Family Emotional Health: A Survey of Family Practice Patients

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As a step toward defining psychosocial areas in which resident training in family medicine is needed, this study assessed the concerns patients had about the emotional health of their families. A questionnaire was developed to survey the patient concerns (ie, worries or perceived problems) for the developmental, psychological, and social functioning of their families. Patients in three family practice settings were administered the questionnaire while waiting for their appointments. Sixty-four percent of the patients perceived one or more areas of concern in their families. Close to half (48.9 percent) had concerns about themselves. Concerns about the emotional well-being of spouses were identified by 39.5 percent of those having spouses, and for children, 38.2 percent of those having children. Also, 39.7 percent expressed concern about their parents' emotional health. Further, while only 3.5 percent of the patients were given a psychiatric diagnosis, 26.5 percent of the charts contained notes revealing psychosocial problems at some patient visit. The results point to a major need for family physicians to develop skills in child, adult, and family evaluation of psychosocial functioning.

What psychosocial knowledge and skills are needed by the family physician? This crucial question needs a prompt but accurate answer. Prompt because the burgeoning family practice residencies are developing, or in many cases already have developed, curricula to teach a psychosocial content based on an impressionistic assessment of need. Accurate because to invest scarce resources in teaching content that will not be used is both wasteful and frustrating to residents and faculty alike. The reaction to such frustration may well be to turn away from the acquisition of psychosocial skills, leaving the family physician deficient in this crucial area.

There are several variables which delimit the knowledge and areas of competency needed by a family physician: (1) the type and frequency of conditions presenting in the office setting; (2) the physician time available to each patient; (3) motivation on the physician's part to treat specific dysfunctions; and (4) motivation on the patient's part to be treated.

The type and frequency of disorders appear to be definable. Surprisingly, however, attempts to define categories of problems, illnesses, or symptoms in the psychosocial area are relatively few in relation to the obvious need. One attempt was the large, ground-breaking study of the content of family practice in Virginia,[1] where behavioral problems represented 6.7 percent of the problems

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recorded. The investigators felt that many common emotional problems, however, were not being reported, eg, impotence and alcoholism. This "under-reporting" was thought to be due to physician reluctance to deal with these problems, aversion to labeling of patients, and also as a function of the recording system which did not permit simultaneous coding for two interrelated conditions. For example, it was not possible to record both pharyngitis and cancerophobia.[2] Behavioral problems ranking among the 100 most common reasons for patient contact in this study were: depressive neuroses (rank 12), anxiety neurosis (15), tension headache (69), abuse of alcohol (80), and family related problems (91).

In a large scale general practice survey in London, Shepherd et al[3] found the consultation rate for conditions given formal psychiatric diagnoses in females to be 131.9/1,000 patients at risk (ie, registered as participants in the practice) and for males to be 67.2/1,000. For females, only respiratory diseases (of 13 disease groups) were a more frequent reason for consultation. Neuroses accounted for 90 percent of the psychiatric diagnoses in both sexes. These patients with psychiatric diagnoses were also much more likely to have concurrent diagnoses of physical illnesses.

Further evidence was found through a questionnaire survey of family physicians in Washington State. Smith[4] found that the physicians responding considered that 20 to 30 percent of their patients had significant psychological or emotional impairment of some sort. They estimated that they spent an average of 26 percent of practice time dealing with these problems. Smith's respondents also felt that their main limitation in providing psychiatric care was time available in their medical practice.

Another investigator, Gardner,[5] reached similar conclusions by using reported prevalence of psychiatric disorder and applying it to family practices. Taking the national average of caseloads reported in 1965, he estimated that of the 2,000 adult patients seen for 7,100 visits by the average family physician, 300 patients and 30 percent of the visits were accounted for by patients having psychiatric disorders. He also concluded that time limitations were a crucial factor in planning for health care of the psychiatrically disordered since the average physician spent approximately 15 minutes per patient. He felt the physician's primary needs were for sensitivity to emotional problems and diagnostic acumen.

Recently, Regier et al[6] concluded from multiple epidemiological studies, including the 1975 National Ambulatory Medical Care Survey, that of the approximately 15 to 20 percent annual prevalence of mental disorders in the general population, 54.1 percent were seen exclusively in the primary care/outpatient medical sector. In contrast, 15 percent were seen in the specialty mental health sector, and 6 percent in both.

These studies clearly underscore the need for family physicians to be skilled in mental health care. They do not, however, indicate which areas are of the greatest importance. Is there, for example, sufficient need to invest resources in training for competency in management of psychosocial disorders in children, marital dysfunction, or early alcoholism? Or shall family physicians with limited time available concentrate on triage or referral of all psychosocial problems? It is therefore of the utmost importance that the more globally defined need for skills be further refined and the specific "need to know" be ascertained.

In attempting to define specific areas in which it is crucial that the family physician have knowledge and skills, the authors felt it was important to examine those problems of a psychosocial nature presenting regularly to a family practice office. There are several levels on which patient needs can be assessed: (1) the conscious concerns of the patient; (2) the observed or elicited psychosocial problems and psychopathology; and (3) the physician recognition of problems in the patient and his/her family. The first level may be assessed by directly asking the patient about his emotional concerns. The second level requires assessment by special interview or tests of mental status of the patient and family members. The third level involves the family physician in identifying the emotional state of the patient and the patient's family. The present study focuses on the first level: assessment of patients' conscious concerns about the emotional health of their families.

Methods

Sample

The study sample was obtained from three family practice settings. Two of the settings were Family Practice Centers served by residents and

faculty in family practice. One of these settings was in an urban, industrialized area and the other in a suburban area. The third was a private group practice in a rural community served by experienced family physicians. The three settings differed somewhat demographically, eg, the rural clinic sample was on the average, older than the other two, but for purposes of this study, the samples were combined. The mean patient age was 35.96 (± 16.51) years. Seventy-two percent of the respondents were female and 28 percent male, reflecting both the usual preponderance of female patients and the fact that the mothers of child patients filled out the questionnaire for their families. Income source was 85.9 percent by employment, 7.4 percent social security benefits, 2.6 percent disability insurance, 0.7 percent welfare, and 2.6 percent unspecified. Household composition was two parents and children for 59.6 percent, one parent with children for 16.5 percent, childless couple for 15.2 percent, and single adult for 9.0 percent.

Questionnaire

The Family Emotional Health Survey Questionnaire was developed to assess the conscious concerns of patients for their families. The questionnaire was divided into five sections. The first section requested demographic information. The remaining four sections inquired about concerns for specific family members: children, self, spouse, parents.

As in any clinical study, it was important that the questionnaire not be too great a burden to the patient nor to the operation of the clinical facility. With this in mind, questions were limited in number, phrased in as nonthreatening a manner as possible, and their actual use was preceded by a pilot study. Following the pilot study, questions not clearly understood by the patients were revised.

Child Concerns

Eleven questions inquired about children. One question applied only to preschool children and asked whether their general development was satisfactory or not. Five questions addressed preschool and/or school age children and asked about parental concerns with respect to school progress, behavior problems (excess fighting, lying, stealing, excess fearfulness, crying), peer relations, emotional state (eg, very sad, withdrawn, angry, irritable), sexual behavior, and alcohol or drug use. Three questions were directed at adult children: ability to work, marital adjustments, and concerns about grandchildren.

Concerns About Self

There were eight questions covering work problems, relations with members of the household, emotional state (eg, very sad, depressed, withdrawn, angry, excessively frightened, very irritable, weepy), peer relations, relations with family members outside of household, sexual problems, marital problems, and if single, concerns about an intimate male or female relationship.

Concerns About Spouse

There were six questions asking about spouse's work problems, problems getting along with household members, emotional state (eg, very sad, withdrawn, angry, irritable, violent, excessively weepy), relations with peers and with friends, sexual problems, and alcohol or drug problems.

Concerns About Parents

Four questions inquired as to parental emotional state, marital relationship, relationship with the patient, and alcohol or drug use.

All but three questions requested only a "yes" or "no" response. The questions about children's behavior problems, the self-concerns about emotional state, and concerns about spouse's emotional state had additionally a "yes-mild" and "yes-severe" response available. If a response was checked "yes," the patient was asked to describe the concern or problem in space provided. It required from 15 to 20 minutes to fill out the questionnaire.

Procedure

Patients were approached while waiting for their appointment. It was explained that the authors were conducting a survey of family emotional health concerns so that families could be better served by their physicians. Cooperation was excellent but as one might expect, if patients did not finish the questionnaire before being seen

Table 1. Family Emotional Concerns

	Number	Mean	Standard Deviation	Range	Percent with One or More Concerns
Total Concerns	286	3.46	2.77	0–21	64.1
Self Concerns	286	1.54	1.00	0–7	48.9
Spouse Concerns	165	.77	.99	0–6	39.5
Child Concerns	168	.69	.78	0–4	38.6
Parent Concerns	186	.62	.88	0–4	39.2

Table 2. Concerns About Self

Area of Concern	N*	Percent Concerned
Work Performance	268	8.6
Relations with Family	227	22.0
Emotional State**	278	33.1
Relations with Friends	283	8.1
Sexual Relations	274	7.7
Marriage	200	16.4
Close Adult Relationship Other than Spouse	75	18.7

*Number answering question
**6.5 percent considered their emotional state a severe concern

by the physician, they were sometimes reluctant to spend additional time to complete it after their visit. Consequently, although there were no refusals to take part in the survey, only 82 percent of the questionnaires were sufficiently complete to be used in the data analysis.

Following the completion of the questionnaire and physician visit, the patient's chart was reviewed to determine (1) diagnosis for this visit, and (2) whether psychosocial problems at this or previous visits had been noted. Noting of psychosocial problems at any time in the chart would indicate physician recognition of this area of concern, and need not be currently noted to be within the physician's awareness.

Results

The most striking aspect of the results as seen in Table 1 is the unexpectedly large percentage of patients acknowledging concern about their family's emotional health. Sixty-four percent of patients had one or more areas in which they perceived problems or concerns in the emotional life of their family. This occurred despite the fact that it is to be anticipated that a questionnaire will often obtain an underestimation of concerns because of reluctance to enter personal data. While 64 percent may still be an underestimation even at this level, it clearly demonstrates that family practice patients are very much aware of the existence of family emotional problems. They are also most likely willing to tell physicians about them.

As can be seen from Table 1, almost half (48.9 percent) of the patients had concerns about themselves. These concerns (Table 2) were mainly about their emotional state ("depressed and lonesome," "emotionally I've been hurt," "depression"), their nuclear family relations ("don't get along with my mother"), and their marital relations ("lack of fulfillment," "my husband"). Again, given the drawbacks of questionnaires, it seems surprising that as many as 7.7 percent of the respondents expressed concerns about their sexual functioning ("inability to reach a climax," "frigidity"). Also to be noted is that 6.5 percent of the patients considered their emotional state of severe concern to them.

Of those patients who were parents, 38.6 per-

cent had one or more concerns about their children. These concerns, as shown in Table 3, focused on behavior problems for 16.9 percent ("fighting because of jealousy," "hyperactive," "very wild at home"), emotional state for 15.8 percent ("daughter withdrawn," "difficult to reach"), and school progress for 10.1 percent. A somewhat surprising 8.4 percent of parents expressed concern about alcohol and drug use by their dependent children.

Concerns about spouses follow a pattern similar to self-concerns but with reduced frequency (Table 4). In this study, 30.5 percent expressed concerns about their spouse's emotional health ("depressed and frightened," "angry, irritable, violent," "very argumentative"). However, concern about work performance was considerably higher for spouses than for the respondents themselves. This probably represents the fact that most spouses referred to were husbands who were the principle source of income for most of these families. Other examples of comments about spouses were: "withdrawn, angry, irritable," "drugs," "very short tempered," "younger daughter extremely antagonistic towards her father," "cannot get along with co-workers," "cannot tolerate the children," "hates the responsibility of married life," "angry, irritable," "my frigidity has very negative affects on him."

Concerns for parents in the emotional area were also considerable. As can be seen in Table 5, just about as many people were worried about the emotional health of their parents as were concerned about their spouses. Concerns about both the parents' emotional state and their marital relationship were high, being respectively 22.2 percent and 16.0 percent. Also to be noted is the 9.5 percent that were concerned about parental drug or alcohol abuse.

When considering how many of these concerns were eventually elicited by the physician, the inquiry was limited to charted information. While only a low 3.5 percent of the charts gave a diagnosis of mental, personality, or psychoneurotic disorders (RCGP Category 5), 26.5 percent of the charts contained notes of psychological symptoms during some visit. In those charts in which psychological symptoms were noted, the patients had an average of 4.38 (±2.98) concerns, while those patients whose charts did not have any symptoms noted had an average of 3.17 (±2.67) concerns.

Table 3. Concerns About Children

Area of Concern	N*	Percent Concerned
Preschooler's Development	74	5.4
School Progress	119	10.1
Behavior Adjustment**	166	16.9
Peer Relations	164	7.9
Emotional State	165	15.8
Sexual Behavior	145	2.8
Alcohol/Drug Use	143	8.4
Adult Child's Work	65	9.1
Adult Child's Marriage	43	6.8
Grandchildren	51	13.7

*Number answering question
**7.2 percent responded that behavior problems were severe

Table 4. Concerns About Spouse

Area of Concern	N*	Percent Concerned
Work Performance	186	12.9
Relations with Family	190	15.8
Physical Health	190	23.7
Emotional State	186	21.5
Peer Relations	189	5.3
Sex	181	6.1
Alcohol/Drug Use	181	6.4

*Number answering question

The difference of these two means was significant ($t=3.20$, $P<.001$). However, there is a large group of patients who expressed often serious concerns whose charts gave no evidence of problems in the psychosocial area.

When psychological problems were noted, it was almost always for patients who had expressed self-concerns on the questionnaire and which had to do with the patient's own mental status. Charting of psychosocial problems rarely reflected a patient's concern about family members. This fact was clarified by a multiple regression analysis of psychosocial problems charted with the four categories of concern. This analysis yielded a

Table 5. Concerns About Parents		
Area of Concern	N*	Percent Concerned
Emotional State	221	22.2
Marital Relationship	188	16.0
Relation with Respondent	216	7.4
Alcohol/Drug Use	222	9.5
*Number answering question		

multiple regression coefficient of .32, with self-concerns representing 94 percent of the variance accounted for by these four categories.

Discussion

The high prevalence of family emotional concerns expressed in the questionnaires clearly attests to the need for psychosocial skills by family physicians. It can be assumed that labeling of a behavior as a problem by a patient does not necessarily mean the patient or family member is in need of treatment. It does mean, as is true throughout medicine, that the patient's perception of a dysfunction or concern about a dysfunction should set into motion physician assessment, evaluation, and advice or recommendations as to the necessity for treatment.

These survey results show that in these settings, patients frequently have a large number of concerns about family functioning which are not being subjected to evaluative procedures. Only rarely was there any indication that a patient's concerns about other family members elicited steps to evaluate those individuals. It is likely that in many cases the physician did know of the existence of behavior problems in the children or mood disturbances in a spouse, and without charting it, urged the patient to have the family member come in. It seems to the authors, however, that when patient concerns about family emotional dysfunction are elicited by the physician, it is much less frequent for a formal evaluation to be offered in the same way that a somatic symptom in a family member will elicit such a recommendation.

These results, then, point to a major need for family physicians to develop skills in child and adult evaluation of psychosocial functioning. Parents need an assessment of their children's emotional and behavioral state and need appropriate guidance and recommendations. There are also strong indications for training in marital and sexual assessment and in evaluating drug and alcohol abuse.

Two often-stated constraints on psychosocial assessment by primary care physicians are the limited time available to the physician and the reluctance of patients to accept help for psychosocial problems. The latter concern is probably spurious. Patients are often uncomfortable about discussing emotional problems, but these questionnaire results, if they tell anything, say that the patients can perceive and communicate a psychosocial concern. The physician who finds most patients unwilling to discuss these issues perhaps needs to assess his inteviewing skills and, if necessary, improve them for his own professional gratification as well as for the patient.

The issue of time constraint is a more difficult but not insurmountable one. Some techniques of rapid assessment and triage for emotional problems have been developed and more need to be developed by the family physician. Many settings use questionnaires to elicit psychosocial and mental status data before the initial physician-patient contact. Such aids are desirable but can form only a part of the data base for the psychosocial assessment. Physician skills in assessment will be the key to effective primary care.

Further studies in the area of family emotional health are clearly needed. Other levels of study which need to be undertaken are: (1) direct patient and family assessment, and (2) physician perception of family dysfunction. Family medicine's goal of treating the family as the clinical unit requires that resident training ensures a high degree of competence in assessment techniques in child, adult, and family psychopathology.

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