

# The Impact of Recent Emotional Distress and Diagnosis of Depression or Anxiety on the Physician-Patient Encounter in Family Practice

Edward J. Callahan, PhD; Carlos R. Jaén, MD, PhD; Benjamin F. Crabtree, PhD; Stephen J. Zyzanski, PhD; Meredith A. Goodwin, MS; and Kurt C. Stange, MD, PhD  
Sacramento, California; Buffalo, New York; Omaha, Nebraska; and Cleveland, Ohio

**BACKGROUND.** Primary care physicians are expected to identify mental health problems. Currently, it is unclear how a recent experience of emotional distress affects the physician-patient encounter and the diagnostic process.

**METHODS.** Using the Davis Observation Code, we studied 1269 encounters between family physicians and adult patients who completed brief questionnaires after the visit. Patients were separated into three groups using self-report and billing data: those denying recent emotional distress, those reporting recent emotional distress but not receiving a mental health diagnosis, and those reporting recent emotional distress and receiving a diagnosis of anxiety or depression.

**RESULTS.** Nineteen percent of patients reported significant emotional distress during the previous 4 weeks; 18% of these patients received a billing diagnosis of depression or anxiety. Patients not reporting emotional distress had the shortest visits (10.0 minutes); recent emotional distress was associated with significantly longer visits: 11.5 minutes for those without a diagnosis of depression or anxiety and 12.8 minutes for those with a diagnosis of depression or anxiety. The visits of patients with a diagnosis of depression or anxiety included more counseling, history-taking, and discussions of family information and substance use, and less time providing physical examination and evaluation feedback. Fewer preventive services and less chatting occurred when patients reported recent distress, regardless of diagnosis.

**CONCLUSIONS.** Recent patient emotional distress has a powerful impact on the structure of the family practice visit, with important implications for efforts to enhance diagnosis and treatment of mental health issues. The challenge for the family physician is to recognize and treat a patient's emotional distress while continuing to fulfill competing medical demands.

**KEY WORDS.** Physician-patient relations; physician, family; depression; office visits; physician's practice patterns. (*J Fam Pract* 1998; 46:410-418)

Family practice was launched as a new specialty with a stated goal of integrating a psychosocial perspective into the delivery of primary care medicine.<sup>1,2</sup> Since the inception of this innovative field, recognition of the role of the primary care clinician in the "hidden mental health network"<sup>3,4</sup> has increased expectations that family physicians recognize and treat emotional problems. Recent guidelines have enhanced these expectations.<sup>5</sup> Although depression and anxiety are the most commonly encountered mental health problems in primary care, under-recognition of both problems is well documented among primary care clinicians.<sup>6,8</sup> Difficulty in recognizing and

diagnosing mental health problems is a multifaceted problem influenced by physician knowledge<sup>6</sup> and attitudes.<sup>9</sup> In addition, physicians may underreport depression and anxiety in billing or even charting because of reimbursement concerns or a fear of stigmatizing the patient to insurers, employers, or others.<sup>10,11</sup>

Despite the importance of recognizing patient emotional distress and diagnosing and treating depression and anxiety, the diagnosis of mental health problems competes with other worthwhile agenda priorities for time, energy, and salience during the primary care outpatient visit. These competing demands and opportunities to diagnose and intervene for a wide variety of illnesses

Submitted, revised, February 20, 1998.

From the Department of Family and Community Medicine and the Center for Health Services Research in Primary Care, University of California, Davis (E.J.C.); the Center for Urban Research in Primary Care Departments of Family Medicine and Social and Preventive Medicine at the State University of New York at Buffalo (C.R.J.); the Department of Family Practice, University of Nebraska Medical Center, Omaha (B.F.C.); the Department of Family Medicine (S.J.Z., M.A.G., K.C.S.), the Department of Sociology (K.C.S.), the Department of Epidemiology & Biostatistics (S.J.Z., K.C.S.), Case Western Reserve University and the Ireland Cancer Center at Case Western Reserve University and University Hospitals of Cleveland (S.J.Z. and K.C.S.). Requests for reprints should be addressed to Edward J. Callahan, PhD, Department of Family and Community Medicine, University of California, Davis, 2221 Stockton Blvd, Sacramento, California 95817.  
E-mail: edward.callahan@ucdmc.ucdavis.edu

and risk factors have only recently been described.<sup>12,13</sup> Competing agenda priorities may be a major reason for underdiagnosis of many conditions, including depression and anxiety, in primary care.

Another key barrier to the recognition of mental health problems in the primary care visit may lie in the patient's presentation. Good and her colleagues<sup>14</sup> note that most patients are reluctant to share emotional concerns. Recent qualitative analysis suggests that patients provide only broad hints about the presence of emotional distress, sharing personal information about the experience of stress only with encouragement.<sup>15</sup> Diagnosis and treatment of a mental health problem in primary care begins with the response of the clinician to the patient's disclosure of emotional issues. Therefore, it is critical to learn which patients bring emotional concerns into the primary care office, and how often, in order to study how the primary care clinician recognizes, evaluates, and responds to that emotional distress. Because of the competing agendas of the primary care outpatient visit, it is also critical to learn how the physician-patient encounter and physician-patient relationship are altered in response to those concerns. How is the encounter changed if the physician recognizes and diagnoses the patient's emotional distress? Which services are omitted when clinicians with limited time per visit attend to and diagnose the patient's emotional distress?

To explore these issues, we assessed characteristics of patients, visits, and time use for three groups of patients visiting their family physician: those reporting no recent emotional distress on the patient exit questionnaire; those reporting recent emotional distress that was not associated with a diagnosis of anxiety or depression; and those reporting emotional distress who received a diagnosis of depression or anxiety. Our hypotheses included: (1) that certain patient characteristics would be more common among patients with emotional distress, including female gender, lower educational attainment, poorer health status, and more office visits in the previous year; (2) that certain of these characteristics (female gender, lower educational attainment, previous diagnosis of depression or anxiety on the medical record) would be associated with a higher rate of diagnosis of current depression or anxiety; (3) that patients' report of emotional distress and its diagnosis would be less common during visits for well care or acute illness; and (4) that the presence of patient emotional distress and its diagnosis would lead to differences in time use during visits, as previously reported with depressed patients in visits to resident physicians.<sup>16</sup>

## METHODS

### STUDY DESIGN AND DATA COLLECTION

This study was part of the Direct Observation of Primary Care (DOPC) study, a cross-sectional examination of the content of outpatient visits to family physicians in north-

east Ohio. The methods of the DOPC study have been described in detail elsewhere.<sup>17,18</sup> Briefly, participating physicians were visited by a team of research nurses while providing outpatient care on 2 separate days. The patient sample consisted of consecutive patients seen during the 2 days of observation. Patients were informed about the study in the waiting room before meeting with their physicians, and were enrolled if they gave verbal informed consent.

Research nurses collected data on the content and context of family practice using the following methods: direct observation of the patient visit using the Davis Observation Code (DOC)<sup>19</sup> and a direct observation checklist, a patient exit questionnaire completed following the visit, review of medical records of all directly observed patients, billing data with Current Procedural Terminology (CPT) codes and ICD-9-CM diagnoses, and questionnaires completed by the physicians following their participation in the study. Research nurses reviewed patient medical records to gather data on patient characteristics including age, sex, whether the patient was new or established, number of visits to the physician and the practice within the previous year, and history of depression and anxiety diagnoses. Marital status, duration of relationship as a patient of the physician, recent emotional distress, health status, and satisfaction with the visit were determined from the patient exit questionnaires. Health status was measured using a modified version<sup>17</sup> of the Medical Outcomes Study (MOS) 6-item General Health Survey.<sup>20</sup> The analyses presented here were restricted to patients, 18 years of age or older, who returned a patient exit questionnaire.

### SAMPLE SELECTION

To test the hypotheses of this study, patients were grouped into three categories on the basis of their recent emotional distress (self-reported on the patient exit questionnaire) and the physician's billing diagnosis for the observed visit. Emotional distress was measured by a single item from the MOS 6-item General Health Survey<sup>20</sup> on the patient exit questionnaire, which asked, "During the past 4 weeks, how much have you been bothered by emotional problems (such as feeling anxious, depressed, or irritable)?" Patients who responded that they had been bothered "extremely" or "quite a bit" on a 5-point Likert-type scale were considered to be symptomatic for emotional distress. Patients who responded that they were "not at all" bothered by emotional problems and had no diagnosis of depression or anxiety were selected for the comparison group.

### MEASURES

Diagnosis of depression or anxiety was measured by ICD-9-CM diagnosis codes listed for the index visit. Research nurses recorded up to five ICD-9-CM codes for each visit obtained from the billing information provided by the practice. These diagnoses were grouped into diagnosis clusters as described by Schneeweiss et al.<sup>21</sup> Individuals

TABLE 1

**Frequency of ICD-9-CM Diagnoses within the Sample that Fall under the Diagnosis Cluster for Anxiety or Depression**

ICD-9-CM code	Description*	n
300.0	Anxiety states	19
300.1	Hysteria	3
300.2	Phobic disorders	1
300.4	Neurotic depression	24
308.0-308.9	Acute reaction to stress	10
309.0-309.9	Adjustment reaction	5
311.0	Depressive disorder	25

Table based on description of diagnosis clusters in Schneeweiss R, et al.<sup>21</sup>

\*In the study sample, there were no patients with the other diagnoses in this diagnosis cluster, which includes: obsessive-compulsive disorder (300.3), neurasthenia (300.5), depersonalization syndrome, hypochondriasis, other neurotic disorders (300.8), unspecified neurotic disorder (300.9), psychosexual dysfunction (302.7), physiological malfunction due to mental factors (306.0-306.9), enuresis or encopresis (307.6-307.7), disturbance of conduct (312.0), disturbance of emotions specific to childhood and adolescence (313.0), hyperkinetic syndrome (314.0), and nervousness (799.2).

were considered to have had their condition diagnosed as depression or anxiety if any of the five ICD-9-CM codes collected for their visit fell under the diagnosis cluster for depression or anxiety. The specific diagnoses that constitute the diagnosis cluster and their frequency in the sample are listed in Table 1.

Nurse-observers used direct observation to record visit characteristics, including length of visit, reason for visit (well care, acute illness, chronic illness, other), whether a referral was made, the presence of another family member, discussion of another family member's problems, whether emotional issues were raised by the patient, and the response by the physician to those emotional issues. The number of problems addressed during the visit was determined from the medical record. Items that assess the interpersonal relationship and communication between the patient and physicians were measured on a 5-point Likert-type scale included in the patient exit questionnaire.<sup>22</sup>

The way in which time was spent during patient visits was measured by the research nurse using the DOC during the visit. The DOC categorizes time use during each successive 15-second interval by noting the occurrence or nonoccurrence of 20 operationally defined behavioral categories.<sup>19</sup>

## ANALYSES

Descriptive statistics on the characteristics of the patients, visits, and physicians in the sample were calcu-

lated. Univariate statistics were used to determine if these characteristics were different between the three comparison groups. Chi-square tests were used for categorical variables, while analysis of variance (ANOVA) was used for continuous independent variables.

Differences in time use during visits were analyzed by comparing the mean proportion of time spent on each activity between the three groups using ANOVA techniques. Post hoc analyses, specifically the Tukey HSD, were used to test the pairwise differences between means for those activities for which time was significantly associated with group. Additional analyses were performed using analysis of covariance to control for potentially confounding patient characteristics.

## RESULTS

A total of 3475 consecutive adult outpatient visits were observed. Of these, 2634 (76%) returned a patient questionnaire, and 2627 responded to the question about their level of emotional distress during the past 4 weeks. The 1347 patients who reported being bothered by emotional distress "slightly" or "moderately" were excluded, leaving 1280 patients, of whom 437 reported being bothered "extremely" or "quite a lot" and 843 reported being bothered "not at all." An additional 11 patients who reported being bothered "not at all" but who had received a diagnosis of depression or anxiety were excluded, leaving a final sample of 1269 patients.

The mean age of patients in the final sample was 52.3 years; 63% were female; 66% were married; and 50% had graduated from high school. These characteristics are similar to the sample of adult patients from the larger DOPC study.<sup>18</sup>

Table 2 shows the association of patient characteristics with self-report of recent emotional distress and mental health diagnosis. Women made up a significantly larger proportion of those who reported being bothered by recent emotional distress and who were not given depression or anxiety diagnoses (72.3%) than of those who did not report recent emotional distress (57.4%). Further, women made up a significantly larger proportion of the population having a diagnosis of depression or anxiety (85.0%) than they did of the population reporting recent distress but not given such a diagnosis (72.3%). Reports of recent emotional distress both with and without diagnosis of depression or anxiety were less common among those with more education. Those with self-reported recent emotional distress were less apt to be married, reported lower overall health status, and had a higher number of visits to the practice in the past year. Patients who reported being bothered by recent emotional distress but who had no diagnosis had slightly lower scores on the continuity of care measure. Having a previous diagnosis of depression or anxiety on the medical record was associated with

TABLE 2

**Association of Patient Characteristics with Self-reported Emotional Distress Symptoms and Diagnosis of Depression or Anxiety**

Characteristic	No Emotional Distress (n=832)	Emotional Distress Undiagnosed (n=357)	Emotional Distress Diagnosed (n=80)	P*
Age (mean years)	53.2	51.0	48.9	.027
Sex (% female)	57.4	72.3	85.0	<.001¶
Race (% nonwhite)	8.8	11.1	10.1	NS
Education (% >high school)	53.0	44.8	40.3	.008‡
Marital status (% married)	71.4	56.2	53.8	<.001‡
Health status (mean)	4.2	2.7	2.8	<.001‡
Duration of relationship (%)				NS
<1 year	20.4	25.8	18.4	
1-6 years	48.6	44.4	59.2	
7 or more years	31.0	29.7	22.4	
Insurance (%)				<.001‡
Medicare	32.2	29.4	20.0	
Medicaid	2.6	9.0	12.5	
Managed care	37.3	30.3	30.0	
Regular care	19.8	17.9	21.3	
Other	2.4	4.4	3.8	
None	5.6	9.0	12.5	
No. of visits in last year to physician	3.7	4.7	4.9	<.001‡
Satisfaction, expectations met (mean)	4.5	4.2	4.3	<.001†
Satisfaction, MOS 9-item Visit Rating Form (mean)	4.4	4.2	4.3	.040†
History of depression on problem list (%)	5.6	29.5	74.7	<.001¶
History of anxiety on problem list (%)	3.0	15.7	50.0	<.001¶
Patient reports that: (1=strongly disagree, 5=strongly agree)				
Can discuss personal problems with physician (mean)	4.4	4.4	4.6	NS
Physician does not listen	1.5	1.6	1.4	NS
Have been through a lot with physician	3.1	3.3	3.7	.001‡
Physician is unaware of other care	3.8	3.6	4.1	.022§
Can see physician for emotional problems	4.0	4.0	4.6	.037‡
Did not bring up desired issues with physician	1.6	2.0	1.8	.001†
Usual provider continuity (mean)	0.7	0.6	0.7	.017†

\*Results of post hoc analyses,  $\chi^2$  analyses for categorical variables, and Tukey's HSD for continuous variables.

†The means in columns 1 and 2 are statistically different,  $P < .05$ .

‡The means in columns 1 and 3 are statistically different,  $P < .05$ .

§The means in columns 2 and 3 are statistically different,  $P < .05$ .

¶All of the means are statistically different,  $P < .05$ .

a higher rate of patient report of recent emotional distress, and with a much higher rate of diagnosis of depression or anxiety for the observed visit.

Those patients reporting recent emotional distress that did not result in a diagnosis of depression or anxiety also

reported more unmet expectations in the visit, lower overall satisfaction with the visit, and were more likely to report that they did not bring up all they wanted to discuss with the physician.

Table 3 highlights a number of differences in character-

TABLE 3

**Association of Visit Characteristics with Self-reported Emotional Distress Symptoms and Diagnosis of Depression or Anxiety**

Characteristic	No Emotional Distress (n=832)	Emotional Distress Undiagnosed (n=357)	Emotional Distress Diagnosed (n=80)	P*
Length of visit (minutes)	10.0	11.5	12.8	<.001††
Reason for visit (%)				
Acute	60.3	64.5	47.6	.004‡§
Chronic	27.5	27.8	46.0	
Well care	12.3	7.8	6.3	
Patient raises emotional content (%)	5.0	21.1	59.0	<.001¶
Physician responds to emotional content (%)	4.8	18.2	55.3	<.001¶
Discordance in reason for visit (%)	22.6	31.1	25.0	.008†
Number of problems addressed during visit	1.8	2.2	2.4	<.001††
New vs established patient (% new)	7.9	6.4	3.8	NS
Other family member present (%)	13.5	17.5	13.2	NS
Referral (%)	11.1	10.4	11.3	NS

\*Results of post hoc analyses,  $\chi^2$  analyses for categorical variables, and Tukey's HSD for continuous variables.

†The means in columns 1 and 2 are statistically different,  $P < .05$ .

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§The means in columns 2 and 3 are statistically different,  $P < .05$ .

¶All of the means are statistically different,  $P < .05$ .

istics of visits by the three groups of patients. Visits of patients who reported recent emotional distress were significantly longer than visits of those without recent emotional distress, and even longer, although nonsignificantly so, if the patient received a diagnosis of depression or anxiety. Depression or anxiety was significantly less likely to be diagnosed during visits for acute illness or well care than for care of chronic illnesses. Not surprisingly, patients who reported recent emotional distress were more likely to have brought up emotional issues during the visit; during more than half of the visits resulting in a diagnosis of depression or anxiety, the research nurse observed that emotional content was initiated by the patient. Observer report of physician response to emotional issues rose in direct proportion to the likelihood that emotional material was raised. Patients with recent emotional distress who did not receive a mental health diagnosis were more likely to report a reason for visit that was discordant with the reason for visit reported by the research nurse observing the visit. Emotionally distressed patients had a greater number of problems addressed during the observed visit, regardless of whether or not their distress resulted in a diagnosis of anxiety or depression.

Table 4 reveals that time use during the physician-patient encounter varied among these three groups. As expected, a higher percentage of visits involved some time

spent in counseling patients with a diagnosis of depression or anxiety (66.3%), compared with patients reporting recent emotional distress but having no mental health diagnosis (26.9%) and patients reporting no recent emotional distress (10.0%). This indicates that a lack of diagnosis of depression or anxiety corresponds with less psychological counseling around emotional distress.

Chatting was less likely to occur during visits by patients who reported recent emotional distress regardless of whether a diagnosis of depression or anxiety was made. Significantly more history-taking and family information gathering took place during visits by those who reported recent emotional distress and who received a diagnosis, while time spent in physical examination was reduced only for those who had a diagnosis of an emotional problem. Overall, preventive services received less attention, but smoking and substance use were addressed more often for those patients having a diagnosis of depression or anxiety.

## DISCUSSION

This study reveals the substantial impact of recent experiences of emotional distress on the physician-patient encounter, supporting three of four hypotheses initially proposed, and suggesting the importance of discussing

TABLE 4

Differences in the Proportion of Time Spent among Patients without Symptoms of Emotional Distress and Those with and without a Diagnosis of Depression or Anxiety

Variable	No Emotional Distress (n=832)	Emotional Distress Undiagnosed (n=357)	Emotional Distress Diagnosed (n=80)	P*
History-taking	54.9	58.6	63.6	<.001†‡
Planning treatment	32.1	31.1	29.9	NS
Physical examination	23.4	20.1	10.6	<.001¶
Health education	19.7	19.3	18.1	NS
Feedback on evaluation results	14.0	13.3	9.8	.001‡§
Family information	8.9	10.4	17.7	<.001‡§
Chatting	9.0	6.6	5.6	<.001‡§
Structuring the interaction	7.7	8.0	6.5	NS
Patient questions	6.8	7.7	6.0	.043
Preventive services	3.8	2.6	2.5	.006†
Procedures	3.9	3.4	0.7	NS
Nutrition advice	1.8	1.8	1.5	NS
Counseling	0.7	2.9	14.2	<.001¶
Exercise advice	1.9	1.4	2.2	NS
Compliance assessment	1.3	1.7	1.6	NS
Smoking behavior assessment or advice	1.3	2.0	0.5	.025§
Assessing patient's health knowledge	1.1	1.5	1.6	.019†
Health promotion	1.1	1.3	1.4	NS
Negotiation	1.0	1.1	1.4	NS
Substance use assessment or advice	0.3	0.7	0.9	.003†

\*Results of pairwise comparisons of means using Tukey HSD.

†The means in columns 1 and 2 are statistically different,  $P < .05$ .

‡The means in columns 1 and 3 are statistically different,  $P < .05$ .

§The means in columns 2 and 3 are statistically different,  $P < .05$ .

¶All of the means are statistically different,  $P < .05$ .

Note: The findings were unchanged in analysis controlling for patient age and sex.

recent emotional distress in diagnosing mental health problems. In Table 3, patients without a diagnosis who reported recent experience of emotional distress were 4 times more likely to address emotional issues in the visit than those who did not report recent emotional distress (21.1% vs 5%), while those with a mental health diagnosis were 12 times more likely to address emotional concerns (59%). This disproportion probably reflects a more open

presentation style of patients whose conditions are diagnosed, and supports the idea that addressing emotional concerns in the visit is an initial step that leads to recognition and diagnosis of a mental health problem.

These data also appear to reflect a change in the content of the visit after a mental health diagnosis is made, supporting the predicted shift from a biomedical strategy, of symptom evaluation to a psychosocial strategy, as

Carney et al<sup>23</sup> have recently hypothesized in their study of various approaches to the diagnosis of depression. Physicians who discuss emotional issues appear to be more likely to make diagnoses of depression or anxiety. Our data also show that physician response to presentation of emotional concerns by the patient increased in direct proportion to how often patients raised such issues, emphasizing the importance of patient input to determine the visit agenda. These observations were part of a pattern of results that support the observation made by Olsson et al<sup>24</sup> that family physicians do more psychosocial management than has been recognized previously.

Recent research has shown that the presence of depressive symptoms changes the content of the physician-patient interaction, as does the provision of a diagnosis of depression.<sup>16</sup> In that study, chatting was found to decrease both in the presence of depressive symptoms and when the diagnosis of depression was made. In our study, both the physician and the patient behaved differently when the patient reported recent experience of emotional distress. The physician took more history from those reporting recent experience of emotional distress, whether or not that resulted in a diagnosis of depression or anxiety. The physician may be attempting to gather the information needed to understand and diagnose the presenting problem or to plan treatment. When a mental health diagnosis was made, counseling time increased the most, whereas time to conduct a physical examination decreased. Counseling was nearly 5 times more likely to take place for those with a mental health diagnosis than for those without such a diagnosis. Substance use was discussed more in such visits, likely reflecting the high comorbidity of mental health issues for those using alcohol or drugs.

Recognition of a mental health problem then substantially shifts the way in which the physician provides care, perhaps optimizing efforts to treat such problems once they are identified. Increases in the portion of the visit allotted for counseling, history-taking, and discussions of family information and substance abuse suggest that the family physician shows sensitivity to the needs of the patient in structuring the content of the visit, providing further evidence of the efforts of family physicians to manage mental health problems of their patients.<sup>24</sup> Preventive services, however, received less attention for those with recent report of emotional distress, supporting the competing demands for time use hypothesis and indicating that those with mental health diagnoses may receive fewer preventive services than those without such diagnoses.<sup>12,13</sup>

While physician behavior is important, patient factors are also important to the identification and treatment of mental health problems in the encounter. Gender has been associated with the ability to report emotional distress, with women more apt to have experienced recent emotional distress, more willing to admit to it, or both.<sup>25</sup> This may be one of the reasons that the physician-patient

encounter is influenced in its content by the sex of both the patient and the physician.<sup>26</sup> The presentation of women as patients appears to be associated with different utilization of primary care as well.<sup>27,28</sup> These data also support recent observations that patients with the diagnosis of depression use services at a higher rate than other patients.<sup>29</sup> Our data suggest differential utilization of primary care services for women compared with men, a difference that complements their different physician-patient interaction within the visit. This higher utilization enhances the probability of recognition of depression, as well as perhaps marking a different style of help-seeking for those who are depressed. Together, these factors may predict the higher rate of diagnosis of women with depression and other mental health problems.<sup>27,28</sup> Those reporting recent emotional distress were also more likely to have made more visits to the practice over the previous year. Marriage was associated with a lower level of emotional distress and diagnosis of mental disorder, suggesting a potential buffering effect for those who are married.

Our data show that as more emotional content was raised during the visit, physicians were more apt to be rated by the nurse-observer as responding to that content, suggesting symmetry between physician and patient communication. Perhaps patients reveal more emotional concerns only if there is a positive response to their initial presentation. In addition, failure to discuss emotional issues was associated with a discordant reason for the visit, supporting early reports of the importance of paying attention to the hidden agenda of the patient.<sup>30</sup>

Those given a diagnosis of a mental health problem felt more strongly that they could see their physician for such problems and discuss them than did the other two groups. However, those with recent experience of emotional problems that went undiagnosed reported that they had left more issues out of their visits than did those who reported no recent emotional distress, emphasizing the importance of open communication about emotional issues.

Recent studies have found that patients with more severe depression are more likely to receive a diagnosis than those with a less severe disorder.<sup>31-34</sup> Family physicians appear to prioritize their response to patients' mental health needs according to the severity of the patient's emotional symptoms. Training physicians to pursue emotional issues raised or hinted at in the physician-patient encounter would be likely to lower the threshold for diagnosis and treatment of mental health problems. The impact of such training on health outcomes, however, needs to be evaluated. For example, when physicians used PRIME-MD, a screening device for detection of mental health problems in primary care, they nearly doubled the number of diagnoses given to patients and began a new treatment or referral for 62% of patients with a PRIME-MD diagnosis.<sup>35</sup> This lowered threshold, however, is likely to come at the cost of less attention to other issues on the visit agenda because it took physicians an average of 8.5

minutes to administer the PRIME-MD.<sup>35</sup> Other interventions may take less time, but that time will either increase the total visit time or decrease the time spent on a competing concern. If the additional diagnoses are made with less serious disorders, increasing diagnosis and treatment may not have substantial impact on patient outcomes.<sup>23</sup> Determining the optimal path toward improved performance of family physicians in detection and treatment of mental health problems may prove a complex task. Data from this study help clarify how the presence of emotional distress and mental health diagnosis currently changes the physician-patient encounter.

Those with undiagnosed recent emotional distress reported having more unmet expectations in the visit and lower overall satisfaction. Recognition of the expectations of patients and meeting those expectations is a priority in the currently competitive primary care service delivery market. These data suggest that meeting emotional needs of patients may be critical to achieving better levels of satisfaction, a factor that may conflict with another popular service delivery objective: increasing numbers of patient visits per day. Resolution of such competing objectives will be a substantial challenge in the ongoing evolution of primary care. The way emotional distress is handled has a strong impact on patient attitude toward the visit.

This is the first broad-scale study of family physicians working with unselected primary care patients in which direct observation and coding of the visit were used. The results have strong implications for the training of primary care physicians and for understanding and facilitating the role of the primary care physician in the mental health network. However, there are limitations to this study that need to be taken into account. First, there may be systematic biases against admitting emotional distress for men in this culture, and possibly for some minority groups.<sup>36</sup> We did not discriminate between new mental health diagnoses made during the observed visit and diagnoses carried forward from prior visits. Making such a discrimination would be useful to further understand how mental health diagnoses are made in primary care and how making such a diagnosis alters subsequent care. There is still considerable need for research on how well family physicians accurately recognize recent emotional distress and mental health problems in order to foster more effective recognition and treatment of mental health problems.

#### ACKNOWLEDGMENTS

This study was supported by a grant from the National Cancer Institute (1R01 CA60862) and by a Robert Wood Johnson Foundation Generalist Physician Faculty Scholar Award to Dr Stange. The authors are grateful to the physicians and office staff members of the Research Association of Practicing Physicians, and to their patients, without whose participation this study would not have been possible. Important suggestions on an earlier draft of this paper were made by Michael Garn, MD. Allen Dietrich, MD, greatly improved the final paper.

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