

Reports from the colleges

Mental health at a family medicine conference: reflective narratives of a family physician and a clinical psychologist

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Introduction

This paper is based on a narrative correspondence between a psychologist and a family physician, both lecturers, at an Israeli National Conference for General Practitioners and Family Physicians (FPs) in Tel Aviv, Israel. This conference has become a traditional forum, in recent years, for providing updates in family medicine for primary care physicians, and discussion of common issues and innovations in daily practice. The first part of the paper describes the psychologist's lecture and his reflections on the cognitive sets limiting FPs dealing with the emotional aspects of patients' complaints. The second part of the paper is the reflective narrative of the FP who was the moderator of the session on mental health in family practice at the conference, and had the initiative to bring the psychologist to lecture. This kind of narrative correspondence is similar to a previous publication, between a psychologist and a FP.¹

The psychologist's reflective narrative

The lecture began with a very short introduction about the emotional problems generally found in family practice: during routine clinical encounters, FPs deal with multiple health problems and multiple priorities which encompass multiple domains, biomedical as well as social and emotional. Some 35% of patients treated by primary care physicians have significant mental health problems.^{2,3} While many of these problems are not related to, a great number are appropriately detected, but not treated properly. Only about 10% are referred to mental health services.⁴

One way of understanding why FPs may have difficulties in dealing with these issues is by understanding barriers that doctors may have in dealing with these issues.

The cognitive approach was outlined emphasising how emotional responses are not influenced by events themselves but by the way the events are interpreted.⁵ This served as an introduction to the misconstrued beliefs that doctors themselves may have about treating these patients.

Why do FPs have difficulties in treating patients with psychosocial issues?

We looked at FP's irrational beliefs. One important overall irrational belief may be related to the way FPs perceive their profession (constantly available, feelings of omnipotence, always ready to give, to act, to serve etc). Yet, over and above these general beliefs about their profession, FPs may have specific irrational beliefs about their dealing with the emotional components of their patients complaints.

FP's beliefs about their role

'I must rule out organic disease. I cannot deal with both concurrently.'

'I am pressed for time: I cannot do everything.'

'If I touch on the psychological aspects of my patients complaints, I will open up an area I will be compelled to deal with problems I have no expertise to treat.' (Solution: sometimes good listening will be more effective than 100 tests or referral to mental health specialists when over 60% of patients never get to see them anyway!)

'If I deal with these problems I will become overwhelmed and burnout.' (Solution: Not necessarily so. I can get supervision through a colleague or a mental health professional. In any case, hearing a patient's story can be less monotonous and fulfilling and by so doing, make my work interesting).

FP's beliefs about how the patient perceives their role

'Patients want me only to rule out organic problems.'

'It is an invasion of my patient's privacy to deal with his/her psychological problems.'

'I will cause my patients undue pain and suffering if I deal with their psychological problems; they may even get angry with me for doing so, and reject me and never return.'

'Patients may become totally dependent on me.'

'I know that patients want expert advice, not from a FP.'

'I do not want to do the "wrong" thing and then get a complaint or run into legal difficulties.'

FP's own difficulties in treating these patients

'I do not have sufficient skills/knowledge to deal with these patients. I should better ignore them rather than open up something that I will not be able to cope with later.'

'It may be painful for me to deal with these issues, to face the emotional problems of another and perhaps see those issues in myself'.

'Patients may react emotionally to me in peculiar ways and I will not understand their inappropriate reactions for something I may do or say [transference feelings]. This may then arouse in me all kinds of intense feelings which I do not understand or do not want to deal with, and I myself may then act inappropriately.'

A case vignette was now presented

Ms G is an unmarried woman aged 30 who lives on her own. Despite her high intelligence and a bachelor's degree in economics, she works in a low-paid clerical job. She had been treated for depression and panic attacks yet constantly complained of 'an inability to sort my life out'. Whatever her family physician advises her to do she explains why change is impossible. The doctor realised that he was getting stuck. One group member of the Balint group he was attending suggested that he reflect to the patient the feelings she aroused in him. At the end of his next meeting with the patient, the doctor did decide to clarify what he was feeling, mainly feelings of helplessness. Suddenly a silence prevailed. Then the patient says sympathetically, with a noticeable twinkle in

her eye, 'I don't want you to feel so bad doctor, I've defeated five FPs before you'. The doctor grinned and instantly felt relieved.

The reflection of his feelings lead to a turning point in their relationship whereby the doctor was able to amicably continue to see his patient, and later was even happy to treat her.

The FP's reflective narratives

'In the session, my aim was to present the way FPs cope with continual work and administrative responsibilities while at the same time dealing with the emotional issues of their patient population. Difficulties doctors have in relating to the emotional stress of their patients may be associated with the complex life stories they hear, coping with life cycle issues, or related to the emotional burden arising from fear of loss of health, functioning and death. Stressors may further be due to: naive fantasies of total healing, fantasies of being a redeemer, conflicts between omnipotence and impotence, or lack of resources and training in receiving psychosocial supervision or support. Furthermore, doctors may have difficulties with the emotional stress projected on to them by their patients, or have difficulties in dealing with the stress related to projective identification.

Through the presentations, I wanted to try to influence those GP's who were less reflective and not as much involved in the emotional and psychosocial aspects of patient care. These doctors show different ways of dealing with stress. Some use the psychological mechanism of splitting, by dividing the patient into body and mind, whereby physical issues are perceived as the work of the FP, while the emotional aspects are perceived as the work of the mental health professional. Some of the GP's emotional overload may be spilled over to their family and personal lives which may affect both patient care, and hinder their own emotional well-being. If the strain becomes chronic, it may even lead to professional stress, including burnout.⁶

The presenter started his lecture by looking at the concepts of CBT, a body of knowledge with which FPs are familiar. CBT is easier for us to understand, perhaps because it may be seen as somewhat similar to the paradigm taught in medical school. However, looking at emotions is very different from the linear perspective. Although there may be a start and an end, in the process, elements unfold that are decidedly not linear such as transference, counter transference, projections and identification.

For me, this reflects what Michael Balint calls: "the mutual investment company" where we sometimes cannot predict how successful our treatment will be, or what the exact treatment formula should be.⁷ For example, did just listening "fix" the problem? Or was it the fact that that the patient feels that someone is empathetic towards him? Or was it perhaps that the patient felt that there was someone who could emotionally contain his/her fear of sadness, anger or confused emotions? It is difficult to measure these processes, as opposed to pharmacological treatment.

The presenter, who understood the language of family medicine helped to bridge the gap between mind and body. He used CBT concepts, very different from the language of psychodynamic psychotherapy. He tried to convey how a doctor, disconnected from the emotional components of patient care, may redefine his position and fuse components, mind and body, into an appropriately integrated whole.

His presentation reminded me of how much I benefit emotionally and professionally in a Balint group, enabling me to bridge the mind body split and by so doing helping me not only in the treatment of my patients, but also in the treatment of myself – the true mutual investment company!"

Conclusion

The lesson of our paper involves the way in which mental health issues can be shared with primary care professionals. Academic teaching should take into account the often irrational beliefs of FP's described, while at the same time, being sensitive to the language of this group.

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