 2,600 RIAGG professionals saw 154,000 different clients or client systems who had in total about one and a half million contacts with the RIAGG, presumably all of them psychosocial in nature (De Haen en Van Lieshout, 1985).

These figures are a warning for all policy makers engaged in planning the mental health care system: mental health care does not start in the RIAGG, but starts in primary health care, in general practice as well as in social work, as social workers see about as many clients a year as the RIAGG's do.

With regard to these figures the sixteen or seventeen patients referred each year by an 'average' general practitioner to mental health care facilities are surprisingly few. They are not so few because problems the general practitioner has to deal with are trivial. On a scale that measures the degree of seriousness, the average score for psychosocial problems is higher than for purely somatic problems (2.7 against 2.1; see also table 4).

Table 4: explicit psychosocial problems and its degrees of seriousness

problem	%	degree of seriousness
fear, nervousness, irritation, stress	21%	++
relation problem	13%	+++
depression, suicidal thoughts or attempts	8%	++++
sleeping disorders	7%	++
problem with work or money	6%	+++
problem with ill relatives	4%	+++
hallucinations, psychoses, etc.	3%	++++
problems in intrapsychic functioning	2%	+++
problems with alcohol, drugs, etc.	1%	+++
sexual problems	1%	+++
memory problems	1%	+++
social isolation	1%	++++
problems with housing or migration	1%	++
other psychological or psychiatric problems	6%	-
other social problems	5%	-
requests for psychofarmaca	20%	-

\+ = not serious
+++++ = very serious

Source: Bensing en Sluijs, 1984.

What do general practitioners do with these problems if they don't refer them to specialists in the field of mental health care?

First: sometimes they simply don't do anything, at least not with regard to the psychosocial problems or psychosocial aspects of somatic problems (in 32% of the cases). That is not as bad as it seems at first sight: many problems disappear without intervention and sometimes it is even better not to intervene. The only problem is to know when to intervene and when not.

Second: when general practitioners do intervene, they do this mostly by talking with their patients. Referring the patient and prescribing psychopharmaca does occur, but only in a small proportion of these consultations (5% and 8%, respectively). The talking may be of a passive nature (listening, assuring, giving moral support).

Table 5: psychosocial problems in consultations with somatic complaints

kind of complaints	total nr. of complaints	a * complaints %	b * complaints %
general	232	35%	65%
blood and blood-forming organs	13	-	-
digestive	104	32%	68%
eye	32	59%	41%
ear	54	70%	30%
circulatory	113	35%	65%
musculoskeletal	161	44%	56%
neurological	49	27%	73%
psychological	-	-	-
respiratory	191	41%	59%
skin	92	42%	58%
endocrine, metabolic and nutritional	24	38%	62%
urological	31	61%	39%
female genital (including breast)	139	49%	51%
male genital	8	-	-
social problems	-	-	-
	N = 1243 complaints (568 consultations)	N = 518 complaints (276 con-	N = 725 complaints (310 consultations)

sultations)

* a: the doctor does not suspect concealed psychosocial problems
  b: the doctor does suspect concealed psychosocial problems

Source: Bensing en Sluijs, 1984.

or of a more active one (exploring, insight enhancing behaviour and so on). Both forms occur at about the same rate. Real psychotherapy is not a common behaviour in general practice, although there are some exceptions.

One more thing needs to be said about the character of the communication between doctors and patients with psychosocial problems. The most important thing for a general practitioner to do in these consultations is to weigh up the situation again and again. In this process two different kinds of assessment must be made.
First, as most psychosocial problems are presented in a mixed or obscure way (43 % of the consultations show this kind of problems), the general practitioner must try to find out whether psychosocial problems do play a role or not. The somatic complaints of the patient can help him a bit but not too much, as can be seen in table 5 (see previous page).

Psychosocial problems do coincide with all manner of somatic complaints, with some more than with others, but that has barely any predictive value.

The second assessment has to do with the degree of seriousness of the problem and the chance of success when treated. It is the weighing of sending a patient home to help himself or be helped by his friends and family (and taking the risk that the problem gets worse) on the one hand and sending him to a mental health care facility on the other - taking the risk that the patient may start on a needless career in the mental health care system with all the dangers of getting stuck there.
I think this double discriminating task (discriminating between somatic and psychosocial and between serious or not serious) is the most difficult charge the general practitioner has. When we talk about the relationship between primary health care and community mental health care, we should not focus on the referral process. Although this referral process is very important for the primary health care workers, they'll have to handle most of the psychosocial problems themselves.
In this handling the double discriminating task just mentioned is the most difficult thing to do. If general practitioners do need help from specialists in the field of mental health care they need it on this subject. Education and post-graduate education, mental health consultation, Balint-groups and all other methods of trans-

mitting know-how can be useful for this.

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2. A GENERAL OUTLINE OF HEALTH SERVICES IN ISRAEL

N. Agmon de Shalit

The health services in Israel are provided by three sources: government and municipalities, the Health Insurance Funds and independent public organizations.

1. The central government, more specifically the Ministry of Health, takes care of the preventive medical care and some (about 40 %) of the hospital care.
2. The Kupat Holim, part of Israel's largest labour union Histadrut, is by far the biggest of the Health Insurance Funds. Primary health care and a substantial part of the hospital care is taken care of by this organization. The Kupat Holim owns the primary care clinics, about 30 % of the family health centers and many Israeli hospitals.
3. Management of Jerusalem's famous university clinic is in the hands of Hadassah, the American zionist women's organization, one of the more important public organizations involved in medical care.

Magen David Adom (the 'Red David's Star'; the Israeli equivalent of the Red Cross) takes care of the ambulance-services and first-aid services during the night and weekends.

There are four medical schools in Israel (in Jerusalem, Haifa, Tel Aviv and Beersheva), their affiliation with the medical services varying from a more limited connection to an extensive involvement (Beersheva).

Family doctors have to attend to a four-year post-graduate training program, including internal medicine, pediatrics, psychiatry and a 22-month 'residency' in one of the primary care clinics. Beside the 400 family doctors who have so far completed this training, a great many other physicians, like pediatricians, work in the primary care setting.

Primary care

Primary care in Israel is mostly provided by the more than 1,200 primary care clinics, the majority of which is owned by the Kupat Holim. In these clinics about 4,000 doctors practise, of whom

about 400 have been educated as family physicians. A typical primary care clinic consists of a team of from two to twelve doctors and an equal number of nurses; the two work together in teams, serving a population of 1,500 - 2,000 people. In addition most of the centers have special workers and medical specialists who come regularly or by appointment. These primary care clinics are responsible for diagnosis and curative help. Home care is given by special home care teams.

In addition to but separate from the primary care clinics there are family care centers, stations for preventive care, most of them run by the government. Efforts are being made nowadays to combine the two types of clinics into single units.

Mental health services

In 1976 a 'revolution' in the Israeli mental health services took place. Some very important steps were taken. First mental health services have since this time been free to all Israeli, through the co-ordination of government and Kupat Holim services. These services include all types of intervention, like prevention, diagnosis, treatment, hospitalization and rehabilitation.
Services are organized at a regional level, the country being divided into 23 catchment areas, with a population of 150 - 250,000 each.

A principal mental health center is the heart of each region, with a medical doctor - according to the plan - responsible for coordination, development and policies of daily services in the area. Thus far, however, responsibility for care is still in the hands of the central government.

There are a great number of mental health services in Israel:
- psychiatric hospitals (approximately 7500 beds)
- psychiatric departments in general hospitals (500 beds)
- out-patient clinics attached either to the general hospital or the psychiatric hospital
- community comprehensive mental health centers
- day care facilities
- hostels and 'protected apartments'
- rehabilitation centers.

Although there are more than sufficient beds and the out-patient clinics are also well spread throughout the community, there is still a great shortage of 'alternative modes of treatment' such as hostels, day-care centers, therapeutic communities, rehabilitation centers and crisis intervention programs.

To this should be added primary mental health care given by other agencies, such as the educational system (i.e. the Ministry of Education and local authorities), universities, health services, the social welfare department, the Kibbutz movement, the army and some volunteer bodies.

In spite of these efforts not all mental health problems in the country have yet been solved. The care of chronic patients, children and adolescents and drug addicts, is still most inadequate and (psycho)geriatrics and prevention are underdeveloped. There are also some geographical problems: most services are in the big cities, whereas the rural areas as well as the far north and south are underserviced. One of the problems is the fact that the population itself still considers the need for psychiatric help as shameful. There is not yet enough awareness among both the public and the helping professions about problems of life style and moral problems. And despite the fact that Israeli society lives in a continuously stressful situation, there is not enough readiness to provide enough help for life-stress problems.

Collaboration between primary care physicians and mental health services is very important.
The number of visits to the primary care doctor in Israel is one of the highest known (ten per person per year), while the number of visits to mental health centers is low. Research in the field being practically non-existent, a very rough estimate shows 36,000 new visits each year in the 60 facilities for ambulatory mental health, amounting to a total of 600,000 visits each year.
A great many of the visits to the general practitioner or family doctor are due to psychosocial problems. Most of the emotional and behavioural problems presented in the primary care however are neither detected nor diagnosed. Furthermore, hardly any attention is given to the emotional component of physical illness. There is therefore a great need for bridging the gap between primary care and mental health care.

'Psychosocial help is part of the job....'
Discussion

In the discussion following the two introductory papers no doubts arose as to the importance of mental health workers sharing their knowledge - either cognitive knowledge or knowledge of the emotional aspects of their work - with primary care physicians. Furthermore Huyse pointed out the necessity of bridging the gap between mental health care and specialist medicine. Students receive most of their training from specialists, he argued, and still there is a lack of models of cooperation between psychiatrists and medical specialists. Though they agreed in principle, Bensing and Agmon said that the lack of training in psychosocial issues was more noticeable in primary care. Resources are limited and therefore the emphasis should be laid on the training of general practitioners, as their relationship with patients is a more stable one and early detection of problems is one of their tasks. Also, many patients prefer to choose a physical complaint as an excuse for visiting their doctor, not daring to start to discuss psychosocial problems immediately. Besides, Maoz observed that contact between primary care physicians and psychiatrists was easier to achieve, as both shared a common philosophy which was patient (and family) centered and had an holistic and integrated approach.

Nevertheless, Bensing argued, differences in 'culture' between primary care and mental health care do exist. General practitioners are 'doers' with a limited amount of time for their patients, while mental health professionals often have - and should have - a lot of time. This difference might be one of the explanations of the low referral rates Bensing showed in her paper. Other explanations might be the long waiting lists in mental health care and the patients' fear of psychiatric treatment and stigmatization. In addition, primary care physicians consider psychosocial treatment as one of their tasks. Having been used to seeing themselves as 'specialists that failed', providing this kind of help has given them a new identity and helped them to see themselves as 'different but no less', when compared to medical specialists.

A last explanation is given by Agmon. For her the main reason for the low referral rates, in Holland as well as in Israel, might be the fact that primary care physicians deny their patients' problems just as they themselves refuse to see them, which might otherwise be a healthy way to deal with them.

Dutch mental health professionals seem to be amazed at these low referral rates, Bensing said, as they see most of their patients after referral from general practitioners and forget that for the family doctor the medical specialist is a far more important partner in his daily work.

The steadily growing popularity of psychologists among general practitioners is mentioned as further proof of the supposed differences in culture between primary care and mental health care. Many Dutch general practitioners seem to prefer these professionals to institutions of ambulatory mental health care: they are easily accessible, waiting lists are non-existent and a good face-to-face contact between them and family doctors is possible. For most institutions 'reaching out' to primary care is a far more difficult task, as it doesn't fit the organizational set-up very well. In spite of all this, Bensing pointed out, psychologists don't 'exist' in terms of Dutch mental health policy. Also, due to the high turn-over of the group - many psychologists start practising after graduating from university and find another job a couple of years later - it is impossible to give reliable figures as to its size and dispersion.

As a last point in the discussion Vrij asked what Dutch professionals and policymakers could learn from their Israeli counterparts. In comparison with the Dutch, Israeli primary care is much better organized, most of the care being given by teams; besides Israeli care has to meet the demands of a multi-ethnic society.
As for the first question, Agmon denied that differences in structure have much meaning. Although the Kupat Holim primary care is very well organized, when working as a psychiatrist close to one of the primary care clinics, she had to 'sell her goods' again and again, only to find out that primary care workers stuck to their usual way of working. Structual changes can't be the solution to the problems in cooperation discussed earlier, she concluded.

As for the many newcomers in Israel, there can't be a single answer to their medical and emotional problems, Agmon thinks, and each group's having a different cultural background should be taken into account.
Acculturation, however, is a big problem, as it involves a process of 'mourning' over all one is leaving behind. Though something is done, a much greater effort is needed. Davidson also signalized the different language of different patients, those with an oriental background - for instance - not talking about 'depression' but about somatic problems: 'My heart is heavy'. It is the general practitioners' difficult task to discover what the problem really is.

3. THE CONCEPT OF ECHELON: LESSONS FROM THE PAST

P. van Lieshout

The interaction between the primary health care system and the mental health care system has received a lot of attention over the last few years. Both researchers and policy-makers have presented numerous ideas on the defects and possible solutions. In this article I will try to draw some conclusions for what I think the agenda for the coming years should be as far as research and policy are concerned.
How should we organize the interaction between the primary health care system and the mental health care system? In order to answer this question, several possible strategies exist. One is the 'idealist' way, by taking all we know about mental health and illness as a starting point. Another way is more pragmatic: we take the actual situation as it occurs, evaluate problems where they occur, and look for feasible solutions. I wish to point to a third strategy and this third strategy aims at trying to learn something from the history of the way the relationship between primary health care and mental health care has been shaped in the Netherlands.

My point of departure is the White Paper on the restructuring of health care systems which was presented in 1974*. Two principles were introduced: the creation of **echelons** and the primacy of a coherent **regional** system of care.
The creation of echelons basically meant the division of the health care system into three divisions: the first, second and third 'line'. The first consisted - among others - of the general practitioner and the district nurse, the second line consisted of the general hospitals and the institutes for ambulatory mental health care, and the third line consisted of the nursing homes and psychiatric hospitals. The guiding principle was that no one could get into a 'higher echelon' without having been seen by a 'lower' one. Referral to a psychiatric hospital was only to be possible after a visit to an institute for mental health care which in turn could only be visited after a visit to the general practitioner.
The second principle, 'regionalization', was soon interpreted by the creation of different forms of cooperation by health care-pro-

* Structuurnota Gezondheidszorg; see also the contribution by J.M. Bensing to this book.

viders in a region. In most cases, cooperation never managed to become more than 'talking together every once in a while', but in some cases it was tranformed into a fusion of different institutes.

In 1974 the principles of creating echelons and stimulating regional coherence, looked very sensible to almost everybody. Now, in 1986 they are under severe criticism. The two principles are even considered as basically exclusive: creating echelons means the segregation of institutions, regionalization means integration. What happened in the years following 1974, more or less confirmed this preliminary conclusion. Although the restructuring concerned the health care system as a whole, I will restrict myself to the mental health care system and show how we in fact **created** a number of problems by the introduction of this concept of echelons, instead of **solving** them.
First of all, general practitioners never managed to become the actual gatekeepers as intended by the system. According to a recent publication by the Netherlands Association for Out-patient Mental Health Care, in 1980 65% of the admissions in regional institutes of ambulatory mental health care (Regionale instituten voor geestelijke gezondheidszorg; RIAGG's) were the result of referrals other than those from general practitioners (Statistisch Zakboekje, 1986). In 1983 this figure was reduced to 58% and in the last year the figure was even lower, but this was to a large extent due to the legal obligation of patients coming to a RIAGG to have a referral-letter from their doctor. So in fact we tried to create a gatekeeper function for the general practitioner by the introduction of rules without any basis in reality. This tendency was strengthened by the way most of the RIAGG's organized their after-hours emergency task in the last years. After hours, people are now only visited by the RIAGG when the general practitioner asks for it. If, for example, a policeman is confronted with somebody about to commit suicide, he cannot reach the RIAGG directly, but has to ask a general practitioner to telephone the RIAGG. As one can imagine, not everyone is satisfied with the manner in which the 'echelon' principle is being forced upon the health care system.

Not only are the general practitioners passed by, but also the RIAGG's themselves. In an ideal system of echelons, the RIAGG's are supposed to be situated between primary care and the intramu-

ral sector. In fact, in 1983, only one third of the admissions to psychiatric hospitals was referred by the RIAGG.
Neither the general practitioner nor the RIAGG succeeded in establishing their 'gatekeeper' function in the mental health care system. What in fact happened was the opposite. Those institutions that were supposed to be in the 'third line', started taking up 'second line' functions: polyclinics of psychiatric hospitals and psychiatric wards in general hospitals rapidly developed and became the competitors of the RIAGG's. And those functions such as supportive psychotherapy that we supposed to be the tasks of the 'second line' institutes were taken up by what are called 'psychologists in the first line'.

These developments clearly illustrate the problems in the concept of echelon. It is not difficult to point out still more problems. One of them is the problem of 'after-care'. In the Dutch health care sytem , RIAGG's and general practitioners are supposed to provide aftercare when somebody has been treated by a psychiatric hospital or RIAGG. As research clearly indicated, aftercare was neglected; the referral of patients back to a lower echelon proved to be even more difficult than the referral of patients to a higher echelon.
There are a number of other significant developments which all more or less undermine the actual value of the concept of echelon. RIAGG's and psychiatric hospitals are encouraged by the government to cooperate in a 'multi-functional unit' (Multi-functionele eenheid; MFE), which means the fusion of third line and second line institutions. In Amsterdam, plans are developed for other 'fusions' between echelons. The proposed regional cooperation in regional institutes for mental health care (Regionale instituten voor geestelijke gezondheidszorg; RIGG's) are increasingly turning into cooperation in specific 'circuits' (i.e. cooperation between several echelons for a specific task) instead of cooperation within echelons.

Fundamental weakness

Thus far two different ways of explaining the failure of the concept of echelon remained open. Either the concept is wrong, or we didn't try hard enough to actually put it into practice. I would argue that the concept itself is wrong. Wrong because it is based

on two assumptions and neither of which is encountered in mental health care.
The first assumption is that mental illness in its broadest sense is more or less like an infectious disease caused by a germ: you are infected, you don't feel well and you go to the general practitioner; he may send you to a specialist, you are cured and feel well again. The 'echelon model' is not just some model for the organization of the health care system, it is a model supposed to provide an adequate reaction to this type of illness.
The second assumption is that the problems people present can be translated into a single diagnosis, to be treated by a single specialist.

Both assumptions are invalid when dealing with mental health care problems. (In fact, I think they are also invalid when dealing with some of the so called somatic diseases, but that is another story).
Mental health care problems can, in many cases, not be cured in the way an appendicitis is cured by removing the problem. Many problems simply stay, cannot be cured and we are only too happy if we find a way for the patient to live with the illness. Fry (cited by Mitchell, 1985), for example, tried to estimate the number of 'chronic' problems in general practice. He concluded that, compared to psychiatric experience in hospital settings, the majority of psychiatric disorders seen in primary care are largely neurotic or behavioral, with relatively few acute psychotic illnesses. Most are affective dysphoric states or adaptional reactions of short duration. There is, however, considerable long term disability - alcoholism, drug dependency and misuse, chronic psychosis and mental handicap. Of all individuals presenting the family doctor with psychiatric problems, Fry concluded, one-third will have an on-off episode, one-third will have occasional but recurring bouts, and one-third will be chronic and persistent sufferers. And, as we know, even if the percentage of chronic problems is 33%, the time it takes up in the practitioners' timetable is considerable.
If we take a close look at the second assumption, the possibility of a clear diagnosis to be treated by one person, we see that that too is invalid. In psychiatry multi-axial classification has become standard with hardly any serious opposition. Strangely enough, the consequences are rarely faced. If a psychiatric patient can have diagnoses on different scales at the same time, why

shouldn't he be treated for all diagnosed problems. And different types of problems at the same time can mean different types of care providers at the same time.
I think the analysis of both assumptions shows that the echelon system, based on the notion of one-level problems that can be cured, clearly cannot be defended.

As a side-issue, I would like to make one remark which I think is very significant. The person who invented the concept of echelon in Holland in the early sixties was Querido. As he was the godfather of our social psychiatry, I long wondered why it was Querido of all people, with his experience in social psychiatry, who introduced a concept which I think was very harmful for the restructuring of the mental health care system. I found the answer by carefully reading his original publications on the concept of echelon. It turned out that Querido proposed something quite different. Querido's main preoccupation was the fact that many people showed mental health problems and couldn't be treated because of the lack of manpower: there were not enough trained psychiatrists. So what Querido proposed was to rearrange the mental health care system and create a second and even a 'one and a half' echelon of trained people who wouldn't treat themselves, but who would spread their knowledge among all those who came into contact with people: teachers, general practitioners, nurses etc. So Querido's proposal was to distribute **knowledge**, whereas the echelon-system in fact **distributes** patients.
Querido's proposal never completely disappeared: the mental health consultation model found its place in which the task of the 'consultant' was to help the 'consultee' appreciate all the dimensions of the disorder in the patient and of the transaction between himself and the patient or client. As a general tendency however, we preferred to move patients instead of knowledge.

New directions

I think neither the distribution of patients nor the distribution of knowledge is an adequate model. Given the fact that mental health care problems are often chronic and have different dimensions, I think it's wise to consider yet another distribution: the distribution of careproviders. Why not look for what I will call a 'mixture of care' for one patient, consisting of different care

providers, including people trained in psychiatry, who, either in turn or together, treat people in primary care. This is not an original idea.In the US, for example, the concept of case-management is a form of 'mixture of care', although only meant for the serious psychiatric problems. It can, however, be extended to less severe problems. In the UK, for example, there is a strong trend to remove psychiatric care from an institutional base out to the wider community, and as close to home as possible. A recent survey undertaken by the General Practice Research Unit showed a rapid expansion of psychiatrists involved in general practice (Mitchell, 1985). Almost 20% indicated that they spent some time in a general practice setting. The pattern of practise showed great differences: there were regular and coordinated home visits, there were psychiatric clinics in health centers and there were visits to the health center for selected patients. Although these forms turned out to be time consuming, the small amount of research that has been done thus far, has shown very satisfying results.
In the Netherlands, as far as I know, these models have not been tried out yet on a large scale. I know of one place, in Kennemerland, near Amsterdam, where general practitioners and psychiatrists decided not only to refer patients, but to try to treat them together. This, however, concerned only psychogeriatric patients.

Now, to come to a conclusion, I will formulate three recommendations for future research.
First of all on a practical level. At this moment in the Netherlands, a lot of attention is paid to the problem of 'recognition' by the general practitioner of mental health care problems and to subsequent referral. This is true both for the manager of a RIAGG and for researchers working with the Goldberg-Huxley model. Both take the echelon-concept for granted. Given the fact that many psychiatric problems are chronic and have different aspects, I think it's worthwile to shift our attention. Research should be undertaken to find out how an adequate mixture of care can be organized. We already know something about cooperation between general practitioners and district nurses, but we should extend this to mental health workers on the one hand, and, perhaps, family members on the other.
Secondly, we have to recognize the fact that, as psychiatric problems, especially in primary care, have different aspects, we not

only have to integrate these aspects on a practical level (i.e. different care providers), but also on a theoretical level. More and more research shows that problems in general practice have both a somatic and a psychosocial component. How they interact remains unknown, and in the Netherlands we hardly have any tradition of research in this respect.
Theory building about psychosomatic complaints is still in an inchoate stage in the Netherlands. Of course, there are several theories, like the stress-theory or psychoanalytic theory, but when it comes down to actual treatment, there only seem to be two options: either take the somatic aspect as the more real and try to cure this aspect in the hope all other problems will disappear or try to take the psychological reality as the ultimate one. I think serious efforts should be undertaken to do more research on new ways of treating these problems.
Thirdly, a final word for our policymakers. I think the most important lesson we can draw from the developments in the Dutch health care system in the last ten years, is not to take institutions or care-providers as a starting point for the restructuring process. The 1974 White Paper essentially tried to rearrange existing institutions in a new way, with no clear idea about the types of care that these institutions provided. An institution like a psychiatric hospital provides several types of care at the same time: shelter, food, treatment, social contacts, daily activities etc. Changing the place of a psychiatric hospital in a health care system means changing the place of all these functions. It would have been better if the place of the institution as a whole had not changed, but each type of care had been rearranged separately. Treatment could have been related to RIAGG's, daily activities to the existing social-cultural facilities in society, etc. So, to put it briefly, not institutions but **functions** should be the target of planning.

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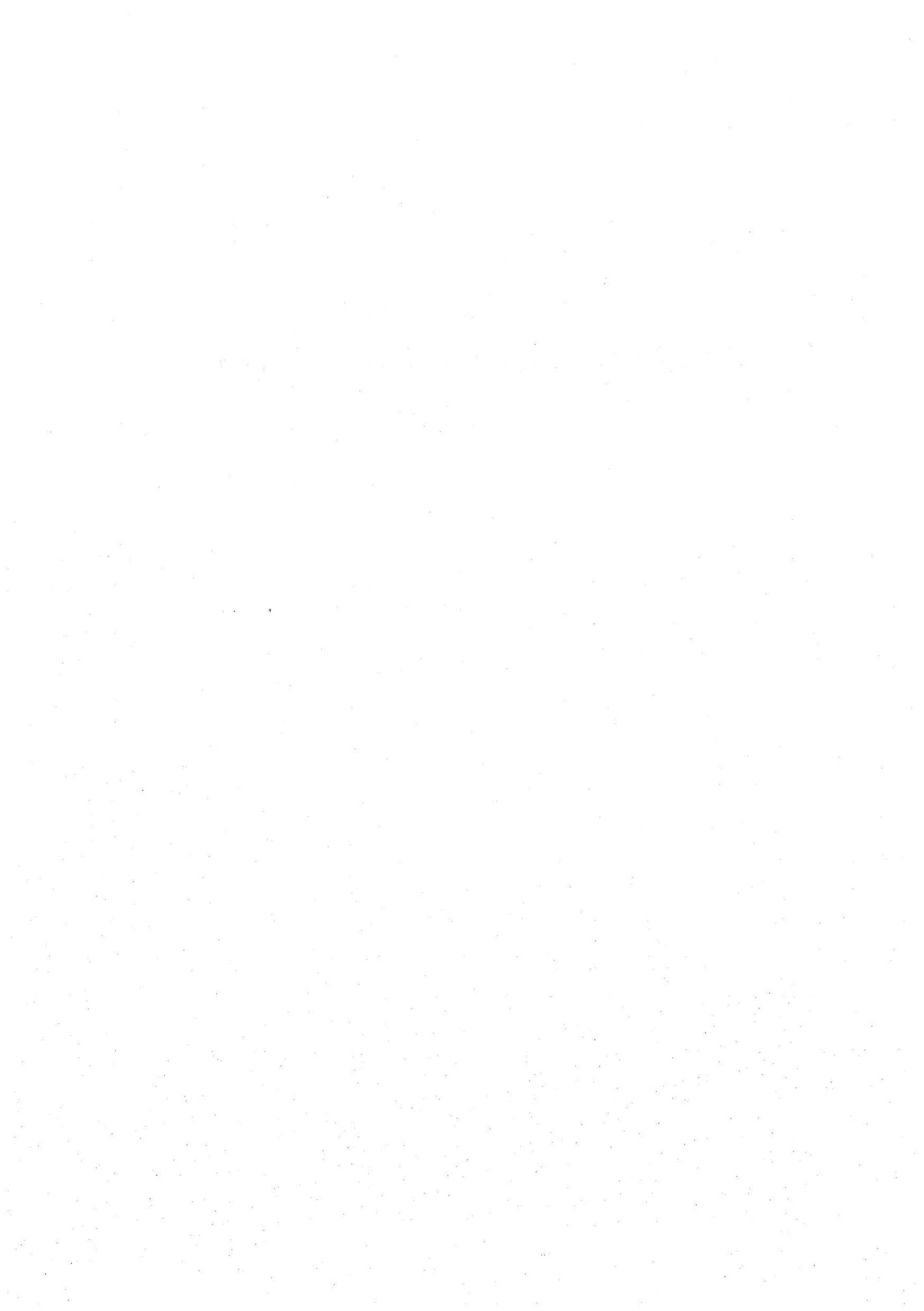
On crossing the boundaries
Discussion

To start the discussion Van Lieshout once again formulated the three proposals he made as a conclusion to his paper: a mixture of care instead of referrals, more emphasis on treatment of psychosomatic complaints and a planning system based on functions. Some discussion arose as to the 'gate-keeping function' of the general practitioner with respect to the RIAGG. Bensing felt the fact that many patients get there without having visited their general practitioner first, does not prove that the system itself doesn't work. Whereas in 1983 42% of all patients were referred to the RIAGG by the general practitioner, only 17% went there on their own initiative; the others were referred by other agencies, like psychiatric hospitals. Furthermore, all general practitioners are informed by the RIAGG, the moment one of their patients arrives. The figures are blurred, Kraan added, because patients might report themselves to the RIAGG 'on their own initiative', but after been advised to do so by their general practitioner. As to the aftercare of psychiatric patients, an even more serious problem than referral (Van Lieshout), Bensing mentioned that about one fourth of these patients visit their general practitioner directly after discharge, another fourth are sent to the RIAGG.
In contrast Davidson pointed out that, generally speaking, every single Israeli mental health center was responsible for the health service in its particular catchment area. Sometimes, he added, the mental health center and the community primary health centers of the catchment area belong to the same institution. But, he added, it is not necessarily a bad thing when patients get to the mental health center without seeing their general practitioner; in somatic care that is often the case and many patients prefer starting treatment that way.
The Dutch system of echelons led to several remarks from Israeli participants. Sofer stressed that the system was directed to the patients who should be treated in as 'low' an echelon as possible. But that doesn't mean, she added, that caretakers should not intermingle and pass the borders. Multidisciplinary groups, formed for instance by asking general practitioners and nurses to join the mental health care teams, can help patients to stop 'shopping around'.

Katz asked Van Lieshout how, in his opinion, one could avoid a planning based on functions leading to the same 'traffic-flow problem' as the one he was worried about. Though the answer to that question was difficult to give, Gersons explained Querido's own disappointment on seeing in which way his ideas were practiced. Originally he used the concept of 'echelonnering' in a function analysis that was based on the treble concept of primary, secondary and tertiary prevention. Although general practitioners have all of these functions, Querido never wanted to equate the general practitioners' work with primary care. In order to make practice correspond with Querido's ideas, however, much of the structural planning process should be skipped and that, he added, was too much to ask.

II. THE FAMILY PHYSICIAN'S CONCEPT OF MENTAL HEALTH



4. A FAMILY PHYSICIAN'S CONCEPT OF MENTAL HEALTH AND MENTAL HEALTH SERVICES

F.J.A. Huygen

In this paper I will try to put into words the views of a general practitioner on mental health and mental health services.
In doing so I will be basing myself on my experience in forty years of practice as the only doctor in a village on the lower Rhine, opposite the city of Nijmegen.
In addition to this personal experience, I am well acquainted with the views of the average general practitioner by virtue of my many contacts with them in my capacity as the head of a large university institute of family medicine. In the present contribution I shall base myself in particular upon the data of the continuous morbidity registration in Nijmegen of all diagnoses, all referrals and hospital admissions, a total of about 12,000 people in four general practices from 1967 up to the present.

In the Netherlands a general practitioner works in primary health care. All referrals to laboratories, to specialists, to mental health care professionals and to hospitals have to pass through him. The reports about his patients come back to him, so he is able to get a good general and detailed view of their medical life history.

It appears from this morbidity registration that only 2 individuals per year per 1000 of the population are referred to a psychiatrist and only 5 to other mental health professionals such as psychologists.
In Lambert's Monitoring Project in Rotterdam, which comprises data from ten general practices over a period of two years, exactly the same figures were found for the mental health services and a considerably smaller number for referrals to psychiatrists. At the same time in both these registration projects many mental health problems were recorded for which a general practitioner's help was sought, rising to a (prevalence) figure of 180 - 190 per thousand of the population. This means that only a very small part, some 4 % of what a general practitioner sees as mental health problems, comes to the attention of the official mental health professionals. The exact diagnostic classification of these mental health problems is notoriously difficult and liable to considerable inter-

observer variation. I will not tire you with details but give you some rough figures about the numbers in broad catagories of mental health problems seen each year by an average general practitioner (see table 1).

Table 1: number of patients with mental health problems in an average practice per year contacting their general practioner and referred to mental health professionals

kind of problems	number of patients	referred to a psychiatrist
psychotic and other serious disturbances	5 - 15	4 - 6
		referred to all mental health professionals, inclusive of social workers
neurotic and less serious disturbances	400 - 500	28 - 35

Of the small number of psychotic and other serious mental disturbances seen by a general practitioner a considerable proportion is referred to psychiatrists and mental health agencies. In this article, however, I won't discuss this category. Instead, I will restrict myself to the less serious neurotic troubles. The nomenclature is somewhat confusing.
In the English literature they are often referred to as psychoneurotic, emotional or psychological disorders, much importance being attached to anxiety as a cause or symptom. Other labels are psychogenic, nervous, functional, hypochondriacal or neurasthenic disorders. Two criteria are essential for this diagnosis in our records. The first is that no somatic cause can be established after adequate investigation (if necessary by specialists), the second, that a psychological cause seems certain or highly probable. (Under this head come the numbers of the ICHPPC-2 070, 071, 073,

075, 079, 086; also social , marital or family problems if giving rise to somatic symptoms for which medical help is asked).

Extent of the problem

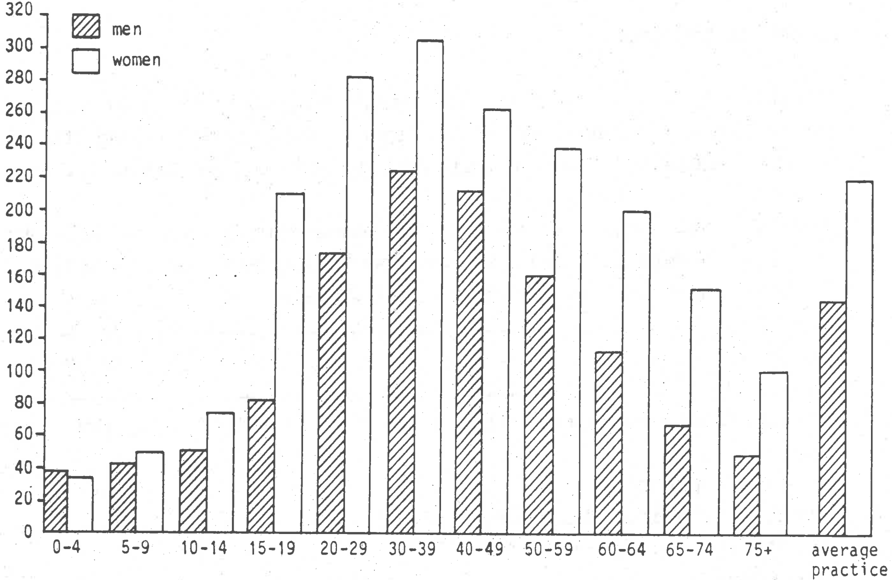
According to our registration of diagnoses, about 90 % of all mental disorders a general practitioner encounters belong to the broad category of nervous-functional disorders (see table 2).

Table 2 : new cases of mental, psychoneurotic or personality disorders per 1000 of the population per year according to sex (CMR 1971-1978; n= 11,880 pat.)

diagnosis	men	women
nervous-functional complaints	123	189
enuresis	3	2
reactive depression	2	2
juvenile behaviour disorders etc.	2	1
addiction (incl. alcoholism)	2	1
oligophrenia	1	1
endogenous depression	1	1
senile dementia,- psychosis	1	1
other psychoses	1	1
psychopathia	1	1
hysterical states (incl. anorexia nervosa)	1	1
schizophrenia	-	1
other	3	5
	---	---
total of all psychomatic diagnoses	139	204

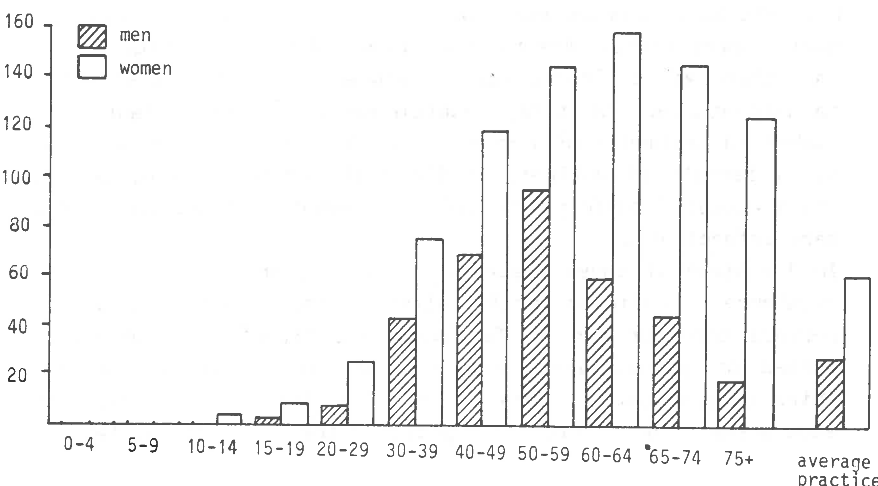
It appears that a general practitioner with an average practice size of 2300 patients will be consulted each year by circa 145 men and 220 women for a new episode of this kind of emotional or nervous disorder (see figure 1).
He will also have about 25 men and 60 women with a simular but chronic pattern of complaints in this practice (see figure 2).

Figure 1: average number of new cases of nervous disorders per 1000 of the population according to age and sex (period 1971 - 1978; n = 11,880)



In the last decade studied in our registration project, diagnosis of nervous disorders in men has always occupied one of the top five positions in the ranking order of all the diagnoses, and in women one of the top three, most frequently the first position.
Such patients make heavy demands on their general practitioner. From our investigations it can be estimated that about 20 to 25 % of the general practitioner's time and workload is occupied by these minor disturbances of mental health. Moreover, it is not a easy job for a general practitioner to help these patients effectively and to satisfy them. They tend to have recourse to him often and for all kind of symptoms and diseases. In a longitudinal follow-up study of seven years we were able to demonstrate that patients with one or more new episodes of this kind of nervous symptom would consult their general practitioner considerably more often than average for the top 12 of our ranking order of somatic diseases; these frequencies doubled for those patients with one or

Figure 2: number of patients in 1978 with chronic nervous disorders per 1000 of the population (n = 11,880) according to age and sex



more episodes of chronic nervous disturbance in the observation period.

As was pointed out before, only a small percentage of these patients , some 5%, are referred to mental health professionals. This is not an easy thing for the general practitioner to do, because patients usually do not like it. Indeed, generally speaking, long-range results of this kind of referral would seem to be rather disappointing.
General practitioners in the Netherlands tend to have rather negative expectations of and experience with the institutions for ambulant mental health care. There are often long waiting lists, as a rule there is no 24-hour service, and such units are apt to fail in emergency cases. A general practitioner often does not know to which of the many professionals in these institutions his patient will be referred and usually the general practitioner will have no personal relationship with him or her. The family doctor will often get late and insufficient information about the patients referred, which hampers his present and later contacts with them.

Furthermore, general practitioners have an idea that the mental health agencies are of an élite character, particularly apt to help those who are verbally gifted and already motivated for this kind of help.
Patients with nervous disturbances are more often referred to organic specialists. Again, our longitudinal investigation shows that there was a clear parallel between the frequency of referrals to laboratories, to X-ray departments and to consultants and the number of episodes of nervous disorder. In the ranking order of all referrals of patients in the last decade studied, this diagnosis occupied third place (only surpassed by childbirth and coronary infarction).
In longitudinal investigations I was also able to demonstrate the existence of definite family patterns. These kinds of emotional or nervous disorder run in families. The transference of such illnesses or pathological behaviour was even evident down to the third generation. In this respect the influence of the mother's side seems to be of greater importance than that of the father's.

So we may conclude that, quantitatively speaking, this kind of disturbance in mental health constitutes an enormous problem, which puts a heavy strain on our whole system of health care. And once more I must add that from a general practitioner's point of view the results of all our endeavours are disappointing. We must also accept the fact that a certain proportion of these patients referred to specialists to rule out any organic disease, are made worse and are damaged by unnecessary investigations, by superfluous medication and sometimes even by operations. A process of what we have called 'somatic fixation' takes place on a large scale, exemplified by the making of endless return appointments to defend or reassure the doctor and to please the patient.

Treatment

What I said about the epidemiology of nervous disorders has an affect on my views on treatment. I regard it as very important to make a distinction between patients presenting symptoms of diminished mental and physical well-being (such as nervousness, listlessness, insomnia, all kinds of bodily dysfunction) only occa-

sionally, and those to whom such symptoms are more or less habitual. Presenting this kind of nervous symptom occasionally is so widespread and frequent among people that it has to be regarded as part of normal life.
Although such symptoms can be very troublesome there is no reason to try and change the psychological and social functioning of these people radically, seeing that most of them will disappear after a while and that the majority of these patients will recover spontaneously. All that is needed is a good case history and a simple examination, where necessary, to exclude any serious somatic cause. Active and empathic listening to patients, helping them to shed light on an existing link with life events or difficult circumstances, is very important.

On the other side of the spectrum are those patients whose nervous disturbances and symptoms are of an ever recurrent habitual nature. My longstanding experience as a general practitioner, with all the referrals, treatments and experiments in the field, has convinced me that it is unrealistic to aim at 'curing' these patients. I have seen too many endeavours in this direction fail, often ending in bonds of fixation between therapist and patient.
I think it is more realistic to strive towards acceptance of the nature of these patients and to help them to accept themselves as they are and to learn to live with their susceptability to symptoms and complaints. This means that a general practitioner has to accept the nature of these patients wholeheartedly, just like those suffering from diabetes, hypertension or vascular pathology. This can help to break vicious circles in the interaction between complaining patients and irritated or rejecting doctors.

Prevention

One last point I want to mention is prevention. As I have already said, this kind of mental disorder runs in families. Usually they become manifest when the children are growing up and come into contact with the world outside their narrow family ties.
But we found clear evidence that parents (especially mothers) with a tendency towards these disorders will call in a general practitioner's help for children much more often than other parents.
A family doctor, having frequent contacts with them, is in a good

position to identify this category of children at risk.
This provides him - at least theoretically - with an opportunity to try and prevent undesirable developments. I think it important for the family doctor to realize this. Perhaps he can help to break a chain of misery and unhappiness running from generation to generation. In my opinion it is especially here, in the field of prevention, that close co-operation between general practitioners and the institutions of ambulatory mental health care is desirable.

5. THE FAMILY PHYSICIAN'S CONCEPT OF MENTAL HEALTH

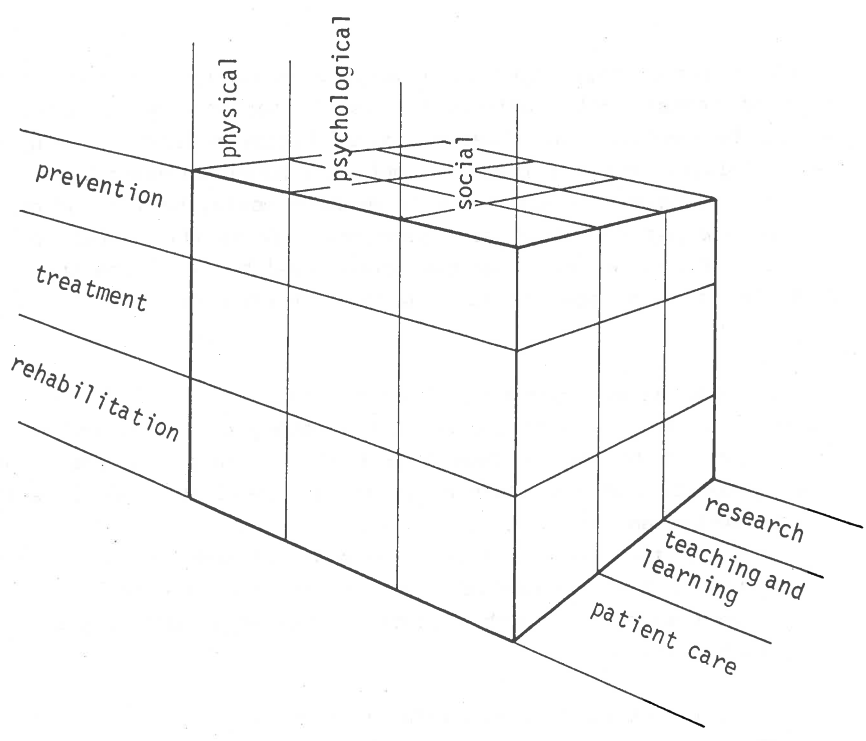
T. Spenser

The main aim of this paper is to share some thoughts on how a concept of mental health affects the family doctor's daily work. It should be seen against a background of family medicine as a growing specialty. Many of these thoughts are based on assumptions; we do not yet have accurate tools to measure mental health and especially how our behaviour as physicians affects the mental health of our patients or even our own mental health. Therefore the second aim of this paper is to stimulate thoughts on possible joint studies.

I have arranged my thoughts in two categories:
Firstly, in keeping with the basic philosophy of family medicine I shall look at the mental health of the individual, the family and the community and add another important issue: the mental health of the doctor and his family.
Secondly, in the context of the 3-dimensional model (see figure 1, next page) I shall concentrate on service (health care), with emphasis on prevention, which I consider the family doctor's special responsibility.

But first I want to give some definitions:
Health is notoriously hard to define. I like this definition, taken from the Royal College of General Practitioners, 1972: 'health is a satisfactory adaptation of the individual to his total environment'. To put this into perspective, here is another definition from the same source: 'a healthy person is one who has been inadequately studied'.
I should like to add the central thought from the recent work of Antonowski (1984), the Israeli sociologist: 'salutogenesis: the sense of coherence as a determinant of health'.
Mental: pertaining to the mind. The shorter Oxford dictionary gives fourteen definitions of mind, two of them include the word 'soul' and none of them the word 'brain'. The first five are concerned only with memory; of the remaining nine, the most suitable is: 'seat of consciousness, thoughts, volitions and feelings'.
A **family physician** is a general practitioner who relates to the individual in the context of the family, and to the family in the context of the community.

Figure 1: conceptual model of health and organized health care



Mental health of the individual

To speak of the mental health of an individual is almost a paradox, because mental health manifests itself entirely in relation to other people. I have taken Erik Erikson's (1963) stages as a framework of reference (see figure 2, next page).

I believe, with Erikson, that basic trust is the cornerstone of mental health. Shakespeare's infant, mewling and puking in the nurse's arms, may well be a case of maternal deprivation, with the development of his basic trust and his mental health at stake. True she is probably a wet nurse and is holding him in her arms, but the family doctor would do well, while excluding pyloric stenosis and another twenty other causes for vomiting, to counsel that

Figure 2: Erikson's stages of development

VIII maturity								ego integrity vs. despair
VII adulthood							generativity vs. stagnation	
VI young adulthood						intimacy vs. isolation		
V puberty and adolescence					identity vs. role confusion			
IV latency				industry vs. inferiority				
III locomotor-genital			initiative vs. guilt					
II muscular-anal		autonomy vs. shame, doubt						
I oral sensory	basic trust vs. mistrust							
	1	2	3	4	5	6	7	8

Source: Erikson, Childhood and Society

source: Erikson, 1963.

family as to how to try to satisfy the emotional needs of that baby.

During the second year of life the human being begins his struggle for autonomy as a creature in his own right. I suspect that this is, after basic trust, the most crucial issue in mental health and therefore, if Erikson is right, the most crucial age are the second and third years of life. It is also the most difficult for parents and doctors to handle, as children at that age are inclined to be very contrary and annoying to adults.

I have noticed in my daily work that most 2 year olds cry when they are brought to the doctor, even under optimal conditions and by the age of 3 no longer cry (unless, of course, they have a good reason, like pain). I consider this an easily observed and recor-

ded manifestation of this struggle for autonomy versus shame and doubt. I have made a point, for several years, of explaining this to parents (usually the mother) as a healthy sign of normal development and tried to guide her in her efforts to socialize her child: the child needs to be allowed, even encouraged, at this age, to explore his own choices. Don't say 'no' unless you really have to; but if you have said 'no', be consistent. This is the way to encourage the development of autonomy but to protect against unnecessary doubt and shame.
In our child development card we printed this 'milestone of development' ('cries at the doctor's at age of 2') as an experimental item and are now beginning to look at the results. The first impression (by no means controlled or randomized yet) is that the 2 year old who does not cry at the doctor's is likely to have other behaviour problems later; and the 3 year old who still cries is already having them. This is one of the little studies I would like to see on a larger scale.

A few words about the school child. The approach to the problem of recurrent abdominal pain in children highlights the bio-psycho-social model, described by George Engel (1977), which is accepted today by both family doctors and psychiatrists.
The typical child with recurrent abdominal pain is one who can never satisfy the high expectations of the parents, even if she is the best pupil in class (as she often is). She is made to feel perpetually inferior in some way. A full history will often enable the doctor to be helpful in his council, instead of embarking on a potentially harmful course of physical investigations, thus perpetuating the problem of inferiority. But he does not always succeed. To confuse this issue, I have to report that in my practice, an Arab village of 1,800 people, we have 4 schoolchildren with proven duodenal ulcers. Table 1 shows that each of these has at least two stress factors.

There is much to say about adolescence, still a neglected age group, in which the family doctor is often the only professional with natural opportunities to help the parents accept behaviour of revolt, at the same time continuing to provide a background of emotional security. Every stage in the family life-cycle has its own opportunities for early detection of mental health problems and educational help by the family doctor.

Table 1: children with duodenal ulcer (Gush Halav 1986)

	age at first symptom	age at diagnosis	age now	place in family	details
female	7	9	11	4th of 6	best pupil in class; family history of d.u.; many emotional, somatizing problems in family, especially mother.
female	10	11	16	4th of 6	strong family history of peptic ulcer; mother with severe medical problems
female	8	12	16	7th of 8	below 3rd %ile in height and weight; father very ambitious and demanding
male	13	13	16	1st of 4	mother very ill; father very ambitious and demanding

One special word about the last stage - maturity or old age. It has been calculated that by the year 2025 one quarter of the population of the western world will be 60 years or over. There is much the family doctor can do to help lonely and depressed old people who may represent Erikson's despair. Sometimes he has to exclude organic causes like hypothyroidism or senile dementia. He can always listen to their fears, often of dying.

As I have gone quickly through this life cycle I have tried to show that the family doctor's preventive and educational activity is his major contribution to mental health. I believe that if we give our young patients this kind of help, the benefit will be reaped when those babies become parents: a long-term investment which requires both faith and carefully planned prospective stud-

ies.

Mental health of the family

It is axiomatic to say that just as every problem a patient brings to the doctor has a mental health component, so it has also to be seen in the context of the family. We believe that an understanding of family is the key issue in mental health.
A family's mental health is manifested by its functioning as a system. Systems thinking is another one of the hallmarks of family medicine and family functioning patterns part of its knowledge base. This, together with the family doctor's personal development and skills, will determine the quality of family care his patients get. Doherty and Baird, two family physicians in Oklahoma (USA), have lately proposed a definition of five levels of knowledge, skills and personal development of family physicians towards the involvement with families under their care (Doherty and Baird, i.p.). These levels are useful as educational objectives in the training of family doctors, and have served as a basis for a document produced by a working party of the Israel Society of Teachers of Family Medicine on the subject of 'The Family in Family Medicine'. The following basic assumptions form part of this document:

- to speak of family is to speak of context;
- the doctor is always part of the clinical systems equation;
- the doctor is the most important drug we have;
- the doctor must learn to live better with uncertainty and with failure and help his patients (and students) to do the same.

Mental health of the community

The basic question I should like to ask under this heading is the following: if we can talk about the mental health or un-health of an individual, or a family, can we do the same regarding a community? Is there such a thing as a sick community, or is this just a place where there are a lot of sick people? Let me give an example. One of the communities I work in, a kibbutz of 400 people, has had in the past ten years three suicides, two fatal road acci-

dents involving the driver, one fatal accident by electrocution of an adolescent, one major involvement in drugs and one schizophrenic who drowned. In comparison, another very similar community five kilometers away has had none of these events. What are the parameters, and what the determinants of the difference? Is it the way the community functions, rather like the way a family functions?

Let us look at one possible parameter: the incidence, prevalence and consultation rates of mental health and psycho-social problems in general practice. Table 2 shows the rates in one English practice.

Table 2: annual person consulting rates in a British general practice of 2,500

		%
minor psycho-emotional problems	250	10
symptoms, not yet diagnosed	375	15
chronic psychiatric problems	100	4
severe depression	10	0.4
suicide attempts	4	0.16

Source: Fry, 1983

John Fry (1983) here gives 'persons consulting' rather than consultations. This means that a person could consult once or many times during that year for that problem. Table 3 shows social pathology in the same practice.

I have looked at another eleven studies and found that the place of ICD group V (mental disorders) as a percentage of all doctor-patient contacts varies between 0.6% and 26.6% of all contacts. I suspect the difference tells us more about the doctor's diagnostic bias and recording habits than about the different patient-populations. I suggest this field as another possible subject for study.

Mental health of the doctor and his family

This subject, although it has received some attention in the lit-

Table 3: social pathology in general practice

condition	annual prevalence per 2,500
'poverty' and handicap	
supplementary benefits	
elderly	60
non elderly	60
attendance allowance	120
mobility allowance	80
invalidity allowance	250
unemployment	100
marriage, divorce, etc.	
marriages	12
divorces	4
one-parent families	40
crime etc.	
burglaries	25
in prison	4
drunken driving	5
sexual assaults	1
juvenile delinquents	10
children in care	3

Source: Fry, 1983

erature, is still not taken seriously enough. Much has been written about 'burn-out'. Doctors are known to constitute a high risk group - broken marriage, alcoholism, depression, suicide. Medical students should be made aware of this problem as part of their syllabus and support systems should be established for the 'impaired physician'. Many doctors do not have a family physician - this would seem to be the first step. The Balint-seminar is the only peer support group which seems to have been widely accepted and may play a useful role in this context.

Mental health service

Mental health problems, like all health problems which the family

doctors team deals with, are divided into three categories: those in which the team provides definitive care, shared care or supportive care.

There is no problem as such where the family doctor team opts out of care, except at the individual patient's request.
When we talk of primary mental health care, we imply the care by a multi-professional team, including social worker and nurse. The consultative psychiatric service, also based on a multiprofessional team, comes into the picture on the level of shared care. The success of shared care depends on defined mutual expectations, successful communication between the family doctor team and the psychiatric team. This, like all professional communication, must be both verbal and written and constitutes exchange of information and opinions, teaching and supervision. This interchange should take place, as far as possible, on the family doctor's and/or patient's home territory. In hospitalized patients the family doctor should always visit at least once, and be involved in planning the discharge.

In supportive care the emphasis is on support of the patient's family. The Israeli Ministry of Health has recently stated that 3000 psychotic patients could be discharged from hospitals if community facilities were available. One of these facilities must surely be a family practice team willing and able to take responsibility for their continued care.
To illustrate this point, I should like to give a short case history:

Man born 1933, member of kibbutz, married, three children
1963 diagnosed as schizophrenic, hospitalized, started on chlorpromazine
till 1966 marital counselling by psychologist
1969 disturbed behaviour reported by wife but did not come for help
1971 acute paranoid schizophrenia - hospitalized two months, wife never talked to by hospital staff. Discharged with signs of phenothiazine overdose
1971 with his and wife's permission I talked to the kibbutz meeting about his rehabilitation.

I made a contract with him that I would look after him in the kibbutz if he undertook to keep me informed about his thoughts and feelings and took his medication when he and/or I thought he needed it. Functioned well most of the time, long periods without medication. I consulted psychiatrists from time to time, but he was never referred again. Kibbutz mem- bers monitored his well being.

1977 I steered the couple through a long-overdue divorce

1980 I helped him through a disastrous relationship with a schizophrenic woman who wanted to marry him.

1982 drowned in the sea whilst on holiday.

Research

Lastly a quotation from Karl Popper, which is also my comment on the subject of research: "It is not his possession of knowledge, of irrefutable truth, that makes the man of science, but his persistent and recklessly critical search for truth".

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6. REFERRAL PATTERNS OF GENERAL PRACTITIONERS AND PUBLIC HEALTH NURSES

L.J. Davidson

The distance between the mental health center and the community causes it to rely on gatekeepers who act as intermediaries between itself and the community. These gatekeepers, who hold community positions such as doctors, nurses and policemen, have the role of identifying problematic individuals and trouble-spots within the community, and of refering them to the mental health center, or of treating them under the supervision of the center.

Gatekeepers however face serious obstacles in their role as identifiers of 'mental disturbance' within the community. Firstly, they are confronted with the vagueness of the term 'mental disturbance'. (This is particularly problematic in the areas of neuroses and psychosomatic disorders, in which anxiety plays a central role). It is reflected in the wide range of estimates of mental disturbance within the community. (Cohen-Gur, 1971; Goldberg and Huxley, 1980; Shepherd et al, 1966).
Secondly, 'mental disturbance' is viewed variously, depending on the cultural context (Hollingshead and Redlich, 1958), and this also has an influence on identification.
Thirdly, the socio-economic characteristics of the community, and of the individuals within it, also influence the identification of mental disturbance and the way the community copes with it. Hollingshead and Redlich (1958) point out the connection between social status and the likelihood of an individual undergoing psychiatric treatment. Dohrenwend and Dohrenwend (1965) also refer to a higher proliferation of mental disturbance among the lower social classes. The question they raised was whether mental disturbance is the reason for, or the result of, low social status.

The medical gatekeepers - general practitioners and public health nurses - provide the majority of referrals to the mental health center, and we will therefore focus on them.

These gatekeepers, who were educated according to the medical model, are given a central role in the community model, and this is the source of a basic conflict.
The medical model is dichotomous in nature, diagnostical, hierarchical and indirect. It makes a dichotomous distinction between

sickness and health, and this makes identification of intermediate cases - in the field of neurosis for example - more difficult (Goldberg and Huxley, 1980). Furthermore, it causes a reduction in the resources channeled into prevention and early identification (Dolev, 1972).
The medical model also necessitates a clear diagnosis, which is difficult to make in psychosomatic conditions and anxiety states. Since it is both indirect and hierarchical, it itself contains its own gatekeepers - the nurses - whose role it is to filter and to act as intermediaries between the patients and the doctors. Despite this role, and their proximity to the community, nurses are not granted the authority to identify and diagnose.

Another thorny issue is the inadequate contact and lack of mutual respect between psychiatrists and general practitioners. The former regard general practitioners as having attained only superficial medical knowledge, while the latter regard psychiatrists as dealing with an inferior professional field, whose very relation to medicine is a matter of controversy. What general practitioners and psychiatrists share is a low rung on the hierarchical ladder of the medical profession. The nurses hold an even lower position in the hierarchy. Moreover, all three groups are in conflict as to who has responsibility for individuals suffering from mental problems. (Shepherd et al., 1966; Goldberg and Huxley, 1980; Link, Levav and Cohen, 1982).

The central question this paper asks is what factors are connected with the gatekeepers' identification and their decision as to whether or not to refer people to mental health treatment.

Duehm and Mayadas (1976) and Shepherd et al. (1966) state that behind the general practitioner's behaviour towards the patient lies a set of implicit assumptions which act as a rationale for his filtering and organization of the information he receives.
Ort, Ford and Liske (1964) describe the interaction between the patient and the doctor as a dynamic process.
Mechanic (1962) emphasizes the disjunction between this meeting in the doctor's clinic, and the natural life situation of the patient. This disjunction forces the doctor to depend on second-hand information, and exposes him to family and community pressures. This phenomenon constitutes one side of the 'doctor's dilemma' described by Bloom (1977). On the one hand the general

practitioner wishes to be involved in the community and prove his expertise, while on the other, he is wary of over-involvement.

Many studies have raised the factors depending on the personality of the doctor, the 'doctor factor', as an explanation for variations in referral patterns. Balint (1964) states that the most widespread medicine used by the general practitioner is the general practitioner himself. Cohen-Gur (1977) and Hull (1980) emphasize the personal characteristics and background of the doctor. Taylor (1965) and Bloom (1977) stress the doctor's personality and orientation.

Most studies deal at length with the variables connected with the doctor's attitude towards psychiatry. This attitude is described as existing on three levels: knowledge, attitudes and behaviour.

1) **Knowledge.** Most of the findings point out the lack of psychiatric knowledge among general practitioners. For example, Cohen-Gur (1978) mentions difficulties in the basic diagnosis of mental disturbance. This can be partially explained by the fact that 90% of her subjects had not specialized in family medicine.
2) **Attitudes.** There are three basic attitudes with regard to the general practitioner's role in the treatment of people suffering from mental problems:
   a) the holistic approach, which maintains that the general practitioner should treat both the body and the psyche as a whole (Branch, 1965; Cumming, 1968; Cohen-Gur, 1978; Goldberg, 1982);
   b) the differential approach (Shepherd et al., 1966), which maintains that the general practitioner himself should treat neurotics and refer people with more severe disturbances to the mental health services;
   c) the situational approach (Kossel, 1963), which argues that the general practitioner's decision on whether to refer to the mental health services should be dependent on the severity of the patient's condition and the ability of the general practitioner to treat him.
   All the above approaches stand in contradiction to the general practitioner's attitudes towards psychiatry, in so far as they perceive it to be a profession only remotely connected with medicine, and are pessimistic with regard to psychiatry's ad-

vancement (Cumming, 1968; Cohen-Gur, 1978), and in addition are unenthusiastic about extending their knowledge in the field (Cohen-Gur, 1978; Hull, 1980).

3) **Behaviour.** In view of their low level of knowledge and their negative attitudes towards psychiatry, the general practitioner's difficulty in identifying people suffering from mental problems is readily understandable (Bloom, 1977; Cohen-Gur, 1978; Goldberg and Huxley, 1980). As a result they do not make systematic referrals to the mental health services and treat their patients themselves, according to undefined criteria.

The link between the public health nurses and the mental health services constitutes a problem in its own right. The public health nurses are involved in the community and in different services related to health rather than to the population. The significance of this involvement is two sided. On the one hand, it gives the nurses an advantage in identifying people suffering from mental problems. Ozer and Miller (undated) claim that the public health nurses' ability for identification is 30% higher than that of the general practitioners. On the other hand there is a danger of over-identification with the community. Their position within the community, together with their lack of knowledge, exposes their decision making on people suffering from mental problems to influences such as social stigmas and norms. Another problem stems from the fact that all the public health nurses are women, which, while facilitating their relations with other women, raises obstacles in their relations with men.
A discrepancy exists between the development of the nurse's professionalism from a mother-like role to that of a highly skilled professional (Weiler, 1975), and the fact that the medical hierarchy places the public health nurse on the lowest rung of the ladder. This is also reflected in the astonishing lack of literature in this field.

Method

The present study encompassed most of the medical gatekeepers in the Galilee area - which is situated in the north of Israel - with the aim of investigating their identification and referral patterns. The study was carried out by means of a structured ques-

tionnaire, prepared and validated especially for the study. The questionnaire was divided into three sections:

1) **Background data.** This comprised questions on personal, educational and occupational background.
2) **Attitudes.** This comprised questions on the following four areas: the etiology of mental disturbance, role perception of the gatekeeper towards patients also suffering from mental disturbances, attitudes towards community and family medicine and towards psychiatry and the psychiatric services and attitudes towards the proliferation of mental disturbance within the community. This section was designed on the basis of mapping sentences, according to the Guttman System. This system is designed to examine the link between the subject's attitudes and his biographical data, as well as between his attitudes and his referral pattern. The system provides a two-dimensional description of groupings of scores with a common basis.
3) **Behaviour.** This section comprised questions on the number of referrals and non-referrals of patients identified by the subjects as suffering from mental disturbance. Data was collected on the basis of the subjects' estimates, since decisions not to refer are generally not registered.

The researchers and research assistants interviewed the general practitioners and public health nurses individually by means of the questionnaire. The data was analysed by means of an analysis of variance and POSAC according to the Guttman System.

Results

81% of the 60 general practitioners interviewed were male, 31.7% were born in Israel, 60% were born in Europe or the Americas and only 8.3% were born in Asia or North Africa. Of those not born in Israel, half had been living in Israel for less than ten years. Most of the general practitioners were in the 30-50 year old age bracket.

All the 51 public health nurses were women, 49% were born in Israel, 31% were born in Asia or North Africa, and 20% were born in Europe or the Americas. All those not born in Israel had been living in the country for over 10 years. Their age range was 20-50

years old.

All the nurses and only 13.3% of the doctors studied in Israel. 43.3% of the general practitioners lacked any specialization and only 11.7% had specialized in family medicine.

60% of the general practitioners and 80% of the public health nurses worked in a multi-colleague clinic, while the remainder worked alone. The case load of the general practitioners was significantly (.000) higher than that of the public health nurses.
33.3% of the general practitioners and 41% of the nurses had access to a consulting psychiatrist, while 30% of the first and 86% of the latter had access to a consulting psychologist.

Hereditary factors
The public health nurses gave hereditary factors a significantly higher score than the general practitioners in the formation of mental disturbance. A similar tendency was found with regard to organic factors. As regards the other factors, no significant difference was found between the two groups.

Role perception of the gatekeeper towards patients also suffering from mental disturbance
The general practitioners perceive their role as providers of physical treatment to a significantly greater extent than the public health nurses. A similar tendency also exists as regards the provision of mental treatment. On the other hand, the nurses perceive their role as providers of family treatment to a significantly greater extent than the physicians. As regards environmental treatment there is no significant difference between the two groups.
As for referrals, the public health nurses perceive this as their role to a significantly greater extent than the general practitioners in the areas of referral for family and environmental treatment, and there is a similar tendency as regards referrals for mental treatment.

Proliferation of mental disturbance within the community
On this specific subject numerous people interviewed abstained from responding. We therefore found it inappropriate to detail this information.
The two groups estimated the proliferation of mental disturbance

among the various populations in a similar way and there was no significant difference between them.

Affective attitudes
The nurses expressed belief in family medicine and professional satisfaction to a significantly greater degree than the general practitioners. As regards affective attitudes towards psychiatry, no significant difference was found between the two groups.

Instrumental attitudes - involvement in psychiatry
As regards instrumental attitudes there are few differences between the groups: the general practitioners come out significantly higher in their knowledge of psychiatry and the public health nurses tend to participate more actively in one-day courses.

Dependent variables
No significant difference was found between the identification rate of the two groups.

An analysis of variance of identification and referral rate
General practitioners in a multi-colleague clinic refer at a significantly higher rate than those in a single worker clinic. A similar tendency exists with regard to their identification rate. The public health nurses' identification rate in a single worker clinic tends to be higher than in a multi-colleague clinic.

Discussion

This study, which was carried out from the viewpoint of the community mental health center, raised the question of the referral patterns of the general practitioners and the public health nurses, who serve from this viewpoint as gatekeepers for the center. We divided their referral patterns into two stages: the **identification stage** - the stage at which the gatekeeper diagnoses a person as suffering from a mental problem; and the **decision stage** - the stage at which the gatekeeper decides either to refer to the mental health center, or not to refer, i.e. to leave the patient within his own field of responsibility.
From the outset we did not hold a predetermined attitude as to whether the prefered decision should be referral or non-referral.

The execution of the community role played by the gatekeeper is complicated by the conflict between the preventative orientation of the community model and the healing orientation of the medical model, according to which the gatekeepers were educated. The ways in which they cope with this conflict will accompany us throughout this discussion. In the discussion we will first deal with the independent variables - the background variables and the attitudes - and will then go on to deal with their effect on the dependent variables.

Background variables

The public health nurses comprise a homogeneous population in terms of their background variables. They are involved in the community both in terms of length of time spent in the community and in their profession, and in terms of their cultural similarity to their communities. They are generally satisfied with their work and have a high level of belief in their profession.

The general practitioners, on the other hand, comprise a heterogeneous population. Their level of community involvement is low and they generally work within the community for a short period of time. The majorty of them serve in communities whose socio-economic structure is alien to them. In addition to their social isolation, some 40% of the general practitioners are also isolated professionally. They work without colleagues in single-doctor clinics and only one third of them are in consultation with psychiatrists or psychologists. This isolation leads to a predisposition towards non-involvement and professional apathy. Only one tenth of the doctors interviewed were trained in family medicine, which is by definition community oriented. In other words, 90% of the general practitioners in the area have a medical orientation.

These characteristics of the general practitioners place them from the outset in a very difficult position with regard to their role as gatekeepers within the community, while the public health nurses have a distinct advantage in this respect.

Attitudes

Both the general practitioners and the public health nurses were divided as to their attitudes towards the etiology of mental disturbances, between those with a medical orientation and those with a community orientation. But over and beyond this division, the

nurses, perhaps due to their low level of knowledge, attributed greater importance to hereditary and organic factors than the physicians.
In addition, as regards their role perception towards patients also suffering from mental disturbances, there is a similar division between those with a community orientation and those with a medical orientation. Personal orientation is determined by the relative strength of the system in which the general practitioner or the public health nurse finds himself, i.e. his involvement in the community system versus his involvement in the medical system. However, generally speaking, apart from the treatment of physical problems, the majority of both groups tend to refer these patients, this because of a feeling of lack of knowledge on their part.
By thus refering, they expect to transfer responsibility for treatment and do not refer with the expectation of merely receiving consultation and supervision. The central explanation for this behaviour stems from their dissatisfaction with communication and cooperation with the psychiatric services.

Proliferation of mental disturbance
Some of the general practitioners and the public health nurses were unwilling to answer questions on this topic for fear of expressing preconceived opinions. At the same time, it was found that, generally speaking, both physicians and nurses believed that the proliferation of mental disturbance was higher among the lowest socio-economic strata. This supports the findings of Hollingshead and Redlich (1958) and Dohrenwend (1965). Regardless of whether their attitude expresses the real situation, we should ask ourselves whether it is a reflection of their ignorance and lack of involvement which constitutes a case of individual experience being used as a basis for unfounded induction and stereotypic thinking.

Effective and instrumental attitudes
The subjects' attitutes towards psychiatry can be divided into four aspects: communication with mental health services, knowledge of psychiatry, motivation to study in the field and the use of psychotherapy.

The feeling of lack of contact between the mental health services and the general practitioners and public health nurses, as reported

by the latter, becomes a question of central importance, since it undermines their ability to function as efficient gatekeepers. This lack of contact also influences their referral patterns, and when they do refer, they generally do so with no expectation of supervision and with no intention of treating the patient themselves.

The two populations report average to low knowledge of psychiatry. The nurses report a level of knowledge significantly lower than that of the physicians. This gap can be explained by the extremely limited psychiatric training they receive. The feeling of lack of knowledge among the general practitioners is intensified by both their professional isolation and by their depth of knowledge, especially among specialists, in other areas of medicine.
Unlike the general practitioners, the public health nurses have a higher level of motivation to increase their knowledge of mental health. This phenomenon can be partly explained by the antagonism of the general practitioners towards psychiatry and psychiatrists.

In practise, both groups make extensive use of psychotherapy, and this points to their inability to rely on drugs alone, especially in cases of patients not suffering from severe disturbances such as psychosis and depression. The use of psychotherapy is problematic in view of their poor knwoledge in the field of mental health in general and psychotherapy in particular.

Referral patterns
As has already been mentioned, the decision making process of the medical gatekeepers can be divided into stages: the critical identification stage, and the decision on whether or not to refer.

Identification
The most conspicuous phenomenon is the severe difficulty encountered by both groups in identifying patients suffering from mental disturbance. Because they are constricted by the medical model, which makes a dichotomous distinction between sickness and health, the medical gatekeepers have difficulty in diagnosing intermediate cases; especially neurotic cases. As has been described by Wills (1978), similarity attraction and personal compatability prevent the gatekeepers from identifying neurotics as suffering from mental problems.

On the affective level, the low identification rate can be regarded as a result of double denial: the refusal to view neurosis as a treatable mental problem, and the refusal to view the mental health services as also being responsible for the treatment of cases of neurosis. We can therefore conclude that most of the patients identified suffered from severe mental disturbances.
The low rate of identification can also be explained by the fear of stigmatizing the patient (Link, Levav and Cohen, 1982), as well as by their doubts as to the effectiveness of mental treatment (Shachar, Ziv and Polack, 1981). The low level of the subjects' knowledge (Gaines, 1979), and their feeling of lack of contact with the psychiatric services (Shepherd, 1966), also contribute towards the low identification rate.

It was found that there was also a connection between the subject's identification rate and the type of clinic in which they work. While doctors who work in a multi-colleague clinic identify at a significantly higher rate than general practitioners working in a single-doctor clinic, the public health nurses working alone identify at a significantly higher rate than those working in a multi-colleague clinic. The doctor's proximity to other colleagues provides him with professional backing, which in turn imbues him with a feeling of competency, allowing him to take the initiative and make identification decisions, even at the cost of stigmatization.
Unlike the general practitioners, a public health nurse working alone is free to explit her involvement with the community and to liberate herself from the constricting attitude towards her professional turf (Weiler, 1975).

Referral and non-referral

The referral rate of the general practitioners was significantly higher than that of the public health nurses.
The doctors' referral patterns are influenced in the main by the type of clinic in which they work and by the accessibility of a consulting psychologist. There are three recognizable groups. The first consists of a large group of general practitioners with a low level of knowledge and involvement in psychiatry, who are isolated from their colleagues and from the community. In general these are doctors with a low rate of identification, and therefore a low rate of referral and non-referral. The second group consists

of doctors who are isolated from the community but operate within a more highly developed professional framework, and have a higher level of involvement and knowledge in psychiatry. These general practitioners have a better rate of identification and refer most of the patients they identify. The third, and smallest group, is composed of general practitioners with knowledge and involvement in psychiatry together with community involvement. These doctors have a high rate of identification and of referral, but are distinguished by the fact that they refer selectively. In other words, they themselves treat mentally disturbed individuals.

The referral patterns of the public health nurses are influenced by the type of clinic in which they work, by their role perception and by their perception of the etiology of mental disturbance. The majority of nurses conform to the medical model and refrain from initiating identification and referral. A small minority find ways to combine their community involvement with initiative, and with the ability to exceed the limited bounds of their medical role.

Conclusion

No one factor can be seen as significantly influencing the coping patterns of the medical gatekeepers with mentally disturbed individuals. It therefore appears that there is a triangle of forces acting upon the general practitioner and the public health nurse in the community, and influencing their behaviour in their role as gatekeepers of the mental health services. The first force is **professional background**, which includes professional training, knowledge of psychiatry and attitude towards the role of gatekeeper. This background is, naturally enough, the medical model, which, although it provides a clear delineation of roles and functions, exerts pressure for decision-making within the medical framework. The second force is the **community**. Its socio-economic characteristics, its cohesiveness, the character of the settlement, the cultural significance of mental disturbance within it, and its non-medical gatekeepers, are all components of the community, express its needs, and as such, influence the medical gatekeepers. The third force is the **mental health services.** This force is characterized by the availability of the services, and the services provided. On the face of it, this is the weakest force in the triangle, mainly because of its isolation from the community.

As we have seen, the system exists in a state of discord. In general, the medical gatekeeper is caught in a power struggle between the community and his professional background. This is actually conflict between models, and paradoxically the gatekeeper occasionally wishes to be community oriented while the community expects him to display a purer medical approach. In this state of helplessness, the gatekeepers tend to displace their anger to the third force, namely the mental health services. Thus, the mental health services are endowed with a central role in mediating between the community and the medical model, by virtue of the fact that they belong to the medical model but nevertheless possess a community orientation.

Some recommendations can be made. Firstly, mental health center workers should go into the community and serve as consultants and as intermediaries between the center and the gatekeepers. By doing so they will be able to reinforce and develop the ability of the gatekeepers to identify, and to cope with a significant number of patients within the community, without needing to refer them to the center. Secondly, Balint-groups should be developed for the gatekeepers. On the assumption that the public health nurses are a homogeneous group with a high level of motivation and availability for supervision, it seems preferable to begin the process with them.

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'General practice is more than just gate-keeping...!'
Discussion

To start the discussion of Huygen's paper, Dokter related an experience he had during a consultation and wondered why general practitioners referred so few patients with psychosocial problems to mental health professionals: "In response to a somatic complaint we send patients to a medical specialist in an earlier stage, but when it comes to talking we do a lot of it ourselves".
Schein also sees the physicians' role as much more than just 'gate-keeping': many patients don't want to be referred to a psychiatrist and want to be helped by their family doctor. Mental health professionals should help the doctor to help his patients and to prevent biopsychosocial problems from coming into being.
It was however not only Schein who, during this discussion, formulated his expectations with regard to 'the other side'. Agmon, while being used to request general practitioners to refer more patients to mental health institutes, now wants them to take care of emotional problems themselves as much as possible, this being a part of good medical care: "Mind and body should not be separated". Huygen also had clear expectations: he wanted psychiatrists to reduce the pressure a general practitioner is exposed to, as many patients cannot be cured at all. Finally, Crijnen expected psychiatry to give a clear conception of how mental illness came about and to produce a single model by which general practitioners can recognize what is wrong with their patients.

Though he didn't feel there is much agreement concerning the important issue of the doctor's role in helping patients with emotional problems - should he 'contain' them or should he 'refer' them - for Kraan the argument was clear: psychiatry helps, and many people who are being 'contained' by their general practitioner, would be better off had they been referred to mental health care providers. Verhaak disagreed. Psychotherapy only helps where people are motivated, he argued, and where a patient wants to go to a psychiatrist himself. Patients with hidden problems or with problems that are very complex and for which a patient has developed a strategy are, however, more difficult to help. It is rather doubtful whether psychotherapy can be of any help for these patients. Preparing a patient before a referral, clarifying his

fears, as Agmon proposed, is hardly a solution: many patients simply cannot express problems which are emotional, said Verhaak, and they expect their general practitioner to do hardly any more than give them a 'pat on the shoulder'

Maoz also thought that for a lot of his patients, the general practitioner was not a 'gate-keeper' anymore: as he received them back after an unsuccessful treatment by someone else, he was often their 'last doctor' and should be aware of that fact. To emphasize the point Maoz cited recent research in which general practitioners were asked to mention the 'most irritating' patients in their practice. All respondents reported very disturbed patients, more or less 'borderline', who could be cured by nobody. The general practitioner should accept the fact that he couldn't help these patients anymore, a psychiatrist might support him in this by sharing responsibility. In practice, though, doctors seem to manage quite well: in the same piece of research the selected patients themselves turned out to be rather satisfied with their doctors. Maoz added that it was impossible to define the boundaries between primary care and mental health care: what can be decided is where each individual general practitioner's boundaries lie.

Gersons, who has a lot of experience with mental health consultation, also found it difficult to define the boundaries or to determine who did the better job: the general practitioner or the psychiatrist. As for the patients' role, he points out that some of them are getting used to thinking about their problems in 'psychotherapeutic' terms: they ask for professional help and don't want to be 'contained' by their general practitioner. His remark accorded with Spencer's point, who argued that a general practitioner, as a 'guidance system', has a chance to help only for as long as the patient believes in him, but has to look for someone else the moment a patient expresses the need for psychotherapeutic help.

Most of the speakers stressed the desirability of a better training, both for general practitioners and for psychiatrists. As to the first, Katz signalized a paradox: on the one hand future doctors should be taught to accept their 'containment function' but on the other hand they should also learn to accept the failure of 'containment', where a patient in the end still had to be

referred. Huygen argued for training in a general hospital or in an ambulatory situation, where doctors could see more than the most severe psychiatric problems and could identify themselves more easily with psychiatrists.
Gersons felt that the intensive training a future psychiatrist received, increased the difference between them and general practitioners; the latter hardly knew anymore what they could expect from psychiatry.

In practice a general practitioner can bridge the gap by consulting a psychiatrist before referring a patient. Except for a few experiments, however, this is seldom done in Holland, due to the rather bureaucratic mental health care system. Agmon, indicating how important personal contact is in providing the general practitioner with reassurance and support, simply said:'Why don't you change it ?'

III. TRAINING ISSUES

7. CONSULTATION AND MENTAL HEALTH PROGRAMS FOR PRIMARY CARE MILITARY PHYSICIANS IN THE ISRAEL AIR FORCE

S. Rabinowitz and J. Ribak

1. Introduction

There is no question but that the primary care physician has a special relationship with his patients. He is responsible for their well being providing integrated care and being available at all times. He has a unique relationship with his patients, the family and the community. Within this broad and comprehensive approach to care psychosocial and emotional aspects of patient, family and environment receive special prominence.
In the Israeli military system, as in other military systems, the primary care physician's population is a special one, consisting, as it does, mainly of adolescent enlisted soldiers. Individuals enter the military environment during the second stage of adolescence commonly referred to as late adolescence or youth. It is a period of dynamic changes involving the evolution from dependency to independence; a process of separation from the older generation which is filled with uncertainty and conflict as the youth struggles with superego issues, attempts to re-evaluate parental models and seeks new relationships and ideas. The adaptation of National Service soldiers to the military system must be viewed within the context of the dilemmas of late adolescence as well as the problems and pressures inherent in the military establishment which may affect his adjustment.

Basic training is the individual's first experience of the military system. It subjects the individual to a deliberate, planned, and highly traumatized set of stresses with an emphasis on group manipulation, ideological and psychological indoctrination and occupational salesmanship. Its aim is to teach the new recruit both technical skills and a sophisticated code of behaviour to lay the foundations for complete socialization to the military system.
The impact of basic training for the individual includes the complete disruption of previous adjustment patterns by the sudden and abrupt changes in demands made on the individual, an increasing depreciation of self-esteem, the withdrawals of parental support and gratifaction of dependency needs, the acceptance of psychological control and support conditional on performance and an alternative approach to the equation of masculine identity.

After the impact of basic training, the soldier begins to learn the specialized military skills connected with his field of operation. In the Israel Air Force (IAF), ground personnel are sent to a training center and thereafter arrive at their home base. Because they will be stationed at the base for a long period of time (for most soldiers the base will be permanent) the process of learning to trust the home base begins. First, the soldier has to trust that the base will provide all of his basic needs (food, sleep, shelter, security, social). Second, he must trust that his superior officers will be consistent in handling his needs and will be available should there be problems. Third, the soldier has to learn to trust the Air Force as a fighting unit and trust the capability of the Israel Defence Forces as a whole. It is clear that the system must provide satisfaction of these needs. Lack of supply of basic requirements , inconsistent handling of needs by officers, lack of basic trust in the Air Force or the defence forces can cause problems.

The expression of difficulties in adjustment to military life is often channeled through somatic symptomatology and hence leads to visits to the military medical clinic. A recent study (Rabinowitz and Reuveni, 1984) revealed that in a group of soldiers who were later referred for mental health treatment, over 70% of the soldiers exhibited clear psychological or mixed psychological complaints three months before mental health referral. Furthermore, studies have shown that effective psychological intervention reduces unnecessary use of medical facilities in a USA Army Health Care setting (Longobardi, 1981) as well as on an IAF Medical Unit (Rabinowitz a.o., 1985). Other mental health problems dealt with by the IAF military physician include psychosomatic disorders, hysterical reactions, depression and - fortunately to a much lesser extent - alcohol and drug abuse and psychosis.
The military doctor has to face many problems specifically related to the professional working within the context of a military environment. Some of these problems are related to the physician's role as a healer and an officer: conflict between the military and medicine, or conflict between the demands of military and the patient. Other problems are communication problems (doctor/patient, doctor/officer), some of which include confidentiality or lack of trust of soldiers' complaints because of their feigning illness.

Finally the physician has to make up his mind as to how much he wants to be involved in and influence community issues in relation to soldiers' health. Here we refer particularly to preventive issues like smoking advice, sex education, stress management or visiting the soldiers' work environment in order to see its influence on their health.

2. Mental health training programs and the military physician

The military physician acts as a first-line detector, evaluator, and in many cases treater of psychosocial and mental health problems. Because of this it is essential to provide him with the relevant skills, training, and back-up support in order to adequately relate to these problems. A series of mental health training programs are essential as well as an appropriate consultative-liaison service.
Over the years the IAF has built up a training program and liaison-consultative service which meets many of the skills and training required to adequately treat psychosocial and mental health problems seen in a military medical clinic. Furthermore, appropriate forums have been provided in order to allow the army physician to raise many ethical and communication problems that may effect his medical performance. In this respect a distinction can be made between the work of the mental health officer at base level on the one hand and special in-service training sessions and day workshops provided by the mental health office service of the IAF to their physicians and paramedics on the other.

2.1. Mental health officer consultation to the military physician and his team on the IAF base

Mental health consultation to the military physician takes place at least twice weekly and deals with soldiers who present with minor mental health or adjustment problems. Consultation to the military physician can be divided into the following areas:

1. mental health consultation-liason prior to specialized referral;
2. discussion of the mental health referral process (information gathering, brief psychosocial history taking, mental health evaluation and diagnosis) so as to make the physician sensitive and skilled in appropriate mental health referral. It should be

noted that feedback from the mental health professional following consultation and referral has been found to be a definite need of the family physician (Fisher, 1978). Within the military system this need is of particular importance since many of the decisions are quick, practical ones which have many broad ramifications for the physician and the other base functionaries;
3. supervision of cases that the physician feels competent to treat without referral;
4. encouraging the physician to participate in mental health interviews with the mental health professional in order to emphasize the relevance of mental health interviewing;
5. sensitizing the physician to relate to issues concerning coordination of the primary care medical team in order to emphasize the importance of effective teamwork (defining objectives, guidelines and responsibilities, clinic staff training and development, communication and coordination of the clinic team);
6. involving the physician in multi-disciplinary groups focusing on multi-problem cases, including medical and mental health issues.

There is much indication that these consultation procedures have helped sensitize the military physician to psychosocial problems seen in the military. A more open communication process has been opened between the mental health professional and the physician. The doctor is now willing to deal with many of the psychosocial issues himself without necessarily seeking out specialized help. This is one of the conclusions drawn in a recent paper on the subject (Rabinowitz and Reuveni, 1984).
Furthermore, the active involvement of the military physician in multi-disciplinary groups focusing on the multi-factorial aspect of health, military adjustment and illness (biological, social, psychological) provides him with a broader perspective of the influence of environmental and psychological factors on general functioning, health and illness. In many cases a joint decision with regard to the soldier's problem is taken. This leads to less psychosomatic or psychological complaints being presented to the physician and hence a decreased utilization of the medical clinic for such problems.

2.2. Educational programs for the primary care military physician and his team

The mental health service of the IAF has also provided special in-service training sessions and workshops for physicians and paramedical workers, in which frontal lectures, role playing and video simulation have been used. A questionnaire was administered to a cross section of airforce physicians, who were asked to describe in which mental health areas they needed assistance. Results of the survey indicated their preferences for mental health issues including malingering behaviour in the military and suicide attempts and threats (first choices), doctor-physician interaction (second choice), and communication and human relationships (third choice). So, as a result of the survey, specific needs of the physicians were ascertained and a number of workshops were provided. This approach goes in accordance with previous studies (Fisher, 1978) which emphasize the importance of the mental health consultant being sensitive to the specific needs of the family practitioner. The workshops cover the following areas:

- emergency mental health problems in the military (suicide and combat stress disorders);
- common mental health problems in the military (coping with stress and conflict, malingering and teamwork);
- doctor-patient relationship and the doctor within the military system (the military physician in the military community, communication, interviewing and human interaction).

We should like to give a more comprehensive picture of two of the workshops being held.

Understanding and treating malingering behaviour in the military

This six hour workshop is based on a recent paper in the area (Mark a.o., 1986) and looks at various aspects of malingering behaviour which include:

- historical aspects of malingering;
- differential diagnosis (malingering and other psychiatric disorders such as factitious disorders, psychosomatic disorders, conversion disorders, hypocondriasis, ganser syndrome);
- etiology of malingering;

- malingering behaviour related to mental illness such as amnesias, psychosis, mental defect;
- six air personnel case studies are being provided illustrating the complex nature of malingering within the military;
- a model for understanding both positive (simulation) and negative (dissimulation) malingering, on the physiological and psychological levels;
- treating malingering within the military with special emphasis on the physician and patients' feelings.

The workshop makes use of a variety of different techniques including physician case presentation, role playing, video-simulation and open, lively discussion.

Communication and human interaction

This eight hour workshop aims at allowing the physician to become an effective communicator and listener. The first section allows the physician to become familiar with the main techniques of effective communication (open versus closed responses, listening versus non-listening responses, affective versus non affective responses). The second section of the workshop helps the physician identify individual emotional aspects of communication which may assist or detrimentally effect adequate communication. The third section engages the doctor in a communication process with a member of the group so as to discern various communication patterns and obtain feedback from the group. Throughout the workshop special emphasis is placed on non-verbal communication and on specific problem areas which effect communication of the physician working within the military system, like - for instance - hierarchy and the soldiers' secondary gain from the sick role.
The workshop makes use of a variety of different techniques including role playing, emotionally laden case vignettes which have been especially made for the military, and video simulation.

Another specialized mental health educational program has been given to the medical NCO (Non-Commissioned Officer) working as a senior paramedical in the clinic. Workshops for this population include looking at the role and specific communication patterns of the clinic NCO and other clinic and base functionaries (officer, military physician, clinic paramedical staff).

3. Research

Joint research projects have been undertaken dealing with the detection and treatment of psychosocial problems in the medical clinic. In a recent paper, discussing the phenomenon of fear of flying in a pilot, special attention is paid to the sensitivity and experience of the referring physician in the detection of the anxiety factor in the complaint originally presented by the pilot.
A recent joint psychological and medical project illustrates the decrease of psychological complaints to the military physician following appropriate brief psychological intervention. Other research studies include evaluation of the effects of short-term psychotherapy and medical use, medical use associated with completion of military service and health-seeking behaviour and medical use.

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8. THE CONSULTATIVE RELATIONSHIP BETWEEN PSYCHIATRY AND GENERAL PRACTICE

B.P.R. Gersons

The members of the World Health Organization-Working Group on First Contact Mental Health Care in Tampere, Finland 1983, formulated four basic principles in their summary report:

1. the promotion of mental health is a vital component of primary health care;
2. the decentralisation of mental health services is essential to bring them into community, where people live and work;
3. at all times an attempt must be made to supply the minimum level of care required, according to the needs and existing resources of individuals and their communities, so as to give them back their own futures; and
4. mental health care skills and resources should be closely integrated into primary health care and social welfare systems, for the purposes of education, support and consultation.

The tasks of this working group - the issue of training in mental health practice in primary health care settings and the examination of the consultative, collaborative relationship between mental health care and family health care systems - are primarily related to the fourth principle: the desired availability of mental health care skills and resources at the primary health care level, as well as the need for integration.

It is necessary however, to realise that the fourth principle in particular, and indeed the other three, are based partly on epidemiological studies and partly on assumptions by experts, based on their experience in practice and on their philosophies. We are therefore obliged to look at these epidemiological studies and assumptions in more detail.

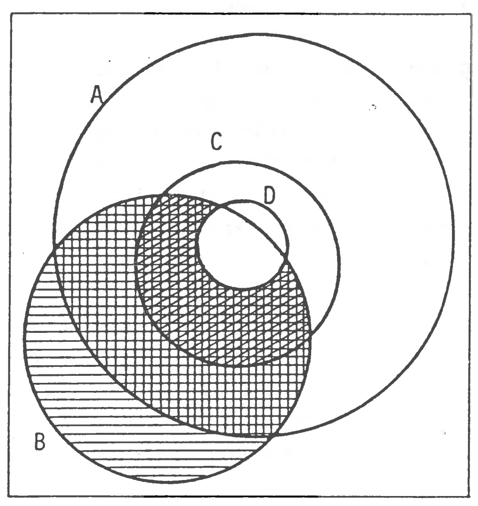
Epidemiological studies

Nearly all epidemiological studies have clearly indicated, that the incidence and prevalence of mental health problems in the population is a multiple of the number of patients treated by specialized mental health services. This striking discrepancy has

contributed to the formulation of many hypotheses, as, for instance, the following two:

- mental health problems can largely be considered as being 'self limiting diseases'; most studies on the impact of life-events indicate an important influence of such events on the development of mental health problems, but they usually fail to show specifically related, disastrous consequences on a longer term.
- because of the epidemic size of mental health problems, the population itself considers such problems as normal occurrences, and not as curable problems, nor do they feel the need to prevent and to cure them; there seems to be some analogy to the Middle Ages, when large-scale infectious diseases, such as plague existed; these diseases were not regarded as curable illnesses, but as the darker side of normal life.

Figure 1: Venn diagram showing the relationship between the first three levels of care



from Goldberg and Huxley, 1980

A = Consult their doctor during year

B = Psychiatrically ill during year (level 1)

C = Identified by their doctor as psychiatrically ill (level 2)

D = Referred to a psychiatrist (level 3)

Do not pass 1st filter (ill, but not consult)

Do not pass 2nd filter (illness unrecognised by doctor)

Do not pass 3rd filter (not referred to a psychiatrist)

Clearly these two contrary hypotheses will lead to quite different approaches to the question of which mental health skills should be available at the primary care level. The work of Goldberg, as well as that of Lamberts, seems to have provided us with an accurate view of the variety and scale of mental health problems at the primary care level. Goldberg and Huxley (1980) showed us, that the sensitivity of general practitioners to the detection and diagnosis of mental problems is by no means adequate (see figure 1).

On the basis of the diagnostic categories Lamberts (1982) used in his survey, a hierarchy of mental disorders among primary care attenders can be made (see table 1).

Table 1: hierarchy of mental disorders detected by general practitioners

other neurosis (hypochondria, neurasthenia etc.)	41,9 %
anxiety -, sleep -, and depressive disorders	33,7 %
alcohol and drug abuse	8,1 %
transient situational disturbances	7,5 %
diverse (learning disorders, sexual problems, etc.)	7,2 %
psychosis	1,6 %

(Source: Lamberts and Hartman, 1982).

The treatment efforts of general practitioners with respect to the detected cases cannot be considered very adequate (see table 2).

Table 2: treatment of mental disorders by general practitioners (in percentages)

pharmacotherapy	37
no therapy	32
'psychotherapy'	17
advice and guidance	14

(Source: Lamberts and Hartman, 1982).

Very little is known about the results of the general practitioners' therapeutic efforts.

Let us return to the opposing hypotheses mentioned before. For the time being we choose, on the basis of our professional conviction and our day to day experience, for the second hypothesis. This hypothesis, which is heavily supported by the epidemiological studies, justifies the effort and energy expended on the implementation of mental health care at the primary level.

Philosophies

Mental health officers and care-givers are, according to Pinel, entrusted with the humane task of organizing cure and care for mentally ill people. In the nineteenth century, as well as in the first part of the twentieth century, such cure and care was usually offered by large-scale mental hospitals. The majority of mental health professionals nowadays, but also the general public, no longer judge this solution as being very humane or very appropriate. The development of crisis intervention, the availability of wide spread ambulatory services, psychotherapy, psychotherapeutic drugs and the availability of special services and homes for chronically ill patients, have resulted in what is called 'deinstitutionalization'. The philosophy underlying the deinstitutionalization movement is the assumption that the patient is not helped at all by bringing him or her to a psychiatric hospital and preventing him or her from ever returning to normal life. The consequences of this philosophy are, that the number of in-patients, at any one moment, has in many countries decreased considerably over the last decades, while the total number of patients admitted to hospital has increased. For our purpose it is important to acknowledge that primary care must, as a consequence of deinstitutionalization, not only serve the large number of people with mental health problems, already mentioned, who are **not** in contact with the mental health services, but also the continually growing number of people who have been in contact with mental health services, or have been admitted and treated in psychiatric hospitals. Family physicians, for instance, now have to attend:

- persons with **'minor' mental health problems**, for instance those related to life events (bereavement, divorce, work or lack

of work, somatic illnesses) and with distressing communicative problems within families;
- persons with **developmental and neurotic problems**, for instance specific child, adolescence and geriatric problems, suicides, alcohol and drug addiction and psychosomatic complaints;
- persons with **'major' mental health problems:** depression, personality disorders, psychotic disorders and the problems of chronic patients.

Mental health skills at the primary care level

The fact that a large number of people suffer such diverse mental health problems and illnesses, forces the family doctor, as well as other team members at the primary care level, to improve their mental health care skills. Such skills are:
- interviewing techniques; the skill of listening effectively;
- crisis intervention and acute psychiatric intervention techniques; the handling of complex communication patterns, the skill to understand emotions and to help improve cognition and problem solving;
- detection and diagnosis; basic knowledge of psychopathology and psychodynamics;
- basic treatment skills; short term psychotherapy, psychopharmacology, long term supportive therapy;
- referral to mental health services; motivation and indication.

One of the pitfalls of such a description of which skills should be improved at the primary care level, is the fact that there are clear limitations to what can reasonably be expected from caregivers at this level, especially when one considers their other duties, like general somatic health care, basic social work and district health nursing. The way in which training of mental health care skills has been integrated in the curriculum of medical students, in post-graduate training, in Balint-groups and also in such efforts as mental health consultation, has often been too idealistic, and consequently not sufficiently related to the limits of the day to day practical situation of primary care givers.

This has however resulted in the situation where we presently know

the nature of skills required at the primary level, as against the skills actually employed in daily practice.
Consequently the extent and direction in which these skills should (and could) be improved, can be deduced. It is as yet unclear to what extent and to what purpose specialized mental health teams or professionals should offer direct services at the primary care level within their own service organizations. Neither are their target groups clearly defined. Some experimental data are available from studies of mental health teams offering direct services at the primary care level. There are also some data from experiments in which indirect services, such as mental health consultation and training and support, are supplied. But apart from a favorable impression, based on process studies, or uncontrolled results, nothing more is available.

The examination of the consultative relationship between mental health care and family health care systems

Considering the fact, that there should be a complementary relationship between the two systems of mental health care and family health care, training is an instrument to influence this relationship. In order to decide what training should be offered, it is necessary to specify the goals. A detailed knowledge of the relationship between mental health care and family health care should offer validated arguments, on which proposals for an effective change in the relationship between the related systems might produce some valid standpoints. One of the basic problems, as often mentioned, in inter-country studies is the fact that the situation between states may vary widely. For our purposes this is however favorable. We are interested in learning more about the sort of mental health care offered by primary care professionals, to whom this care is offered, and the problems about which they consult each other. Such a study should throw more light on matters such as:

a. the spectrum of detected and/or treated mental health problems at the primary care level;
b. those mental illnesses which are not included in the spectrum;
c. those mental health problems or illnesses which are difficult

to treat at the primary level and are therefore referred, or a consultation may take place about them;

d. the spectrum of mental health problems treated or illnesses at the mental health care level;
e. an opinion on omissions in this spectrum;
f. mental health problems or illnesses for which consultation or help is asked by primary care professionals.

The development of training in mental health practice in primary health care settings

As was argued before, it would be very helpful if training directed at the desired goals could be based on evaluation studies of mental health needs at the primary care level. For the time being, such training can be motivated by the assumption that such needs do indeed exist at the primary care level. Evidently, more medical psychology and psychiatry is offered nowadays in most medical curriculums. However, this increase is still a slow process and not very much is known as yet about the possible long-term favorable results. Considering the epidemic dimensions of mental health problems, more accurate programs, directed towards on-the-job training, should presently be developed. Examples of successful efforts towards rapid spread of knowledge and skills are the PSE training in London and the video-equipped DSM-III training.

Before a summing-up is given of the whole range of desired skills, to be acquired by the primary care worker. A consultant should offer a feasible, comprehensive short-term training program, including the skill of listening effectively, crisis intervention, diagnosis and psychopharmacology.
Such a program should be related to 'real-life' cases, and role play in particular and the use of video equipment should be employed to help increase these skills.

Obviously, the consultant should first develop his or her own abilities to offer such a training program to the primary care workers. The consultants themselves must learn consultation skills, based on the description of Gerald Caplan's 'mental health consultation' (Caplan, 1970). They must concentrate on case-con-

sultation; they must learn to give an appropriate advice for treatment to a general practitioner, based on their own evaluation of a patient, seen in a face-to-face contact. Consultants must also learn to give consultation without actually having seen the patient, which might help to consider many more possible hypotheses and solving-strategies. In such situations the extensive discussion of the case, but also role-playing, will possibly enhance the sensitivity of the general practitioner for the detection of mental health problems, and will increase his skills in helping and treating people with mental illnesses.

The consultative relationship can result in an earlier detection of mental problems and disorders, in prevention of deterioration towards severe mental disorders and in more adequate referral of patients to psychiatrists.

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SUMMARY REPORT OF THE WORKING GROUP ON FIRST CONTACT MENTAL HEALTH CARE. Tampere, Finland, April 25-29, 1983. World Health Organization

9. MODELS OF COMMUNICATION AND COLLABORATION BETWEEN MENTAL HEALTH SERVICES AND GENERAL HEALTH SERVICES

B. Maoz

Epidemiological findings show a great discrepancy between the estimated prevalence of mental health problems and the number of problems detected by general practitioners and referred to mental health services. Table 1 shows some figures based on British, Dutch and Israeli studies.

Table 1: estimated one year prevalence of mental health problems (m.h.p.'s) per 1000 inhabitants (adults older than 15 years)* and levels of care

country	community	visited g.p.'s	detected by g.p. as m.h.p.	referred to and seen by mental health services
	(level 1)	(level 2)	(level 3)	(level 4)
GB	250	230	140	17
NL	175 - 260	155 - 240	155	26
ISR	273	± 270	45**	13 - 32
			208***	

* all Israeli studies: adults older than 20 years.
** diagnosed cases from medical records and other agencies (1961).
*** general practitioners' appraisal (1962).

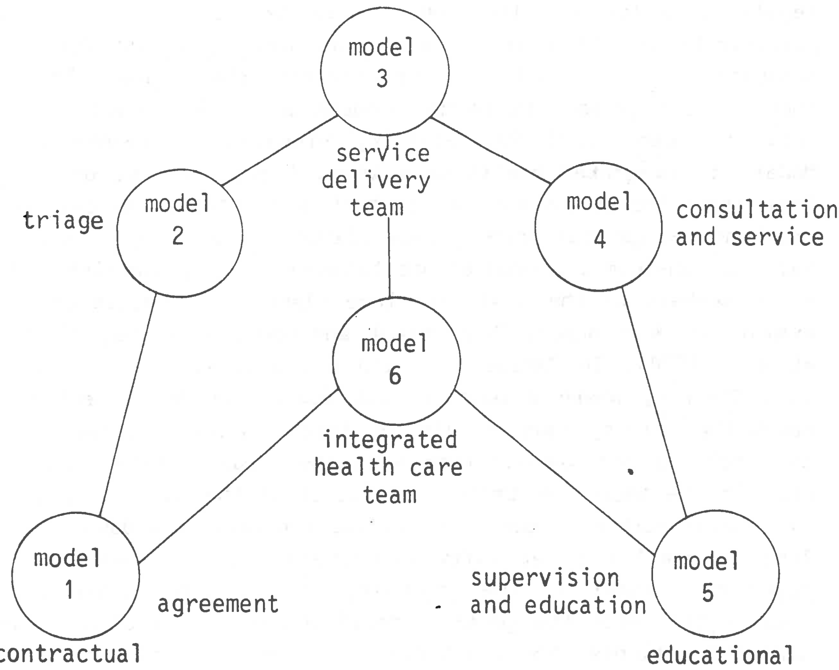
Source: Britain: Goldberg and Huxley (1980)
The Netherlands: Ormel and Giel (1983)
Israel: Litmann (1983)

Goldberg and Huxley (1980) have shown in their research that general practitioners are usually able to deal with minor mental disorders. But according to Shepherd (1983) even in a Western country like Britain, only about 10 % of the patients consulted their general practitioner openly and overtly about psychological problems. Ninety percent of the British patients (and certainly a higher percentage in less developed countries) with psychological problems presented them to their general practitioner in a somatic way.

Harding et al. (1980) found that especially when symptoms such as headaches, pains-in-the-abdomen, lower back pain, cough and general weakness were the symptoms presented, general practitioners tended to miss the psychological problem that was 'hidden' behind that symptom. But from our own study of the 'first filter' (between level 1 and level 2), we learned that people with just these symptoms consulted their general practitioner more often - probably because they had a psychological problem which was not expressed overtly and thus often not detected. These findings raise the obvious question: what can be done by mental health professionals in order to improve the ability of the general practitioners and other primary physicians to treat mental health problems?
Pincus et al. (1983) describe various models of collaboration. These models are based on three aspects of collaboration between mental health and general health practice services i.e. the constitutional, functional and educational aspects. By constitutional is meant the organization and administrative agreements between the two services; by functional, the collaboration between mental health professionals and general practitioners, especially in the area of the diagnosis and treatment of a common patient; by educational, the reciprocal providing of knowledge and a common understanding of health issues.
Six models are described based on these three dimensions (see figure 1, see next page).

Model 1: agreement. Mental health services and general health services (especially general practitioners) reach certain agreements concerning for example referrals to mental health services and referrals back to the general practitioner. Nearly all public mental health clinics in Israel have such agreements with the general health services of the area. This is easier when the mental health services and the general services belong to the same general health system.
Model 2: triage. In this model a certain sector of the catchment area is represented in the mental health clinic by a regular staff member. For example, in the Beersheva system we now have social workers (Treating, 1982; Gross and Shalit, 1983) who work partly in a community primary care clinic and partly in the regional mental health clinic which both belong to the General Health Insurance Fund. This social worker represents 'her' primary health clinic in the mental health clinic.

Figure 1: conceptual models of linkage between general health and mental health systems of care



Model 3: service delivery team. The mental health clinic has one of the constituent services in a multidisciplinary medical center. This situation can be found in various medical centers in Israel, for example in Haifa and Tel Aviv. In this model, the mental health clinic backs up the other clinics.

Model 4: consultation and services. The mental health service sends a team of consultants to support community primary care clinics at fixed regular intervals. The goals of this consultation-liaison program towards primary care are partly educational and partly functional. This model also exists in various areas in Israel, for instance in Safed, Afula, Natanya, Raanana, Petach Tikva, Ashkelon and Beersheva. The Beersheva consultation service to community primary care clinics will be described in more detail below.

Model 5: educational. Functional and especially educational ties connect the mental health services with the general health services. In this model mental health professionals not only provide regular consultations to primary care teams, but, in addition, participate in the training and educational programs for family medicine residents (and other primary care physicians). In Israel there is a four-year residency program in family medicine at four university centers: Haifa, Tel-Aviv, Jerusalem and Beersheva.
Model 6: integrated health care team. A psychiatrist or a clinical psychologist becomes a constant and integral member of the staff of the general primary care clinic. In this clinic many formal and non-formal consultations between the psychiatrist and the other members of the staff can take place. Such models exist for example in West Haven, Connecticut and Houston, Texas, USA (Adams et al., 1978). In Israel, we find a variation of this model in Beit Shemesh, where a psychiatrist comes one day a week to the community primary care clinic to treat psychiatric patients in this setting and discuss them with the local general practitioners. In the Negev, we tried a variation of the model: a psychiatric social worker on our staff worked regularly two days a week in Arad, a small city at fifty kilometers from Beersheva. She saw psychiatric cases in the community primary care clinic and had some contact with the general practitioners of the clinic concerning the patients. She was backed up by our central mental health service.

Two of the subjects mentioned in this description are particularly of interest: the role of the primary care social worker and the psychiatric-liaison consultation program for community primary care clinics.

The position of the primary care social worker is quite new. In the Negev area it has been in existence for about three years. A description of this new role, the problems that should be dealt with by these social workers, and the community and service resources that are at their disposal were carefully defined and listed (see table 2, see next page).

Table 2: List of psychosocial problems to be treated by the social worker in primary care clinics of the Negev area

problems within the framework of family functioning
problems of children
problems of the elderly
somatic problems
mental retardation (adults)
environmental problems
problems of mobilizing (financial) resources
mental problems (in coping and adjustment)
behavioural problems

Over a period of one year, an analysis of the activities of this new type of social work (Gross and Shalit, 1983) showed that most of their referrals came from the general practitioners of the clinic, but there were some direct referrals from the population. During 1982, 15 cases per 1000 inhabitants were seen. This figure does not result from the level of demand, but rather from availability. The majority of the problems that were treated by primary care social workers were mental health problems. One can, therefore, assume that in community primary care clinics where a social worker was available (mostly only part-time) the detection and treatment of mental health problems improved. The social workers who referred some of their cases to the regional mental health clinic formed a living bridge of collaboration between the general health services and the mental health services (some cases were also referred from the mental health services back to them).

The goal of the liaison consultation program is to sharpen and improve the ability of general practitioners to detect, evaluate and treat mental health problems in their own clinics. The program is being carried out in ten teaching primary care clinics, where medical students, young graduates of residents in family medicine work. The consultant is always the same representative of the mental health service, a psychiatrist or a clinical psychologist. During the consultation, which takes place every three weeks, one or two cases, families or problems are discussed by the entire team of the primary care clinic. The director of the clinic, a

general practitioner, is the chairperson of the sessions and responsible for their agenda.
It is interesting to see how every primary clinic has its own way of using these consultations and how the process of communication between the consultant and the consultees (and thus between the two services) evolves. This process of communication is not always an easy or a smooth one.
Accordingly, before the mental health liaison-consultation program starts, its goal and purpose should be clear for both teams (general practitioners and mental health professionals). A contract including the rules of the game and the division of responsibility should be negotiated. But in spite of all these steps, one should be prepared for a lot of overt and covert resistance during the first months. This resistance may be manifested in various ways. Our lengthy experience with this type of consultation has shown that a sensitive, flexible, open, strongly motivated and patient mental health-consultant will finally succeed in establishing satisfactory cooperation with the general practitioner's team.

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'We can help them to live happier lives ...'
Discussion

In the discussion Huygen pointed to two difficulties in the relationship between primary care and mental health services: general practitioners on the one hand and psychiatrists on the other see a different population of patients, due to the mechanism of selection. There is also a difference because a specialist only sees his patients for a short period of time, while a general practitioner has much longer contact with his: "It makes us modest and at the same time optimistic to see so many patients recover without any help".
Agmon noticed that psychiatrists and general practitioners handle a different definition of what is normal and what is not. Psychiatrists try to change the boundaries and wonder if patients might be able to live better, have a better love-life or be better parents. "I believe we can do it", she said, acknowledging that transformation doesn´t occur in every single treatment. In reaction to her optimism, Margolis stated that many patients simply did not want to live happier lives; in such cases no professional could do anything. Verhaak also warned against the wrong interpretation from Goldberg's data i.e. where many people were suffering, help should be given on a larger scale: many people don't see themselves suffering. In this respect Katz mentioned the right to make the wrong choice as being a fundamental human right: a minimum level of care, however, should be provided.
While pointing to a paradox - that of advocating the family doctor's 'containment function' and at the same time complaining about waiting lists - Gersons concluded that the general practitioner's expectations from mental health care were unclear and also that general practitioners didn't appear to know what psychiatry could offer. On the other hand Sofer felt the psychiatrist should know more about what the general practitioner, as the 'main provider of mental health services', actually does and should give him feedback or advice with respect to his work. Maoz finally concluded that psychiatrists should be better taught as to how to talk with general practitioners.

10. COMMUNICATION AND COLLABORATION BETWEEN PRIMARY CARE PHYSICIANS AND MENTAL HEALTH SERVICES.

N. Agmon de Shalit

Despite everything that has been said and written about bridging the gap between psychiatry and family medicine, I believe that there is still a great need to develop and encourage better understanding and closer, more productive collaboration between the two disciplines. Psychiatrists still do not know enough about the work of the general practitioners and their expectations of psychiatry, the general practitioners, on the other hand, are still suspicious of psychiatry and the patients are paying the costs.

In the classical model the general practitioner treats the 'physical complaints' and refers his patients to a psychiatrist as soon as 'emotional problems' come into view. As communication between general practitioner and psychiatrist is conducted via these referrals, some questions arise as to when the general practitioner does or does not refer to a psychiatrist; what he knows about patients in treatment and with what expectations and recommendations patients are referred back to him.
The answer to those questions might reveal frustration, disappointment, claims, blame, anger and - most of all - a great need for better understanding and collaboration.

In my view, primary physicians do have an arduous task in prevention, diagnosis and treatment. A patient presents himself with a symptom, but often this symptom is only a pretext, through which the patient introduces himself, examines the doctor, tests him, asks permission, excuses himself, expresses his anxiety and tries to find out how far he can trust the doctor, and how much help he can hope to accept. Behind the symptom there are often various personal or family problems. Let me give a brief example.

A couple was referred to the psychiatric clinic by their pediatrician. The wife was depressed, anxious, and expressed fear that her husband might be homosexual. She started to think so after their first baby was born some months ago and the husband became uninterested in her and preferred to spend more time at work or with his unmarried male-friends. The only outlet the wife had for her anxieties and depression was her newborn baby. She

became overanxious about the baby, and visited the pediatrician more and more often. This doctor, who saw a healthy baby, developing well, could not understand the mother, who was too shy and inhibited to talk about her anxiety.
When the well-trained pediatrician invited the couple for a talk, he found out that they had difficulty in adjusting their relationship to the change in the family. The mother had a slight, almost biological, post-partum depression. The father, who was a very insecure and sensitive man felt rejected and became jealous of the new baby. As a result he detached himself from his wife and baby and there had started a chain of reactions which could have become very destructive to the future of these young people and their child.

This case illustrates the fact that primary care has a great opportunity for implementing mental hygiene and for prevention and early detection of behaviour disorders and emotional problems, provided that - and this is very important - a truthful dialogue has developed between the patient and his family doctor and between the family doctor and the psychiatrist. Many doctors, however, do have a difficulty with psychological medicine, which originates from very deep human fears and anxieties about themselves. We are all afraid of death, insanity, anger, love, hate, rejection, exposure and dependency - and the best way to cope with this fear is either to avoid it or to project it into others - in this case our patients - and to isolate it there. Putting limits and barriers between doctor and patient is a consequence of the need not to become too much involved and not to care too much in order not to get hurt. Unfortunately this need is reinforced in most of our studies at most of our medical schools, where medicine is taught emphasizing the dichotomy between body and soul. The student is encouraged to detach himself from psychological processes, either to ignore them (especially his own psychological reactions) or to refer them to the psychiatrist.

As a result, psychiatrists arrived, who believed they had a monopoly of the 'humanistic medicine' and wanted to teach general practitioners a better understanding of their patients, better communication, skills like 'listening with the third ear' and a psychological language - and no wonder they failed for such a long time! While they wanted to teach better communication and under-

standing, they failed to communicate effectively and to understand the general practitioner better.

Psychiatrists spoke a strange language, their attitude was omnipotent, aloof, secretive - and they were rejected by the primary care physicians.

I have experienced the pain myself. I was involved in many programs which aimed at training family doctors in mental health in order to enable better collaboration and communication. We tried courses, lectures, seminars and clinical-case discussion. We had weekly meetings, monthly meetings, evening meetings and morning meetings. They were held at home, at the hospital, at the clinic, at the seashore and in the mountains. Most of the participants were interested and fascinated - but I always felt that the learning experience remained isolated and was not well integrated into the family doctor's daily work, thought and practice. I also found most of the times that I was more eager to give than my partners were willing to accept. I felt like a kept woman, somebody to meet one evening a week, or one weekend, but not to be taken home.

In the hospital setting the psychiatrist remained unaccepted as part of an integrated team. He remained an outsider, and the residents accepted him with their well known ambivalence. As for the primary care clinic, when the family doctor asked for help he was very helpless and impotent; when we offered help and collaboration he became suspicious and politely aggressive, and his message was: "You cannot help anyhow!" In order to prove this was so, he would pick one of his most complicated cases for consultation, loaded with psychosocial and medical problems and present it with a sceptical nod: "Let's see what you can do with an alcoholic father, an epileptic, retarded mother and six children with severe behavioural disorders, all living together in a small two-room apartment!" When I tried to talk with the family doctor about our feelings when we feel so impotent, helpless and angry, it turned out to be nonsense to him. He wanted immediate and concrete solutions, a recipe. He wanted me either to take over this family, as my patients and my responsibility, or to leave them and himself alone.

My conclusions were that learning should be part of our daily work and should be the common experience of two equal parties: not a teacher and a pupil, but two sides who should be willing to connect and who should be equally active in this experience, with shared responsibility and participation.

One such program ran for two years in our clinic, as a part of an in-service training program offered by the Hebrew University Medical School and Kupat Holim, the Labour Union Health Insurance Fund. The group involved in this program consisted of twelve primary care physicians, most of them pediatricians, two child psychiatrists, two residents in psychiatry and one or two residents in family medicine. During the next two academic years we all met one morning a week, for five hours.
Each morning was divided into three sections:

1. Group discussions, a variation on Balint-groups. These discussions were held in unstructured meetings during which the participants could present a case or bring up any topics or question, be it personal or professional. Only touching upon group-dynamics, everybody was very careful not to turn these discussions into 'group therapy' sessions.
2. Clinical work: examining, interviewing, diagnosing and later on also treating patients who either came to the mental health clinic for help or came to the primary care physician who invited them to come with him to the psychiatric clinic.
3. Clinical discussion.

In the beginning it was the psychiatrist who had the responsibility, primarily in the clinical part of the program. But as time went on all participants became more and more active: they brought their own patients, they took upon themselves interviewing and treatment, they prepared theoretical material or chose topics for discussion.

The goals of the program were:

- to find a common language and to enable a free and fruitful communication between psychiatrists and primary care physicians as well as among the latter themselves;
- to increase the awareness and understanding of behaviour and emotional problems in primary care medicine;
- to emphasize the importance of and to provide tools for early detection of such problems;
- to understand and estimate better the emotional reaction to physical illness;
- to learn more about life-style and life-stress situations;
- to examine the role of the family doctor within the family and to understand the importance of the doctor-patient relationship as a 'healing tool';
- to let psychiatrists and family doctors learn more about each

other's work, problems, dilemmas, expectations and frustrations.

Before I go on to estimate the results of such a program and to answer the question whether or not the goals mentioned were achieved, I want to mention briefly what topics were brought up in the morning group discussions:

1 'Pure' medical problems, either specifically physical syndromes known to indicate an emotional problem (like enuresis, encopresis, tics and stuttering) or so-called psychosomatic diseases (like asthma or anorexia).
  Discussing these problems was of course an easy way to start to communicate - like walking on safe and well known ground.
2 Problems in medical psychology, like chronic illness, terminal illness, malignancy, death in the family and other less dramatic ones like having an operation, hospitalization, heart attack or kidney dialysis.
  Discussion on these topics were maybe the most exciting and revealing ones. It really related very closely to our daily work - yet the emotional component of these situations was found to be very neglected. The group returned again and again to these topics, each time daring to go deeper into the feelings of patients, families and doctors.
3 Psychological problems in the family, such as divorce, single parent families, adolescence, bereavement, alcoholism and abused children. At first the primary doctors had difficulty in seeing their role in this area, but when they grasped the meaning of a family living in stress - and stress was accepted as a medical problem - the group became very much involved in understanding, diagnosing and trying to see their helping role.
4 The 'doctor's professional identity', like his relations with patients and mental health workers, his place in the medical system and team work.
  In this area psychiatrists and family doctors sometimes stood opposite to each other and at other times stuck together with strong common feelings. Each doctor could talk about his/her insecurity, loneliness, isolation, expectations and frustrations, anger and an overall feeling of dissatisfaction - which unfortunately characterizes the Israeli medical community today.
5 Some personal problems which the participants brought to the fore had mainly to do with the parent-child relationship and with old age: their children and their parents!

6 Group processes.
   Basic notions - like trust, competition, leadership, commitment, acceptance, anger, disappointment, dependence and closeness - were discussed. These discussions helped to form a group cohesion; also they could be related to family dynamics and to the doctor-patient relationship.
7 Some basic notions of psychotherapeutic techniques had to be discussed - without us pretending to turn the participants into their patients' or each other's therapists. Learning these notions, some of them being basic notions of communication (like 'non verbal communication') other being more specific ones (like 'clarification' and 'interpretation'), helped the participants in developing a common language.

We started our program with a group of sixteen participants, and ended with fourteen. One of the family doctors died of a heart-attack, which caused the group to go through a very difficult period during which many fears, anxieties and feelings of guilt emerged. Another family doctor left the program after one year because, as she explained, the meetings caused to develop many of her own personal problems within her.

Did we achieve our goals? Did we facilitate communication and collaboration between primary care physicians and mental health workers?

Unfortunately we did not develop any tools to measure the results of the program, and we can only rely on subjective feelings - which of course is not very scientific. The group, though, enjoyed the program and the attendance was regular and steady. At the end of the program and one year later the participants reported that they had changed their attitude to mental health problems significantly and that they had widened their approach to sickness and health. They even reported their family life had become more open. All participants were willing to continue collaboration between the primary care clinic and the psychiatric clinic. Some primary care physicians were interested in getting supervision in their treatment of some of their patients' emotional problems.

One of the pediatricians started in her own clinic a small center for the detection of early developmental problems. Another general practitioner became involved in a teaching program for medical students and a third one collaborated in a program of ours, working with patients waiting in the doctor's waiting room.

All in all the program turned out to be a wonderful experience. When we wanted to repeat it with a second group, however, we did not succeed. First of all there had been a change in the chairmanship of the post graduate program of the medical school, and the new man did not believe that emotional problems in primary care were of any importance. And even though their attitude was quite positive, Kupat Holim did not care enough or did not have enough power and influence to stick to the program. The saddest reason of our failure, however, is that it turned out to be impossible to mobilize a considerable group of family doctors who would demand or fight for such a program or who really believed in it.

11. CHANGES IN THE DOCTOR'S PERSONALITY AS A RESULT OF PARTICIPATION IN A BALINT-GROUP *

H.J. Dokter, H.J. Duivenvoorden and F. Verhage

In his book 'The doctor, his patient and the illness' (1957), Balint focussed a special attention on the importance of listening: "The ability to listen is a new skill, necessitating a considerable though limited change in the doctor's personality". He thought that he was able to bring about this change by working with a group of general practitioners selected for this purpose.

In 1982 two Rotterdam professionals, a psycho-analyst and a general practitioner began two such groups; 22 general practitioners participated.

These groups met for one and a half hours every fortnight over a period of two years. At the end of the first six months, which had served as a trial period, an agreement was made with the members of the group to continue for a further one and a half years. The aim of the group was to provide the doctors with psychological skills which would enable them to function more effectively as general practitioners. To achieve this an attempt was made to bring about Balint's 'considerable though limited personality change'.

An investigation was carried out in an attempt to measure this change. Three of the questions posed in this investigation were:

1. Did the doctors who had had two years training in the group change for the better as a result of their participation?
2. Is it possible to differentiate between subgroups on the basis of the Balint-characteristics, as measured at the start of the group meetings?
3. Is it possible to differentiate between the subgroups on the basis of the personality characteristics of those patients with whom the doctors have difficulty, as measured before the start of the group meetings?

* Complete results of this investigation are to be published in Family Practice, 1986.

Method

After two years, three subgroups in the group of 22 general practitioners who originally applied could be distinguished :

a. the group that soon gave up, which we refer to as the 'drop-outs' (n=8);
b. the group that participated for one and a half years and took part in an interim measurement at the end of this period, but then dropped out. We call these the 'late drop-outs' (n=6);
c. the group that participated in the study group for two years ('stayers') (n=8).

A questionnaire was designed in order to measure the 'limited change in the doctor's personality'. This questionnaire was first filled in by the participants during the first session of each group (n=22). After one and a half years they were asked to answer it for the second time (n=14) and again after two years, when the group was dissolved (n=8).
The questionnaire consists of five sections.
The first section contains biographical information about the participants like age, sex and number of years experience.
The second section contains forty-eight statements concerning Balint-characteristics. These characteristics were formulated and given their working form on the basis of a pilot study carried out by Metz (1982) (see tabel 1) (see next page).

The third section contains seventy-five personality characteristics that refer to the doctor and to those patients with whom the doctor has difficulty, respectively. These characteristics are mainly based on Duivenvoorden's research into the motivation for psychotherapy (Duivenvoorden, 1982). The doctor first had to describe his own characteristics and then the characteristics of the 'troublesome' patients. By putting a cross against the relevant personality characteristics, the doctors could indicate to what degree they had difficulty with certain types of patients. No investigation was done into which patients actually caused difficulty to the doctors.
The fourth section consists of Leary's interaction rose (Leary, 1957).
In section 5 of the questionnaire, which was only answered at the first meeting, the doctor could indicate his motives for joining the group.

Table 1: faces of neurotic forms of behaviour towards patients

1. dilution of responsibility
2. concealing oneself behind anonymity
3. inability to listen
4. feelings of insecurity
5. sensitivity to threats of abandonment or proximity
6. unconsciousness of own emotions
7. absorption in the apostolic function
8. inability to handle appraisal, reward or punishment
9. inability to feel empathy
10. feeling of being manipulated
11. inclination to compete
12. identification with the patient
13. feelings of omnipotence
14. falling back in regression
15. voyeurism

Results

The crucial question in this investigation is whether, at the end of two years training in the group, the general practitioners have changed for the better as a result of their participation in the group. For both this question and the following one, the number of doctors on which the findings are based is very small and the results have to be interpreted with the necessary caution.
After one and a half years, one doctor showed a clear change with regard to two of the forty-eight Balint-characteristics: he learned to accept that certain systems (such as the family) can come to a deadlock and he learned not to try to change these systems, irrespective of the price that had to be paid. Another doctor changed in the sense that he no longer felt that he had to play the role of a father-figure. No changes were recorded in Balint-characteristics among the other doctors.

There were, however, certainly favorable improvements to be seen concerning the personality characteristics of patients with whom the doctors said they had difficulty. During the first measurement at the start of group work, the eight doctors who stayed on the

course indicated that they had difficulty, on average with 11.50 characteristics, compared with an average of 8.38 characteristics when measured two years later. It is important to mention that a shift had occurred in the personality characteristics mentioned (see fig.1).

Figure 1: average number of personality characteristics in patients that a general practitioner finds troublesome

before (Jan.83) \ after (Jan.85)	+	-	
+	5.13	6.38	11.50
-	3.25		
	8.38		

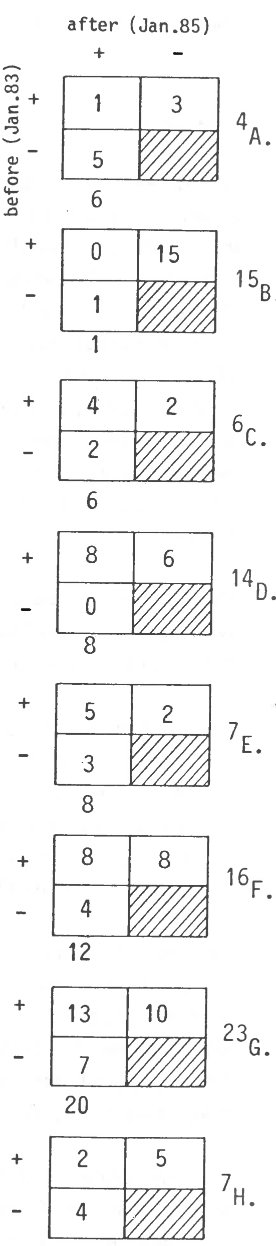
With some characteristics, an average of 5.13 per doctor, the doctors had difficulty at both the beginning and at the end; an average of 6.38 characteristics had disappeared but their place had been taken by, on average, 3.25 other characteristics.

At the individual level the differences are extremely large. As can be seen in figure 2 one doctor (B) changed from 15 to 1, while another (D) declined from 14 to 8; one doctor (F) went from 16 to 12 after two years and another (G) changed very slightly or not at all. It is clear that the shift can mainly be ascribed to doctor B.

As already mentioned three subgroups could be distinguished: drop-outs, late drop-outs and stayers. The question is whether these subgroups can be differentiated on the basis of either the Balint-characteristics or the personality characteristics of the patients.
As for the Balint-characteristics, relatively more of the stayers indicated that they:
- found it difficult not to get involved with patients with protracted problems;
- did not act quickly;
- were frightened of making mistakes;
- allowed themselves to be got round;
- felt manipulated;
- could not say "no".

Thus it seems that these doctors are more dependent and more 'sensitive' than the other two categories.

Figure 2: personality characteristics of troublesome patients



The late drop-outs were mainly differentiated by:

- eagerness to act as a father-figure;
- eagerness to hear that one is a good doctor;
- little difficulty in handling their own anger;
- satisfaction with their own way of dealing with things;
- the opinion that unsuccessful treatment must be attributed to the patient;
- the opinion that the way one functions as a general practitioner has nothing to do with one's own family background.

These doctors are certainly not dependent. They seem narcissistic and do not take up a dependent position.

The drop-outs, however, are primarily characterized by;

- the inclination to regard themselves as a good example;
- the inclination to interfere with other people's business;
- irritation at the behaviour of the specialist;
- indicating that they do not have the slightest difficulty with patients who choose another general practitioner;
- few doubts about their own way of dealing with things;
- having difficulty with those who do not follow advice;
- indicating that their feelings are easily hurt;
- the inclination to hide their feelings or to mask them.

These doctors are more narcissistic than

the late drop-outs.

Discussion

An attempt was made to find out whether a consultation group for general practitioners has any effect. What unmistakably emerged was that a considerable shift took place: a shift in the type of patients with whom the doctors said they had difficulty. Although the greatest caution must be exercised in interpreting the result from a single Balint-group ending up with only eight participants, it is evident that fundamental changes took place in four of the eight stayers. There was, however, no control group, so the question remains as to whether the shift can actually be ascribed to participation in the Balint-group concerned; on the other hand it is difficult to imagine how this shift could be explained by other factors.

Though they experienced a favorable shift with respect to difficult patients, the remaining four stayers gained no final 'benefit' from the group. There are two plausible reasons for this:

1. As far as these doctors were concerned the meetings came to a premature end.
2. It is equally realistic to suppose that this method of consultation is not a success with doctors having particular types of problems; it is also possible that this method should be combined with another one.

As for the Balint-characteristics of the group hardly any changes could be observed. These characteristics, however, refer to fundamental aspects of the personality, in which one should not expect any change to occur, using this approach. The personality characteristics of the doctors, as indicated in the third section of the questionnaire, did not change either.

On the other hand, one must not overlook the possibility that a shift, be it fundamental or not, might have taken place but that the method developed for measuring it was not sensitive enough. It is therefore essential to limit the conclusion to: changes do indeed occur but, in as far as they can be measured with the tools devised, they are not really substantial ones.

All in all, it can be said that working in the group gradually leads the participants to deal with their patients in a different and more competent manner. Where the drop-outs are concerned, we have come to the conclusion that, during their work with the group, these doctors became aware of the fact that patients are much more problematical than they originally thought. A number of doctors could not bear this and left the group. A possible explanation for this could be found in the recognition of one's own 'ego'. The somewhat dependent, less narcissistic doctor can accept this insight and carries on, while the more narcissistic doctor is unable to bear it, involving as it does the recognition of his own problems in those of the patient. Balint (1966) thought that "the aim of the course has not been to change general practitioners into psychiatrists, but rather to enable them to become better general practitioners". Experience in leading this consultation group has taught us that 'better' in this context means: the insight that the patient is more problematical than appears at first sight and the ability to deal with this insight in a competent way.

Bacal says that "the pre-seminar general practitioners's professional work tends to be interfered with by certain internal problems which he carries into the doctor-patient relationship, and he has little or no awareness that these problems interfere with his professional functioning". As it is important that the doctor's own problems do not interfere with his work as a general practitioner, a good doctor does have some insight into them and is better able to cope with them. This insight can also be obtained by working in the group.

To summarize, it can be concluded that the personality of the doctor does not change fundamentally as a result of joining a Balint-group. However, it does play an important role in the observed differences between the stayers in the group and the drop-outs. The training seeming successful, further research is very much to be desired.

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12. THE CONTRIBUTION OF PSYCHIATRY AND MENTAL HEALTH TO THE TRAINING PROGRAM OF RESIDENTS IN FAMILY MEDICINE

B. Maoz

Epidemiological data clearly illustrate that the majority of those mental health problems which are detected are not treated by mental health services. They are treated by general practitioners, social workers and nurses who work in their team or by other primary care providers. In another article in this book, I describe what mental health professionals might do in order to improve the ability of general practitioners to recognize, detect and treat mental health problems. In this article I will focus on training and education.

The great breakthrough in this area was, of course, accomplished by Balint in his famous seminars that were held in England during the fifties (Balint, 1964). Since that time progress has been made and fundamental questions have arisen, some of which we would like to discuss here.
For example, general practitioners are not able to use any psychiatric or psychodynamic classification for their purposes. A simpler and more problem centered evaluation and classification must be used, like: Does the patient suffer from a 'purely somatic', 'primarily psychological', or 'mixed' problem? What is his or her basic coping pattern ? In other words, the general practitioner's approach is much more practical, managerial and problem-oriented than that of most mental health professionals. Goldberg et al. (1982) found that those general practitioners who were the most sensitive detectors of mental health problems were self-confident, had an outgoing personality and a good academic education (including sound medical knowledge). Lesser (1985) pointed out that these features can be taught and that the sensitivity of general practitioners to mental health problems can be largely improved. The most important thing in his opinion is that they can be trained to become first-class interviewers.

Lesser developed a schematic educational mode for general practitioners to reach this goal. The 'problem-based interviews in general practice' consist of the following steps: problem sensing, problem detection, problem description, problem assessment, intervention and treatment and evaluation of problem-oriented treatment.

Lesser emphasized that in contrast to many psychiatrists and psychologists, general practitioners must get relevant information in a short time and must often take relatively quick and practical decisions.

The differences in the process of thinking and working between 'psychological practitioners' and 'medical practitioners' were stressed very clearly by Brown and Zinberg (1982). They summarized these differences in five areas:

1. **Values.** Whereas the medical practitioner is goal-oriented, thinks in terms of ruling out, tends to be active and takes much responsibility for his patients, the psychological practitioner is process-oriented, thinks in terms of ruling in, tends to be less active and tends to put the responsibility on patients.
2. Different professional **education:** medical students in the later clinical years tend to be interested in the somatic-physical aspect only and tend almost to neglect the psychological aspect.
3. Attitude towards and behaviour with **emotions,** the medical practitioner trying to avoid as much as possible any relation to emotions and feelings and the psychological practitioner working mainly with emotion.
4. Different **expectations** of patients. As already mentioned above, a patient approaches a medical practitioner with a somatic symptom and not with an overt psychological problem. Sometimes after the somatic symptom has been related to, he or she then wants to talk about a personal problem.
   Patients who come to a psychological practitioner have often already passed a somatic investigation and therefore are ready to talk immediately (although they may continue, also in the mental health clinic, with the description of their somatic complaints).
5. **Intimacy.** While the medical practitioner must find a balanced relationship between distance and closeness in order to be able to treat the patient (the family) for a long time, the psychological practitioner uses the development of intimate relations between therapist and his or her fantasy and thinking, and interprets them to the patient.

With regard to the fact that many mental health problems are dealt with by primary care providers, it is important to emphasize that the above-described two categories of medical and psychological

practitioners can be integrated into one profession (Lesser, 1985; Brown and Zinberg, 1982) and in principle, that medical practitioners are able to treat mental health problems. Despite the ties between the two professions, psychiatry and general practice, interdisciplinary tensions may occur (Lesser, 1981). It thus becomes clear that psychiatrists, psychologists and other mental health professionals should play an important role in the training program of residents in family medicine and general practice.
The residency program in family medicine in Israel takes four years, including a three months' residency in psychiatry (usually ambulant psychiatry). Residency programs exist in Jerusalem, Tel-Aviv, Haifa and Beersheva.
In Beersheva family medicine residents receive their theoretical training on a fixed study-day every week, during three years. In the curriculum of these weekly study-days psychiatry, behaviour sciences and communication skills play an important role. The department of family medicine and the department of mental health of the Ben-Gurion University in Beersheva, developed a joint residency-program for family physicians. This program is carried out in four teaching approaches:

1. Frontal class teaching in seminars, with active participation of the residents. These seminars cover relevant issues such as the individual and family-life-cycle, selected and relevant topics of psychopathology, the psychosomatic approach in medicine, psycho-pharmacology, principles of counseling and psychotherapy and sexology.
2. A course in communication skills.
3. A Balint-group, which has become an integral part of the program.
4. 'Family representations' with multi-disciplinary comments.

The above mentioned Balint-group serves not only as usual as a discussion and supervision-group for the doctor-patient relationship but also as a place where residents from different countries can develop a common approach. In the Balint-group they can also discuss their often frustrating relationship with 'red tape' and the medical establishment. Further, in this group they can try to define for themselves the not always clear role of the family physician and identify with their new profession.
There is of course a great need for a scientific evaluation of the outcome of these training programs which are carried out by a

small group of enthusiastic mental health professionals.

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'How difficult it is to change people ...'
Discussion

In respect of Dokter's lecture Margolis expressed some doubts as to the validity of the study. He wondered if the questionnaire technique was a good one, as analysis of the results was done by people who had interests in it themselves. He also regretted the absence of any data on the early drop-outs, who did not fill in the second questionnaire. The results, he added, are not very satisfying, only four out of twenty-two participants showing any change.
In response to a question posed by Agmon ('In what respect did the physicians' work change?') Dokter pointed out that primary care physicians underestimated their importance in helping patients with the mental problems due to - for instance - bereavement. If a family doctor won't visit these patients anymore, he argued, the number of mental patients will surely increase.
In reaction to the results of Dokter's research Schein felt that family doctors and their patients were very heterogeneous, which made it difficult to interpret the results. Many doctors were not at all interested in the treatment of psychosocial problems, Schein felt. Gersons disagreed. Most medical students do want to learn. What really matters is using the appropriate method to teach them, lest they lose interest and motivation. Dokter's study, Gersons said, confirmed his doubts about the Balint-method: the results were poor and other methods should be chosen.
Rabinowitz, who had experiences in Balint-groups himself and had no doubts as to the favourable effects of a joint effort by family doctors and mental health professionals, added that the preparation of students before joining a group was of the utmost importance. Sensitizing the family doctors for work in the group prevented them from dropping out later. According to Katz, personal growth is very difficult to measure. She agreed with Gersons, though she welcomed the effort and saw peer-supervision, as in the Balint-group, as important. Huygens closed the discusion with a sceptical sound. "Don't you think", he asked, "that the results indicate how difficult it is to change people?"

13. THE PHYSICIANS' INTERVIEWING SKILLS IN PRIMARY HEALTH CARE: RELEVANCE AND EFFECTS OF TRAINING PROGRAMS

H.F. Kraan, A.A.M. Crijnen and J. Zuidweg

In 1869 Tolstoy wrote in his great novel 'War and Peace', that the societal function of physicians was not dependent on making the patient swallow substances. In Tolstoy's opinion, physicians were, however, indispensable and necessary, because they satisfied 'a mental need need for the invalids and for those, who loved them'.
More than hundred years later we still recognize this kind of 'care-giving' as an important role of the physician. In Tolstoy's statement the dilemma between the humanistic, holistic versus the reductionistic technological approaches in medicine is also discernible. The conflicting relationship between both approaches, often described as the art and the science of medicine, have not altered much over years, notwithstanding the tremendous growth of knowledge that has taken place, especially in medical technology. Tolstoy's 'satisfying a mental need for the invalid' - for long considered an art - has also been drastically changed by the scientific development in behavioural medicine and psychiatry. The increased knowledge caused considerable replacement of artistry and craft- manship in the 'care-giving' professions by social technology (DiMatteo and DiNicola, 1982). The 'mental needs' of Tolstoy's days would probably nowadays be called somato-psychic problems and minor psychiatric syndromes, like depression, anxiety and psycho-somatics.
Not only the patient, but also the care-giver himself has been subject of study over the last twenty years, often with the aim of improving his competence. According to Fabb and Marshall (1983) different psychological properties or skills are to be discerned that make up together the physician's competence. In addition to his attitudes towards patients and his own professional role, the possession of knowledge, medical interviewing skills, perceptual and interpretative skills and problem solving skills are considered as discernible dimensions of medical competence. This theoretical distinction makes sense because these competence aspects require their own educational and evaluative approaches.
In this article we focus on one aspect of competence necessary in Tolstoy's 'satisfying a mental need for the invalid': the physicians' interviewing skills in primary mental health care. Medical interviewing skills are, according to Schouten et al. (1982), defined as the physicians' skills, needed in order to exchange

information with the patient about diagnosis and treatment.
First we justify the choice of this competence aspect. Next we examine guidelines for the design of training programs, taking the present program in the Maastricht Medical School as an example. Finally, we turn to the evaluation of training programs in medical interviewing skills.

The importance of physician-patient communication in primary health care

Physician-patient communication plays a major role in primary health care. Several arguments in support of this statement can be found in the literature.

Epidemiological arguments

In epidemiological studies it is found that the prevalence of 'minor psychiatric syndromes' is high (20-25%) (Goldberg and Huxley, 1980; Shepherd et al., 1982). These 'minor psychiatric syndromes' encompass mainly depressive, anxiety-related and psychosomatic symptomatology, often in combination with somatic complaints. Although spontaneous remission is also high, 10-25% of these 'minor cases' seem to become more seriously or chronically disabling. Johnstone and Goldberg (1976) have shown, that early detection and treatment of 'minor cases' result in relief of symptom and psychological pain, without 'medicalizing' the illness and with probable cost benefits. However, in other studies (Goldberg and Huxley, 1980; Goldberg and Blackwell, 1970) it is shown that about 30% of these patients with 'minor psychiatric syndromes' are not detected. Golberg et al. (1982) repeatedly found in studies with family practice residents, that their ability to make accurate ratings of psychiatric symptoms ('detection of cases') is partly determined by interviewing style, and partly by certain personality attributes. Self-confident, extroverted physicians, aware of their feelings and with high academic ability tend to make more accurate assessments. In respect of the interviewing style of the physicians it appeared, that a more accurate assessment of psychiatric symptoms is achieved by means of directive psychiatric questioning, supportive comments, exploration of social background, sensitivity to non-verbal cues and maintaining eye contact.

In addition to the epidemiological figures of these minor syndromes and the role of the physicians' interviewing skills in detection and diagnosis, there is another argument for the importance of medical interviewing skills. According to a study of Shepherd and Clare (1982) only 84 of 1530 patients with 'minor psychiatric syndromes' were referred to a psychiatric outpatient department and only 47 were admitted. These figures imply, that the majority of these patients receive cure and care by their general practitioners. Irrespective of the kind of treatment provided, it is evident that the general practitioners' interviewing skills are of paramount importance for treatment.

The 'physician's competence' argument

Medical interviewing skills are the basic clinical method in both general practice and psychiatry (Pendleton et al., 1984). Studies have shown the positive halo-effect of adequate interviewing upon other aspects of medical competence in these disciplines:

- Several authors (Goldberg et al., 1982; Elstein et al., 1978; Rutter and Cox, 1981; Giel 1982) suggest, often on empirical grounds, that the physicians' interviewing skills determine accurate data collection from the patient and therefore contribute to attaining a more accurate diagnosis.
- Since 1975 Eisenthal, Lazare and co-workers study the use of the so-called negotiated approach in initial psychiatric interviews. In this type of consultation several subjects are negotiable: the problem definition, treatment goals, methods, conditions and so on.

  The negotiated encounter in (primary) mental health care was already proposed by Adolf Meyer in the twenties. Later it was described by Balint (1976), Levinson et al. (1967), Scheff (1968) and others as the most effective consultation model in mental health care.

  Eisenthal et al. (1983) reported two significant antecedents of patient satisfaction as a measure of outcome: the perception of being understood by the other and the participation in the treatment decisions. They showed that both antecedents were largely determined by the physician's interviewing skills. The study shows the central role of the interviewing skills in the negotiation consultation model.

The 'physicians' own needs' argument

Physicians' satisfaction has been shown to be a positive factor in the quality of care provided (Pendleton and Hasler, 1983).A physician interested in psychiatric and psychosocial issues may feel a need to improve his interviewing skills. Training in interviewing skills is a valuable investment of time, when we remember that general practitioners treat the majority of patients with 'minor psychiatric syndromes' themselves. For physicians treating these patients, the 'general psychotherapy' of Frank (1975) or the counseling models of Ivey (1983), based on rather 'simple' interviewing skills, will be of value (for more information we refer to the literature cited).

However, many physicians suffer from low satisfaction in their work, because of communication problems with their patients. A striking example is the phenomenon of 'somatic fixation', caused by an unbalanced communication pattern, in which the physician pays too much attention to the somatic aspects of the problem neglecting the psychosocial aspects. These problems often have their roots in deficiencies in the physician's interviewing skills (Grol et al., 1981).

Moreover several medical educators have pointed to 'countertransference', that is broadly defined as feelings about the patient, that are incompletely recognized and disturb the physician-patient communication (Ekstein and Wallerstein, 1972; Engel, 1977). Some authors consider it as a common phenomenon in physicians (Balint, 1976; Platt et al., 1979), but no data obtained systematically are available on this subject. In a small sample study Smith (1984) attributed the following interviewing behaviours to countertransference: avoiding certain topics (e.g. suicidal thoughts, loneliness), controlling the patient (changing subjects, inappropriately interrupting, etc.), attempts to be pleasing, detachment (avoiding to relate with the patient about emotional topics), etc. Besides these overt behaviours he found on the emotional level indirect evidence for countertransference as fear of causing harm, fear of affect, feelings of inadequacy, strict biomedical orientation, over-identification with the patient.

From these arguments it not only becomes clear, that deficiencies in interviewing skills play an important role in these difficulties, but also that interviewing skills ought to be taught in conjunction with the elaboration of emotional issues.

The arguments from the patients' side

In the literature, the adequacy of medical interviewing is correlated with several measures of the 'immediate outcome of care':

- Patients' increased recall of information, provided by the physician on the diagnosis of the problems presented and the rationale of the further management plan (Ley, 1983).
- Increased 'patient satisfaction' (a.o. Lebov, 1974). This rather vague variable has been found to be an important intermediate variable for patients' adherence to advice (Freeman et al., 1971; Ley, 1983; Wolf et al., 1978).

  Our own research (Crijnen et al.,1986) has revealed that several dimensions can be discerned in this variable of 'patient satisfaction'. It was shown that 'patient satisfaction' was determined by increased cognitive and emotional insight and by the physician's facilitation of emotional expression in the patient.

These data underscore the significance of the relation between the physicians' interviewing skills and immediate outcome of care.

Health care policy arguments

The Dutch Government adheres to a policy assigning the general practitioner a central position in the prevention, cure and care of 'non-serious' psychiatric problems (Nota Geestelijke Volksgezondheid, 1984). This type of health care requires more extensive training of the general practitioners' diagnostic interviewing and skills in counseling and in supportive care.

Guidelines for teaching programs in medical interviewing, especially for primary mental health care

In an extensive review of the literature Carrol and Monroe (1980) selected the effective ingredients in training programs for medical interviewing. They formulated recommendations for the design of training programs based on their findings. These guidelines, which we follow in this section, are: explicit (behavioural) statements of the interviewing skills to be taught; a structured teaching program, encompassing the skills to be taught; direct individualized feedback; standardized presentation of illustrative, protocolar patient interviews; continuity of training. Moreover, we add two other guidelines, originating from the experiences of

the Maastricht training programs in medical interviewing: integrative teaching of cognitive, behavioural and emotional elements of medical interviewing and the close link between teaching and evaluation.
These seven guidelines for teaching programs will be discussed:

1. Explicit, behavioural statements of interviewing skills
The design of instructional programs should include **explicit** statements of the interviewing skills to be learned and evaluated. At the Maastricht Medical School the teaching program uses a taxonomy of interviewing skills in primary mental health care. This taxonomy may serve as an overview of interviewing skills, relevant to initial interviews in primary mental health care. Moreover, based on it, an evaluation instrument has been constructed: the Maastricht History-taking and Advice Checklist (MHAC) (see Appendix).
The taxonomy consists of seven parts of which the first five contain skills pertaining to process and content of the different phases in those interviews. The last two parts deal with process skills. We give an overview of these seven parts, accompanied by a few examples of interviewing skills (for the complete taxonomy we refer to the appendix):

a) Clarification of the request for help.
This is the patient-centered phase of the interview. By means of mainly open-ended questions, good listening and other active, facilitative behaviour, the physician collects information about the problems and symptoms from the viewpoint of the patient: emotional impact of the problem, causal attributions, attempted solutions, reactions from the patients' primary group and so on. The result of this phase ought to be a statement by the patient about the help he desires from the physician.
The skills in this part of the checklist are derived from the work of Schouten et al. (1982), Byrne and Long (1976) and Pendleton et al. (1984).
Examples of items:
- Asks the patient why (s)he presents this problem at this particular moment.
- Asks the patient to give her/his opinion about the causes of the problem.

b) History-taking.

During this phase the physician has to make an in-depth exploration of the main problem(s) within a psychiatric frame of reference. This exploration pertains to factors which aggravate or alleviate the problems/symptoms, history of the symptoms, previous treatment, relationship between somatic complaints and psychosocial problems, and so on.

The skills grouped in this part of the taxonomy stem from the work of Schouten et al. (1982) and MacKinnon et al. (1971).

Examples of items:

- Explores somatic aspects in the mental health problem.
- Explores which factors decrease and/or eliminate the complaint/problem.

c) Psychiatric examination

In this phase of the interview the physician deals with the systematic exploration of symptoms and impairment in function accompanying psychiatric disorders which are important to primary care, like affective disorders, anxiety disorders, psychosomatic and somato-psychic disorders, substance abuse and psycho-organic syndromes, etc.

The skills in this part of the taxonomy come from the work of Goldberg et al. (1982) and Giel (1982). Examples of items:

- Examines symptoms of affective disorders.
  - a) disturbances in mood and affect
  - b) biological features
  - c) disturbances of thought
  - d) suicidal ideation and behaviour
- Examines disturbances in memory.
  - a) immediate recall
  - b) recent (short-term) memory
  - c) remote memory.

d) Socio-emotional exploration.

This phase deals with the exploration of a broad domain of social and interpersonal functioning, professional functioning, family life, sexual functioning, traumatic events during childhood, developmental issues.

The skills in this part of the taxonomy are derived from several primary care oriented diagnostic classification systems of mental health problems, compiled in a review by Lipkin and

Kupka (1982).
Examples of items:
- Asks for perspectives and aspirations in life.
- Asks for social support.

e) Presenting solutions.
In this phase the physician is concerned with providing information about the problem presented (diagnosis, causal relations problems/symptoms, prognosis), negotiation about the problem definition and possible solutions, giving a concrete advice (further exploration, treatment plan, referral). The skills pertain especially to the process and less to the content of the solution which is, of course, mainly determined by the character of the problem.
The skills in this part of the taxonomy stem from the work of Eisenthal et al. (1983), Stimson and Webb (1975), Ley (1983).
Examples of items:
- Asks the patient for his expectations about help.
- Checks if the patient has a different point of view on the problem definition and/or proposal for help and discusses any difference of opinion.

f) Structuring the interview.
This part of the taxonomy gives a summary of the physicians' skills in structuring the phases of the interview: in announcing and closing a phase of the interview, in controling the sequence and timing of the phases, in opening and in terminating the interview.
The skills described in this part of the taxonomy are to some extent discussed by Schouten et al. (1982).
Examples of items:
- Concludes the phase of 'clarification of the request for help' with a summary.
- Starts the phase of 'presenting solutions' with information about diagnosis /problem definition.

g) Basic interviewing skills.
Following Hess (1969) we make within these basic interviewing skills a theoretical distinction between interpersonal and communicative skills. Interpersonal skills refer to interviewing behaviour, which contributes to establishing patient rapport,

trust and acceptance. They are important for patient compliance and satisfaction(Korsch et al., 1968; Hulka et al., 1976). These effects are attributed to several interviewing skills: showing empathy, warmth and concern, active listening, facilitative behaviour, instillation of positive expectations, self-disclosure.

Communicative skills promote the information flow between physician and patient. These skills are related to structuring the interview (see above) and the use of appropriate techniques of questioning, providing information and giving advice.

Examples of items:

- Explores the patient's feelings during the interview.
- Facilitates the communication with the patient.

2. A structured teaching program

According to this guideline the interviewing skills to be taught should be grouped in a teaching program with clear objectives. In the literature several examples of thoroughly elaborated programs are encountered. Lipkin et.al. (1984) describes such a program for primary care internal medicine. It has four general objectives: patient-centered interviewing and treatment; biopsychosocial approach to clinical reasoning and patient care; personal development of humanistic values; psychosocial and psychiatric medicine. Each general objective is expressed in requirements of knowledge, skills and attitudes.

Another well-known program with a well-defined, hierarchical list of interviewing skills is the micro-counseling program of Ivey (1983). In this hierarchy 'attendant behaviour' (appropriate eye contact, attentive body language, following the patient's topic of interest) and client observation skills should be mastered, before the student proceeds to the 'basic listening sequence' (open and closed questions, facilitation, paraphrasing, summarization and reflection of feelings). After attainment of a reasonable level in this skill, gradually more complex skills like reflection of meaning, focusing, influencing skills, confrontation, sequencing and structuring the interview and skill integration are learned. The necessity of mastering 'easy' before more complex skills, is the educational rationale and the ordering principle of this program.

3. Direct observation and feedback

A crucial variable in the design of interviewing programs is the provision for direct observation and feedback. Despite this platitude, it is nevertheless common in clinical teaching for interviewing students/residents not to be directly observed and commented on by their supervisor. In training programs feedback by video is a useful device, but the use of this technology may sometimes complicate the situation more than help it. During videotape replay students tend to pay a lot of attention to other aspects of the consultation, for instance problem-solving aspects, peculiarities of the case presented or their own physical appearance on the screen.

4. Standardized presentations of illustrative patient interviews

In their review Carrol and Monroe (1980) conclude "that standardized presentations of patients may be more effective for teaching clinical interviewing than live, spontaneous demonstrations of patient interviews". It seems likely that for demonstration purposes, recorded or edited interviews via film or videotape would be more efficient to illustrate certain skills than live, unrehearsed interviews. A 'spontaneous' interview may fail to exhibit expected interview behaviours, therefore a series of such demonstration interviews may exhibit only a limited range of relevant interviewing skills.

5. Continuity in training

Programs of interview training should have continuity through curricula or post-graduate training. The reason for this stems from our knowledge about the 'natural history of interviewing skills'. Several authors (Helfer, 1970; Scott et al., 1975) report on the development of the students' interviewing skills, when no formal training is provided during the medical curriculum. These studies show a general pattern of an increasing directiveness in the interviewing style, yielding more factual, organic information. However 'human aspects' receive increasingly less attention: students show a decreased tendency to use open-ended questions and to give reassurance, support and empathy. Consequently it has become evident that training programs were needed to counteract these deteriorating tendencies in the interviewing style of students and physicians.

6. Integrative teaching of behavioural, cognitive and emotional elements in medical interviewing

Proponents of 'confluent education' and 'experiential learning' (a.o. Rogers, 1957) stress integration of cognitive, behavioural and emotional (attitudinal) elements during learning processes. The attitude of the physician towards patients and their problems, determine to a large extent the interviewing skills. Nevertheless, some critical remarks should be made. Ajzen and Fishbein (1980) made an extensive study of the relationship between an individual's attitude and his behaviour. They concluded that the prediction of an individual's future behaviour (like interviewing skills) from his present attitudes has a low to moderate reliability. Situational factors (such as time restrictions, external pressures, unexpected incidents during the consultation hour) and the external norms (for instance, the influence of the belief that prestigious colleagues would or would not perform a certain behaviour) lower the degree to which behaviour is determined by attitudes.

Nevertheless in training programs attention should be paid to the physicians' attitudes and other emotional aspects, like (minor) countertransference reactions. As stated in the introduction the physicians' attitude to caring has remained a basic condition in his profession. The 'second stream education' at the Maastricht Medical School may serve as an example of an integrated program for physician-patient communication in the broadest sense. This program , with a small group teaching format, runs parallel to the 'main stream' of the first four years (the 'thematic blocks' of the curriculum). It consists of four parts, integrated into one teaching program:

a) Structured training courses in interviewing skills during the first four years of the curriculum. The skills are taught according to a hierarchy in complexity (like in Ivey's microcounselling method, mentioned earlier) and according to the students' needs born in clinical situations. The teaching format is a highly structured program with use of videotapes, that show each skill separately and in context. The courses consist further of role playing and exercises with videotapes presenting 'critical incidents' in demonstration interviews.
b) Interviews with simulated patients, where students may act as 'physician' and as 'critical observer'. Several students will interview the same patient, in such a way that the videotaped interviews can be compared. These interviews are reviewed by

peers, students and experts. Not only the interviewing behaviour but also other aspects of competence (diagnostics, treatment plan) are discussed.

c) Students have clinical experience in health care throughout their curriculum. Experience with actual patients may be subject of discussion within the small group. The emotional impact on the students by the patient and his problem gets attention. Problematic interviews caused by deficient skills or countertransference get attention. When a student has mastered an adequate interview technique, as he has shown in the past with simulated patients, the difference between a problematic interview with a 'real' patient and his usual interviews with simulated patients may be a strong learning experience (Smith, 1984).

d) Attitude-development.
Students' experience in health care practice, in interviews with simulated patients, but also experience with colleagues and educators can be further explored by the group. Attention is paid to the students' emotions, underlying norms and values towards patients and health care systems.
The main focus in this part of the program is on the behaviour of the student, interacting with patients. These interactions are analyzed using the models of Leary (1957), and with techniques of value clarification (Simon et al., 1978).

The same format may be implemented in the future training of general practitioner-residents, which will be extended to two years.

7. Teaching and evaluation

Evaluation should be closely connected with training programs for two mean reasons:

- To assess the effects of an **entire training program** (program evaluation). Independent variables in the program evaluation may be the content and objectives of the training program, the teaching format and methods, or the time investment of educators and students. The dependent (outcome-) variable in these studies are the (increased) level of interviewing skills of the students/physicians.
- To assess the progress of **individual students** on various types of interviewing skills as result of a training program. Furthermore, specific weakness may be pointed out to individual

students in order for them to make corrections in their interview behaviour (formative evaluation).

Data from both sources should be used continuously to adapt the training program. In the next section we will go more deeply into the results of the evaluation of our students and general practitioner-residents.

The student/physicians' levels of interviewing skills in primary mental health care, as result of training

The Maastricht History-taking and Advice Checklist (MHAC) was used to assess students' and residents' levels of interviewing skills.

The MHAC is based on the taxonomy of interviewing skills in primary health care, described in the previous section and in the appendix. The seven parts of the taxonomy constitute the item domain of seven corresponding subscales.

Evaluation studies with undergraduate medical students and residents in general practice yielded data for the assessment of their pattern of growth in these seven types of skills during the years of study.

These seven growth patterns which we characterize briefly, are the result of the integrated training programs described in the previous section.

From these findings some specific recommendations for training programs are derived.

1) Clarification of the request for help.

   Young medical students tend to listen to patients' stories, concerns, emotions and opinions about their illnessess. Later during their medical study they display these skills to a lesser extent or lose them completely, unless the training program pays attention to them. The reason for this fall in the collection of patient-centered information is the students' preoccupation with the diagnostic process and their concern not to miss a single detail in their patients' medical history.

   Our training program gives sufficient attention to the patient-centered information. The same development holds for the residents in general practice, who originally mastered these skills but easily tend to neglect or 'forget' them under pressure (time, patients with serious life-threatening problems, demanding patients). The training should be aimed to preserve these skills pertaining to the patient-centered phase of the inter-

viewing, which are extremely important in mental health problems.

2) History-taking
The skills in this phase grow during the undergraduate curriculum and become more efficient during the residents training (less questions yielding more relevant and accurate information). In case of obvious mental health problems some interviewers tend to neglect the somatic aspects during this phase. The result is sometimes a kind of counterpart of 'somatic fixation', sometimes called 'psychosocial fixation' (Grol et al., 1981).

3) Psychiatric examination
From our studies it became evident that students and residents neglect systematic questioning on symptoms and on psychological functioning. For instance questions about depressive symptoms, antecedents and consequences of anxiety and phobia or objective assessments of complaints about memory impairment are often incomplete or totally omitted. They frequently touch on many of these subjects, but don't probe more thoroughly or feel inhibited about asking more directive and closed questions.
It looks as if mental health problems force future physicians into a non-directive, counseling style, which is contrary to the more directive questioning, necessary during this phase of the interview (Goldberg, et al., 1982). Attention to these aspects appears to be a necessary component of training programs in primary mental health care.

4) Socio-emotional exploration
Often residents in general practice don't distinguish this phase of the interview from the phase 'clarification of the request for help'. As the style of the latter should be marked by open-ended, non-directive questioning with the patient frequently taking the lead, residents continue this style during the socio-emotional exploration that therefore often lacks systematic orderliness. Residents and students often explore - following the patients' flow of thoughts and emotions - pertinent and problematic areas of life in depth. However, they neglect sometimes to go into other areas of life, not spontaneously brought up by the patient like emotional aspects in human relationships. They are reluctant to go into these difficult areas for the patient, which may be loaded with shame and guilt. But neglecting strong areas of patient functioning may also be a result of this lack of 'broadness' in the socio-emo-

tional exploration. These points should be an issue of concern in interview training programs.

5) Presenting solutions
In case of mental health problems students and residents often tend to lose themselves in vague formulations while informing patients about the nature of their problems. The explanation to the patients themselves of their complaints in terms of stressful life-events/circumstances or underlying emotional conflicts is often superficial or totally omitted. The same often holds for the information about the rationale of the treatment plan. The negotiation process during consultation may be hampered by a deficient provision of information on the part of the physician. Data from our studies show considerable growth in these skills as result of training (Kraan et al., 1986), making this part of the interviewing program of great value.
Another argument for careful attention to this phase of the interview comes from the fact that general practitioners devote the bulk of the time during their short interviews to this 'presenting solutions' phase.

6) Structuring the interview
Students learn easily to structure the medical interview on somatic problems, as a result of the training program. However, in cases of mental health problems students and residents in general practice don't structure the interview very much. Opening and termination procedures of the interview are rather easily learned. However, the distinction between non-directive patient-centered parts (clarification of the request for help; some parts of the socio-emotional exploration) and systematic, physician-centered parts (history-taking, psychiatric examination) is often not sharply drawn in introductory statements and closing summaries.
Emotional exploration during the phase of presenting solutions (Schouten et al., 1982) is also often neglected or contaminated by the collection of new information, which should take place earlier during the interview. Although more difficult to learn than somatic problems, interview training programs in primary mental health should pay attention to these rather complex skills of 'structuring'.

7) Basic interviewing skills
Earlier we made the distinction between interpersonal and communicative skills. In our studies (Kraan et al., 1986) it was

found, that the net effect of the integrated Maastricht training program can be at best summarized as inhibiting in both types of skills. This decline, in the interpersonal skills especially, was described earlier as the 'natural history of interviewing skills'.
The communicative skills likely improve as a result of the more behavioural approach in the skill training part of the program (Goldstein, 1973; Ivey; 1983).
The interpersonal skills are favorably influenced by the Attitude-development part of the training program.
Although this differential effect of the Maastricht training program on interpersonal and communicative skills has not empirically been confirmed, we still recommend, particularly for residents in general practice, the earlier described integrative training approach.
Moreover, we found in our studies (Kraan et al., 1986) that residents show great variations in level when using the following complex interpersonal and communicative skills: focusing, summarization of emotions, content and process, confrontation, interpretation, self-disclosure (Brammer, 1973; Ivey, 1983). Although not so easily trainable, these skills should be improved in residents deficient in these skills, because of their importance to primary mental health care.

Concluding and summarizing remarks

The importance of the physicians' interviewing skills in primary mental health care is underscored by several arguments: the pivotal role of the physicians' interviewing skills for diagnosing and treating minor psychiatric syndromes, the need felt by physicians to improve the communication with patients in general and the present Dutch health care policy, allotting general practitioners a greater responsibility in mental health care.
Reviewing the literature and applying results of our evaluation research has yielded guidelines for the design of training programs for interviewing skills pertaining primary mental health care. Because explicit behavioural statements of interviewing skills to be learned is a necessary prerequisite we designed a taxonomy of skills. It was used as the base to construct an evaluation instrument to measure the physicians' skills in initial interviews, called the Maastricht History-taking and Advice Check-

list. This instrument is of value in the close connection between training and evaluation, which is needed to assess the progress of individual students and to study the effects of entire training programs.
Training should be structured in a way, that the interviewing skills will be taught according to clear objectives and proved educational methods. Direct observation and feedback as well as standardized presentations of illustrative patient interviews appeared to be decisive in the teaching methods. Further it is an important educational rationale to integrate behavioural and cognitive elements with emotional aspects. Emotions foster or hamper (e.g. countertransference) the physician in using the proper interviewing skills.
Evaluation studies showed deficits in the interviewing skills of students/physicians, providing further guidelines to determine the content of the training programs. Under external pressure students/physicians seem easily to neglect the collection of patient-centered information, failing to detect the essential request for help. Further some reticency is observed to ask for somatic information, when mental health problems are obvious. Often a lack in flexibility of interviewing styles is observed preventing the physician from changing from a non-directive to a more directive style, necessary in the interview phases such as psychiatric examination and some parts of socio-emotional exploration.
Finally, without training some basic communicative and interpersonal skills (e.g. reflection of emotions, summarization, checking of provided information) show a tendency to decrease. Complex communicative and interpersonal skills, like confrontation, interpretation, self-disclosure should be taught, because of their importance for primary health care.

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The main point of the discussion turned out to be the checklist itself and in particular the necessity for physicians to put all of the questions mentioned to their patients when examining them: does the number of questions the doctor asks, improve the conversation? Verhaak pointed to an ambiguity in the presentation. On the one hand the taxonomy was presented as a mere observation scheme, without any assessment aspects; on the other hand conclusions were being drawn on the students' performance. This might be incorrect: maybe people learn how to handle the conversation more efficiently during their studies, and how to get to know things without having to ask them. Agmon expressed similar thoughts: not putting all of these questions, she said, might be a matter of knowledge, more than a matter of interview style. Sometimes one is not able to ask the right questions, without knowing much. Sometimes, however, one doesn't ask all of the questions because one knows a lot and doesn't have to know more. Besides it is more than skill that characterizes a conversation. What is important in the contact between doctors and patients is also the physicians' ability to create an atmosphere in which the patient can talk freely about hidden things he might feel ashamed of. The doctor should not ask everything as that might be frightening for the other; instead he should give the patient the feeling that it is safe to talk. In this respect learning to listen might prove to be of more importance than learning to put the right questions.
Verhoeff also suggested that the figures presented might show that the scheme actually doesn't measure any 'skills' or 'knowledge' but merely the empathy shown by the doctor.

Katz wondered how the scheme might be used as an educational tool. What questions are a 'sine qua non', she asked, and what questions are not?
Talking on education Sofer put forward another problem. As the scheme is rather extensive, she wanted the educators who make use of it to make their students familiar, in an early stage of their training, with the physician's stress which is the result of the limited amount of time he can spend with each of his patients. Van Lieshout posed another problem; he felt a doctor didn't make use

of a checklist, but worked with a 'decision-tree', in which an implicit hierarchy might be found.

Reacting to the doubts expressed Kraan and the other Maastricht speakers stressed that their list should just be seen as a checklist, not all items of it being necessarily part of the conversation. Or, as Crijnen pointed out, it provides the students a framework which gives some impression of what they should learn. As students discuss the videotaped conversation, the instrument is also a teaching tool. It is no good, he added in reaction to Sofer, to fix a time limit in this learning process.
As Kraan explained, research is carried out at present to find out which questions in the scheme are the indispensable ones and which questions might be removed. In addition, a study will be undertaken in which patients will be interviewed on the quality of their doctor's work.
In reaction to the remarks made, Crijnen maintained that the different parts of the scheme did measure different qualities. Those parts dedicated to clarification and basic interview skills are related to interpersonal skills and empathy, the other parts to more doctor-oriented skills, because 'being empathic is not enough to make one a good doctor', as Zuidweg said. Aspects of the process were being measured, Kraan told Agmon, but the question arose as to how to teach doctors to create an open atmosphere and how to teach them to listen.

Teaching how to learn

Israeli experience in teaching communication skills to future primary care physicians.

In a response to the Maastricht contribution to the symposium, Margolis gave a broad outline of the experience gained at the Beersheva Medical School, part of the Ben-Gurion University of the Negev, in teaching communication skills to future primary care physicians.

First he said something about the background of the Beersheva curriculum. The new medical school has two important features:

- it has been established with the intention of trying to deliver people who are sensitized to primary care. As there are already three other medical schools in Israel (in Haifa, Jerusalem and Tel Aviv) it is this 'intention' that justifies the existence of the school;
- medical school and health services are merged. The school's dean, for instance, is also the director of the health services in the region.

The curriculum itself is based on the concept of spiral learning, which means that the students come back again and again to the same topic, but always at a higher level of sophistication. For example, in the area of interpersonal skills, students in the first year get some experience with interviewing, the main object of which is to get them to talk with people, not necessarily patients. In the second year they do the psychiatric interviewing course, which teaches them a scheme for more formal psychosocial learning, while in the fourth year they learn full scale medical history taking.

In the fourth and sixth years, during the primary care clerkships, they actually do a job as a clinical clerk in a primary care setting for four and six weeks, respectively. After the seventh year, when students have their MD-degrees but before the residency training, they may elect to do a year in a primary care clinic. Finally, they may elect to do a primary care residency, the most demanding of which is the family medicine residency, but a primary care track in pediatrics is being actively planned, and it is being considered in internal medicine. Eventually these people will hopefully change community care.

The primary care clerkships are seen as being the key experiences in learning interpersonal skills and psychosocial attitudes. Four months before the first clerkship in primary care was ever taught, a team which resembled an extended clinical team (including, among others, a social worker, a general practitioner, a pediatrician and a clinical psychologist), constructed a job description for the Israeli primary care physician describing which skills a practitioner should have.
The behavioural objectives for the primary care clerkships were then derived from this job description. As a member of the team, the student's job includes working with patients, structured home visits, participation in team meetings, coordination of care with consultants and also allowing oneself to be videotaped while interviewing actual patients.
The evaluation of the students work is related to the instructional objectives; the preceptor's evaluation is the most important.

This description of the Beersheva curriculum poses certain questions:
- is the idea of spiral learning a good one ? Do we know what to teach at the different levels ?
- do we know what to teach during the years of residency training ?
- do we know what interpersonal skills to teach in non-primary care residencies, like radiology and surgery ?

In answering one of Margolis' questions, Rabinowitz stated the importance of making medical students sensitive to their own feelings. Practical work might help in this respect, like role playing, in which students learn to control their feelings, of omnipotence or impotence, for instance.
Margolis said that a resident should be able to see himself as a learner. The fact that so many doctors left the Balint-group Dokter studied, might be due to their unwillingness to learn. Margolis' remarks led to a discussion on the topic of learning. Agmon sees a different attitude in undergraduate and graduate 'learners', the latter thinking: 'Now I know'. In the Beersheva Medical School sixth year students in particular prove to be little inclined to learn new things, occupied as they are with their future, while primary care residents are eager to learn: they can't yet handle the new feeling of not knowing the answers.
Gersons, while pointing to the fact that the young medical schools

in both countries, Maastricht as well as Beersheva, both stress the importance of teaching communication skills, wondered how much a student should learn: isn't there a danger of exposing him to these topics in a too early stage? What should be the optimum dose of skills to be learned? Katz agreed. It's important to see the danger, she said and teachers should be aware of it. Huyse also thinks Gersons' warning is important. A psychiatrist shouldn't try to teach surgeons all he knows about interpersonal relationships, just as surgeons don't teach surgery to psychiatrists. It is most important however, to be available: if a psychiatrist is 'there' he will be called upon when needed. On the other hand, Margolis remarked, surgeons do have communication problems which they should be able to solve themselves.
The discussion on learning was closed by Spenser who experienced a paradox: after being a teacher for twenty years, he says, his major function in teaching is to provide a role model of how to be ..... a learner!

14. USING VIDEO AND THE SUPERVISION OF COMMUNICATION GROWTH IN MEDICAL EDUCATION

C.A. Katz

In this article I want to share with you not only the tale of how I have reached a reasonably useful way of teaching systems thinking, using a triangular (or rhomboid) model for stimulated recall and reviewing videotaped in-vivo interviews, but also some explication of the beliefs and premises on which this endeavour has been based.

To talk about the supervision of communication skills I assume several sets of variables. Three critical ones are:

1. What category of behaviour does supervision belong to: to teaching, training, modulating or testing?
2. What do I mean by communication: mutual understanding, successful negotiations, adequate simplification of meaning or shared complexity of intention?
3. To which skills do I refer: context manipulations, successful persuasion, language (probing) as tool, listening as tool, language practice awareness - word usage, syntax, paralanguage or listening?

These sets form the context of what I wish to set forth here - the story of an effort to develop a mode of teaching communication skills to medical students and family practice residents, knowing that one meets students at particular junctures in an ongoing vocational life-cycle. Knowing, too, that in any meeting between any two people 'crosscultural understanding' is needed. Each participant in the conversation needs to translate in order to understand the other's meaning.

Belief and premises about teaching

1. Our understanding about the logic of conversation determines what we can teach about conversations: "All normal conversation is logical. With this understanding you will begin to hear not only what people say but also what they really believe. You will begin to hear a person's inner self talk, or even multiple selves in a single speaker; just as we can be of 'two minds'

about something, we can also follow different trains of thought, each with a compelling logic, simultaneously" (Cassel, 1985, p. 66).

2. There has been a shift in educational emphasis from factual knowledge towards methods of thinking. The basic goal is to have the student or resident think critically about what he does in his meetings with clients. He can learn to be more aware of his decision making process, and to further improve it.
3. The development of the professional self of the student depends on his specific and unique ways of seeking help and of helping (two faces of the same coin). Fostering his cultivation of an awareness of that duality fosters his growth in operating within systems.
4. Speaking of doctors and patients is always speaking about interpersonal relationships. There is therefore no escaping the mutuality of their encounter, or the dynamics of its product.
5. The physician-patient encounter always has status and power aspects. Its aim is achieving co-operation on a shared endeavour. To learn to work the a-symmetries, to the patient's advantage, one must become a student of systems thinking. The student-supervisor encounter works likewise. In the one, the hierarchical structuring is upward (being supervised) and in the other downward (interviewing patient).
6. One of the core resistances to learning is that one must expose his weaknesses and dilemmas in order to learn and to do this in the face of possible consequences to status or advancement. Thus, cushioning, framing the exposure is critical to usefully maximizing it.
7. Learning to listen is an on-going process. There are always new potentialities for growth, of an increasing complexity. That is, it is possible to become a better communicator.

Communication is behaving

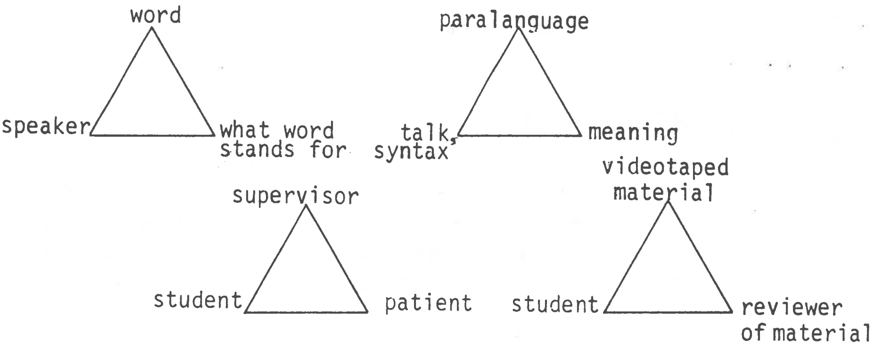
The goals in my communication work are fostering apprehension, training in modulation and improving the student's ability to live with uncertainty.

Today's technical possibilities make holding up a dynamic mirror to the student a relatively easy task. The student can be videotaped in his client encounters and in his supervisor-encounters vis-à-vis those client-meetings and can review with the pos-

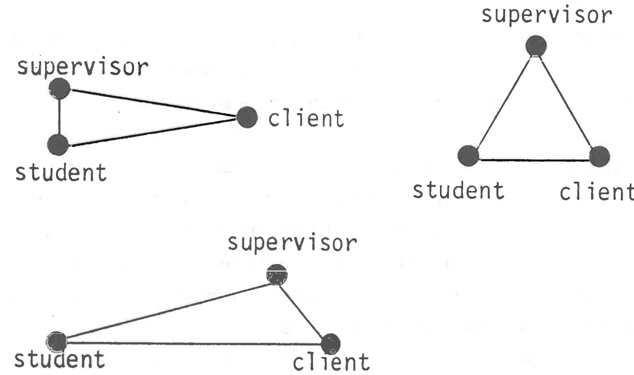
sibility of 'stills', 'repeated review' slow downs and other techniques that video allows. Videotaped recordings capture and hold episodes. Videotaped episodes can be compared with the criticism created and its referential adequacy determined.

Facilitation of a student's or resident's confrontation with his performance can become a major way of fostering his apprehension of his own behaviour, modulation of his own communication decisions and tracing of his own improved dealing with uncertainty. These three (apprehension of self, modulation and monitoring of behaviours, and dealing with uncertainty) are critical to the developing of 'perspective' on self, which slowly promotes professional growth. To teach 'communication' is to teach perspective. I am talking about a certain kind of process, of non-summative evaluation. In addition, playback features of videotape make it possible to scrutinize expression, tempo, explanation and movement (Heilveil, 1983).

The parallel process is obvious but worth spelling out:



Focusing on our key 'triangle' (medical student - supervisor - patient) we may assume that persons will vary on many parameters, like distancing, for example:



It is not that one of these is preferable that is the issue, but that the student can come to know his own tendencies, be more conscious about how he distances, in general, his decision making process and thus urged to assume responsibility for the freedom he exercises. Needless to say, working with supervisors using this triangular model is very possible.

Skills and developmental objectives

In the context of working with medical students and physicians on communication issues the point is not to choose between the protocol oriented thinking or the systems-oriented thinking but to dare to work on both, and thus on both sides of the brain (see table 1) (see next page).

This cannot be done all at once. One must organize the goals in some sort of an on-going, sub-suming mode, at least as to emphasize and build one's 'lesson plans' accordingly. Doing this three additional developmental tracks should be taken into account:

1. where the individual student is in his own thinking, over what communication issues he is puzzling, probing, ambivalent or stuck.
2. what common issues his peer group is concerned with.
3. at what formal stage of vocational development he is (first year medical student, second year residency and so on).

Table 1: moving from emphasis on linear thinking to additional emphasis on context or systems thinking

linear thinking	context thinking
protocols	metaphors, myths, private languages
reality testing	support for subjective realities
specific terminology	inter-subjective dictionary
observer status	catalyser
authoritative mode	empowering mode
exactness	complexity
focus field/focus	
reduction	circularity
diagnosis→change	change→diagnosis
dealing with symptom bearer and unknowingly affecting family	knowingly intervening with family, dealing with symptom bearer.

Contemplation of the student's or resident's encounter with self must assume not only Engel's critical systems thinking (from cell to society) but also the interfering interlocking system of individual development level, Ericsonian development stage, cohort engagement and specific end point to vocational teaching.
This does not supersede the use of check-lists. Personally, I think such checklists are useful to the student (to set out an over-all frame of 'what is expected of him') and to the supervisor, as a guide as to what specific territory has or has not to be covered. I find check-lists not much more useful than that, although I respect that for some teachers, they are fundamental tools. I think that the variety of 'maps' of individual work among supervisor-student-patient must in some way reflect the territory, but need not be so specific to it (Cole, 1982, p. 667).

This does not preclude an orientation of 'catch as catch can', of naturalistic 'learning according to opportunity' or of serendipity. But many supervisors are too uncomfortable, for whatever reasons, with such an existential pedagogical program. It does preclude a communications teaching approach which deliberately or assumptively eclipses a mooring in the various subjective aspects of the inter-subjective, physician-patient or physician-supervisor relationships.

Professional persuading

Encouraging a resident or medical student to perceive himself as his own basic tool, entails en-couraging (in the sense of promoting in him the courage) to perceive himself as having a style which he can extend and modify, and to perceive the importance of learning about persuasion, engaged in a context of negotiation. All of these (persuasion, personal style and negotiation) go against the grain of the traditional emphasis on protocols, on specificity and reduction. And yet, believing that the physician needs both sides of his brain entails training him as a communicator to function in both linear and analogic modes, not all at once, but in an ongoing process of exposure to self.

Exposure to self

Once we have made the assumption that there is no self-proof (self-free) way of becoming a professional communicator, on the one hand, and have acknowledged the human tendency to reduce information, so as to reduce uncertainty, to 'fix', to calibrate, so as to stay on a clear course, we can attend to the implication of how people process information: "How people process information (...) through sensing, imaging, feeling, thinking and acting. In exploring the phenomena at the boundaries of interface between people, we have uncovered generic systems pertaining to all people, relating to one's sense of self, aspects of self, and the fit, the interactive dance of physical and verbal behaviour with others" (Duhl, 1983, p. 163).

Exposure to self means exposure of self. If we are to go beyond a dydadic interior dialogue with self, or self and video tape of

self, to the more complex, and therefore challenging triangle of self, image of self (videoed or otherwise) and supervisor (peer or otherwise) the challenge is to the ability of the individual to focus on his perceived weaknesses and to bring them to another person rather than to deny or conceal them. The parallel process between this and the patient's coming to the physician is obvious. The atmosphere, the ambiance of the encounter becomes crucial to what the student or trainee will dare to perceive, dare to expose, dare to discuss. Thus we promote the rather protected, insulated and relaxed context mode of the actual training/teaching encounter. Whereas the exposure is maximal and inevitably anxiety producing, the teaching setting is paradoxically and deliberately moratorium-like, laboratory-like, as non-judgmental as possible.

Before detailing the style of my tape-processing procedures, I would mention that this non-judgmental mode is the rule governing other largely experimental learning tasks I and my colleagues use: simulations, Balint-groups, family presentation, peer supervision tape review, exercises such as 'how do I best learn?', 'gestalt parts party', map-building (individual/group, sub-group) of terms such as 'crisis', 'change' and 'health'.

Video review

In deciding how to design 'stimulated recall' we must reflect on the particular culture of the particular medical school and on manpower availability. Personally, I think at least one member of the team should have an on-going clinical commitment.
Variety and modes of recall processing are delimited by the assessment of possibilities in a particular setting and the particular teaching biases and peculiarities of staff themselves. Thus wide use of live simulation and pre-packaged tapes are, to my mind, a function of supervision style and creativity, and the amount of daring to work in-vivo.

My procedure with undergraduates has been to do on-site video-taping

- of the discussion between student and myself, or nurse, or whoever chooses the patient/interviewee.
- then of the session between clerk and patient where
  (a) supervisor is present or not, according to his usual prefer-

ence

(b) I am active or not (besides my filming) according to previous rapport with student and others, and

- then of the meeting between supervisor and clerk (with or without presence of patient according to the supervisor's mode).

As near to the date of filming two to four such consecutive meetings, the clerk is invited to review the tapes with me. He will have been encouraged to first view them on his own. It will be his option to invite his supervisor to also be present in the review session (a session lasting anywhere from an hour to four). Subsequent sessions occur in about 20% of the cases - either for remedial or for follow-up, or for enrichment purposes.
For the duration of the work, my loyalty is, a priori, to the student. Thus I do not have the supervisor's problem of resolving loyalties to patients, to supervisor and to his setting.
The clerk may focus on his own behaviours, his appearance, his listening, the difference in the way he relates to the patient and to the supervisor, the difference between his dealing with the patient and the supervisor's, paralanguage features (speech-rate, pause-speech rate ratio, tone or voice quality, volume, articulation), choice of words, sentence construction, logic (orderly, complicated, ambivalent, magical....), his confrontation and dealing with patient's private language, his non-denotative word-meanings. I try to facilitate this and to have him evaluate himself. My parting question revolves around what aspect of his communication he would like to next concentrate on.
There are modifications of the above when I work with the supervisor on his work, but the mode is the same. There is often more emphasis on the therapeutic possibilities of the spoken language, and the dealing with multiple loyalties.

This method has the limitations of 'buck-shot' work. It is not continuous enough. This can be somewhat circumvented by holding on a tape, for the student (or clerk, or resident), clear segments of his work at various intervals, from his first to his final year in medical school or residency.
It has to its advantage the intensive individual quality of the work (the review meetings are private 'sessions') and that it is structured (in-vivo, multiple personae) as to allow for much intrinsic complexity to be explicated. As a non-reductionist, systems-oriented teacher, promoting this dealing with complexity is

not only a pedagogical option, but a value.

With residents, I have been able to use an on-going (20 - 30 sessions over eight months) peer-supervision model, where colleagues are usually in the role of supervisor. This has allowed me to also use processing of the group dynamic, to deliberately interject topics (e.g. telling 'bad news' and accepting or rejecting 'gifts') and to foster the group's evolvement into a support group. Details of this, I shall leave for another occasion.

In summing up, although the fundamental assumption of medicine is that the mutual relationship between doctor and patient is inherently benevolent (they are not basically adversaries), the medical interview is also endemically characterized by conflict. It is always a cross-cultural meeting and in order that there be a 'meeting of the minds' the physician must exercise the powers of his professional negotiation skills.
Examination of the logic of conversation, with all that it can reveal of the symptoms, beliefs, assumptions and premises of patients as well as those of his physician, is a tool that serves this relationship.

Attending to and developing these skills can entail a whole set of confrontational self-exposures which will promote the physician, as a professional communicator, in the art of practising medicine. To this end, the processing of video-material can be a blessing. Artful processing can also be a learned set of skills.

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IV. RESEARCH ISSUES

15. CLASSIFICATION AND COURSE OF NEW MENTAL HEALTH PROBLEMS IN PRIMARY CARE*

F.W. Wilmink, J. Ormel, R. Soeteman, K. van der Meer, B. Krol and R. Giel

1. Introduction

Much of a general practitioner's time is devoted to interviews with patients suffering psychological distress. Often, this distress is expressed in somatic complaints. Although the estimates vary, most studies (e.g. Bensing et al. (1980), Verhaak (1981)) report that the percentage of interviews where psychological distress plays a role in the symptomatology is in the 40-70% range. On the average these interviews take more time than interviews with patients with purely somatic complaints (Bensing, 1984). Not much is known, however, about how well general practitioners identify these patients and which factors are responsible for non-identification, nor about the course of the symptomatology and which factors are determinants of this course. As a consequence, not much is known about whether identification can be improved and whether better identification leads to better treatment and an improved prognosis. In this paper, we shall describe a study which tries to assess the course of the symptomatology and the determinants of this course. It also addresses the issue of identification and two factors which may influence the identification, viz. the severity of the symptoms and the attitude of the general practitioner towards his patients. The main purpose of the study is to arrive at a multi-axial classification of patients with mental health problems which has prognostic value. The explicit formulation of such a system may improve the identification and give guidelines for optimal treatment (Goldberg, 1982). After the description of the study, some preliminary results on case identification by general practitioners are presented.

2. Course of mental health problems and determinants of the course

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From several studies (e.g. Harvey-Smith and Cooper(1970), Giel et al. (1978), Mann et al. (1981), Huygen et al. (1984)) one can conclude that about 30% of the patients presenting symptoms of psychological distress recovered after one year, about 50% improved, while some 20% did not improve.
However, such figures must be considered with great caution, as care definitions vary among studies, while, too, 'old' and 'new' problems are considered jointly.
In a review of longitudinal studies on the course of psychological distress Ormel and Giel (1983) conclude that six factors explain 50-70% of the variance in outcome. These factors are

1. clinical severity of the symptoms
2. personality factors
3. presence of physical illness
4. extent and quality of the patient's social network
5. distressing social or socio-economic situation
6. presence of mental health problems in the patient's history.

The reader will note some resemblance between these factors and the five axes of the the DSM-III system, although the latter system focuses on the more severe symptomatology. We suggest that these six factors be used in the construction of the beforementioned classification system that should be of help to the general practitioner in establishing appropriate treatment and prognosis. From evaluation of the course of the symptomatology the system can be subsequently adapted according to the findings. The study from which we present results was set up along these lines.

3. Design of the study and instruments used

In this section we shall describe the design of the study and the instruments used in a shorthand manner. For a more detailed description, the reader is referred to Giel et al. (1986).
Twenty-five general practitioners were sampled with stratification on their attitude towards patients (see next section). They saw some 2800 patients between 16 and 65 years old. A form was completed by the general practitioner for all these patients. Furthermore, each of the patients was handed a General Health Questionnaire (GHQ).

The GHQ is known to correlate substantively with psychiatric caseness and is widely used as a screening instrument.
The general practitioner was asked to decide whether the symptoms presented could be considered as expressing or being related to psychological distress.
Also, he or she had to determine from his/her files whether the patient had presented symptoms expressing or being related to psychological distress in the past year. If so, the patient was considered 'old' unless the symptoms had begun in the past month. Otherwise the patient was considered to be'new'. The patient was considered to have a mental health problem (MHP) if the general practitioner labeled the symptoms as expressing or being related to psychological distress , or if the GHQ-score was 5 or above, or both.
Every 'new' patient with a MHP in the view of his/her general practitioner was interviewed, as well as one-third of all other 'new' patients with a MHP. Furthermore, some 60 patients without a MHP were interviewed as well as some 45 patients with an 'old' MHP who were considered by the general practitioner to be chronic complainers. In all some 350 patients were interviewed, out of whom 50 participated in the pilot study done.
The interview addressed the six factors that were mentioned in the preceding section. Specifically, the clinical severity of the symptoms was assessed by taking the Present State Examination (PSE, Wing et al.(1981)). The PSE is a structured interview in which the presence, in the past month, of some 130 symptoms is assessed. By means of a computer program, the severity of the clinical picture is expressed on an eight point scale called ID, a value of 1 indicating no symptom present, and values of 5 or above indicating the presence of psychiatric illness. The validity of this procedure is widely accepted.
After about one year the 350 patients will have their second interview. In the meantime, their general practitioners keep record of all their contacts with these patients. From the resulting body of data we hope to be able to construct a classification system of MHP's in general practice with prognostic value.
By now, the first wave of interviews has almost been completed. The processing of the interview data, however, is rather time consuming so that at present we only have results for a subset of 161 patients. The results will be presented in section 5.

4. The identification of cases by the general practitioner

Probably the best known study on the identification of cases by general practitioners is the one by Goldberg and Blackwell (1970). Blackwell, being a psychiatrist who went into general practice, 'missed' one-third of the cases, where caseness was defined by psychiatrists. With broader definitions of caseness the difference between general practitioners in the fraction of patients labelled as 'cases' are impressive (e.g. Goldberg and Huxley (1980), Verhaak (1981)), some general practitioners seeing twice or thrice as many 'cases' as other general practitioners (Lamberts and Hartman (1982), Verhaak (1986)).
To some extent these differences can probably be explained by different definitions of caseness that general practitioners use, even in spite of explicit instructions given by the investigator. However, it is even likely that some general practitioners are more sensitive than others to mental health problems and more inclined to look for them. This might be reflected in the way they interact with their patients. In fact, Verhaak (1986) showed that the general practitioners' actual behavior towards his patients is reflected in his attitude to medicine in general. He developed a self-report questionnaire which reliably measures five aspects of this attitude, viz. the estimated influence of psychological factors on 12 diseases (like such as myocardial infarction and rheumatic arthritis), the risk the general practitioner is willing to take by not referring to a specialist, his willingness to cooperate with the patient, his opinion about which psychotherapeutical tools should be within the scope of the general practitioner and whether he feels competent to use these tools. The total score was shown to correlate about .70 with behavioural measures like attention, posing open-end questions and clarification of the problem for which help was sought. The question to be answered in this paper was whether the score on this questionnaire was correlated with the number of psychiatric cases identified by the general practitioner.

5. Some preliminary results

At present, we have only two subsets of data at our disposal, one originating from the pilot study, and the other consisting of the first 161 respondents that are 'new' and have been interviewed. It

was also known how many patients had been seen by all participating general practitioners. From the pilot data we were able to predict expected numbers of 'old' and 'new' patients, and for the 'new' patients how many would be classified by either general practitioner or GHQ or both as having a MHP. These numbers agreed quite well with the numbers that were actually observed (these numbers were: observed 18, 52, and 50, expected 17, 46 and 49, the remaining respondents being either 'new' and not MHP or 'old' and MHP). We have therefore extrapolated the results from the observed subset to the total number of 2499 patients who filled in the GHQ. These extrapolated figures are given here, and it will be clear that they must be considered as provisional. In Giel et al. (1986) the definitive numbers will be presented.
About 50% of the patients returned the GHQ spontaneously, another 40% did so after a reminder. Of the patients that were selected for an interview, again some 10% refused the interview. We have some data on these non-responders as they usually returned the GHQ form on which several additional questions were asked as sex, age, marital status, etcetera. Similar data are available from the form the general practitioner has completed for each patient. We cannot yet present results, however.
Of all patients, some 30% had contacted their general practitioner for a MHP in the last year. Of these, about 20% were considered to be chronic complainers by their general practitioners (with considerable variation among general practitioners) and of these 40% was found to suffer from depression according to the PSE, unrecognized by their general practitioner. In view of results presented by Katon (1982) that depression is one of the underdiagnosed diseases in general practice, being recognised in about half of the cases, this result should not come as a surprise. Nevertheless, we feel that a figure of 40% is impressive and accentuates what was said in section 1 about the possible improvement of prognosis by better recognition of these and other states.
The general practitioners were divided into three groups, viz. high scorers (having a family medicine attitude, n=7), low scorers (having a clinincal attitude, n=7) and a middle group (n=11). They saw 750, 603 and 1146 patients, respectively.

5.1. Relationship between GHQ and PSE

It will be recalled that a score on the GHQ of 5 or above

indicates the probable presence of psychiatric illness, and that a value of 5 or above for the ID of the PSE indicates the presence of psychiatric illness. Making a cross table, we found (from 'new' patients who returned the GHQ and did not refuse the interview) the following results:

	ID 5+	ID 4-	
GHQ score 5+	86	399	485
GHQ score 4-	4	767	771
	90	1166	1256

These figures indicate that in a sample of general practice patients the GHQ with respect to the PSE has high sensitivity (86/90 =.96) and moderate specificity (767/1166 =.66).These results are in line with previous results (e.g Hodiamont and Veling (1984)).
The moderate specificity is usually explained by means of two arguments. First, physical illness can produce 'no' answers to GHQ questions like "have you been getting out of your house as much as usual", thus producing false positives. Second, some people with trait neuroticism may give 'scoring' answers even while not contacting their general practitioners for their problems. In more refined analyses it may be possible to differentiate between these two groups and the patients who have recently acquired symptoms of psychological distress.

5.2. General practitioner and GHQ

The next step is to compare the judgement of the general practitioner with the patient's score on the GHQ. For the 'low', 'middle' and 'high' group of general practitioners we find the following results:

G.P.	MHP	GHQ 5+	GHQ 4-		
'low'	+	23	8	31	sensitivity = 23/94 = .24
	-	71	201	272	
		94	209	303	
'middle'	+	53	21	74	sensitivity = 53/220 = .24
	-	167	335	502	
		220	356	576	
'high'	+	41	12	53	sensitivity = 41/171 = .24
	-	130	194	324	
		171	206	377	

From these results it is clear that the general practitioner's attitude does not influence his sensitivity for MHP's if the criterion is the GHQ.
Nevertheless, this sensitivity is low, but this could be due to the relatively large number of 'false positives' that the GHQ produces when compared with the PSE. One might argue that the general practitioners correctly identify the 'true positives'. But from the final section is is apparent that this line of reasoning doesn't hold.

5.3. General practitioner and PSE

In this section we use the PSE as the criterion against which the judgement of the general practitioner is evaluated. In doing so, we find the following cross table:

PSE-ID

GP	MHP	5+	4-		
	+	10	21	31	sensitivity = 10/26 = .38
'low'	-	16	256	272	
		26	277	303	
	+	23	51	74	sensitivity = 23/36 = .64
'middle'	-	13	489	502	
		36	540	576	
	+	20	33	53	sensitivity = 20/28 = .71
'high'	-	8	316	324	
		28	349	377	

If the observed sensitivities could be interpreted as independent success probabilities, the difference between .38 and.71 would be significant at the 1% level.
Because of the extrapolation made, however, such an interpretation is unjustified here. Nevertheless, the results are suggestive of a hypothesis that recognition of psychiatric cases by a general practitioner depends on his/her attitude towards medicine in that family medicine minded general practitioners appear to recognize psychiatric cases better than more clinically orientated general practitioners.

6. Conclusion

In the previous sections we have examined how well general practitioners recognize symptoms of psychological distress in patients who have not consulted their general practitioner for such symptoms in the past year. From the results, which were extrapolated from incomplete data, it appears that the attitude of general practitioners towards medicine as defined by the poles 'family medicine orientated' versus 'clinic orientated' is correlated with the number of psychiatric cases identified. A more refined analysis of the complete dataset, however, is necessary to substantiate

this conclusion. The results of that analysis will be presented in due time in Giel et al. (1986).

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16. THE CLASSIFICATION OF PSYCHOSOCIAL DISORDERS IN PRIMARY CARE

T. Spenser

A classification of health problems is an essential basic communication tool for service, teaching and research. It is a dry subject to talk and write about, but nevertheless fascinating - for compulsive types.

The International Classification of Diseases of the World Health Organization (WHO) and especially its ninth revised edition (ICD-9, 1975) is the basis for all classifications. It consists of seventeen main sections and two supplementary sections, of which three are especially relevant here:

- V: 'mental disorders'
- XVI: 'symptoms, signs and ill-defined conditions'
- V-code: 'factors influencing health status'

The ICD-9, however, has two main drawbacks. In the first place, it is too detailed to be convenient as a working tool for general practice and not detailed enough for psychiatry. Besides, its fifth section includes glossary descriptions, but no diagnostic criteria.

Therefore, both psychiatrists and general practitioners have developed their own modified classifications, with diagnostic criteria added.

The psychiatric classification is the Diagnostic and Statistical Manual of Mental Disorders (DSM-III), developed by the American Psychiatric Association in 1980. The classification used by general practitioners is the International Classification of Health Problems in Primary Care (ICHPPC-2) developed by the World Organization of National Colleges and Academies of general practitioners and family physicians (WONCA) in 1983.

Both DSM-III and ICHPPC-2 are fully compatible with ICD-9, which is essential, especially for joint research projects.

In addition, Israeli general practitioners have developed a shortlist of ICHPPC-2, also fully compatible.

The difference in detail of all these lists reflect the **quantitative** differences in clinical content of the daily work of different health professionals. In primary care, for example, the shortlists reflect a relative predominance of contacts on the symptomatic level (ICD-9, section XVI). Table 1 illustrates this point.

Table 1: comparison of the number of rubrics in three areas of four classifications

	total number of rubrics for all health problems	number of rubrics for symptoms (ICD-9, XVI)	number of rubrics for psychosis
ICD-9 (1975)	several thousands	91	64
DSM-III (1980)	not relevant	0	95*
ICHPPC-2 (1983)	367	34	6
Israeli short-list of ICHPPC-2 (1985)	197	38	3

* not strictly comparable, as psychosis does not appear as a group in DSM-III.

In addition to its diagnostic criteria, the DSM-III's special feature is its systematization of the bio-psycho-social approach by building five axes into each diagnosis, adding to the ICD codes (axis 1 and 2) a physical, social stress and functioning evaluation. This is an enormous contribution to the development of communication between psychiatrists, family physicians and other mental health professionals, both medical and non-medical.

What follows are some relevant sections of the ICHPPC-2 classification, its Israeli short-list and examples of diagnostic criteria.

Psychoses and neuroses (or neurotic disorders) **as groups** still appear in ICD-9 and also in ICHPPC-2 and its Israeli short-list. Figure 1 shows this section of ICHPPC-2 (see next page).

In DSM-III, however, these groups are no longer included. One reason is the lack of consensus as to how to define them. Another is DSM-III's attempt to create a different hierarchy of mental disorders which allows inclusion in one category or rubric of both

Figure 1: Section V (mental disorders) in ICHPPC-2

Position no.	*ICHPPC code*	*List of diseases, disorders, and health problems*	*Changes from ICHPPC-1*	*Comparable ICD-9 codes*
		V. MENTAL DISORDERS		
		Psychoses (except alcohol & drug induced)		
66	**294-**	**Organic psychosis** *incl.* non-alcoholic acute or chronic delirium, senile & presenile dementia	L	290, 293, 294
67	**295-**	**Schizophrenia, all types** *incl.* paranoid states & reactions		295, 297, 298.3, 298.4
68	**296-**	**The affective psychoses** *incl.* psychotic depression, involutional melancholia, mania, hypomania, manic-depressive, reactive depressive psychosis	L	296, 298.0, 298.1
69	**298-**	**Other & unspecified psychoses** *excl.* alcoholic (3031)	L	298.2, 298.8, 298.9, 299
		Neuroses		
70	**3000**	**Anxiety disorder, anxiety state** *excl.* anxiety causing a somatic complaint (3001)	W	300.0
71	**3001**	**Hysterical & hypochondriacal disorders** *incl.* factitious disorders, compensation neurosis, conversion hysteria, hysterical state, anxiety causing a somatic complaint, hyperventilation syndrome, cardiac neurosis *excl.* psychogenic disorders of sexual functions (3027), tension headache (3078), insomnia (3074)	W	300.1, 300.7, 306
72	**3004**	**Depressive disorder (neurotic depression)** *incl.* depression NOS, *excl.* brief depressive stress reactions (308-)	W	300.4, 311
73	**3009**	**Other neuroses** *incl.* neurasthenia, phobic state, obsessive compulsive disorders, occupational neurosis, neurosis NOS	W	300.2, 300.3, 300.5, 300.6, 300.8, 300.9

'psychoses' and 'neuroses'. An example is the rubric 'affective disorders' (mood disorders), which includes both manic-depressive psychosis ('bipolar disorder') and neurotic depression ('dysthymic disorder').
What is important, therefore, is to look at the diagnostic criteria of the individual clinical entities (rubrics).
Below two examples are given of diagnostic criteria.

As for **'schizophrenia'**, the criteria used in DSM-III refer to a group of schizophrenic disorders, in which five types are coded and further defined (figure 2) (see next page).

In ICHPPC-2, the criteria refer to 'schizophrenia', without further sub-coding. In this classification schizophrenia is defined as "a disorder of at least six months duration, which grossly impairs the patient's capacity to meet ordinary demands of life, without evidence for primary mood disorder, primary drug abuse, or organic brain syndrome, which shows one of the following:
- disordered thought (illusions, delusions, hallucinations or paranoïd state);
- disordered mood (ambivalence, constriction or inappropriate mood);
- disordered behaviour (withdrawal, regression, bizarre behaviour, catatonia)."

The main difference between the two criteria definitions is their length (detail) and is appropriate to the frequency with which each psychiatrist and family physician, respectively, encounters schizophrenia. (Generally the ICHPPC-2 definitions are shorter in order to keep the book to a manageable size).

The two definitions are, however, quite compatible and it is not by chance that ICHPPC-2 begins with the time factor (minimum duration of six months), non-compliance with which is responsible for occassional mis-diagnosis by all mental health professionals. All this assumes, of course, that the diagnostic criteria are accepted by the clinicians.

As for **'somatization disorder'** (ICD code 300.81), this entity appears for the first time in DSM-III, distinct from both 'conversion disorder' (300.11) and 'hypochondriasis' (300.70). It does not appear in the other classifications, except under 'other

Figure 2: Schizophrenic disorders in DSM-III

Schizophrenic Disorders

Diagnostic criteria.

A. At least one of the following during a phase of the illness:

(1) bizarre delusions (content is patently absurd and has *no* possible basis in fact), such as delusions of being controlled, thought broadcasting, thought insertion, or thought withdrawal
(2) somatic, grandiose, religious, nihilistic, or other delusions without persecutory or jealous content
(3) delusions with persecutory or jealous content if accompanied by hallucinations of any type
(4) auditory hallucinations in which either a voice keeps up a running commentary on the individual's behavior or thoughts or two or more voices converse with each other
(5) auditory hallucinations on several occasions with content of more than one or two words having no apparent relation to depression or elation
(6) incoherence, marked loosening of associations, markedly illogical thinking, or marked poverty of content of speech if associated with at least one of the following:
(a) blunted, flat, or inappropriate affect
(b) delusions or hallucinations
(c) catatonic or other grossly disorganized behavior

B. Deterioration from a previous level of functioning in such areas as work, social relations, and self-care.

C. Duration: Continuous signs of the illness for at least six months at some time during the person's life with some signs of the illness at present. The six-month period must include an active phase during which there were symptoms from A, with or without a prodromal or residual phase, as defined below.

Prodromal phase: A clear deterioration in functioning before the active phase of the illness not due to a disturbance in mood or to a Substance Use Disorder and involving at least *two* of the symptoms noted below.

Residual phase: Persistence following the active phase of the illness, of at least *two* of the symptoms noted below not due to a disturbance in mood or to a Substance Use Disorder.

Prodromal or Residual Symptoms

(1) social isolation or withdrawal
(2) marked impairment in role functioning as wage-earner, student, or homemaker
(3) markedly peculiar behavior (e.g., collecting garbage, talking to self in public, hoarding food)
(4) marked impairment in personal hygiene and grooming
(5) blunted, flat, or inappropriate affect
(6) digressive, vague, overelaborate, circumstantial, or metaphorical speech
(7) odd or bizarre ideation, or magical thinking, e.g., superstitiousness, clairvoyance, telepathy, "sixth sense," "others can feel my feelings," overvalued ideas, ideas of reference
(8) unusual perceptual experiences e.g., recurrent illusions, sensing the presence of a force or person not actually present

Examples: Six months of prodromal symptoms with one week of symptoms from A; no prodromal symptoms with six months of symptoms from A; no prodromal symptoms with two weeks of symptoms from A and six months of residual symptoms; six months of symptoms from A, apparently followed by several years of complete remission, with one week of symptoms in A in current episode.

D. The full depressive or manic syndrome (criteria A and B of major depressive or manic episode), if present, developed after any psychotic symptoms, or was brief in duration relative to the duration of the psychotic symptoms in A.

E. Onset of prodromal or active phase of the illness before age 45.

F. Not due to any Organic Mental Disorder or Mental Retardation.

neurotic disorders', but would most likely be mis-diagnosed as either 'conversion' or 'hypochondriasis', both of these being 'somatoform disorders'. Figure 3 shows the diagnostic criteria of 'somatization disorders' in DSM-III.

The importance of this entity for general practitioners lies in the fact that it depends on an accumulation of symptoms over the years in patients who consume a great deal of their doctors' time and nerves and the health care system's money, without benefit. These patients are an extreme demonstration of the need for a satisfactory classification of symptoms on the way to a diagnosis.

This is the advantage of ICHPPC-2, which lists thirty-four separate rubrics for symptoms in section XVI, the Israeli short-list containing thirty-eight!

Finally, figure 4 shows the section on 'mental disorders' (V) from the Israeli short-list of ICHPPC-2. This section is completed by one rubric from the 'supplementary classification' (V-code), entitled: 'All social, marital and family problems and maladjustments, including poverty, housing, educational, illegitimacy, occupational, legal'.

In conclusion, I have tried to show the relevance of the current classifications of psychosocial disorders to diagnosis, communication between clinical workers and joint research in the mental health field.

Figure 3: Diagnostic criteria of 'somatization disorder' in DSM-III

300.81 Somatization Disorder

Diagnostic criteria.

A. A history of physical symptoms of several years' duration, beginning before the age of 30.

B. Complaints of at least 14 symptoms for women and 12 for men from the 37 symptoms listed below. To count a symptom as present the individual must report that the symptom caused him or her to take medicine (other than aspirin), alter his or her life pattern, or see a physician. The symptoms, in the judgment of the clinician, are not adequately explained by physical disorder or physical injury and are not side effects of medication, drugs or alcohol. The clinician need not be convinced that the symptom was actually present, e.g., that the individual actually vomited throughout her entire pregnancy; report of the symptom by the individual is sufficient.

Sickly: Believes that he or she has been sickly for a good part of his or her life.

Conversion or pseudoneurological symptoms: Difficulty swallowing, loss of voice, deafness, double vision, blurred vision, blindness, fainting or loss of consciousness, memory loss, seizures or convulsions, trouble walking, paralysis or muscle weakness, urinary retention or difficulty urinating.

Gastrointestinal symptoms: Abdominal pain, nausea, vomiting spells (other than during pregnancy), bloating (gassy), intolerance (e.g., gets sick) of a variety of foods, diarrhea.

Female reproductive symptoms: Judged by the individual as occurring more frequently or severely than in most women: painful menstruation, menstrual irregularity, excessive bleeding, severe vomiting throughout pregnancy or causing hospitalization during pregnancy.

Psychosexual symptoms: For the major part of the individual's life after opportunities for sexual activity: sexual indifference, lack of pleasure during intercourse, pain during intercourse.

Pain: Pain in back, joints, extremities, genital area (other than during intercourse); pain on urination; other pain (other than headaches).

Cardiopulmonary symptoms: Shortness of breath, palpitations, chest pain, dizziness.

Figure 4: 'Mental disorders' in the Israeli short-list of ICHPPC-2

KEY WORDS

excl. = excluding
incl. = including
NEC = not elsewhere classified
NOS = not otherwise specified
NYD = not yet diagnosed
( ) = number out of sequence

V. MENTAL DISORDERS

069 Psychoses; *excl.* alcohol (080) and drug induced (083)
073 Neuroses;
incl. anxiety state, hysterical and depressive disorder

Other mental and psychological disorders

074 Specific learning disturbances and delay in development of certain skills needed for schooling;
excl. mental retardation (085)
075 Insomnia and other sleep disorders
076 Tension headache, psychogenic backache and other pain of mental origin (psychalgia);
excl. headache NOS (258), migraine (090), lumbalgia (238)
077 Transient situational disturbance, acute stress reaction, adjustment reaction;
incl. grief reaction
078 Behavior disorders (any age);
incl. hyperkinetic child
079 Sexual problems of psychogenic origin;
excl. marital problems (370)
080 Chronic abuse of alcohol; *incl.* alcoholic psychosis
082 Abuse of tobacco
083 Other drug abuse or addiction; *incl.* psychoses
085 Mental retardation
086 Others; *incl.* organic brain syndrome, personality disorders, stammering, enuresis of psychogenic origin

On finding a common language
Discussion

In the reactions to Wilmink's and Spenser's papers both the necessity and the opportunity to find a common language between primary care physicians and mental health professionals are under discussion. As Rabinowitz made clear, lack of communication between the two sectors of health care exists and agreement on a common language might be a good way to bridge the gap.
Kraan also paid a compliment to Wilmink c.s. and Spenser on their efforts. As to the first piece of research he stressed what to him was its major finding: that general practitioners with an open attitude towards mental health problems could recognize major psychiatric disorders, not minor ones. Wilmink agreed, adding later in the discussion that the implications of this finding were not too injurious, as most patients who visit their doctor do recover after six or seven months and only a small minority have serious problems, that need to be 'discovered'. And these problems, he said, are recognized by low scoring doctors just as well as by the others.

As a general point of criticism, Kraan expressed his doubts as to the validity of measuring attitudes in order to predict (in this case: interview-) behaviour. Verhaak reacted by pointing to the fact that the decision of a general practitioner to see a problem as a problem can also be regarded as an 'attitude'; the researchers in this respect do not measure the relation between attitude and behaviour, but between two different attitudes.
As for Schein's paper, Kraan wondered if the shortened Israeli classification scheme had any implications for treatment: 'Can it be used in a decision-tree?' Although stressing that that was not its purpose, Spenser agreed that application in practice ought to be the next stage in the long-term research planning process. Sofer did work with the scheme in her primary care clinic and she expressed serious doubts as to its usefulness: the scheme turned out to be difficult to get to know and - once known - was of little use, as many diagnoses were not covered by it at all. In the end, she added sadly, she 'dropped it completely'. To which Spenser retorted, that she might instead have turned to the other, more extended correlated international classification schemes, like ICHPPC or DSM-III.

Huygen advocated the opposite. In general practice, he said, only a small minority of the patients have serious diseases. A patient's main problem is often also expressed in continually changing complaints, which makes it necessary to tranfer these complaints from one category to another every few months. Consequently, it is difficult to design a distinction that is useful in daily practice. Instead, Huygen is inclined to put most of the psychological and social disorders a primary care physician has to handle into one 'box', labelled 'minor emotional disturbances'.

Agmon is worried. Communication between primary care and psychiatrists is important, and she noted with regret that in general practice categories are 'put together' while, on the other hand, in psychiatry a more and more refined classification scheme is needed. Though she understands the family doctors' need for a scheme that is easy to handle ('a general practitioner doesn't want all those papers which he requires because he is not familiar with psychiatric diagnoses') she is afraid the two disciplines will drift apart.
She summed up four reasons for classification: it is needed for administrative reasons (filling in forms, and the like), for research, for the making of treatment plans and in order to develop a common language.
Her remarks led to much discussion. Margolis felt that it might be helpful to discuss the problem by taking specific cases and exploring why differences between psychiatrists and general practitioners arise. Verhaak pointed to the poor theoretical base of psychiatry which makes it hard for psychiatrists - as opposed to, for instance, internists - to show why a distinction between several categories is important, the implications for treatment being the same.

Maoz thinks classification is an historical document: it gives an idea of the way people in different ages feel about psychiatry. In practice classification is needed as a language used for communication. In order to classify referral letters as 'good' and 'bad' ones, the language used by the general practitioner is an important tool: does he use a psychiatric term without seeming to know what is meant by it, or does he prove to know, in his referral letter, why he thinks the term is appropriate? The problem is, Maoz said, that most of the psychiatric classification

is based on hospitalized patients' problems. What is needed is to come to terms with general practitioners, to 'sit together' and find a less complex classification for ambulatory disorders. As long as this type of classification doesn't exist, psychiatrists will speak two languages: one with their fellow psychiatrists and one - a much simpler one - with general practitioners.
At the end of the discussion Gersons brought back a question discussed earlier: is mental health care really a vital component of primary health care? Though not sure of the answer to this question himself, Gersons felt that in practice a common language between psychiatrists and general practitioners does exist. A term like 'neurosis', for instance, is of little use to both professional groups and general practitioners make use of the same axes as do the psychiatrists in the DSM-III classification scheme, because, as he put it, 'no good classification is possible without a multiaxial system'. Time was lacking for any comments on this provocative conclusion.

17. INTERPRETATION AND TREATMENT OF PSYCHOSOCIAL COMPLAINTS BY GENERAL PRACTITIONERS

P.F.M. Verhaak

During the last few years a heated debate has been carried on as to the general practitioners' role in the detection and treatment of psychological, psychosocial or psychiatric complaints. To what extent should psychosocial problems been treated in primary care? Is the average general practitioner capable in detecting and solving this kind of problems? These and other questions are put forward and are certainly not answered yet. (Compare for instance the contribution in this reader by J.M. Bensing).
Being a research fellow I cannot give any conclusive or decisive answers to questions raised by this debate. What I can do, however, is to present some of the results of an investigation of ours which was aimed at finding those factors that influence the way general practitioners interpret and treat psychosocial complaints.

It seems that the assessment of complaints differs considerably among general practitioners, in the sense that one particular general practitioner attaches significance to psychological and social factors in very many more cases than others. The frequency with which general practitioners prescribe psychopharmaca, refer patients to mental health care facilities, or even enter into therapeutic discussions appears to vary from one doctor to another. (Shepherd et al., 1966, Goldberg and Huxley, 1980)
These differences represent a difference in the bias of doctors towards psychiatric assessments only: nothing is said about the accuracy of the judgement. However, in our opinion, to talk about the accuracy of a general practitioner's judgement of his patients' complaint - does it have a non-somatic component in it or not - is extremely difficult. In our view, in the daily practice of a general practitioner we cannot speak of 'psychosocial diseases'. We can only speak of patients who ask for help for complaints which the doctor judges to be not merely physical (Kraüpl-Taylor, 1971).
It is significant that not every complaint has to be allocated either to the class of somatic disease and symptoms or to the class of psychosocial problems or psychiatric 'disease', but that it can have both a physical aspect and a psychosocial one. If we take the line that psychosocial complaints are not natural units

of assessment, but based on the interpretation of those who judge them, it is not surprising that we encounter such variety in these judgements.

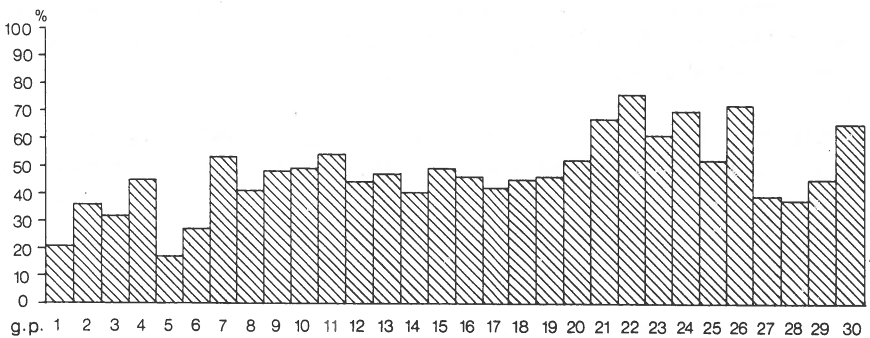
To study the factors that are related to a general practitioner's interpretation and consequential treatment of complaints, we have used a field study design, in which thirty general practitioners participated.
About fifty randomly chosen consultations done by each of these doctors were videotaped. From observation of the tapes we collected data on the treatment given and on the doctor-patient communication. In addition, each complaint in each consultation was judged by the doctor himself in one of the following categories:
- this complaint is strictly somatic
- this complaint is mainly somatic, but mental factors come into play
- this complaint is presented in somatic terms, but I suppose that mental factors are behind it
- this complaint is mainly mental, emotional or social.

Further, expectations of doctors and patients in respect of one another were collected on a questionnaire, one for each consultation.
Finally, the general practitioners filled in a single questionnaire on their views and norms and on some of their personal and practice characteristics.

We now come to discuss the differences between general practitioners in interpretation and treatment of psychosocial complaints; we will also focus on the factors that might explain this variance.
Figure 1 shows the proportion of complaints that each general practitioner judges to be not merely somatic (see next page).

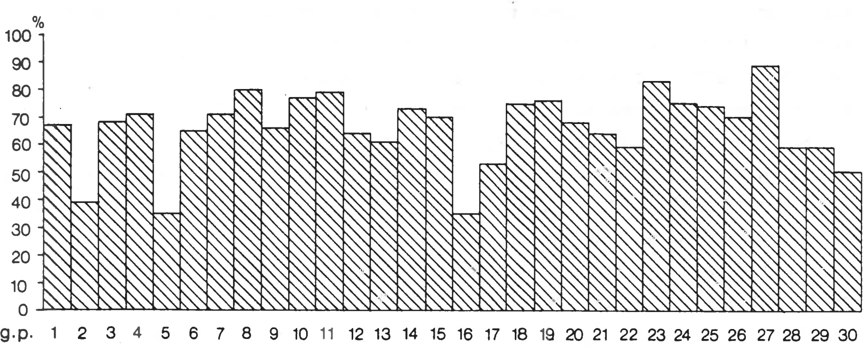
We see marked differences: while doctor 5 interprets 17% of all complaints as not merely somatic, doctor 22 thinks so of 76% of the complaints.

Figure 1: proportion of complaints that is judged by the g.p. as 'not merely somatic'



By observing the consultations, we could assess the treatment of those complaints that either the general practitioner or the observing research-fellow judged to be not merely physical.
In figure 2 we show the proportion of these complaints that received attention in some way: the doctor did some counseling, gave a prescription or advice, or referred the patient to a more specialized agency.

Figure 2: proportion of recognized non-somatic complaints, that is discussed and eventually treated in the consultation



Some doctors react to 35% of the not purely somatic complaints, others to almost 90% ; the average is 66%. When a complaint is seen as 'mainly psychosocial', the average proportion of reactions increases to about 90%. However, complaints that are presented somatically, but do have psychosocial aspects in them, are on average neglected in almost half of the cases.

Let's now have a look at the relationship between interpretation and treatment on the one hand, and the interview style of the general practitioners on the other, the latter as it is assessed by observing the consultations.
We distinguish four aspects of the interview style:
- affective attitude
- patient centered behaviour
- structuring the consultation
- probing.

The doctors differ from one another on virtually all subsidiary aspects of this interview style. In these differences a pattern can be seen: a doctor who is positively assessed because of the interest he demonstrates, is in most cases also positively assessed with regard to the other aspects. In the following, such positive assessment is called an 'open interview style'.
The doctor's interview style seems to be a fairly stable character trait: ranking the general practitioners on the basis of their interview style in consultations where complaints are judged to be purely somatic, yields almost the same results as ranking them on the basis of their talking to patients with psychosocial complaints.
The more 'open' a general practitioner's interview style is, the more non-somatic judgements he gives, and the more he reacts to the psychosocial aspects in his consultations (1).
We have also looked for other explanations of the differences noted. We distinguish two types of doctors on the basis of their views concerning disease and the part they play in this respect: those with a 'general medicine approach' and those with a 'clinical approach'. (cf e.g. Haney, (1971), Staudenmayer and Lefkowitz (1981), Parlow and Rothman (1974).
The first are doctors who are prepared to take some risks in the medico-technological area, so that the individual patient does not become unneccessarily lost amid clinical assaults; these are doctors who wish to develop an egaliterian relationship with their

patients and who regard psychosocial aspects as being important in many cases.
The second ones, the 'clinical' doctors, attach much value to the biological aspects, take few risks, and are more concerned with the physical complaint than with the person who is the carrier of the complaint.
As for our theme, we found that doctors with a 'general medicine approach' judge a complaint to be not purely somatic more often than the others. They also react more often to these complaints.

Apart from the general practitioners' general orientation, we have looked at factors that determine the doctors' opportunities to treat psychosocial aspects of complaints: practice size, competence (that should increase when more post-graduate courses have been attended to), available time and support from other disciplines. Moreover, we think the task perception of the general practitioner in this respect is of importance.

Doctors who regard themselves as competent and who devote a considerable amount of time to consultation and consult with social workers, also treat a lot of psychosocial complaints. A doctor with a small practice devotes relatively much time on average to each consultation.
Doctors who regard the treatment of psychosocial complaints as their job, however, do not treat these more than those who do not regard it as their job. Nor do doctors who have had considerable postgraduate training in any sense treat more psychosocial complaints than doctors who have little postgraduate training.

Except for post-graduate training, none of the variables examined were related to interpretation: this was according to our hypothesis, as the resources of a general practitioner should have an effect on what he actually does, not on what he thinks.
Finally, the role of the patient comes into the picture. Our theory was that psychosocial interpretations will occur more often when patients regard their general practitioner as an appropriate source of help for psychosocial and social problems and in consequence voice these complaints more frequently.
This theory appeared - on the general practitioners' level of analysis - right: patients who trust their doctor in the domain of psychosocial care, more often offer overt psychosocial problems to them (2); in consequence these doctors more often judge complaints

to be non-somatic.

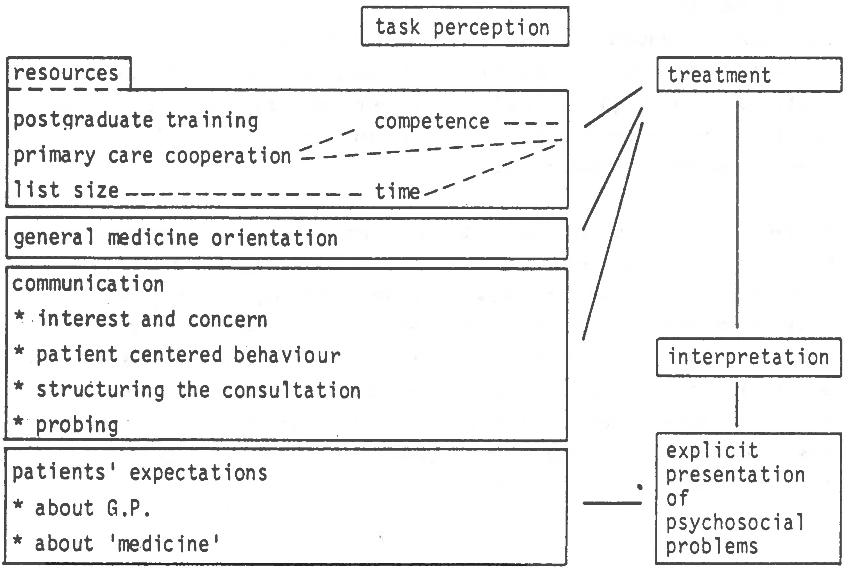
The different factors that influence the psychosocial assessment of the doctor are independent: the doctor with an open interview style makes more psychosocial judgements than others, even when we check for his professional orientation and the number of explicitly psychosocial complaints he encounters.
A doctor with a clinical approach, and an open interview style also encounters more psychosocial complaints than a clinically oriented doctor with a closed interview style. And so the relation between explicit psychosocial complaints and psychosocial judgements exists after the doctor's professional orientation has been checked.

Regarding the interrelationship between interpretation and treatment, our naïve hypothesis was that interpretation was situated between the independent variables 'communication', 'orientation' and 'expectation' on the one hand and treatment on the other hand. On close analysis, however, interpretation appears to be not so much the cause as the effect of treatment: a doctor does not first make a judgement on the nature of a complaint and then start 'discussion therapy'. On the contrary, he talks about psychosocial problems, tries to find out what their backgrounds are, attempts to make this clear to the patient, and comes to an assessment of whether or not psychosocial aspects are important to this complaint.

From our empirical findings, we conclude that doctors with a general medical approach, an open interview style and resources in time and skill, examine the psychosocial complaints more often, as a result of which they record more psychosocial interpretations of complaints. The interrelationship between the variables discussed is depicted in figure 3 (see next page).

From our investigation some conclusions might be drawn. First, we think that general practitioners should more often than is presently the case devote attention to the possible psychological and social backgrounds of complaints.
In approximately 40% of the cases in which a doctor suspects a psychosocial background to somatic problems, nothing is done. Psychosocial factors that are side-effects of somatic complaints are even more often neglected.

Figure 3: interrelation between the variables discussed



Secondly, in view of the relations that have been found, we do not regard this failure as due to an absence of skills, but due to an absence of a basic attitude that should be systematically taught in the training of general practitioners. The poor return on investment in postgraduate education in this respect, shows us that this basic attitude should be 'acquired' in the beginning of training.

So, looking at these results, what kind of inferences can be made regarding the possibilities general practitioners have in dealing with psychosocial complaints? What can be said about the assistance they may need from mental health professionals?
As we saw, general practitioners are rather passive and neglecting when being confronted with somatic complaints that also have some psychosocial aspects on it. Therefore we suggest that general practitioners should learn in their basic education how to cope with the psychosocial problems that are the consequence of a

somatic disease. As a patient should be treated 'as a whole', this is a task of the doctor himself, though he might be trained by a mental health professional.
In those (frequent) cases in which the general practitioner suspects psychosocial influences in a somatic complaint, he might occasionally be right in not taking any action; in a good number of other cases, however, he might be in need of consultation with a mental health professional.

As far as the purely psychosocial complaints are concerned (a minority of all non-somatic complaints discussed), there may sometimes be a referral. We have the impression, though, that this is only done when it is really needed, when the patient wishes so, and when waiting lists aren't too long. Although the extent to which a general practitioner should treat these patients has not yet been determined by the professional group itself, we conclude that educational efforts may eventually lead to general practitioners trying more often to treat them.

Notes

1. For correlation coefficients, means and standard deviations (also concerning relationships mentioned in the following), see Verhaak (1986).

2. We made a distinction between overtly/explicitly presented psychosocial complaints and psychosocial judgments by the doctor. The former are defined by the words the patient uses to express his problem: if this happens in terms of psychological or social problems the complaint is 'overtly psychosocial presented'. The latter depends solely on the judgement of the general practitioner expressed in the four categories mentioned before. A complaint that is judged as 'mainly psychosocial' may be put forward in strictly somatic terms (e.g. lower back pain).

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'What is the meaning of a complaint ...?'
Discussion

In doing research, Rabinowitz stated, it is important to give feedback to the doctors who participated in it, in order to increase their willingness to join the effort.

Kraan felt that Verhaak's conclusion that interpretation is rather the consequence of treatment than its starting point, should lead one back to the discussion on classification, this being one of the difficulties in this respect. Besides he reminded us of the role postgraduate training plays in the way doctors treat psychosocial problems. As Verhaak found out, doctors who participate in training do see, but don't treat more problems than others; this leads to the conclusion that doctors who join postgraduate training courses are those who are already interested in the subject.

Sofer was puzzled by Verhaak's finding that general practitioners treat patients with psychosocial problems, presented as somatic ones, in only half of the cases in which they actually saw these problems. She turned the question around: what if doctors proved to miss the somatic problems presented on a large scale? A general practitioner, said Verhaak, clearly cannot afford to do so.
He cannot ignore somatic problems in the way he can - and sometimes deliberately should - leave the social and emotional ones in peace in order not to disturb the equilibrium the patient himself might have developed in respect of these problems. The fact is, however, that too many general practitioners miss emotional aspects of somatic complaints too often, even in cases in which they really should take up and explore the emotional backgrounds of a complaint. Sofer insisted that a family doctor should first look for somatic disorders: the public expected him to do so! Having a limited amount of time, he has to be aware how to spend it, he has to choose what to do.
Agmon disagreed. Sometimes, she said, patients really want their doctor to explore the 'real problems' that are hidden behind the somatic complaint, the latter often being a mere excuse for the visit. If mental health really is an essential part of primary care - and Gersons wondered if that was the case - than how do we know whether the complaint is more than that? How do we handle

this problem? It is not enough to discuss emotional problems only and ask if the doctor should treat them or not. A doctor should also give help in respect of the emotional components of somatic complaints, like a heart-disease, he should be worried about 'the patient-as-a-whole'.
Verhaak didn't think there was much disagreement in this respect: if a patient was ill everybody expected the doctor to give emotional care as well. The problem starts and the struggle arises when a patient presents a somatic problem and the doctor can't be sure whether or not there are social and emotional problems 'behind' it.
For Huyse the discussion had reached a critical point. In a continuum between 'purely biological' and 'purely psychological' problems - both seen in their social context - medical specialists could help primary care physicians at the biological end, as mental health care could do in the psychological one. A gap exists between the two, which, however, can be filled by general hospital psychiatry. It is the psychiatrists' task, Huyse thinks, to give consultation to general practitioners by stressing the interrelation between biological, social and psychological factors. Psychiatry should take this interrelation into account, that being the only solution to the problem discussed.
Katz pointed to the negotiating process in the relation between doctor and patient: who determined the content of it? For her it was a patient's basic right to speak his own language. A patient's identification of a problem does not automatically lead to his/her presentation of it in the conversation with the doctor. For Maoz there is an unmistakable difference between psychiatrists and medical specialists: while the latter try to exclude things -'What isn't the cause of the problem'- psychiatrists try to include all different aspects of the patients in their perception of them.
As a conclusion to the discussion Stoelinga defined a major theme which came out of it. Instead of posing the question: "How sick is a person?", he said, it is important to find an answer to another one: "How is a person sick?" or "What is the meaning of his complaint?" In order to answer that question another approach to diagnosing is needed, he added.

V. CONCLUSION

On bridging the gap

Final discussion

Bensing and Agmon were requested to make some concluding remarks on the symposium. After four days of work Bensing arrived at the - 'impressive' - conclusion that the differences between primary health care and mental health care are greater than those between the two countries on this issue. Also she noticed the similarity of the discussions held here and those between general practitioners and medical specialists. This phenomenon - a discussion common to different countries as well as to different parts of the health care system - was due to an essential difference between primary care on the one hand and mental health care and secondary medical care on the other: While mental health professionals and medical specialists deal mainly with sick patients and have to decide repeatedly how to cure or how to care, primary care professionals see mostly healthy people and have to wonder whether to care or cure at all. This difference in experience makes mental health care professionals apt ot think that all patients can be helped to live better lives, whereas primary care workers, handling so many relatively less serious complaints, stress their self-limiting character. In order to increase the mutual understanding, professionals in both fields should realize and experience these differences. Mental health consultation, Balint-groups and other shared experience was of utmost importance, Bensing concluded.

On the basis of the 'truthful' discussions held during the seminar, Agmon likewise concluded that professionals in primary care and mental health care didn't know much about each other: improvement was needed. During this week, she noticed, common things became more common indeed, but differences became more polarized. One of the most striking discussions arose on the question whether mental health care actually belonged to primary care and, if so, whether it should be integrated with in it or form a special chapter. Much uncertainty also existed in the field of referrals and consultation: how do we refer and - an intriguing question - who wants whom and how much? In order to answer these questions research is needed, Agmon stressed, and it is especially in this respect that the two countries can join their efforts, Israel

having clinical knowledge and teaching experiences but little research. Her last remark was one about psychiatry. Psychiatrists move between feelings of impotence and feelings of omnipotence, she said, the latter being prevalent nowadays. While helping psychiatry to be realistic once again, general practitioners should be aware of the psychiatrists' resistance, as omnipotence is a 'wonderful feeling'. On the other hand, Agmon concluded: "We are willing to share some of it with you, and that is good."

Seeing the lack of communication between general practitioners and psychiatric centers as a major problem, Davidson advocated the psychiatric team within the primary care setting, as is found in Israel in various places. Rabinowitz thinks a primary care psychologist might be helpful in this respect, the psychosocial area being more easy for him to handle than for a clinical psychiatrist.

Dokter has his doubts to all this: a social psychiatrist visiting the health center he practises in, could not do much: the organization of care and the general practitioners' attitude make it impossible to see patients together. Kraan had more trust. In Maastricht about 60% of all RIAGG patients came after been referred by a general practitioner. Whenever a referral occurred, the general practitioner was phoned and asked about the patient's problem, his own expectations and caregiving thus far. A small amount of bargaining following this discussion has increased the amount of referrals, quantitatively as well as qualitatively. Also the Maastricht RIAGG visits chronic patients together with general practitioners.
Katz thinks it is very important for mental health professionals to visit general practitioners in order to share experiences. She also stressed the need for all professionals to be willing to see oneself as a part of the picture and to experience the imcompleteness of one's job.

Margolis had two points he wanted to mention. First, he noted the different composition of the population in the two countries. The fact that about 75% of the Israeli are immigrants is important for discussions on both health care and research: in Israel the return of questionnaires can never be as high as in the Netherlands.

Secondly, Margolis wanted to advocate the concept of algorythms of care. In the last fifteen years a change in the perception of algorythms - or protocols - of care took place. Whereas protocol directed approaches to problems used to be distrusted by medical doctors, nowadays the concept is accepted, as recent publications - describing, for instance, a protocol for the treatment of childhood depression - show.

Maoz felt a protocol of consultations should be made that is broad and flexible enough to incorporate the various kinds of consultation that exist. In Israel a lot of different ways 'of bridging the gap' flourish, varying from a psychiatrist visiting a primary care clinic at regular intervals, to psychiatrists and general practitioners seeing patients together. The process of finding a 'basic trust' between consultant and consultee is a long one: one has to get to know each other, (often unconscious) resistance has to be dealt with, whereas administrative procedures might be the cause of a lot of problems. What is necessary is to try out and evaluate various types of collaboration, in Holland as well as in Israel. After research has been completed - and like Agmon before him, Maoz thinks the Dutch can help the Israelis in this respect - a protocol consisting of four or five good systems of collaboration can be written. Spenser also calls 'evaluation' a key-word and advocates the making of models, 'with highly motivated people', to be evaluated and eventually applied elsewhere.
Finally, Huyse pointed to the experience general hospital psychiatry has in this respect. In evaluating consultation, emphasis was laid on describing the consultation and measuring the effectivity of it for the consultees: how often did they follow advice given? Why didn't they do it?

Though often seen as the 'ambassador' of the concept in the Netherlands, Gersons had some doubts as to the need for mental health consultation. Whereas consultation is especially relevant in large, not too densely populated countries like Turkey and Spain, where mental health teams travel around the country and people in the villages 'look forward' to their visits, countries like Israel and Holland, with many caregiving professionals, might very well be able to do without.

Further, referring to Bensing's distinction between primary care and mental health care, Gersons notices a shift in attention in psychiatry from the 'healthy' side to the 'sick' side. Even psychiatrists who have been engaged in prevention for years, are paying more and more attention to patients in the 'backyards' of the mental hospitals.

Bringing the symposium to an end turned out to be difficult. Maybe it was Margolis who summarized the participants' feeling best. With regard to both countries as well as both fields, there is an opportunity for 'collaboration' and for making connections to the future, he said. And though it will be hard work to make these connections flourish, he added, it surely can be done!

18. EPILOGUE

G.J. Visser

When people from two countries and with different professional backgrounds meet and talk about the interaction between the fields they represent, two things can happen: compatriots either notice how much they have in common and how different they are when compared to people in other countries, or colleagues cross the border and share their common experience of dealing with the other profession. In the course of the Dutch-Israeli symposium on the interaction between mental health services and the primary care sector, it became clear that national differences didn't come first: those involved either in primary care or in mental health care clearly recognized each others experience and problems, notwithstanding differences in setting.
Evidently the relation between the two sectors of health care is so complicated, that common problems occur in two countries that differ in many respects, as was also stressed during the symposium. Even defining the problems between primary care and mental health care is not an easy thing to do. "The problem is", the general practitioner might say to the psychiatrist, "that you can't solve my patients' problems sufficiently well and that you can't teach me how to solve them either". To which the psychiatrist might answer that the general practitioner should listen to him more carefully and be more willing to refer patients for psychiatric treatment. Both would agree, however, that a big 'gap' between them has to be bridged.

During this symposium many possible reasons for the relationship being so complicated were mentioned. There is a certain degree of competition, both general practitioners and mental health professionals claiming that helping patients with so-called 'psychosocial' - opposed to 'psychiatric' - problems is part of their job. There are some organizational problems, like the bureaucracy of the mental health institutions and the existence of waiting-lists, that make it difficult for general practitioners to refer patients or to contact with mental health professionals (and also: the organization of primary care doesn't make it easy for the latter to contact a general practitioner). Furthermore, there might be the doctors' inability to see his patients' psychosocial problems or his (unconscious) denial of these problems, which

prevents him from having to act. On the other hand the patient himself might raise objections to a referral to a mental health professional, only seeing a physical problem or being afraid to be considered a psychiatric patient the rest of his life. Most of all, however, differences in 'culture' make it hard to come to the mutual understanding and collaboration that both sides want to be brought about.
What do those differences stand for? Painting a portrait of the two professions, we see on the one hand the general practitioner, a pragmatic and individual professional, who sees dozens of patients each day, having a limited amount of time for each of them. Being a family doctor, he gets to know his patients - at least the ones who visit him regularly -, knows something about their way of life and about the setting they live in. In his daily practice, the general practitioner is able to solve most of the problems he is confronted with himself; where not, he can refer his patients to a great many specialized professionals, of whom the psychiatrist is only one - and surely not the most important.
On the other hand we see the psychiatrist, who sees fewer patients a day, has much more time for each of them and is specialized in listening and clarifying. While seeing his patients for only a relatively short period of time and in his own consulting-room, he can't be too familiar with their daily life. However, he is confronted with problems that are too serious to be treated in general practice. As for his contacts with general practitioners, for him they are important professionals, as many of his patients are referred by them.

Of course, some things can be said about these little portraits. Especially in the bigger cities and in areas with a floating population, the general practitioner is no longer the families' adviser he used to be, while on the other hand some reaching out by mental health institutions is certainly done. The description is also limited to the medical components of both primary care and mental health care: social workers on the one hand and psychologists on the other might very well play a mediating role in the relation between both sectors.

These restrictions taken into account, however, the descriptions given might correctly sum up the main differences in practising between professionals in the two sectors. During the symposium it became gradually clear to what disagreements these differences can

lead.
First of all there is the discussion on the necessity of psychiatric treatment. General practitioners are apt to refer only a minority of all patients who present psychosocial problems to a mental health professional. Apart from the fact that psychiatric treatment is often judged as unsuitable for a patient - this treatment, and especially psychotherapy, presupposes a patient's ability to put his problems into words - general practitioners have the common experience that a great many problems in the long run pass off without any intervention. Many patients also develop a strategy for dealing with a persisting problem in a satisfactory way, in which case a doctor is little inclined to persist with a referral, the risk of stigmatization still existing, in Holland as well as in Israel.
Psychiatrists of course judge the necessity of psychiatric treatment in a different way. As was said before, their patients' problems are the serious ones that don't 'disappear by themselves'. Not being too familiar with the average problems a general practitioner has to handle, they see themselves as being able to teach more patients to live a happier life, if only they could get into contact with them. It is this 'feeling of omnipotence' - as it was called during this symposium - that makes psychiatrists ask general practitioners not to be too strict while acting as a gate-keeper to secondary care: a merely satisfactory way to handling problems can be changed into a really good and efficient way to deal with them.

Another difference in opinion exists on the related problem of the effectiveness of psychiatric care, once started. "Psychotherapy helps", the psychiatrist says, referring to the results of scientific research. "It really does", the general practitioner responds, "but only if patients want to change and are motivated to be helped". And he points to the patients who keep visiting him with vague complaints, who don't want to change, however miserable they may seem to be to an outsider. Can a psychiatrist help them?

A third issue that makes an easy contact difficult is the language general practitioners and psychiatrists use in talking together. In his daily practice the general practitioner is content with broad categories, such as 'socio-emotional problems'; as a more refined classification scheme's implications for treatment would be about the same, he can do without it. For the psychiatrist

broad terms are not precise enough: science develops and a psychiatric terminology is created that fits the ever more unraveled reality.
The general practitioner does not know the detailed psychiatric classification that causes the psychiatrist to speak two languages: one with his fellow psychiatrists and one, a simpler and for him more foreign one, with general practitioners.

So much for the troubles. For during this symposium a lot more happened than a mutual exchange of unsatisfactory experience. One important phenomenon is the often repeated willingness to 'bridge the gap' - not, it must be stressed once again, between the two countries, but between both professions concerned. To know more about each others' work might gradually lead to a better understanding, a better collaboration, a better referral of patients, an easier dialogue with respect to these patients, the development of a common language.
Consultation and education are the two 'key concepts' in this respect. Some models of consultation are described in more detail in the papers presented. The variation in these models is enormous: they range from the agreement to have contact by phone each time a general practitioner refers a patient to a mental health institution to the taking part of a psychiatrist in a primary health care team. What these models have in common, however, is a certain one-sideness: it is always the psychiatrist who gives consultation, the general practitioner who asks for it - notwithstanding the fact that psychiatrists might very well learn from primary care as well. Also consultation seems to be most effective when centered on discussion on the treatment of difficult 'cases' the general practitioner has to deal with; there is little experience with consultation based on discussion on topics of a more general character.
In spite of some participants' scepticism with regard to either the desirability or the effectiveness of mental health consultation, optimism predominates: it is seen as a major contribution to improve the interaction.

The same goes for efforts in the field of education. Two important missions are to be undertaken in this respect.
On the one hand psychiatrists-in-training should be taught how to communicate with general practitioners in order to improve their functioning as consultants. Training in an ambulatory setting - in

addition to training in a mental hospital - might be fruitful in this respect.
On the other hand education is important in order to teach general practitioners - be they students or practising doctors in post graduate training - to communicate better with their patients, to give them room to talk freely about their non-physical problems. It was noted during one of the discussions held that the younger universities in both countries especially - Beersheva and Maastricht - are active in this field, thus proving their 'raison d'être' amidst a couple of other, older, medical schools. In response to the Beersheva experience the question remained unanswered as to whether it was desirable to confront medical students in an early stage of their studies with rather intense training in communication skills.

One remark needs to be made on the differences that exist between the two countries that participated in this symposium. Though striking differences in the two health systems were noted - the Israeli primary care mostly provided by multidisciplinary teams - these don't seem to play a part with regard to the interaction between primary care and mental health care. What really is important, however, is the different population in both countries. The patient being topic of discussion a couple of times - 'Does he want to talk about his problems? Does he want to be referred?' - the fact that about three fourths of the Israeli population consists of people who were born elsewhere, does make a difference: they react differently on psychosocial problems, they have different expectations from medical professionals.

All in all, during the symposium an exchange of personal experience has taken place. In the near future more than that has to be done. What is needed most is to find the answers to the difficult questions posed. By setting up experiments the borders between the two health care systems might be empirically settled, the tasks of general practice and social work (the latter's role being rather under-represented during these days) on the one hand and psychiatrists and psychologists on the other more accurately defined. Also, the best way to mould the widely accepted idea of mutual consultation into concrete form might best be found by closely examining and evaluating the different possible models in practice. It is especially in this respect that future collaboration between the participants to the symposium will lie.

APPENDIX

Taxonomy of interviewing skills necessary in primary mental health care*

This taxonomy is the item domain of the Maastricht History-taking and Advice Checklist (MHAC). Definitions and criteria for scoring of the items are described in a users' manual.

I. Clarification of the request for help

1) Asks for the reason for visit.
2) Asks the patient to describe his complaints/problems.
3) Explores the emotional impact of the complaints/problems.
4) Asks the patient to clarify why (s)he presents this problem at this particular moment.
5) Asks the patient to give his opinion about the causes of the problem.
6) Asks how the complaints/problems are discussed with the family or primary group.
7) Asks how the patient tried to solve the problem by him/herself.
8) Explores the consequences of the complaints/problems for daily life.
9) Asks which life circumstances or which other problems accompany these complaints/problems.
10) Asks for the ways, in which the patient usually resolved similar problems in the past.
11) Asks the patient if the complaints/problems might be a burden to others.
12) Asks for recent life-events.
13) Asks the patient to state which help (s)he desires.

II. History-taking

14) Explores the intensity of the complaints/problems.
15) Asks for the course of the complaint during the day.
16) Asks for the history of the complaint/problem.

*see p. 123 ff

17) Analyses which (causal) factors provoked the complaints/problems.
18) Analyses which factors increase the complaints/problems.
19) Analyses which factors maintain the complaints/problems.
20) Analyses which factors decrease and/or eliminate the complaints/problems.
21) Explores the functionality (gains) of the complaints/problems.
22) Asks for illnesses and/or mental health problems in the past.
23) Asks for professional treatments and their effects in the past.
24) Asks for professional consultation in the present time.
25) Asks for the present (ab)use of medication.
26) Asks for the (pseudo)hereditary aspects of the complaints/problems.

III. Psychiatric examination

27) Examines symptoms of affective disorders:
    a) disturbances in mood and affect
    b) biological symptoms
    c) disturbances of thought
    d) suicidal ideation and behaviour
28) Examines symptoms of anxiety disorders:
    a) character and intensity of anxiety
    b) fobic symptoms
    c) anxiety in-/decrease factors
    d) consequences of anxiety
29) Examines disturbances in consciousness and orientation:
    a) mild disturbances: drowsiness, concentration, disturbances
    b) disturbed orientation (time, place, persons)
30) Examines disturbances in memory:
    a) immediate retention and recall
    b) recent memory
    c) remote memory
31) Examines perceptual disturbances:
    a) distinguishes hallucinations from illusions and pseudo-hallucinations
    b) character of hallucinations
32) Examines disturbances of thought:
    a) disturbances in the stream of thought
    b) disturbances in the content of thought

c) disturbances in the perception of the own processes of thought.

IV. Socio-emotional explorations

33) Explores feelings of love/affection in interpersonal relations
34) Explores agressive feelings in interpersonal relations.
35) Explores perspectives and aspirations in life.
36) Explores care-giving.
37) Explores feelings of responsibility.
38) Asks for religious feelings.
39) Explores character traits and/or self-image.
40) Explores the quality of the relations with family/primary group.
41) Asks for social support.
42) Asks for cultural differences in social relationships.
43) Examines the present professional functioning.
44) Examines the functioning during leisure time.
45) Explores the sexual functioning.
46) Explores the sleep.
47) Explores the eating habits.
48) Explores the use of substance.
49) Explores the (dis)satisfaction with the housing conditions.
50) Explores the (dis)satisfaction with the financial situation.
51) Explores the history of education and profession.
52) Explores early developments up to adolescence (traumatic experiences, socio-emotional and psycho-motor development).

V. Presenting solutions

53) Provides a problem definition or 'diagnosis' in understandable terms.
54) Gives information about causal and maintaining factors of the complaints/problems.
55) Gives information about the prognosis of the problem; without and with treatment.
56) Explores the patient's expectations concerning help.
57) Explores how much responsibility the patient will take for his/her treatment.
58) Introduces a proposal for help (with alternatives).

59) Explains how the proposal for help goes with the problem.
60) Dicusses the pro's and con's of the proposed help.
61) Asks for the patient's opinion about the proposed help.
62) Explores how 'important others' might influence the proposed help.
63) Checks if the patient has a different point of view on problem definition and/or proposal for help and discusses any different opinion.
64) Asks the patient to make a choice out of several proposals of help.
65) Gives concrete information, how a given advice should be followed.
66) Checks if the patient understood a given advice.
67) Makes appointments about further follow-up.

VI Structuring the interview

68) Introduces him(her)self at the beginning of the interview and makes his functional relationship clear to the patient.
69) Offers a plan for this consultation.
70) Concludes the clarification of the request for help with a summary.
71) Concludes history-taking, psychiatric examination and socio-emotional exploration with an ordering of the main results.
72) The clarification of the request for help section precedes history-taking, psychiatric examination and socio-emotional exploration.
73) Completes clarification for the request for help, history-taking, psychiatric examination and socio-emotional exploration to such an extent that solutions can be presented.
74) Starts 'presenting solutions' with information about the problem definition/diagnosis.
75) Asks at the end of the interview, if the main problems have been discussed satisfactorily.

VII. Basic interviewing skills

76) Facilitates the communication with the patient.
77) Uses closed-ended questions in a proper way.

78) Concretises at the proper moment.
79) Reflects in a proper way emotions, which are non-verbally or covert verbally expressed.
80) Reacts adequately to emotions, which are directed towards him/herself as a physician.
81) Asks the patient for his feelings of the moment.
82) Summarizes the content of the patient's statements properly.
83) Provides information in small units.
84) Checks if the provided information has been understood.
85) Makes, when necessary, meta-communicative comments.
86) Makes, when necessary, proper confrontations.
87) Takes the medical history and reviews the systems in an appropriate way.
88) Puts the patient at his ease.
89) Sets the proper pace during the interview.
90) Uses language, that is understandable for the patient.
91) The physician's non-verbal behaviour is in agreement with his verbal behaviour.
92) Makes a proper eye-contact with the patient.

List of participants

N. Agmon de Shalit, M.D., child-psychiatrist, director of the Department of Mental Health Services, Ministry of Health, Jerusalem, Israel.

J.M. Bensing, psychologist, director of the Netherlands Institute of Primary Health Care (NIVEL), Utrecht, The Netherlands.

A.A.M. Crijnen, M.D., general practitioner, State University of Limburg, Maastricht, The Netherlands.

L.J. Davidson, M.D., psychiatrist, director of the Psychiatric Hospital in Safed, Israel.

H.J. Dokter, M.D., professor of family medicine, Erasmus University, Rotterdam, The Netherlands.

B.P.R. Gersons, M.D., professor of ambulatory and social psychiatry, State University of Utrecht, Utrecht, The Netherlands.

F.J.A. Huygen, M.D., emeritus professor of family medicine, Catholic University of Nijmegen, Nijmegen, The Netherlands.

F.J. Huyse, M.D., psychiatrist, Academic Hospital Free University, Amsterdam, The Netherlands.

C.A. Katz, M.Sc., instructor of communication skills, Ben-Gurion University of the Negev, Beer-Sheva, Israel.

H.F. Kraan, M.D, lecturer in social psychiatry, State University of Limburg, Maastricht, The Netherlands.

P. van Lieshout, psychologist/philosopher, Netherlands Center for Mental Health (NcGv), Utrecht, The Netherlands.

B. Maoz, M.D., professor of psychiatry, Ben-Gurion University of the Negev, Beer-Sheva, Israel.

C.Z. Margolis, M.D., professor of pediatrics, community health and primary care, Ben-Gurion University of the Negev, Beer-Sheva, Israel.

L. Meertens, M.D., physician, State University of Limburg, Maastricht, The Netherlands.

S. Rabinowitz, Ph.D., psychologist, director of the Department of Psychology, Israel Air Force, Israel.

D.T.D. de Ridder, psychologist, Netherlands Center for Mental Health (NcGv), Utrecht, The Netherlands.

M. Schein, M.D., lecturer in family medicine, Ben-Gurion University of the Negev, Beer-Sheva, Israel.

G.P. Sofer, M.D., general practitioner, Ben-Gurion University of the Negev, Beer-Sheva, Israel.

T. Spenser, M.D., senior lecturer in family medicine, Ben-Gurion University of the Negev, Beer-Sheva, Israel.

B. Stoelinga, National Service Institute for Prevention, Utrecht, The Netherlands.

P.F.M. Verhaak, Ph.D., psychologist, Netherlands Institute of Primary Health Care (NIVEL), Utrecht, The Netherlands.

J. Verhoeff, Ph.D., vice-inspector-general for mental health care, Ministry of Health, Leidschendam, The Netherlands.

G.J. Visser, sociologist, Netherlands Institute of Primary Health Care (NIVEL), Utrecht, The Netherlands.

A. Vrij, M.D., inspector for the primary health sector, Ministry of Health, Leidschendam, The Netherlands.

F.W. Wilmink, M.D., general practitioner/psychologist, Department of Social Psychiatry, State University of Groningen, Groningen, The Netherlands.

J. Zuidweg, M.D., physician, State University of Limburg, Maastricht, the Netherlands.