

Education about Pharmacotherapy and Psychotherapy of Anxiety among Primary Care Physicians in Croatia: Balint Group Approach

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Aim. Balint groups help general practitioners to be sensitive to the psychological needs of anxiety patients and cope with their stress and mental health. We evaluated knowledge about pharmacotherapy and psychotherapy of anxiety among Croatian primary care physicians before and after a course based on Balint group methodology.

Methods. There were 111 primary care physicians (general practitioners and specialists in general practice) who attended the Balint course as a part of their continuous education during 2003. Course participants answered questions on pharmacotherapy and psychotherapy of anxiety before and after the course.

Results. At the beginning of the course, there were significantly more specialists in general practice who gave correct answers on definition of anxiolytics and about their side effects (chi-square test, $p=0.046$ and $p=0.030$, respectively). Before the course, high number of physicians in both groups agreed that psychotherapy could be used by non-psychiatrists (70-80%, no significant difference), but after the course significantly more specialists in general practice were aware that supportive psychotherapy could be used in general practice (chi-square test, $p=0.002$). Before the course significantly more specialists in general practice knew that only supportive psychotherapy can be used in general practice (chi-square test, $p=0.010$), but after the course general practitioners' correct answers increased and the difference was not significant. Daily usage of psychotherapy before the course was significantly more frequent among specialists (chi-square test, $p<0.001$), but this difference disappeared after the course. Number of general practitioners who never used psychotherapy decreased after the course (chi-square = 4.83, d.f. = 1, $p=0.028$). Linear regression analysis revealed female sex to be a significant predictor for the positive effects of the course ($B=0.71$, $p=0.025$).

Conclusion. The Balint course significantly reduced differences in knowledge of pharmacotherapy and psychotherapy of anxiety between specialists in general practice and general practitioners and improved prospects for the practice of psychotherapy among general practitioners.

Key words: anxiety; drug therapy; physicians, family; psychotherapy

According to the World Health Organization (WHO) 2001 Report, mental disorders are commonly encountered in primary health care, affecting 20-25% of the population at some time during their life. In 2000, mental and neurological disorders accounted for 12% of the total disability-adjusted life years (DALYs) lost due to all diseases and injuries. Yet, only a small minority of those affected by mental diseases receives any treatment (1).

Anxiety may be the next major global health problem. A significant number of the world's population is so severely plagued by chronic and excessive anxiety that many consider its disabling effects to be more serious than those of lung diseases, sleep disorders, drug addiction, and major depression. The studies conducted in several western countries also addressed generalized anxiety disorder's emergence as a serious health problem affecting approximately 5%

of the world population. Even though generalized anxiety disorder was the most frequent anxiety disorder seen in the primary care setting, less than 20% of the patients received proper treatment – suggesting that the condition was poorly recognized and diagnosed (2).

The WHO 2001 Report recommended the integration of mental health care (1) into primary health care primarily because of lesser stigmatization of patients and improved screening. A half of the patients with such problems are not recognized in primary health care and one third are wrongly diagnosed and treated. Although the therapy is recommended for 60% of recognized cases, it is appropriate in only 5% of the cases (3).

Physicians themselves express their discontent with their previous education in that field (4) and even two thirds think that they need additional educa-

tion (5) in communication and psychological counseling. Consequently most general practitioners (GPs) refer their patients to psychiatrists, are not engaged in psychotherapy (6), and apply medication as the only possible solution. Twenty years ago, the oldest group of anxiolytics, benzodiazepines, was considered as being the "magic bullets," but it is now known that their application resulted in an army of addicts. According to the data by the Ministry of Health for the year 2000 the number of addicts depending on sedatives in Croatia is on the third place, behind the treated addicts on opiates and treated addicts on cannabinoids (7).

A serious question to be addressed is how to take those drugs away from the patients (8) and stop recruiting the new ones. According to the data even the physicians with a good knowledge of anxiolytic application and with additional education underestimated the possibility of addiction and carelessly kept prescribing those drugs (9,10).

The result of unrecognized and inadequately treated patients with mental health problems are their frequent visits to the doctor (11,12). The practice overload resulted in stress (13) and "burnout" among doctors. Even 77.8% of young doctors experienced "burnout" at work and expressed their need for support (14).

At the beginning of the sixties, Michael Balint (15) recognized this problem and warned of the importance of good patient-physician relationship. He started group work with family physicians. A group consisted of 8 or 9 general practitioners, who were invited to present the case histories of patients who were bothering or puzzling them. The immediate gain was that they were able to share some of their worries about these difficult patients with their colleagues. Balint thought them to be good listeners and encouraged them to find out more about the person behind the symptoms by showing an interest in the patients' personal lives. Other physicians in the group would all contribute by expressing their thoughts on what was going on and what the patient really wanted, so the presenting physician had the benefit of seven or eight other points of view. Often the others would notice things that the presenting physician has missed because he or she was too closely involved. They began to understand the powerful feelings which some of these difficult patients can induce in a physician and stopped disliking the patients – when they understood them better. And the patients appreciated being listened to and being treated as human beings. A few would lose their symptoms once they were able to talk about their personal problems to a sympathetic physician (16).

Work in Balint groups is present in Croatia since 1983. Each year the Croatian Association of Balint Groups organizes a course. One of the topics at this course is therapeutic and professional relationship. The theme of the course for primary health physicians held in 2003 was "Psychotherapeutic Approach towards the Anxious Patient – Balint Approach." After short lectures on this theme, a Balint demonstration group was held.

We decided to evaluate the effect that the course had on physicians' knowledge on psychotherapeutic approach and pharmacotherapy of anxiety. The improvement of knowledge about anxiolytics and psychotherapy among general practitioners and specialists in general practice was compared by analyzing their knowledge and opinions before and after the course.

Subjects and Methods

Course

Weekend courses were held in Zagreb, Šibenik, Zadar, and Valpovo for a total of 111 physicians. The participants were general practitioners and specialists in general practice.

Before the courses, the participants answered 5 questions assessing their knowledge on anxiolytics (indications for prescription, strict definition of anxiolytics, groups of anxiolytics, side effects, and usage), 2 questions on supportive psychotherapy in general practice and one question on their use of supportive psychotherapy.

At the beginning of the courses, there was a series of short introductory lectures on neurophysiologic aspects of GABA system and benzodiazepine, use and misuse of anxiolytics, psychoanalytical concepts of personality development and anxiety disorders in children. Balint demonstration group (fishbowl, refs. 15,16) was then organized with members of the Croatian Association of Balint Groups (experienced Balintians) and participants who came across this form of work for the first time. Case or problem was presented spontaneously by any member of the group and an experienced Balint leader led a discussion centered on doctor-patient relationship (17,18). Then, all participants were divided into Balint groups having about 10 participants each. Two educated Balint leaders led each group according to the Balint group principles (15). Cases of anxious patients from everyday practice were discussed in all groups, with the emphasis on doctor-patient relationship and its application in diagnosis and therapy.

At the end of the course, all participants together formed a focus group to provide a feedback to course leaders (19). Then they again answered 5 questions on anxiolytics, 2 questions on supportive psychotherapy in general practice and one question on their intention to use supportive psychotherapy in the future.

Participants

Physicians from family practice (n=111) in Croatia attended the course, 61 general practitioners and 50 general practice specialists. In spite of the fact that Croatia was the first in the world to start with vocational training of primary care physicians (20), both general practitioners with basic education and specialists in general practice with vocational training are allowed to work in family practice.

The mean age of the participants was 39.8 ± 7.8 for general practitioners, and 47.0 ± 6.9 for specialists (Student's t-test = 5.13, $p=0.001$). Out of a total of 61 general practitioners 16 were under 35 years of age, as were only 2 out of 50 specialists in general practice. Consequently, there were more participants among general practitioners with fewer years of working experience, (33/61 under 10 years of working experience) than among specialists in general practice (only 5/50 under 10 years of working experience). The mean working experience was 11.9 ± 9.2 years for general practitioners and 19.8 ± 7.6 years for specialists in general practice. There were 50/61 (82%) of women among general practitioners and 42/50 (84%) among specialists in general practice.

In the past, general practitioners had participated significantly less at Balint courses (2 general practitioners vs 14 specialists in general practice, chi-square test = 13.61, $p < 0.001$) and in other psychological education (5 general practitioners vs 13 specialists in general practice, chi-square test = 7.91, $p = 0.011$) than specialists in general practice. There was no significant difference among them in attendance to other continuous education courses (11 general practitioners vs 14 specialists in general practice chi-square test = 0.34 $p = 1.000$).

Statistical Analysis

Results were presented in absolute and relative frequencies. Differences in numbers of general practitioners and specialists in general practice who gave correct answers were tested using the chi-square test. The relationship between sex, age, working experience, and specialization as predictors, and the change in knowledge scores as criterion was investigated by linear regression analysis. Values $p < 0.05$ were considered significant. Statistical verification was done on SPSS 9.0 software (SPSS Inc, Chicago, IL, USA).

Results

Knowledge on Anxiolytics

At the beginning of the course, there were significantly more specialists in general practice who gave correct answers on definition of anxiolytics and about their side effects (Table 1). After the education the differences in number of general practitioners and specialists in general practice who answered correctly about anxiolytics were not statistically significant (Table 1). Before- and after-course comparisons within the groups of general practitioners or specialists in general practice revealed no differences. Generally, the level of knowledge for both groups was not high (Table 1).

Knowledge on Psychotherapy

Before the course, high number of physicians in both groups agreed that psychotherapy could be used by non-psychiatrists (70-80%, Table 2, no significant difference), but after the course significantly more specialists in general practice were aware that supportive psychotherapy could be used in general practice. Before the course, significantly more specialists in general practice knew that only supportive psychotherapy can be used in general practice, but after the course general practitioners' correct answers increased and the difference was not significant (Table 2).

Practicing Psychotherapy

Significantly more general practitioners than specialists in general practice never used psychotherapy both before (chi-square = 10.74, d.f. = 1, $p = 0.001$) and

after (chi-square = 8.18, d.f. = 1, $p = 0.004$) the course, while the numbers of those who used it occasionally did not differ. Daily usage of psychotherapy before the course was significantly more frequent among specialists (chi-square = 13.04, d.f. = 1, $p < 0.001$), but this difference disappeared after the course (Fig. 1A).

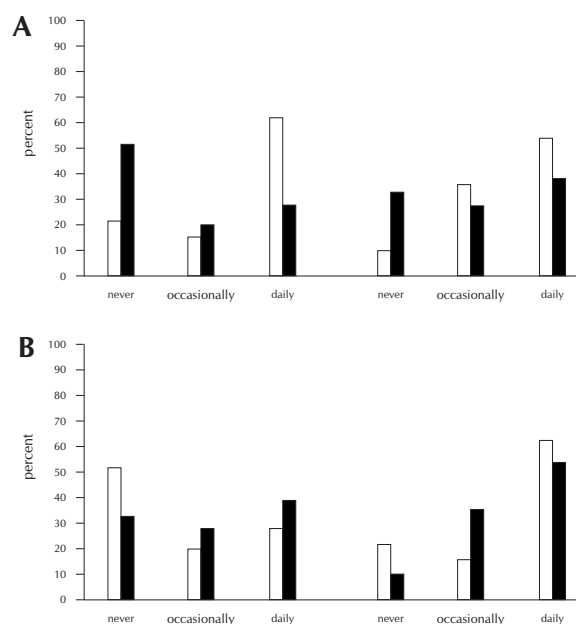


Figure 1. Frequency of practicing psychotherapy before and after education. Asterisk marks statistically significant difference at 0.05 level (Chi-square test). **A.** Practicing psychotherapy between general practitioners and specialists in general practice before and after course. Open bars – specialists in general practice, closed bars – general practitioners. **B.** Practicing psychotherapy within general practitioners (GP) and within specialists in general practice before and after education. Open bars – before, closed bars – after.

Table 1. Knowledge about anxiolytics of general practitioners (GP, n = 61) and specialists in general practice (SGP, n = 50) before and after education

Questions about anxiolytics	No. (%) of physicians who answered correctly					
	before education			after education		
	GP	p*	SGP	GP	p*	SGP
Indication	31 (51)	0.163	32 (64)	30 (49)	0.118	32 (64)
Definition	30 (49)	0.046	34 (68)	30 (49)	0.118	32 (64)
Groups	31 (51)	0.107	33 (66)	29 (47)	0.083	32 (64)
Side effects	30 (49)	0.030	34 (68)	30 (49)	0.118	32 (64)
Usage	21 (34)	0.413	21 (42)	23 (38)	0.131	26 (52)

*Chi-square test.

Table 2. Knowledge about psychotherapy of general practitioners (GP, n = 61) and specialists in general practice (SGP, n = 50) before and after education*

Questions about psychotherapy	No. (%) of physicians who answered correctly					
	before education			after education		
	GP	p	SGP	GP	p	SGP
Supportive non-psychiatric psychotherapy	43 (70)	0.095	42 (84)	43 (70)	0.002	47 (94)
Types of psychotherapy	24 (39)	0.010	32 (64)	41 (67) [†]	0.309	38 (76)

*Chi-square test.

[†]Significant difference in comparison to percentage of GPs who answered correctly before education (chi-square = 9.52, d.f. = 1, $p = 0.002$).

Within groups comparison revealed a decrease in number of general practitioners who never used psychotherapy (chi-square = 4.83, d.f. = 1, $p=0.028$) and an increase in the group of specialists in general practice who used psychotherapy occasionally (chi-square = 5.20, d.f. = 1, $p=0.023$).

Relationship of Gender, Age, Years of Working Experience and Specialization to the effects of the course

Average scores divided by sex, age, working experience, and specialization from the 7 questions knowledge test applied before and after the education are shown in Table 3. Linear regression analysis performed to assess the relationship between the change in test scores as a criterion and these four variables as predictors revealed only sex as a significant predictor ($B=0.71$, $p=0.025$), ie, that female physicians benefited more.

Table 3. Knowledge ($n_{\text{questions}}=7$) about pharmacotherapy and psychotherapy according to gender, specialization, age, and working experience before and after education

Characteristic*	Correct answers			
	before		after	
	mean	95% CI	mean	95% CI
Gender:				
male (n = 19)	4.3	(3.0-5.5)	4.2	(2.9-5.4)
female (n = 92)	3.7	(3.1-4.2)	4.3	(3.7-4.9)
Specialization:				
GP (n = 61)	3.2	(2.5-3.9)	4.5	(3.8-5.2)
SGP (n = 50)	3.8	(3.0-4.6)	4.9	(4.2-5.5)
Age (years):				
< 35 (n = 18)	2.2	(1.2-3.3)	3.1	(1.7-4.4)
> 35 (n = 93)	4.1	(3.5-4.6)	4.5	(3.9-5.1)
Working experience (years):				
< 10 (n = 30)	3.6	(2.6-4.6)	3.9	(3.3-4.9)
> 10 (n = 81)	4.2	(3.2-5.3)	4.3	(3.7-4.9)

*Abbreviations: GP – general practitioners; SGP – specialists in general practice.

Discussion

Our study showed a Balint-course-related increase of the awareness of possibility of use of supportive psychotherapy in general practice among specialists, and increase of knowledge about supportive psychotherapy in general practitioners. The knowledge of general practitioners about the definition of anxiolytics and their side effects, which was weaker than that of the specialists' before the course, equaled that of the specialists' after the course. This may have a practical value because it is known that family physicians with satisfactory graduate psychiatric education or with additional education in that area have better knowledge and prescribe less psychotropic drugs (21). However, even after our course the level of knowledge about anxiolytics was not satisfactory either neither among general practitioners nor among specialists in general practice. Other studies also showed that special education for reducing benzodiazepine usage among physicians (22) and registrars (23) does not always and immediately improve their benzodiazepine prescription.

Significantly more general practice specialists than non-specialists practiced psychotherapy before the course on a daily basis, and the course increased the number of non-specialists who intended to use it.

That means that the course encouraged general practitioners to use psychotherapy. It appears that the course increased the caution towards use of psychotherapy among specialists, because the number of those who decided that they will use it occasionally increased after the course, on the expense of both those who had used it on a daily basis and those who never practiced it. Indeed, the number of specialists in general practice who used psychotherapy daily decreased for 8% after the course. We believe that specialists in general practice overestimated their practicing of psychotherapy at the beginning of the course as physicians of higher educational level, but after the course they recognized its real psychotherapeutic value in their practice.

Our study showed that only female sex could be associated with beneficial effects of the course, whereas age, specialization, and work experience could not. Literature data on these issues are controversial. A study from Great Britain (24) reported that higher psychological content scores were significantly associated with younger general practitioners, while Australians (25) associated sensitiveness with older general practitioners. Other characteristics reported from those studies were general practitioners' list size, annual psychiatric referral rates, quantities of benzodiazepine prescription, postgraduate psychiatric training, as well as female gender, interest in mental health and previous mental health training.

A serious limitation of this study is the fact that the education period was rather short to either stably increase the knowledge or affect the attitudes. Since it deals with subtle, qualitative changes in the psychological domain, systematic group training lasting one or two years at least is required (15). Such an evaluation is expected in our groups that have been working continuously for several years.

The potential differences in initial knowledge between specialists in general practice, who had encountered Balint group methodology within their vocational training, and general practitioners, who did not, also represented a limitation in our study. Further investigations should be done to investigate the influence of the previous knowledge on the results that can be obtained by this method.

Despite relatively limited effects achieved in this study, we believe that Balint group approach should be encouraged as a means of improvement of general physicians' work with anxiety patients. Primary care patients (26) ask for and accept psychological treatment from their general practitioners. Rates of underdiagnosis of psychological problems in primary care are disturbingly high (27) and every education offers some improvement and even a small improvement in psychological management would be sizeable.

References

- 1 World Health Report 2001. Mental health: new understanding, new hope. Geneva: World Health Organization; 2001.
- 2 Rossi AS, editor. Caring and doing for others: social responsibility in the domains of family, work, and community. Chicago: University of Chicago Press; 2001.

- 3 Lecrubier Y. Prescribing patterns for depression and anxiety worldwide. *J Clin Psychiatry*. 2001;62 Suppl 13:31-6; discussion 37-8.
- 4 Sivik T. Education of general practitioners in psychosomatic medicine. Effects of a training program on the daily work at Swedish primary health centers. *Gen Hosp Psychiatry*. 1992;14:375-9.
- 5 Nielsen JM, Vedsted P, Olesen F. The postgraduate training of general practitioners in communication and counseling. A questionnaire survey in the county of Aarhus [in Danish]. *Ugeskr Laeger*. 2002;164:895-9.
- 6 Shilling KH, Bass RL. Use of adult psychiatric services by primary care physicians in midwestern cities. *Nebr Med J*. 1990;75:37-42.
- 7 Health status and health care in the Republic of Croatia 2000 [in Croatian]. Zagreb: Hrvatski zavod za javno zdravstvo; 2001.
- 8 Zitman FG, Couvee JE. Chronic benzodiazepine use in general practice patients with depression: an evaluation of controlled treatment and taper-off. Report on behalf of the Dutch Chronic Benzodiazepine Working Group. *Br J Psychiatry*. 2001;178:317-24.
- 9 Holden JD, Hughes IM, Tree A. Benzodiazepine prescribing and withdrawal for 3234 patients in 15 general practices. *Fam Pract*. 1994;11:358-62.
- 10 Boixet M, Battle E, Bolibar I. Benzodiazepines in primary health care: a survey of general practitioners prescribing patterns. *Addiction*. 1996;91:549-56.
- 11 Bellon JA, Delgade A, De Dios L, Lardelli P. Psychosocial and health belief variables associated with frequent attendance in primary care. *Psychol Med*. 1999;29:1347-57.
- 12 Karlsson H, Lehtinen V, Joukmaa M. Are frequent attenders of primary health care distressed? *Scand J Prim Health Care*. 1995;13:32-8.
- 13 Wilters JH. Stress, burnout and physician productivity. *Med Group Manage J*. 1998;45:32-4, 36-7.
- 14 Schweitzer B. Stress and burnout in junior doctors. *S Afr Med J*. 1994;84:352-4.
- 15 Balint M. The doctor, his patient, and the illness. New York (NY): International Universities Press; 1957.
- 16 Salinsky J. Balint groups and psychoanalysis: what have the Romans done for us? *Br J Gen Pract*. 2001;51:506.
- 17 Hopkins P, editor. Patient-centred medicine. London: Regional Doctor Publications; 1972.
- 18 Kulenović M, Blažeković-Milaković S. Balint groups as a driving force of ego development. *Coll Antropol*. 2000;24 Suppl 1:103-8.
- 19 Kitzinger J. The methodology of focus groups: The importance of interaction between research participants. *Soc Health Illnes*. 1994;16:103-19.
- 20 Budak A, Grahovac V. Development of general practice in the Republic of Croatia through history. In: Budak A. Organization of work and experience from general practice. Zagreb: Medicinski fakultet Sveučilišta u Zagrebu; 1990. p.11-19.
- 21 Kisely S, Linden M, Bellantuono C, Simon G, Jones J. Why are patients prescribed psychotropic drugs by general practitioners? Results of an international study. *Psychol Med*. 2000;30:1217-25.
- 22 Pimlott NJ, Hux JE, Wilson LM, Kahan M, Li C, Rosser WW. Educating physicians to reduce benzodiazepine use by elderly patients: a randomized controlled trial. *CMAJ*. 2003;168:835-9.
- 23 Zwar NA, Wolk J, Gordon JJ, Sanson-Fisher RW. Benzodiazepine prescribing by GP registrars. A trial of educational outreach. *Aust Fam Physician*. 2000;29:1104-7.
- 24 Ashworth M, Godfrey E, Harvey K, Darbishire L. Perceptions of psychological content in the GP consultation—the role of practice, personal and prescribing attributes. *Fam Pract*. 2003;20:373-5.
- 25 Hickie IB, Davenport TA, Scott EM, Hadzi-Pavlovic D, Naismith SL, Koschera A. Unmet need for recognition of common mental disorders in Australian general practice. *Med J Aust*. 2001;175 Suppl:S18-24.
- 26 Fritzsche K, Armbruster U, Hartmann A, Wirsching M. Psychosocial primary care – what patients expect from their General Practitioners. A cross-sectional trial. *BMC Psychiatry*. 2002;2:5.
- 27 Scott J, Jennings T, Standart S, Ward R, Goldberg D. The impact of training in problem-based interviewing on the detection and management of psychological problems presenting in primary care. *Br J Gen Pract*. 1999;49:441-5.

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