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The need to act versus reluctance to act: a qualitative study of primary care antidepressant prescribing for patients with common somatic conditions of uncertain cause

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ABSTRACT

Background The National Institute for Clinical Excellence recently called on doctors to exercise more caution in prescribing antidepressants. Antidepressants are used in the management of patients with common somatic conditions of uncertain cause. The factors influencing the prescribing of antidepressants to this group of patients are not fully understood.

Aim To explore general practitioners' and mental health professionals' perspectives on the use of antidepressants for patients with chronic fatigue syndrome (CFS), irritable bowel syndrome (IBS) and chronic back pain (CBP).

Design of study A randomly selected sample of general practitioners and mental health practitioners in England were invited to participate in one of 16 focus group discussions. Clinical scenarios, including the use of antidepressants for patients with CFS, IBS and CBP, were discussed.

Setting Meeting room, outside participants' work environment.

Methods Purposive sample of six groups. Each comprised 9–13 participants (49 GPs and 15 mental health practitioners). Group talk was thematically analysed to identify their views on antidepressant prescribing.

Results Two overarching and opposing themes emerged. The first was the *need to act*. Reasons for action included: lack of clear research evidence, desire to help patients, and a need for GPs to maintain their own self-worth. The second theme was a reluctance to prescribe antidepressants because of the potential for harm, their short-term effects and preference for somatic treatments for IBS and CBP.

Conclusions The perception that *action* is preferable to *inaction* poses a barrier to effective clinical practice and can lead to internal conflict between practitioners' beliefs and actions.

Keywords: antidepressant prescribing, conflict, medically unexplained conditions

Introduction

GPs currently spend £380 million annually on antidepressants (see Prescription Pricing Authority website, Mental Health Drugs Review, October 2005)[1] and the National Institute for Clinical Excellence (NICE) recently raised concerns about overprescribing.[2,3] These concerns primarily relate to the

use of antidepressants in patients with depression and anxiety, but the underlying concerns about the possible harm caused by antidepressants applies to all patients prescribed these drugs, including patients with somatic conditions of uncertain cause.

The Health Select Committee recently concluded that over-prescribing was due to general practitioners (GPs) being too easily influenced by pharmaceutical industry promotions.[4] Other reasons for prescribing antidepressants to patients with somatic or mental health symptoms are reported to help both patients, by reducing their anxiety, and GPs by enabling them to close the consultation, to help maintain their therapeutic relationship and enable them to retain their authority.[5–8]

In this paper, we describe GPs' and mental health practitioners' (MHPs') perspectives on the prescribing of antidepressants to patients with chronic fatigue syndrome (CFS), irritable bowel syndrome (IBS) and chronic back pain (CBP). These are common conditions in primary care, and the underlying causes remain unexplained. Mental health interventions, including antidepressants, are sometimes used, although the effectiveness of antidepressants in primary care has only been demonstrated for patients with IBS.[9,10]

Methods

Participants and procedure

We report on a subset of data from a larger research programme (described elsewhere).[10] Sixteen group discussions about the use of mental health interventions (including antidepressants) in patients with CFS, IBS and CBP, were facilitated by one of the authors (RR). These were held between February 2002 and January 2003 and involved 135 GPs and 42 MHPs. Fewer MHPs than GPs participated because half the groups comprised GPs only and half were mixed. This design fulfilled all of the objectives of the larger research programme.

Each meeting lasted 4 h and was audiotaped and transcribed verbatim. RR made field notes and kept a non-attributable 'journal' of the group processes. The meetings were held at the same venue and followed a written protocol. Clinical scenarios, including the use of antidepressants for patients with CFS, IBS and CBP, were discussed (see Appendix 1). Each scenario was intended to encourage participants to discuss their prescribing behaviour and perspectives on their behaviour – the scenarios helped to provoke initial discussion (and contributed to the objectives of the larger programme). Participants were free to move away from particular scenarios and reflect on their individual experiences. RR ensured that the utilisation of mental health interventions (including antidepressants) was discussed, and that all group members were able to participate fully.

Analysis

Six transcripts were purposively selected to ensure a mix of GP talk and MHP talk was analysed. Selection was made before the transcripts were read to avoid biasing our selection. Each transcript was between 150 and 200 transcribed pages; hence it made analytical sense to intensively focus on six transcripts (i.e. we wanted to be able say 'a lot about a little' and not 'a little about a lot').[11] We paid particular attention to *all* of the talk that directly or indirectly referred to antidepressants.

Two transcripts were independently analysed to draw up a preliminary list of codes. Following the constant comparative method, analysis was an iterative process.[12] Based on initial *in vivo* codes, emerging themes were tested by expanding the reference data set to the six transcripts and eventually to the entire data corpus (16 groups). Returning to the corpus of 16 groups to test our early themes based on intensive analysis of six transcripts, permitted confidence in our thematic credibility. Fragments are drawn from the first six transcripts for illustrative purposes. Also, following the comparative method, which involves seeking out 'deviant cases',[13] we aimed to ensure that all observations could be properly accounted for and that analytical claims were not prematurely generated.

Representation of thematic analysis can result in the de-contextualisation of speakers' words, which may fragment or even misrepresent the meaning as it appeared in the original sequential talk. Therefore, care was taken to analyse the 'antidepressant-talk' in the broader context of the surrounding utterances, to ensure a fair interpretation of the meaning of the fragments reproduced in this paper.

Findings

The six groups reported on included 49 GPs and 15 MHPs. Three transcripts were from groups comprising GPs only ($n = 10$, $n = 9$; $n = 11$), and three from groups comprising GPs and MHPs ($n = 7$ GPs + 4 MHPs, $n = 5$ GPs + 5 MHPs, $n = 7$ GPs + 6 MHPs). Findings are divided into two broad sections: (1) antidepressant prescribing: the need to act, as opposed to (2) antidepressant prescribing: reluctance

to act. These were not mutually exclusive views or constructed behaviours. For example, some practitioners reported prescribing, while still also expressing reluctance about doing so.

Antidepressant prescribing: the need to act

The majority of participants reported prescribing antidepressants for patients with CFS, IBS and CBP, but there was a common display of discomfort when 'admitting' to prescribing, because of a lack of conviction that antidepressants constitute a 'good treatment option' (GP18, CFS). This meant that there was a confessional quality to many of the participants' contributions and a moral timidity expressed in much of the group talk.

> 'Well, I have to put my hand up as the prescriber I'm afraid ...' (GP22, CFS)

Participants acknowledged the difficulty of being able to justify the described approach to antidepressant prescribing.

> 'It is a dubious activity but it is what people do.' (GP14, CFS)

Nevertheless, the need to *do something* was described as paramount, despite some GPs' concern of the potential for them to be perceived to be overly influenced by pharmaceutical industries' marketing strategies.

> 'And I'm not a drug fan ... my practice doesn't see drug reps and it hasn't done for 20 years. Nevertheless it is one of the things that you can actually offer your patients.' (GP7, CFS)

Some GPs dealt with the evident disparity between beliefs and action by conceding to regular prescribing of selective serotonin reuptake inhibitors (SSRIs) *only*, on the basis that they have fewer side-effects than tricyclic anti-depressants.

> 'I deal them out like smarties. But almost always SSRIs except for chronic back pain.' (GP18, CBP)

The research evidence for the effectiveness of antidepressants received little attention. Where it was discussed, participants noted their lack of confidence in the findings available, and ambivalence about how research findings should influence their practice.

> 'It's difficult to know isn't it from the evidence whether [antidepressants] are a good treatment.' (GP18, CFS)

For the majority of participants, the perceived shortcomings in the research evidence justified 'a trial of antidepressants' at some point in the patient's care trajectory (GP62, CFS).

Other justifications for action were offered during the group discussions. First, a desire to help patients was explicitly discussed.

> 'Sincerely you are doing it because you are wanting to try and help.' (GP14, CFS)

However, it was evident that the *need to act* was also motivated by participants' own needs.

> 'So long as it makes us feel better ... we have done something then ...' (GP61, CFS)

And this motivating influence included a need to be accountable and fulfil their role as medical practitioners.

> 'I need to be seen to be doing something.' (GP18, CFS)

Indeed, participants described the prescribing of antidepressants in terms that suggested it protected them in their professional roles, both from potential claims of negligence:

> 'You would be ... medically and legally wrong not to try it. If you haven't tried it then I think probably you would be questionable.' (GP7, CFS)

and from feelings of 'impotence' in situations where there were few alternative management solutions:

> '... You've often so little else to offer and [antidepressants] are often a treatment of desperation you know ...' (GP14, CFS)

This justification was most often described for CFS, and least often for IBS, where somatic therapy was the reported norm.

> '... I don't think any of us feel ... well I don't feel as impotent with IBS ...' (GP123, IBS)

A pragmatic approach to prescribing was also patently evident. The limited availability of other treatments (due to local resource constraints or a lack of alternative recommended treatment strategies), combined with the immediacy of antidepressants were strong drivers for their use.

> 'I would try the antidepressants first because they are available and quick.' (GP123, IBS)

The ability to conclude a brief consultation with an action, which did not require lengthy dialogue with patients, provided further motivation to prescribe.

> 'You do because of time restraints; in general practice use the single bullet.' (GP10, CFS)

The immediacy of providing a prescription in comparison with other mental health interventions, for which there are often lengthy waiting lists, provided a further pragmatic reason for their use.

'... There is 6 months wait [for cognitive–behavioural therapy, CBT], try this in the meantime.' (GP2, CBP)

Finally, participants reported that their actions were partly driven by clinical instinct, and this was presented as a necessary and essential component of clinical practice.

'I think in general practice, whatever the studies show, quite often you just bat from the hip don't you?' (GP123, CFS)

In line with this, some doubted that it would ever be possible to distil the management of complex conditions, such as CFS, into simple treatment algorithms, and that management by instinct would, by necessity, prevail.

'I think we are going to work on our gut instincts in how to manage personalities and situations in general practice, and I don't think there is ever going to be one method that's going to be easily fitted into guidelines for this subject.' (GP10, CFS)

Antidepressant prescribing: reluctance to act

In contrast, some participants were concerned about the *laissez-faire* implications of using a 'trial of antidepressants'.

'Aren't we desperately letting people down?' (GP15, CFS)

For others, the potential harm that could be caused by antidepressants had not been considered.

'... I must admit (not being a doctor) I hadn't actually thought ... about the side-effects of the antidepressants but I am quite struck by the argument that antidepressants do cause bowel problems.' (MHP 4, IBS)

When harm was discussed, for some it signalled a need to challenge the message that was embedded in much of the group talk, that there is no risk of harm.

'Let's not pretend that antidepressants are side-effect free.' (GP59, CFS)

Issues of harm were linked to the risks of side-effects, particularly with reference to IBS.

'... My worry about treating the symptoms with antidepressants is that some of the side-effects can make the irritable bowel worse.' (GP57, IBS)

The potential for 'withdrawal effects' and 'addiction' were also raised (MHP21, CFS). However, for some, the potential to do harm was considered to be a factor common to all pharmaceuticals, and was therefore discounted on the basis that decisions to weigh up the likely risks and benefits of treatment were pervasive across clinical decision making.

GP16: 'Do you think that they are risk free having antidepressants? That there is no kick back?'

GP27: 'In what way?'

GP16: 'Well I mean in the sense of there is no potential harm ...'

GP27: 'Well there is in paracetamol, there is in cocodamol ...' (CBP)

Some expressed a reluctance to prescribe because antidepressants had only 'short-term effectiveness' (GP16, IBS).

'... I would accept that there could be an improvement with antidepressants. But ... that would only be maintained as long as that person was on the antidepressants ...' (MHP21, CFS)

Reluctance to rely on antidepressants also resided in participants' discussions about the limitations of antidepressants relative to alternative modes of treatment. For example, reliance on antidepressants often did not facilitate a valuable shift of the locus of control from doctor to patient.

'But at least [with CBT] you have taught something that somebody can do ... whereas with the antidepressants ...' (MHP30, IBS)

The extent to which practitioners were reluctant to prescribe antidepressants varied across the three conditions. Participants expressed a reluctance to use antidepressants as a first-line treatment for IBS and CBP, due to the availability of alternative interventions.

'... irritable bowel syndrome we just give people one of 20 different 'bowel-meds' by rotation, until people find one that suits them. And back pain ... we all have an algorithm for that we just follow ... regardless of whether or not they presented with insomnia, depression or a funny feeling in their left ear, we just *do* the thing, you know ...' (MHP1, IBS)

In addition, for CBP in particular, it was argued that all physical causes had to be ruled out first before considering psychological causes for the patient, 'because of the possibility of litigations in the future' (GP120, CBP). Only once somatic management options that addressed physical symptoms had been exhausted, would mental health interventions be considered for patients with IBS and CBP.

'For people that don't respond, then you are into the psychological ...' (GP101, IBS)

And another:

> 'We have done it all, we excluded everything and still they have got their pain ... that is where the psychological interventions come into play in practice ...' (GP103, CBP)

In contrast, for CFS, participants were more willing to consider antidepressants at an earlier point in the management pathway, because they were more likely to believe that CFS had a psychological component.

> '... the organic cause the IBS patient believes they have, may be one that we can recognise and go along with. Whereas with chronic fatigue syndrome a lot of the patients' health beliefs seem a bit wacky.' (GP14, IBS)

And another:

> 'If chronic fatigue walks through your door you immediately think psychological don't you? If chronic back pain walks through your door, you don't immediately jump to that conclusion ...' (GP17, CBP)

> 'I would think that there's more of an obvious psychological component to CFS than IBS.' (MHP21, IBS)

Discussion

Antidepressant prescribing for patients with somatic conditions was driven by participants' reported dominant need to act. This was not without its costs, as demonstrated by the conflicted nature and confessional quality of much of the talk. Participants struggled to discuss the 'right way' to manage patients, and acknowledged the disparity between their beliefs about the effectiveness of antidepressants for these conditions and their prescribing of them. The place of antidepressants in the management hierarchy varied across the three conditions. This difference was intimately connected to reported beliefs about the underlying causes of IBS, CFS and CBP, the availability of other treatments and medico-legal concerns.

Action, in the form of prescribing antidepressants, was described in ways that suggested it allowed participants to fulfil their medical role in their own and their patients' eyes. The familiar problem of time pressures within the primary care consultation, which prevented GPs from responding in other ways, was also cited. The time it takes to fully explain the rationale for antidepressants and their potential risks was not discussed, nor were possible implications for treatment adherence if patients did not have ample opportunity to share their concerns.[14]

The potential to cause harm was cited as both a driver and disincentive for action. Prescribers were concerned about harming their therapeutic relationship and about exposing themselves to possible litigation if they missed an organic diagnosis in patients with CBP and IBS. Participants who were reluctant to prescribe were also concerned about the therapeutic relationship in terms of the dependence upon the doctor that antidepressants might engender in patients. They were also worried about unwanted pharmacological effects. This argument was dismissed by some 'prescribers' who argued that the side-effects of antidepressants should be placed within the context of the potential iatrogenic effects that can be caused by all prescribed medication.

Although the potential for harm was raised by both 'prescribers' and those who were more obviously reluctant to prescribe, the issue was not fully explored in any of the discussions. For example, the potential for unforeseen side- and withdrawal effects to undermine the doctor–patient relationship was not discussed, nor was the varying balance between potential benefit and harm according to the type and severity of the presenting complaint. Overall, mental health practitioners contributed most to the discussions of harm. This was probably because their practice was not directly influenced by long waiting times for other mental health interventions, which, unlike GPs, they could themselves provide as an alternative to antidepressants.

Comparison with other studies

Our finding of the dominant need of practitioners to act in order to help both patients and themselves has been reported in another study of physicians' perspectives on patients with CFS and fibromyalgia.[5]

In common with our findings, Britten also found that doctors may write prescriptions in order to maintain relationships with their patients, despite the fact that patient expectations do not necessarily support practitioners' perception of their need for a prescription.[7]

The need for GPs to prescribe in order to retain their authority in a situation in which they feel powerless has been previously reported for patients with medically unexplained conditions.[5] This is clearly a robust finding, which has implications for professional practice. The need to act was most often talked about as synonymous with prescribing, and this may be tied to the medical professional's role; prescribing is 'what they do' and it is what 'defines an encounter as medical and not social'.[15]

Finally, our results are in line with those of Rogers and Pilgrim who reported that GPs resorted to the use of antidepressants for patients with depression because time pressures prevented them from responding in other ways.[6]

Methodological considerations

Transcripts were examined both from groups of GPs and from mixed groups, in an attempt to elucidate the perceptions of both GPs and MHPs. However, the preponderance of GPs in the sample resulted in our ability to explore GPs' understandings of their practice in greater depth, compared with MHPs.

Each focus group was run according to a strict protocol, following the Nominal Group technique. While this aided the quantitative analyses reported elsewhere, it precluded the flexibility permitted by the grounded theory approach. Hence the facilitator was unable to change the question format during later groups to explore emerging issues during early groups.

Our method enabled us to analyse participants' reported rather than their actual behaviour. This allowed us to understand how practitioners formulate and rationalise practice and what they perceive to be 'the basis of their actions'.[13] Insights from this paper should be combined with and understood in the context of the increasing range of detailed micro-interactional examinations of doctors' and patients' negotiations about prescriptions.

The research setting may have influenced our findings in another way: it is plausible that when practitioners are required to discuss complex issues with peers in a focus group they are at pains to produce moral accounts of the work they do and to demonstrate sensitivity to the dilemmas of practice in order to 'come across as morally adequate, competent and reasonable'.[16] This may have resulted in an impression of greater conflict than is actually 'experienced' in daily practice.

Notwithstanding these potential limitations, our findings resonate with other studies in this field and give confidence in the theoretical generalisability of the work. Our findings also highlight a schism between notions of best practice, evidence and guidance and individual practitioners' constructions of medically unexplained conditions and their (pragmatic) management.

Conclusions and implications for practice

For effective implementation of the NICE recommendations to reduce antidepressant prescribing and of recent calls to 'target treatment more appropriately',[17] we need to understand practitioners' motivations for prescribing and the contexts within which they operate. The Health Select Committee concluded that GPs were unduly influenced by the pharmaceutical industry. While this may be a factor in some cases, our study suggests there are additional and complex influences at work. Prescribing antidepressants is driven by the practitioner's need to act, for themselves as much as their patients, within the constraints of limited resources and uncertainty about best practice. Individuals' rationalisations of and conflict about pragmatism versus idealism in practice was embedded in much of the group talk. This is not insignificant, since the practice consequence is one of practitioners continuing to resort to the prescribing of antidepressants on occasions when antidepressants may not represent the best available treatment.

Uncertainties were explicit in the group talk. Perhaps if such uncertainty were more openly discussed with patients, it may be possible to formulate *inaction* as a positive decision. Such discussions may be facilitated by clarifications of the patient's expectations. Patients often do not desire medication or have expectations of cure, and will often be aware of the complexity of their conditions.[17] In opening up such discussions, practitioners may well 'reduce the burden of expectation' on themselves, and encourage a move to 'facilitated self-management'.[18] Balancing uncertainty, authority and medical expertise continues to present a challenge and requires that practitioners and patients work together. Empirical evidence of expert laity, of patients and doctors negotiating complex and sensitive care pathways together exist. Issues of uncertainty can be discussed with positive effect.[19] For practitioners and patients to routinely address the uncertainties of managing common somatic conditions will require somewhat of a sea change. The 'burden of expectation' needs to be lifted, and uncertainty to be seen not as threatening to undermine professional expertise, but viewed as part and parcel of medical practice. For now, simple interventions, such as the use of patient information leaflets in general practice surgeries, in which the various treatment alternatives are made clear, have the potential to enable patients to steer the practitioners' *need to act* towards a fuller consideration of treatments – treatments that may be less immediate but more appropriate in the longer term.

In summary, the conflict between beliefs and behaviour was an omnirelevant feature of the group talk. This conflict not only promises to interfere with 'best practice' but also has the potential to thwart practitioners' job satisfaction and wellbeing. Recommended hifts in clinical behaviour should be

grounded in a sound understanding of the complex underlying motivations to *act*, some of which we have introduced in this paper.

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AUTHORS' CONTRIBUTIONS

RR undertook data collection. The qualitative analysis was planned and carried out by GL and RR. GL and RR wrote the paper and both authors approved the final version.

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ETHICS

The study received ethical approval from the London School of Hygiene and Tropical Medicine Ethics Committee.

CONFLICTS OF INTEREST

None.

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Appendix 1

Scenarios for treating CFS

Chronic fatigue syndrome (CFS) is characterised by severe, disabling fatigue and other symptoms including musculoskeletal pain, sleep disturbance, impaired concentration and headaches. Two definitions of chronic fatigue syndrome (from the US Centres for Disease Control and Prevention and Oxford, UK) are widely used. Both sets of criteria required that debilitating fatigue be present for at least six months, some functional impairment and that these features have not been caused by any other identifiable clinical condition. However the British criteria include the presence of mental fatigue, while the American criteria include a requirement for several physical symptoms.

Please indicate your level of **agreement** for using each different intervention (i.e. CBT, BT etc.) for treating a patient with *chronic fatigue syndrome* by placing a ✓ in the appropriate box. Please use the 9-point scale where 1 = strongly disagree and 9 = strongly agree:

When the patient suffering from CFS needs to return to work:	**... to improve physical functioning** **Strongly ..... Strongly disagree agree**	**... to improve psychological functioning** **Strongly ..... Strongly disagree agree**
	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
1 CBT/CT is a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
2 BT is a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
3 Brief psychodynamic therapy is a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
4 Antidepressants are a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

When the patient suffering from CFS demonstrates symptoms of depression:	**... to improve physical functioning** **Strongly ..... Strongly disagree agree**	**... to improve psychological functioning** **Strongly ..... Strongly disagree agree**
	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
5 CBT/CT is a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
6 BT is a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
7 Brief psychodynamic therapy is a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
8 Antidepressants are a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

When the patient believes that CFS has an organic cause:	**... to improve physical functioning** **Strongly ..... Strongly disagree agree**	**... to improve psychological functioning** **Strongly ..... Strongly disagree agree**
	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
9 CBT/CT is a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
10 BT is a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
11 Brief psychodynamic therapy is a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
12 Antidepressants are a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

When the patient suffering from CFS does *not* contribute economically to the household:	**... to improve physical functioning** Strongly disagree 1 2 3 4 5 6 7 8 9 Strongly agree	**... to improve psychological functioning** Strongly disagree 1 2 3 4 5 6 7 8 9 Strongly agree
13 CBT/CT is a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
14 BT is a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
15 Brief psychodynamic therapy is a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
16 Antidepressants are a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

When the patient suffering from CFS does *not* demonstrate symptoms of depression:	**... to improve physical functioning** Strongly disagree 1 2 3 4 5 6 7 8 9 Strongly agree	**... to improve psychological functioning** Strongly disagree 1 2 3 4 5 6 7 8 9 Strongly agree
17 CBT/CT is a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
18 BT is a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
19 Brief psychodynamic therapy is a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
20 Antidepressants are a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

When the patient suffering from CFS is willing to try any treatment recommended by you:	**... to improve physical functioning** Strongly disagree 1 2 3 4 5 6 7 8 9 Strongly agree	**... to improve psychological functioning** Strongly disagree 1 2 3 4 5 6 7 8 9 Strongly agree
21 CBT/CT is a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
22 BT is a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
23 Brief psychodynamic therapy is a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
24 Antidepressants are a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Scenarios for treating IBS

Irritable bowel syndrome (IBS) is defined as the combination of abdominal pain, disordered bowel habit (diarrhoea, constipation or alternating diarrhoea and constipation) and abnormal abdominal distension in the absence of demonstrable gastrointestinal disease.

Please indicate your level of **agreement** for using each different intervention (i.e. CBT, BT etc.) for treating a patient with *irritable bowel syndrome* by placing a ✓ in the appropriate box. Please use the 9-point scale where 1 = strongly disagree and 9 = strongly agree:

When the patient suffering from IBS demonstrates symptoms of depression	**... to improve physical functioning** **Strongly ..... Strongly disagree agree** 1 2 3 4 5 6 7 8 9	**... to improve psychological functioning** **Strongly ..... Strongly disagree agree** 1 2 3 4 5 6 7 8 9
25 CBT/CT is a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
26 BT is a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
27 Brief psychodynamic therapy is a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
28 Antidepressants are a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
When the patient believes that IBS has an organic cause:	**... to improve physical functioning** **Strongly ..... Strongly disagree agree** 1 2 3 4 5 6 7 8 9	**... to improve psychological functioning** **Strongly ..... Strongly disagree agree** 1 2 3 4 5 6 7 8 9
29 CBT/CT is a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
30 BT is a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
31 Brief psychodynamic therapy is a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
32 Antidepressants are a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
When the patient suffering from IBS recognises that the condition is exacerbated by stress:	**... to improve physical functioning** **Strongly ..... Strongly disagree agree** 1 2 3 4 5 6 7 8 9	**... to improve psychological functioning** **Strongly ..... Strongly disagree agree** 1 2 3 4 5 6 7 8 9
33 CBT/CT is a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
34 BT is a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
35 Brief psychodynamic therapy is a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
36 Antidepressants are a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
When the patient suffering from IBS shows no symptoms of depression:	**... to improve physical functioning** **Strongly ..... Strongly disagree agree** 1 2 3 4 5 6 7 8 9	**... to improve psychological functioning** **Strongly ..... Strongly disagree agree** 1 2 3 4 5 6 7 8 9
37 CBT/CT is a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
38 BT is a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
39 Brief psychodynamic therapy is a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
40 Antidepressants are a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Scenarios for treating chronic back pain

Chronic back pain (CBP) is characterised by the experience of constant or intermittent benign musculoskeletal pain which may manifest in the upper or (more commonly) the low back. Definitions often include the requirement that the back pain should have been experienced for at least 6 months. No organic cause for the pain can be identified.

Please indicate your level of **agreement** for using each different intervention (i.e. CBT, BT etc.) for treating a patient with *chronic back pain* by placing a ✓ in the appropriate box. Please use the 9-point scale where 1 = strongly disagree and 9 = strongly agree:

When the patient suffering from CBP suffers from pain-induced insomnia:	**... to improve physical functioning** **Strongly ..... Strongly disagree agree**	**... to improve psychological functioning** **Strongly ..... Strongly disagree agree**
	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
41 CBT/CT is a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
42 BT is a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
43 Brief psychodynamic therapy is a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
44 Antidepressants are a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

When the patient suffering from CBP shows no symptoms of depression:	**... to improve physical functioning** **Strongly ..... Strongly disagree agree**	**... to improve psychological functioning** **Strongly ..... Strongly disagree agree**
	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
45 CBT/CT is a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
46 BT is a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
47 Brief psychodynamic therapy is a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
48 Antidepressants are a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

When the patient suffering from CBP demonstrates symptoms of depression:	**... to improve physical functioning** **Strongly ..... Strongly disagree agree**	**... to improve psychological functioning** **Strongly ..... Strongly disagree agree**
	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
49 CBT/CT is a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
50 BT is a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
51 Brief psychodynamic therapy is a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
52 Antidepressants are a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

When the patient with CBP believes their condition has an organic basis:	**... to improve physical functioning** **Strongly ..... Strongly disagree agree** 1 2 3 4 5 6 7 8 9	**... to improve psychological functioning** **Strongly ..... Strongly disagree agree** 1 2 3 4 5 6 7 8 9
53 CBT/CT is a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
54 BT is a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
55 Brief psychodynamic therapy is a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
56 Antidepressants are a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
When the patient suffering from CBP does not have sleep problems due to the pain:	**... to improve physical functioning** **Strongly ..... Strongly disagree agree** 1 2 3 4 5 6 7 8 9	**... to improve psychological functioning** **Strongly ..... Strongly disagree agree** 1 2 3 4 5 6 7 8 9
57 CBT/CT is a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
58 BT is a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
59 Brief psychodynamic therapy is a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
60 Antidepressants are a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
When the patient suffering from CBP is willing to try any treatment recommended by you:	**... to improve physical functioning** **Strongly ..... Strongly disagree agree** 1 2 3 4 5 6 7 8 9	**... to improve psychological functioning** **Strongly ..... Strongly disagree agree** 1 2 3 4 5 6 7 8 9
61 CBT/CT is a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
62 BT is a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
63 Brief psychodynamic therapy is a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
64 Antidepressants are a good treatment option ...	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐