

Training general practitioners to improve their recognition of emotional disturbance in the consultation

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SUMMARY. *The detection of emotional disturbance by general practitioners in the consultation is known to be low. This study measured the detection rates of emotional disturbance among 10 established principals in general practice, as compared with the general health questionnaire, before and after 10 months of training. The training comprised a fortnightly seminar based around video recordings of ordinary consultations. The results showed that nine of the 10 doctors improved their ability to identify cases while one over-diagnosed cases following the training. The general health questionnaire detected emotional disturbance in 51.5% of the patients studied. During the seminars it became apparent that factors both within the doctor and the patient prevented detection of emotional disturbance and these are described. It is concluded that diagnostic accuracy depends on the interaction between doctor and patient, and that this has implications for the organization of general practice both in terms of longer consultation times and of adequate support for the doctor.*

Introduction

IN recent years there has been an increasing awareness of the high prevalence of emotional disorder and psychiatric illness in patients presenting to their general practitioner.^{1,4} Studies of the prevalence of emotional disturbance have revealed a prevalence of 39.6% for consecutive patient consultations in Manchester² and 42.9% in Lewisham.³ No more than 10% of this emotionally disturbed population are referred to psychiatric services, the remaining 90% being treated within primary care.⁵ There is no firm agreement as to what constitutes a psychiatric case in primary care.^{6,7} Taking a narrow view, if psychiatric illness is defined as susceptibility to physical treatment then 10% of the emotionally disturbed may be classified as suffering from major psychiatric illness and 20% from minor psychiatric illness.⁸ A broader view depends upon the validity of the general health questionnaire which is used to indicate emotional disturbance.^{1,4} This questionnaire has been found to be a valid and reliable indicator of emotional disturbance,⁹ correlating with standard psychiatric classifications.⁶ Recently, an attempt has been made to bring these two views together by modifying the cut-off point of the general health questionnaire.⁴

There have been few longitudinal epidemiological studies of the outcome of emotional disturbance or psychiatric illness in general practice. The studies that have been carried out suggest

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that at one year approximately 25% of the emotionally disturbed population have recovered, 50% have run a variable course and 25% have remained chronically disturbed.¹⁰ These three categories are still applicable after five years.¹¹ Several studies have shown that the greater the initial degree of emotional disturbance as measured by the general health questionnaire the more likely is the disturbance to be chronic.^{11,12} Whatever the view taken about a psychiatric case, general practitioners have to deal with a wide range of emotional disturbance, from distress in the consultation to managing specific treatment interventions, and they work not just with physical treatments but with a spectrum of psychological interventions. It is therefore important that general practitioners should be able to recognize emotional disturbance in the consultation.

It is well documented that general practitioners vary widely in the accuracy with which they are able to detect emotional disturbance, and that they miss between 30% and 50% of cases that are identified by the general health questionnaire.^{2,3} Only one study has published details of an attempt to train general practitioners to recognize emotional disturbance with greater accuracy;¹³ this involved trainee general practitioners and a didactic teaching format. The aim of the present study was to determine whether the accuracy of detection of emotional disturbance in the consultation by family doctors could be improved using a reflective, psychodynamic approach.

Method

Eleven general practitioners from 10 practices took part in the three phase study. Seven were members of a young practitioners group who had expressed an interest in being involved in the study following a presentation on psychotherapy in general practice given by one of the authors (P.J.W.). The remaining four doctors heard about the project by word of mouth, and asked to be included. All the general practitioners were in practice during the study and had been qualified for an average of four years. One did not complete the training because of a change of practice.

Phase one

The general practitioners asked 100 consecutive patients presenting in their surgeries to complete the 30-item general health questionnaire prior to consultation. Immediately following the consultation the general practitioners decided whether each patient was a psychiatric case or not without knowing the patient's general health questionnaire score. The criterion used for a case was that 'emotional disturbance or psychiatric illness was making a clinically significant contribution to the patient's presenting symptoms'.¹³

Phase two

During the training phase the general practitioners were divided into two groups which met once every two weeks for two hours over a 10 month period.

Each general practitioner, in turn, videotaped a series of consecutive consultations in his usual surgeries. Patients gave consent to be videotaped for teaching and research purposes and

also completed the 30-item general health questionnaire prior to the consultation. After the consultation the doctor rated each patient as a case or not, again blind to the general health questionnaire responses. The videotaped consultations were viewed and discussed at the fortnightly seminars led by two of the authors (P.J.W. and V.A.G.). Each general practitioner videotaped and presented three series of consultations at roughly equal intervals over 10 months. Those consultations in which the general practitioner disagreed with the general health questionnaire were particularly interesting.

During the seminars, discussion was directed towards the nature of the interaction between doctor and patient. The aim was to become aware of factors within the doctor and the patient which prevented the exploration of emotional disturbance. The factors within the doctors which were examined were their interviewing style in terms of the questions asked, their use of verbal and non-verbal cues, their ability to make empathic contact with the patient, their management of interactive sequences, their feelings about the patient and their use of defences against experiencing the patient's feelings. The factors within the patients which were examined were their motivation for consultation, the mode of presentation of their problems (both verbal and non-verbal) and their defensive avoidance of direct emotional contact with the doctor.

Phase three

Following the training phase the general practitioners repeated phase one, with 100 consecutive patients being asked to complete the 30-item general health questionnaire and rated blind by the general practitioner as a case or not.

Analysis

The number of general health questionnaires returned that could be analysed ranged from 79 to 100 per doctor in phase one and from 87 to 101 in phase three.

Agreement between the general practitioner and the general health questionnaire was assessed in two ways. First, a general health questionnaire score of five or above was rated as a case⁹ and the resulting cases/non-cases were compared with the general practitioners' judgements using Cohen's kappa. Secondly, the actual general health questionnaire scores were compared directly with the general practitioners' judgements using Somers' delta. This involves comparing the cases and non-cases identified by each doctor in each phase of the study using a Wilcoxon rank sum test. Delta can then be calculated from the rank sum test statistic.¹⁴ It gives a further measure of agreement between the doctors' judgements and the general health questionnaire score, that is whether the doctors' judgements were close to the cut-off point or not. Changes in the general practitioner's performance between phases one and three were assessed by comparing these measures of agreement between the phases using repeated measures analysis of variance (equivalent to a correlated t-test).

In addition to overall agreement, the ability of the doctors to detect cases in each phase was assessed using Light's conditional form of kappa.¹⁵ Kappa values conditional on general health questionnaire scores of five or more are reported, and give similar information to Goldberg's identification index.²

Results

Table 1 shows the kappa scores in phase one (May 1985, 924 patients studied) and phase three (March/April 1986, 914 patients studied). Following training six doctors improved their kappa scores noticeably, three did not change and one produced a lower score. Using Landis and Koch's benchmark for values

of kappa,¹⁶ of the six who improved, one went from poor to moderate agreement, three from fair to moderate, and two from moderate to substantial agreement. The doctor who produced a lower score went from moderate to fair agreement.

The 95% confidence intervals reported in Table 1 show that in both phases most doctors had kappa scores indicating reliably better than chance agreement (the confidence intervals not including zero). Similar results were obtained using the rank sum test.

A repeated measures analysis of variance carried out on the kappa scores showed a mean improvement of 0.12 between phases one and three, but this was not significant. This is not surprising given the wide variability in initial agreement. In particular, doctor 10 showed the best initial performance but one of the worst in phase three. With this doctor's data removed, there is evidence of reliable improvement for the rest of the group ($F=7.69$, 1,8 degrees of freedom, $P<0.025$). Similar results were obtained using non-parametric analyses. A repeated measures analysis of variance comparing the Somers' delta scores in phases one and three for the whole group indicated some improvement, although this was not significant. Without doctor 10's data, there was greater evidence of improvement, but this still did not reach significance.

Only doctor 10 showed a marked deterioration in accuracy following training and the results indicate that he was overdiagnosing emotional disturbance compared with the pre-training phase. Doctor 1 overdiagnosed emotional disturbance following training but he also increased the number of cases accurately identified so that his overall accuracy of detection was not impaired.

Table 2 shows conditional kappa scores before and after training. Over the period all the doctors, apart from doctor 10, improved in their ability to identify cases. A repeated measures analysis of variance carried out on the conditional kappa scores

Table 1. Kappa scores with confidence intervals before and after training.

	Kappa (95% confidence interval)	
	Before training	After training
1	0.05 (-0.21, 0.31)	0.50 (0.33, 0.67)
2	0.19 (-0.06, 0.44)	0.19 (-0.06, 0.44)
3	0.24 (0.00, 0.48)	0.54 (0.37, 0.72)
4	0.30 (0.10, 0.50)	0.56 (0.40, 0.72)
5	0.33 (0.13, 0.53)	0.29 (0.10, 0.48)
6	0.34 (0.12, 0.56)	0.52 (0.35, 0.69)
7	0.39 (0.19, 0.58)	0.34 (0.16, 0.53)
8	0.49 (0.32, 0.67)	0.70 (0.56, 0.84)
9	0.52 (0.35, 0.70)	0.62 (0.45, 0.78)
10	0.56 (0.37, 0.74)	0.30 (0.10, 0.50)

Table 2. Conditional kappa scores with confidence intervals before and after training.

	Conditional kappa (95% confidence interval)	
	Before training	After training
1	0.03 (-0.08, 0.15)	0.61 (0.40, 0.83)
2	0.11 (0.02, 0.20)	0.12 (0.02, 0.22)
3	0.17 (0.02, 0.31)	0.46 (0.28, 0.64)
4	0.23 (0.08, 0.39)	0.44 (0.28, 0.60)
5	0.23 (0.10, 0.36)	0.26 (0.08, 0.43)
6	0.25 (0.09, 0.41)	0.52 (0.33, 0.72)
7	0.29 (0.13, 0.44)	0.37 (0.16, 0.57)
8	0.45 (0.26, 0.65)	0.71 (0.54, 0.89)
9	0.44 (0.26, 0.63)	0.60 (0.41, 0.80)
10	0.43 (0.25, 0.61)	0.29 (0.08, 0.49)

showed a reliably larger proportion of doctors improving than would be expected by chance ($F=7.84$, 1,9 df, $P<0.025$).

Goldberg's probable prevalence formula⁵ was calculated separately for each of the 10 general practitioners to ascertain the level of probable psychiatric disturbance among the populations studied in phases one and three. In May 1985 probable emotional disturbance was detected in a mean of 52.1% of the patients (standard deviation 7.7%, range 44–68%) while in March 1986 the mean was 50.9% of patients (SD 5.3%, range 40–60%). There was no statistical difference between the two samples and overall the general health questionnaire identified 51.5% of these patients as probably disturbed.

Observations from the seminars

Factors within the doctor. The detailed examination of the videotaped consultations in the group seminars indicated that various factors within the doctor led to a failure to diagnose emotional disturbance.

First, it became clear that the doctors often missed vital non-verbal and verbal cues from the patient, sometimes because the doctor was not looking at the patient. Many patients gave verbal cues while the doctor was carrying out a physical examination, especially if they had been hurried through a consultation, and these were often missed by the doctor.

Secondly, in the absence of definite verbal or non-verbal cues the doctors generally failed to ask open questions about the patient's current emotional state; this contrasted with their use of open questions about physical health.

Thirdly, various affective or attitudinal states within the doctor seemed important. At first some of the doctors avoided exploring patients' emotional problems as they feared being overwhelmed by personal details and felt that unless they could solve these problems it would be wrong to explore them. This attitude gradually ameliorated as the doctors realized that patients could be helped by listening and by being understood. Emotional exhaustion towards the end of a surgery was apparent, especially if doctors had been exposed to several patients projecting feelings of helplessness or hopelessness, and this often led to the doctors failing to be receptive to patients' emotional problems. Patients suffering from chronic physical, social or personality disorders, who were often frequent surgery attenders, were particularly likely to induce this withdrawal. When the doctors' feelings were discussed it was clear that the withdrawal was secondary to negative feelings about the patient, which were sometimes only vaguely appreciated at the time of the consultation. With the help of the seminar the doctors were able to use these negative feelings as information about the patient and this reduced their guilt about failing to do anything and allowed a structure of thought concerning the patient to develop.

It appeared that the doctors who modified these aspects of their behaviour and attitudes made the most progress over the course of the study.

Factors within the patient. There were factors within the patient which made accurate diagnosis of emotional disturbance difficult and these also became apparent during the seminars. Patients consistently began the consultation with a physical complaint, even though it became apparent that an emotional difficulty was the main problem. It seemed likely that the patients believed that the doctor expected a physical presentation. A few patients referred to emotional states but then became defensive if the doctor took the statement seriously. Many of these patients were considered to be a case by the doctor but had a negative result on the general health questionnaire probably because they would not admit they had an emotional problem.

A proportion of patients seemed to come to the doctor not

for diagnosis or explanation but for covert motives, including the wish to be emotionally contained (mothered), to obtain narcissistic gratification, to get rid of feelings on the doctor, and to defeat the doctor.

Other patients seemed acutely sensitive to cues from the doctor. On several occasions where the doctor missed an emotional disturbance the videotaped consultations were examined only to find no verbal or non-verbal cues from the patient. Often the doctors then volunteered that they had wanted to hurry the consultation and presumably the patients had picked up the fact that the doctor was not prepared to listen.

Certain technical difficulties became apparent. For example, it often seemed intrusive to ask adolescents about their emotional problems as they might then lapse into a threatened silence and it was hard to assess any emotional disturbance in the neurotic part of schizophrenics because it was obscured by the psychotic part of the personality.

The general practitioners' views. At the end of the project the doctors commented that the training had changed their style of consulting. They felt more able to understand their patients emotionally and were less anxious about following up emotional cues. They felt more able to empathize with their patients and yet remain objective, and they felt less guilty about not actively solving an emotional problem once it was introduced. Finally, they were aware of when they were being receptive to their patients' emotional communications, and when they were not.

Discussion

This study was successful in its attempt to improve the diagnostic accuracy of established general practitioners in assessing emotional disturbance in general practice. The only other comparable study¹³ used trainee doctors as it was thought that their interview style would be more amenable to change. However, the established practitioners in this study were able to change and this was achieved not by didactic teaching¹³ but by allowing them to think about the doctor-patient interaction and its meaning, psychologically and psychodynamically.

The seminars demonstrated that for accurate diagnosis the consultation needs to be patient centred rather than doctor centred.¹⁷ The doctor needs to listen, stay attentive and show interest in what the patient is saying rather than impose a rigid structure on the interview and ignore or interrupt the patient. Although their study was not specifically concerned with emotional disturbance, Tuckett and colleagues noted that two thirds of patients reporting themselves to be anxious or depressed did not mention this fact to their general practitioner.¹⁷ They hypothesized two reasons for this failure to report, which seem to be confirmed by our observations; first, patients do not feel it is expected of them to report emotional symptoms, and secondly, they feel hurried. The first could be dealt with by a change in the doctor's attitude and interview technique but the latter only by changing the appointment structure to give longer and less hurried consultations.

Our study suggests that doctors fail to pick up emotional cues from patients because of defences within themselves. Tuckett and colleagues have enumerated these defences as tunnel vision, emotional withdrawal, being busy, being obsessed with technical aspects, being omnipotent and possessing an apostolic function.¹⁷ All these phenomena were apparent in the videotapes studied. Although Balint¹⁸ did not feel that one could change the views of doctors on what the patient should or should not be able to tolerate, and what should or should not be done, we felt that the doctors' perception that emotional states could be talked about did increase during the seminars. Tuckett and colleagues¹⁷ remarked that the question of whether the doctor's

defences are a good or bad thing is an open one. Our experience is that sensitivity to the emotional state of the patient involves relinquishing defences, and it seems that a supportive structure, such as the series of seminars described here, is necessary to cope with the increased anxiety that this entails.

The prevalence of emotional disturbance at 51.5% of consecutive consultations as measured by the general health questionnaire is higher than that found in previous studies.¹⁻⁴ Two factors may have contributed to this. First, the majority of general practitioners in the study were from inner city practices with a socially deprived population which might be expected to have a high rate of emotional disturbance. Secondly, the doctors in the study all had an interest in the psychological aspects of their patients' difficulties and emotionally disturbed patients may choose to consult a doctor they perceive as being interested in patients' emotional problems.

The question of what treatment should be given to the large numbers of emotionally disturbed patients in general practice remains to be answered. We hope to address this in further studies.

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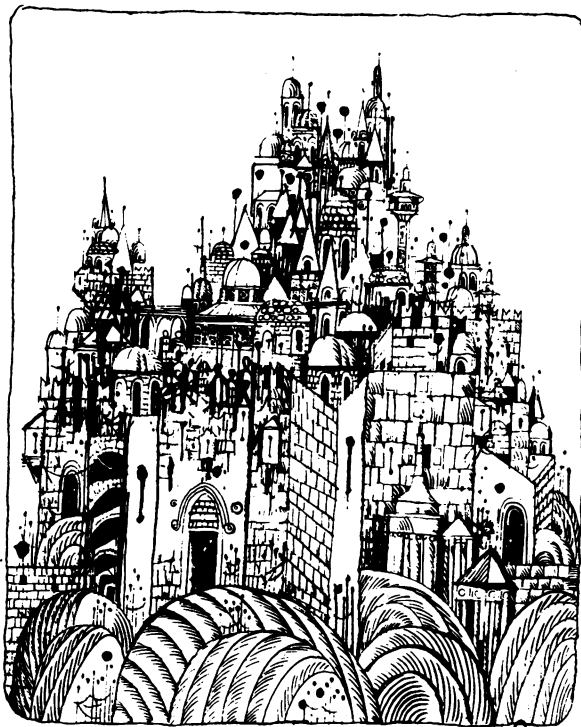
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