Letters

Psychological Measures in Primary Care

The article by Sansone et al[1] published in the 1998 July/August issue of the ARCHIVES is particularly timely given the extensive amount of information available regarding the effect of psychosocial factors on the maintenance of health and the prevention of illness. The use of behavioral measures in clinical practice is not only an important area of concern for family practitioners, but also an equally valid concern for providers in the health sciences in general. Although this article is a good start, it marks only the beginning of our understanding of the behavioral measures that are used or could be used in clinical practice.

We recognize the need for survey questionnaires to be brief to maximize the response rate from busy clinicians. Nevertheless, we wish to draw attention to the small number of psychological measures assessed out of the many available measures and to the restriction of content to a few areas and conditions. There are many other clinically relevant behaviors such as stress, coping, quality of life, anger, and fears that are prevalent and affect practice. The contention that many more behavioral issues arise in practice is supported by the response to the write-in item in the study that identified an additional 21 different psychological measures used by clinicians. This is almost double the number of measures surveyed. Therefore, we would encourage physicians considering the use of specific behavioral measures in their practice to review Frank's[2] earlier extensive coverage of relevant instruments for physicians and to conduct a search of the Health and Psychosocial Instruments database (Health and Psychosocial Instruments Behavioral Measurement Database Services, Pittsburgh, Pa). This database of 63 000 records is a worldwide resource for instruments in the health and behavioral sciences.

We believe that these resources provide physicians with a comprehensive overview of the health and psychosocial measures available for use, and aid in the identification and selection of the specific measures needed to address the many behavioral issues that are commonplace in daily practice.

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1. Sansone RA, Wiederman MW, Sansone, LA. Use of psychological measures in primary care. *Arch Fam Med.* 1998;7:367-369.

2. Frank SH. An inventory of psychosocial measurement instruments useful in primary care. In: Stewart M, Tudiver F, Bass MJ, Dunn EV, Norton PG, eds. *Tools for Primary Care Research*. Newbury Park, Calif: Sage Publications; 1992: 229-270.

In reply

In response to Drs Zyzanski and Perloff, we agree that our survey of primary care physicians regarding psychological measures that they use in practice is only a start toward understanding the prevalence of such instrument use. As Drs Zyzanski and Perloff noted, we were limited as to the number of specific instruments we could feasibly ask about (hence the write-in section in the survey), yet we chose the instruments with an eye toward probable frequency of use, especially for assessing psychiatric concerns. We further agree that the number of self-report instruments that may be of some use to primary care physicians is virtually unlimited. Drs Zyzanski and Perloff provide useful references in this regard, and compendia[1] of instruments having to do with such specific areas as sexuality,[2] eating, and weight-related concerns have been published recently. However, in encouraging primary care physicians to take advantage of the multitude of psychological instruments available, we urge caution for the following reasons:

1. The fact that there are literally thousands of previously used or previously published self-report instruments does not mean that they are of equal quality and usefulness. Self-report measures vary widely with regard to reliability and validity, and the extent to which these issues have been investigated. Furthermore, many of the previously used and previously published instruments were designed for, and have been used exclusively in, research contexts. Accordingly, these instruments frequently do not entail cut-off scores or provision of guidance regarding the meaning of individual scores, rendering them all but useless to the individual physician in practice.

2. Many of the psychological instruments offered for use in primary care were developed with existing psychiatric diagnoses and nomenclature in mind. Accordingly, they often focus on assessing, or screening for, a specific Diagnostic and Statistical Manual of Mental Disorders, Third Edition[3] *diagnosis. While this is a worthy goal, many of the psychological phenomena of potential interest to primary care physicians falls outside of the narrow criteria for a* DSM *disorder. For example, the* DSM *contains criteria for full-blown somatization disorder and hypochondriasis, yet physicians will likely see many more patients who tend to experience emotional and psychological distress as somatic symptoms than they will patients with a corresponding* DSM *disorder. Instruments are needed to assess patients along relevant continua rather than with an eye to categorization as psychologically disordered or not.*

We recently confronted this issue when we sought to study somatization and hypochondriacal worry in pri-

mary care (data collection under way). We were able to find previously published measures to screen for obsessive-compulsive disorder, but none that assessed more generic forms of worry and would generate individual scores along this continuum. Similarly, we found previously published scales of somatization, yet these invariably consisted of laundry lists of somatic complaints, without distinction as to whether they had a basis in legitimate medical problems.

3. Psychological assessment is a profitable business, and as such our mailboxes are frequently filled with catalogues and flyers announcing the latest assessment instruments for sale. Many times these advertisements contain sensationalistic claims as to what the test can do for the clinician. Unfortunately, however, many of these instruments seem to be created out of a profit motive rather than in the interest of scientific advancement.

In summary, we join Drs Zyzanski and Perloff in encouraging practicing physicians and other health care professionals to consider expanding their use of psychological measures to better understand and serve their patients. We agree that such nonpsychiatric concepts as stress, coping, quality of life, and personality are of great potential use in assessing and treating patients from a holistic approach. We add, that the use of self-report instruments is an inexact science at best and a totally misleading endeavor at worst. Accordingly, we strongly encourage health care professionals to educate themselves regarding test use and, by and large, to use those instruments that have an established history of research and relevant clinical use behind them. As with many aspects of life, so it goes with psychological assessment instruments: new and exotic is not always better, and if it sounds too good to be true, it probably is.

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1. Allison DB, ed. *Handbook of Assessment Methods for Eating Behaviors and Weight-Related Problems*. Beverly Hills, Calif: Sage Publishers Inc; 1995.
2. Davis CM, Yarber WL, Bauserman K, Schreer G, Davis SL, eds. *Handbook of Sexuality-Related Measures*. Beverly Hills, Calif: Sage Publishers Inc; 1998.
3. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, Third Edition*. Washington, DC: American Psychiatric Association; 1980.

Commonly Used Medicinal Herbs

I especially enjoyed the article by O'Hara[1] et al, "A Review of 12 Commonly Used Medicinal Herbs," which concisely and generally accurately discussed 12 commonly used herbal medicines and reviewed a few toxic herbs.

There are 2 areas that deserved further comment in such a review article. (1) Herbs that come from Asian and Latin America countries have a high rate of contamination (30% in 1 study) and generally should be avoided. Contaminants include heavy metals such as lead, mercury, arsenic, phenylbutazone, and cortisone.[2,3] (2) The statement by the authors that the adverse effects of ginkgo biloba are similar to placebo may not be accurate. While it appears quite safe considering its extensive use, at least 2 cases of spontaneous hemorrhage in patients using ginkgo biloba have been reported, including 1 spontaneous subdural[4] hematoma and 1 spontaneous hyphema.[5] Ginkgo biloba has platelet-inhibiting properties. Certainly, patients who are taking anticoagulants or other platelet inhibitors should be aware that they may be at increased risk of bleeding while taking ginkgo biloba.

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1. O'Hara M, Kiefer D, Farrell K, Kemper K. A review of 12 commonly used medicinal herbs. *Arch Fam Med*. 1998;7:523-536.
2. Olujohungbe A, Fields PA, Sandord AF, Joffbrand AU. Heavy metal intoxication from homeopathic and herbal remedies. *Postgrad Med J*. 1994;70:764-769.
3. Kao RJ. Adulterants in Asian patent medicines. *N Engl J Med*. 1998;339:847.
4. Rowin J, Lewis SL. Spontaneous bilateral subdural hematomas associated with chronic ginkgo biloba ingestion. *Neurology*. 1996;46:1775-1776.
5. Rosenblatt M, Mindel J. Spontaneous hyphema associated with ingestion of Ginkgo biloba extract. *N Engl J Med*. 1997;336:1108.

Sun Protection and Children

We recently reported results of a community-based intervention that increased the use of sun protection in children.[1] Intervention materials appropriate for schools through grade 4, day care centers, and primary care offices are now available without charge on the Internet at http://nccc.hitchcock.org/sunsafe.htm.

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1. Dietrich AJ, Olson AL, Sox CH, et al. A community-based randomized trial encouraging sun protection for children. *Pediatrics*. 1998;102:1-8.

A READER ASKS

Synthetic Granuloma

Q Regarding treatment for synthetic fiber granuloma of the eye: Can a primary care physician manage this problem without an ophthalmology consult in patients presenting without visual problems?

A It would be useful to generalize your question, and address the issue of when a primary care physician may safely manage conjunctival and corneal foreign bodies, and when referral to an ophthalmologist is indicated. There are 3 important considerations when making this decision: the history of the foreign body, the depth of penetration into the ocular tissue, and the age and cooperation level of the patient.

The history in most patients is clear, with a sudden onset of ocular pain or irritation associated with a particular activity. In children, however, the history may be unknown. In these cases, it is important to rule out the

possibility that a foreign body may have penetrated the eye or orbit, because such injuries may result in sight-threatening complications. Signs of possible ocular penetration include decreased vision, subconjunctival hemorrhage, marked conjunctival swelling, clouding of the cornea, and absence of the red reflex. If there is a question of ocular penetration, then evaluation by an ophthalmologist is warranted.

If the history is known, the next consideration is the depth of the foreign body. Most conjunctival and corneal foreign bodies are superficial. These often can be removed in the primary care physician's office without the need for special equipment. Prior to attempting removal, topical anesthetic eyedrops should be placed in the eye to minimize discomfort. Simple measures are often effective in removing such foreign bodies. These include irrigation with a saline solution or gently swabbing the eye with a cotton-tipped applicator. In my experience, most primary care physicians are comfortable dealing with such problems. If penetration of deep tissue is suspected, or if a foreign body does not dislodge with the measures described above, then referral to an ophthalmologist is usually necessary.

The third important consideration is the age and cooperation level of the patient. Young infants (<1 year old) can usually be examined in the office, and superficial foreign bodies removed, while the infant is securely wrapped in blankets. Older children and adults are usually apprehensive, but are able to cooperate with gentle encouragement. Toddlers are the most difficult age group, and an adequate examination may be impossible in the office. In such children, and in those in whom a deeply penetrating foreign body is suspected, examination under anesthesia by an ophthalmologist may be necessary to assess an ocular foreign body accurately and safely remove it.

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Clinical Pearl

Biotin for Brittle Nails

Two thousand five hundred micrograms per day of biotin improved dry splitting nails for 63% of patients. The average time to noticeable results was 2 months. (*Cutis*. 1993;51:303-305.)