Clinical Training of Psychologists in Family Practice Settings: An Examination of Special Issues

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This article considers issues of education and preparation relevant to psychology trainees in departments of family medicine. Special issues unique to training in a medical setting, such as confusion about professional identity and divergence in world views, are discussed. This article also addresses a range of relational issues, including trainee relationships with residents, patients, and attending physicians. Supervision of the psychology trainee is also considered, eg, teaching, counseling, and advocacy supervisor roles. This article concludes with specific suggestions and guidelines for future training of psychologists in family medicine settings.

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Clinical training is a crucial part of the education of all health professionals. For psychologists, clinical training occurs during internships that are usually offered in psychiatric practice settings such as university counseling centers, county mental health centers, and inpatient psychiatric units. Recently, internship training for psychologists has become available in nonpsychiatric medical settings such as family medicine teaching clinics. While conventional clinical training has received considerable attention in the professional psychology literature,[1,2] little attention has been given to training psychologists in family medicine clinics. This paper highlights the special features of behavioral science training in family medicine settings.

The Goals of Training

While common goals exist for all psychology training programs, training in family medicine settings has two distinctive areas of emphasis. First, psychology trainees learn how to work in a collaborative consultative relationship with family physician colleagues.[3,4] Second, training emphasizes an understanding of the interaction of the patient's personal, family, social, and cultural background and the effect of these factors on illness expression and treatment outcome.[5-9] These two areas of emphasis necessitate consideration of the contextual and relational issues related to training in the family practice setting.

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Contextual Considerations

Trainees in any new setting are often anxious,[10] but the anxiety of behavioral science trainees in a family practice setting is often related to factors that are unlike those in typical mental health settings. Patient disrobing, invasive examinations of anatomy, and routine contact with various bodily fluids and smells are often new experiences for psychology trainees. Procedures, precautions, laboratory tests, and the unique language, abbreviations, and shorthand terminology of the medical system create a mix of wonder, confusion, and detachment. The chronic disease, physical decay, and death commonly seen in medical settings can also provoke apprehension and discomfort.

In a traditional psychology internship, trainees are usually surrounded by role models from their own profession. When psychologists train in a family medicine setting, the trainee finds that clinical personnel have diverse backgrounds and responsibilities. Residents, not psychology students, are most often the focus of attention for teaching. Medical diagnosis and pharmacological treatment are primary concerns. Both faculty physicians and residents appear to wield great power over their patients, making life-and-death decisions and leaving the more mundane tasks and less influential roles to nonmedical personnel. Even supervising behavioral science faculty may appear to have only an ancillary role with little direct influence on clinic activities. Such observations can generate feelings of insecurity in the psychology trainee's identity and lead the trainee to question the nature and importance of his or her role.

Psychology trainees, by education, perceive the biopsychosocial model[11] to be the *sine qua non* of good medical practice. Members of the medical system, on the other hand, still often subscribe to the biomedical model that largely excludes psychosocial considerations.[12,13] Patients too are sometimes more comfortable with purely physical explanations of their symptoms. The contrasts between the physicians' and patients' allegiance to the biomedical model versus the psychologists' allegiance to the biopsychosocial model may lead to disagreements over the most appropriate approach to patient care. It also may leave the psychology trainee excluded from an apparent "coalition" between patients and physicians.

Relational Considerations

The primary role of the psychology trainee is multifaceted and complex, reflecting shifting boundaries and many levels of intimacy. The psychology trainee often teaches family practice residents specific psychosocial knowledge and skills. Psychology trainees may also function as cocounselors with residents and participate in patient management.[14,15] Trainees often provide feedback to residents and evaluate resident performance, a process that may involve challenging resident assumptions about the nature of patient care.[16] At a more intimate level, trainees sometimes serve as personal counselors to residents, which may prompt self-reflection and uncover family-of-origin issues that provoke potentially problematic countertransference responses.[17] Exceptional skill is required in this role, and, if handled clumsily, alienation between resident and trainee can result.

Educational background and professional goals are obviously different between psychology and family practice trainees.[18,19] Allegiance of the psychology trainee is ultimately to a psychologist faculty supervisor, whereas the resident's is with the attending faculty physician. The consultative and teaching activities of psychology trainees may interfere with the resident's speed and efficiency in seeing patients. Some residents may feel that the psychology trainee's presence interferes with the resident-patient relationship.

The behavioral science trainee's role with patients has a number of levels of involvement. At the lowest level, the trainee makes suggestions to residents regarding management of patient care. The next most involved level includes face-to-face contact between patients and the psychologist trainee, with the latter serving as an equal collaborator in patient evaluation and intervention. At the highest level of involvement, the psychology trainee acts as a consultant or clinician who independently assesses and manages the patient, relaying information back to the resident.

Patients encountered in medical settings often pose challenges for psychology trainees; for example, patients may not accept intervention because the trainee is not a medical doctor and cannot prescribe medicine. Some patients somatize their psychological dysfunction[20] which, for psychologically minded trainees,[21] gives evidence of limited therapeutic potential. Ethnic and cultural influences on the expression of physical symptoms[22] may be unfamiliar to psychology trainees. Finally, the patient-resident-trainee association is vulnerable to all the complications that attend triadic relationships;[23] power imbalances, indirect communication, and poor boundary definition can easily develop and cause problems. Dissension between trainee, patient, and resident regarding health belief models may produce conflict and misguided efforts.

The trainee's relationship with the attending physicians can critically affect the quality of the trainee's experience. The extent to which the attending physician recognizes, includes, and approves of the psychology trainee establishes a model that influences relationships between psychology trainees and family practice residents. The attending physician who ignores or sabotages the psychology trainee's efforts may thereby set up a pattern in which residents and other clinic personnel fail to take the psychology trainee seriously. It is nearly impossible for the psychology trainee to function productively in such an environment.

Supervision

Having highlighted several contextual and relational issues of behavioral science training for psychologists in a medical setting, we now move to ways in which such issues can be addressed. Effective supervision is the key to engineering the educational value of the trainees' experiences. The supervising psychologist plays a critical, multifaceted role in the trainee's adjustment, attitude formation, and skill development.

Of primary importance is the modeling that the supervising psychologist provides. The supervisor's integration into clinical activities, professional relationships, and personal style demonstrates how to function outside of a traditional mental health environment. The supervisor also shows how to acknowledge, accept, and work with differences in perspectives between psychologists and physicians. Since the career pattern of the behavioral scientist in family medicine may be ill defined,[24] modeling is the single most important means of addressing the trainee's professional identity development.

Entering an unfamiliar environment, the trainee needs information and tutoring on the structure and functioning of the medical system. Supervisors must provide information on the operation of both clinical and educational activities in medicine. Some grounding in predoctoral education, major professional hurdles, the residency selection process, and current issues in medical education all contribute to a broader

understanding of residents with whom trainees will interact. Addressing particular dynamic characteristics of the environment, especially the power differential between various clinic personnel, helps the trainee form appropriate expectations for his or her role.

Teaching psychology trainees how to effectively consult with residents about behavioral and psychosocial patient management is of critical importance, as trainees typically spend significant time in this role. The first step, assessment of resident needs, demands close knowledge of resident personality style, skills, and attitudes. Supervisor observation of psychology trainees interacting with residents is useful in this regard. Helping the psychology trainee make cogent, simple, and practical suggestions, as well as identifying the "teachable moment," will increase the trainee's sense of competence. Trainee sensitivity is especially important when exploring resident countertransferential or family-of-origin issues that may affect patient care.[25]

Psychologist supervisors must teach trainees about patient management skills. The psychology trainee must learn how to develop relationships with patients under time constraints, lack of continuity, and from the sometimes subordinate position that may exist for psychology trainees in a medical setting. The supervisor must teach the trainee how to be a strategic problem solver across a wide spectrum of diagnostic and pragmatic difficulties. Training in short-term therapeutic models with modest goals is important. Supervisors can also help trainees vary their clinical repertoire and more adequately address the needs of patients with different cultural backgrounds.

The psychology trainee and psychologist supervisor may form an unusually close relationship, largely due to the trainee's dependence on the supervisor for cues and guidance for professional behavior. The association fosters identification with the supervisor, an appropriate response in a close teacher-trainee relationship. However, closeness to a supervisor may result in personal revelations on the part of the trainee that are more appropriately addressed in a therapeutic relationship. The skilled supervisor should be willing to explore these and other intricacies of the trainee-supervisor relationship but only within certain limits.[26,27] This can help the trainee determine appropriate boundaries regarding disclosure of personal material. Referral to another psychologist to deal with personal issues is also an option.

A less obvious but no less important area for supervisory activity is to serve as the trainee's advocate. The supervising psychologist should develop a conscientious liaison with the trainee's attending physician(s). Expectations regarding the trainee should be discussed with attending physicians, and appropriate behaviors for both trainee and attending physician should be established. The supervisor may even enlist the attending physician in the educational experience of the trainee by identifying specific concrete ways in which the physician can be involved.

Recommendations

Psychologists and physicians involved in the education of several psychology trainees should consider each of the following recommendations. Attention to these issues can help the psychology trainee transition from observer/learner to consultant/provider.[28]

First, reduce the trainee's sense of isolation and role nonconformity. Training psychology students in small groups may serve this goal. Simultaneous experience in a more traditional mental health setting may preserve the trainee's emerging sense of professional identity as a psychologist.

Second, lay detailed groundwork for the trainee's experience. Preparation of both physician faculty and residents regarding expectations for the trainee is essential. An introductory period of up to one month, during which time trainee responsibilities might be limited entirely to observation, may facilitate orientation and adjustment to the trainee's new clinical setting.

Third, focus on process during supervision. Although all supervision involves attention to the trainee's experience, gains in self-knowledge may be of greater value than specific skills or content knowledge taught by the supervisor.

Fourth, use modeling and self-disclosure. Modeling interactions with residents and patients clarifies the behavioral scientist's role and teaches appropriate intervention techniques. Similarly, the supervisor's willingness to share personal experiences as a behavioral scientist in family medicine helps to develop the trainee's professional identity.

Fifth, identify rewards. The supervisor can highlight for the trainee the satisfactions of the behavioral scientist's role. Knowing a patient has been well served, seeing a difficult resident make a personal breakthrough, or witnessing personal growth in professional interactions all contribute to the excitement and reward of the psychologist's work.

Behavioral science training of psychology interns in a family practice setting holds provocative challenges and opportunities for both the supervisor and trainee. Because behavioral science training is an integral part of the family practice residency, and because these trainees are the behavioral scientists of the future, the issues raised here warrant further systematic exploration. Attention to teaching and training issues by both physicians and nonphysicians fosters the growth of excellence in family medicine training and the care that patients receive.

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References

1. Hess AK, ed. Psychotherapy supervision: theory, research, and practice. New York: Wiley, 1980.
2. Schlessinger N. Supervision of psychotherapy. A critical review of the literature. Arch Gen Psychiatry 1966; 15:129-34.
3. Dym B, Berman S. The primary health care team: family physician and family therapist in joint practice. Fam Syst Med 1986; 4:9-21.
4. Glenn M. Collaborative health care: a family-oriented model. New York: Praeger, 1987.
5. Jemmot JB 3d, Locke SE. Psychosocial factors, immunological mediation, and human susceptibility to infectious disease: how much do we know? Psychol Bull 1984; 95:78-108.
6. Pilisuk M, Boylan R, Acredolo C. Social support, life stress, and subsequent medical utilization. Health Psychol 1987; 6:273-88.
7. Doherty WJ, Campbell TL, eds. Families and health. Beverly Hills, Calif.: Sage Publications, 1988.
8. Engel GL. The need for a new medical model: a challenge for biomedicine. Science 1977; 196:129-36.
9. Doherty WJ, Baird MA, Becker LA. Family medicine and the biopsychosocial model: the road toward integration. In: Doherty WL, Christianson CE, Susman MB, eds. Family medicine: the maturing of a discipline. New York: Hawthorne Press, 1987.
10. Gustin JC. Supervision in psychotherapy. Psychoanal Psychiatr Rev 1958: 45:63-72.
11. Engel GL. The clinical application of the biopsychosocial model. Am J Psychiatry 1980; 137:535-44.
12. Baird MA, Doherty WJ. Risks and benefits of a family systems approach to medical care. Fam Med 1990; 22:396-403.
13. Glenn ML. The resurgence of the biomedical model. Fam Med 1988; 20:324-5.
14. Sargent J. Physician-family therapist collaboration. Fam Syst Med 1985; 3:454-65.
15. Glenn ML. Toward collaborative family-oriented health care. Fam Syst Med 1985; 3:466-75.
16. Ransom DC. Random notes: a sense of purpose for teaching behavioral science in family medicine. Fam Syst Med 1985; 3:494-9.
17. Stein HF. The psychodynamics of medical practice: unconscious factors in patient care. Berkeley, Calif.: University of California Press, 1985.
18. Doherty WJ. A missionary at work: a family therapist in a family medicine department. Fam Ther Networker 1986; 10:65-68.
19. Shapiro J. A revisionist theory for the integration of behavioral science into family medicine departments. J Fam Pract 1980; 10:275-82.
20. Miranda J, Perez-Stable EJ, Munoz RF, Hargreaves W, Henke CJ. Somatization, psychiatric disorder, and stress utilization of ambulatory medical services. Health Psychol 1991; 10:46-51.
21. Farber BA. The genesis, development, and implications of psychological-mindedness in psychotherapists. Psychotherapy 1985; 22:170-7.
22. Henderson G. A practitioner's guide to understanding indigenous and foreign cultures. Springfield, Ill.: Charles C. Thomas, 1989.
23. Ross JL, Doherty WJ. Systems analysis and guidelines for behavioral scientists in family medicine. Fam Med 1988; 20:46-50.
24. Wolosin RJ. Behavioral scientists: anticipations, satisfactions, frustrations. Fam Med 1987; 19:296-8.
25. Carifio MS, Hess AK. Who is the ideal supervisor? Prof Psychol Res Pract 1987; 18:244-50.
26. Schacht AJ, Howe HE, Bernam JJ. Supervisor facilitative conditions and effectiveness as perceived by thinking- and feeling-type supervisees. Psychotherapy 1989; 26:475-83.
27. Shapiro J. Parallel process in the family medicine system: issues and challenges for resident training. Fam Med 1991; 22:312-19.
28. Kennard BD, Stewart SM, Gluck MR. The supervision relationship: Variables contributing to positive versus negative experiences. Prof Psychol Res Pract 1987; 18:172-5.

Implementing the US Preventive Services Guidelines in a Family Practice Residency

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Background: *Despite growing emphasis on preventive services, physicians still provide low levels of these services to their patients. Barriers to providing preventive services might be modified by more effective teaching models at the residency level. The purpose of this study was to evaluate a practice-based teaching model designed to increase resident compliance with the US Preventive Services Task Force Guidelines.* Methods: *In Phase One of this study, physicians received didactic education about the US Preventive Services Task Force Guidelines. Subsequently, physicians' compliance with these recommendations was monitored. During Phase Two of the study, a comprehensive two-visit "Health Check" appointment was instituted. It incorporated a computerized health risk appraisal that was reviewed with patients. After the Health Check program was implemented, physicians' compliance with the guidelines was again audited.* Results: *The chart audits revealed an overall increase in the level of preventive services provided by physicians from 31% in Phase One to 74% in Phase Two (P<.01).* Conclusions: *This type of teaching model can effectively increase the level of preventive services provided to patients in a family practice residency.*

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Family medicine is committed to the principles of continuous, comprehensive health care, including preventive medicine, health promotion education, and screening for asymptomatic disease. With the release in 1989 of the US Preventive Services Task Force Guidelines,[1] emphasis has been placed on promoting the health of American citizens. But despite these guidelines and widespread agreement among physicians regarding the importance of preventive services,[2-3] studies report low levels of delivery of preventive services by physicians (compliance with only 20% to 50% of recommendations).[4-8] Patients expect more preventive services than their physicians provide,[2-3] and physicians actually deliver fewer preventive services than they perceive they do.[3] If the potential effect of preventive services is to be realized, physicians must be more involved in the process of health promotion.

Much has been written about the reasons that physicians provide low levels of preventive services.[9-12] These reasons, or "barriers," can be divided into three broad categories[13] related to the physician,[14-17] the patient,[10,11,16,18] and the health care system (Table 1).[9,10,12,19]

Many of these barriers would seem to be surmountable at the level of residency training.[9] This study sought to determine if a practice model, based on the US Preventive Services Task Force Guidelines, would improve physicians' delivery of preventive services—above levels achieved with didactic education alone—in a family practice residency. Previous studies have shown that family practice residents have low compliance with preventive medicine recommendations but that a systematic program can improve compliance at both the residency level and in private practice.[22] However, no studies to date have reported implementation of the US Preventive Services Task Force Guidelines in an organized, practical way that can be used by primary care educators and practicing physicians alike.

Methods

The Toledo Hospital Family Practice Residency is a training program affiliated with an 800-bed community hospital. Eighteen residents and five full-time physician faculty members provide ambulatory care for 3,300 patients at the W.W. Knight Family Practice Center, with an average of 15,500 patient visits per year.

From the Toledo Hospital Family Practice Residency Program, Toledo, Ohio.

Table 1

Barriers to Preventive Medicine

Physician-Related Barriers[14-17]
Personal health beliefs and performance
Ignorance of the recommendations
Perceived impotence to help patients change lifestyles
Unconvinced of the value of preventive services
Forgetting to suggest preventive services
Lack of immediate positive feedback
Role perception: not their job, rather for public health professionals
Prior training in disease orientation
Lack of peer support
Poor counseling skills
Misperceptions of patient's desires

Patient-Related Behaviors[10,11,16,18]
Ignorance or low educational level
Indifference to recommendations
Peer pressure or cultural issues to counter recommendations
Infrequent visits to the physician
Multiple medical problems and problem-focused health care
Lack of assertiveness in asking for preventive services
Lack of cooperation with suggestions made
Poor communication or relationship with the physician
Not scheduling regular "physicals"

System-Related Behaviors[9,10,12,19]
Costs and lack of reimbursement by insurance
Conflicting recommendations by differing groups
Practice setting: lack of support, time pressures, lack of referral sources
Inadequate medical record to remind of necessary preventive services
Fragmented care

Table 2

Demographics of the Study Groups

	Phase One Post-education N=50	*Phase Two Post-Health Check N=53*	P
Age			<.05
19 to 39	21 (42%)	20 (38%)	
40 to 64	19 (38%)	30 (56%)	
Older than 65	10 (20%)	3 (6%)	
Sex			NS
Female	30 (60%)	39 (74%)	
Male	20 (40%)	14 (26%)	
Marital Status			NS
Single	10 (20%)	13 (25%)	
Married	26 (52%)	26 (49%)	
Divorced	7 (14%)	7 (13%)	
Widowed	4 (8%)	3 (6%)	
Other	3 (6%)	4 (7%)	
Race			NS
White	34 (68%)	44 (83%)	
Black	14 (28%)	8 (15%)	
Other	2 (4%)	1 (2%)	
Payment Method			<.05
Private insurance	8 (16%)	18 (34%)	
HMO	19 (38%)	27 (50%)	
Medicaid	6 (12%)	3 (6%)	
Medicare	9 (18%)	3 (6%)	
Self-pay	8 (16%)	2 (4%)	

NS = not statistically significant

Our intervention conisited of two sequential phases. Phase One involved educating physicians about preventive health issues. During Phase Two, the "Health Check" program for providing preventive services was conducted.

From July 1990 through October 1990, Phase One of the study was implemented. During that time, the physicians in the W.W. Knight Family Practice Center participated in several group didactic sessions to learn about various aspects of the report of the US Preventive Services Task Force. They also participated in individual and small group discussions on the same topics. In addition, the physicians completed two different health risk appraisals for themselves and then discussed the results and the appraisal questionnaires in small-group sessions. During behavioral science sessions, interviewing and counseling skills related to preventive services were emphasized, such as sexual history taking and counseling.

Phase Two began in January 1991, when the Health Check program was initiated by a marketing effort directed at family practice center patients. This promotion consisted of a direct mailing plus brochures, which were made available in the waiting and examination rooms. The secretaries, nurses, and physicians also actively suggested this program to patients. The first Health Check appointments occurred in February 1991 and consisted of a package of two office visits.

During the patient's first Heath Check visit, the physician was provided with an outlined synopsis of the US Preventive Services Task Force Guidelines for the patient's age group and was expected to perform a history and physical examination extensive enough to provide an accurate basis for counseling, screening recommendations, and immunizations. At the same visit, the physician presented each patient with a health risk appraisal questionnaire to be completed before leaving the office. (The health risk appraisal was developed by the University of Michigan Fitness Research Center, 401 Washtenau Avenue, Ann Arbor, MI 48109-2214.)

Between the first and second visits, the patient completed any screening tests recommended by the physician; the health risk appraisal was scored by computer. Just prior to the patient's second visit, all the screening data and the health risk appraisal were reviewed together by the resident physician and a supervising faculty member. At that time, recommen-