# Patients' reasons for not presenting emotional problems in general practice consultations

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*SUMMARY*

***Background.*** *Patients commonly do not mention emotional problems in consultations, and this is a factor in general practitioners' (GPs') difficulty in identifying psychological morbidity.*

***Aim.*** *To investigate patients' self-reported reasons for not disclosing psychological problems in consultations with GPs.*

***Method.*** *From nine general practices, a sample of patients with high General Health Questionnaire scores, who planned to present only somatic symptoms to the GP, were interviewed after their consultation with the GP. The interview covered their reasons for not mentioning emotional problems. A patient satisfaction questionnaire was administered.*

***Results.*** *A total of 83 patients were interviewed. Sixty-four patients confirmed that they had not mentioned emotional problems in the consultation; 23 (36%) of these gave primarily realistic reasons for not presenting emotional problems (e.g. able to cope with distress), 29 (45%) gave reasons related to psychological embarrassment or hesitation to trouble the GP, and 12 (19%) were mainly deterred by the doctors' interview behaviours. The latter group had significantly lower satisfaction scores than patients in the other two groups. In addition, patients in all groups commonly reported perceptions of lack of time (48%) and that there is nothing doctors can do to help (39%) as barriers to mentioning emotional problems.*

***Conclusion.*** *An understanding of patients' reasons for not disclosing emotional problems can assist in identifying subgroups of patients with different management needs.*

*Keywords: emotional problems; patient satisfaction; consultation; general practitioners.*

## Introduction

GENERAL practitioners (GPs) commonly do not identify many of their patients with psychological problems.[1-4] This is particularly likely to occur when patients present primarily physical symptoms[4-6] and do not mention psychological problems or mention them late in the consultation.[7]

Non-presentation of emotional problems in general practice has been found to be associated with lower levels of psychological distress than when patients present emotional problems directly,[6,8,9] and, in a proportion of patients, this may be associated with somatization (a denial of the significance of psychological distress).[6,10,11] There is also evidence that doctors' interview behaviours may deter patients from presenting emotional problems.[12,13] In addition, it has been hypothesized that patients may have difficulty presenting emotional problems because of fear of stigmatization, because of embarrassment, or because they feel that GPs do not have time to be interested;[14-16] and consumer surveys commonly find about one-third of the population reporting that they would not be able to discuss personal problems with a GP.[17-19] However, other than a study by Murray and Corney,[20] whose small sample of low attenders with psychosocial problems reported beliefs that psychological problems are not amenable to medical help, there has been no empirical study of patients' reported reasons for not presenting psychological problems in primary care.

The aim of this study was to investigate patients' reasons for not presenting emotional problems to GPs by interviewing patients who had high symptom scores indicative of psychological distress and who did not mention psychological problems in their consultations with the GP. A subsidiary aim was to identify subgroups of patients from their reasons given for not presenting psychological problems, and to investigate association of subgroup membership with other aspects of illness presentation and with patient satisfaction.

## Method

Nine GPs in North and East London participated in the study. The doctors were experienced GPs (mean = 19.6 years in general practice), approached on the basis of their interest in psychological aspects of patient management: a pragmatic recruitment strategy in view of the demands of the study on participating doctors. The GPs were aware of the purposes of the study.

Consecutive adult patients attending weekday surgeries were invited by receptionists to complete a screening questionnaire. The screening questionnaire comprised the 30-item General Health Questionnaire (GHQ)[21] and a check list of 34 common symptoms including 'depression' and 'anxiety, tension, or nerves', with an introductory question asking patients to tick the main problem or problems that they had come to see the doctor about. All subsequent consultations with the GP were audiotaped with the permission of patients (6.2% refused).

Patients aged 18 to 75 years, with GHQ scores of five or more — the standard cut-off for detection of psychiatric caseness[21] — and scores on the symptom checklist indicating that they had come to see the doctor about somatic symptoms only, were eligible for interview for this study. Ten patients meeting these eligibility criteria were targeted for interview from the surgeries of each participating GP. Where there were more patients meeting the eligibility criteria than there was time to interview within five days (median = two days) of the consultation, patients with the highest GHQ scores were approached first for interview (on the basis of the increased specificity of higher GHQ scores).[21] Where patients were unable to be contacted or refused the interview, then, if still within five days, the patient with the next highest GHQ score was approached. Interviews were conducted in patients' homes by the first author.

### *Interviews*

The semi-structured interview covered details of patients' presenting physical problems, patients' accounts of their emotional problems, and their account of what took place at the consulta-

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tion with the GP. On the basis of patients' accounts, the interviewer made ratings of the chronicity since onset of emotional problems (with reccurrence after a year symptom-free, rated as a new onset), whether the emotional problems interfered with patients' lives or patients were able to cope with them, and a rating adapted from Bridges and Goldberg[6] of the relationship of psychological factors to the patient's presenting somatic complaints (psychological disturbance secondary to physical illness, psychological disturbance with somatic presenting symptoms, and unrelated physical illness and psychological problems).

If patients indicated that they had not mentioned their emotional problems at the consultation, the interviewer then asked for reasons for not discussing emotional problems and how they would have felt if the doctor had enquired about emotional difficulties. Each reason given by the patient was classified by the interviewer against a list of 18 reasons (including 'other') drawn up from pilot interviews. In addition, the interviewer made an overall judgement based on the weight given by the patient to each reason, as to whether the patient's reasons were primarily reality based (e.g. the patient was coping satisfactory with their emotional problems, or the medical problems were too pressing), were primarily concerned with being deterred by some aspect of the doctor's communication, or were primarily related to psychological concerns of embarrassment or hesitation to trouble the doctor. These three primary reasons were selected on the basis of pilot interviews as distinguishing patients with potentially different management needs.

The interviews were audiotaped, with the patient's permission, and a random sample of 30 interviews were rated by an independent blind rater. Inter-rater agreement (kappa values) of the interview ratings reported in the results ranged from 0.59 to 0.87 (median = 0.71). Kappa values for key ratings reported in the results were as follows:

- overall rating of primary reason for not presenting emotional problems = 0.65,
- chronicity of emotional problems = 0.79,
- patient reported coping = 0.77,
- relationship of emotional to presenting physical problems = 0.59,
- patient's wish for GP to ask how felt emotionally = 0.76.

### *Patient satisfaction*

After the interview, patients completed a 50-item questionnaire regarding their satisfaction with the consultation.[22] The questionnaire items were selected or adapted from existing measures of patient satisfaction with consultations used in both the medical interview and psychotherapy research literature.[23,24]

### *Coding of audiotapes*

The audiotapes of the consultations were coded using a system designed to assess the extent to which psychological discussion takes place in a consultation compared with discussion of other issues.[22] The duration of the consultation was also timed. Two external raters, each blind to other aspects of the study, coded each audiotape.

### *Statistical analyses*

Data analysis was undertaken using SPSS. Cohen's kappas for inter-rater agreement were obtained from the SPSS Crosstabs programme. Differences between groups of patients were tested using chi-square tests for categorical variables, and *t*-tests and analyses of variance for continuous variables. Preliminary analyses indicated that the relevant continuous variables were approximately normally distributed and parametric tests were appropriate.

## Results

The number of patients at each stage in the selection of the study sample are given in Figure 1.

A total of 397 (36.6%) of the 1085 patients completing screening questionnaires had GHQ scores of five or more; of whom, 258 indicated on the symptom checklist that they had come to see the GP about physical symptoms only. Of these 258, 83 (32.2%) were interviewed, nine (3.5%) refused the interview, 14 (5.4%) were unable to be contacted at the address given by the GP, 12 (4.7%) were over the age of 75 years, and the rest (140; 54.2%) were not approached for interview. A median of 10 patients of each GP were interviewed (range = 7–10).

Sixty-four (77.1%) of the 83 patients interviewed reported that they had not mentioned their emotional problems to the doctor in the consultation. There was agreement between these patient reports and codings from the audiotapes as to whether there had been any psychological discussion in the consultation for 56 (87.5%) of these 64 consultations. Of the eight consultations where there was disagreement, four consultations had five or fewer utterances coded as definitely psychological (<1% utterances in the consultation), and, for the remaining four, closer examination of the consultation at least partly confirmed the patient's view (e.g. the patient had talked about being depressed in the past but not currently).

### *Patient characteristics*

The mean GHQ score of the 64 patients who did not mention emotional problems was 13.4 (SD = 5.4): 40 (62.5%) were female and the mean age was 40.0 years (SD = 14.7). Half (50.0%) reported that the physical problems for which they were seeking help were recent onset (a month or less), and 17 (26.6%) reported more than one physical problem. Emotional disturbance reported was more long-lasting, with 29 (45.3%) reporting emotional problems of over six months' duration.

### *Patient reasons*

A mean of 3.1 reasons were given by the 64 patients (one to seven reasons per patient) for not discussing emotional problems. The most common reasons (those mentioned by more than five patients) are shown in Table 1. The perception that doctors do not have sufficient time was the reason most commonly reported,

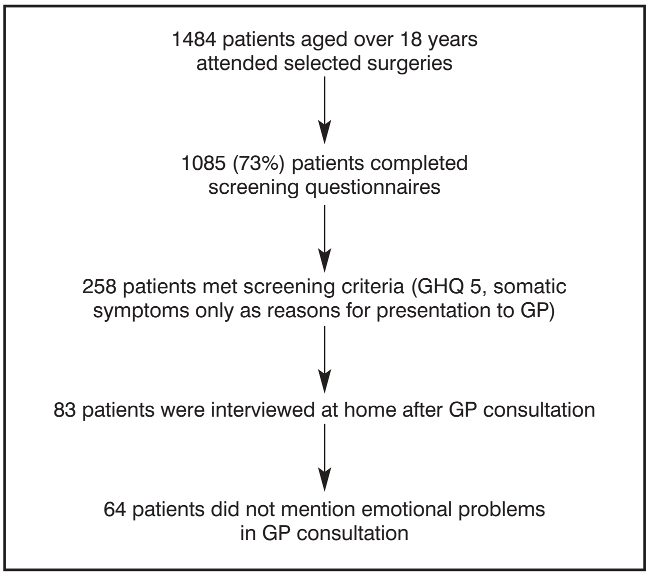


**Figure 1.** Selection of study sample.

**Table 1.** Reasons given by patients for not talking to GPs about emotional problems, with breakdown for three patient subgroups differing in primary reason for not presenting emotional problems.

| | Number (%) of patients mentioning reason | | | |
|---|---|---|---|---|
| Reason mentioned by patient | All patients (n = 64) | Subgroup A (n = 23) Reality | Subgroup B (n = 29) Patient hesitation | Subgroup C (n = 12) Deterred by doctor |
| Common to all groups | | | | |
| Doctors don't have enough time | 31 (48%) | 9 (39%) | 14 (48%) | 8 (67%) |
| Nothing doctor can do | 25 (39%) | 8 (35%) | 10 (34%) | 7 (58%) |
| Doctor's business is medical | 7 (11%) | 2 (9%) | 5 (17%) | 0 (0%) |
| 'Reality' reasons | | | | |
| Feeling better, not that bad | 18 (28%) | 17 (74%) | 1 (3%) | 0 (0%) |
| Feel can cope on own | 6 (9%) | 3 (13%) | 3 (10%) | 0 (0%) |
| Medical problems too pressing | 5 (8%) | 5 (22%) | 0 (0%) | 0 (0%) |
| 'Patient hesitation' reasons | | | | |
| Trivial, fear of time-wasting | 14 (22%) | 2 (9%) | 11 (38%) | 1 (8%) |
| Don't find it easy to talk about | 6 (9%) | 0 (0%) | 6 (21%) | 0 (0%) |
| Not wanting to seem weak, should cope | 5 (8%) | 0 (0%) | 5 (17%) | 0 (0%) |
| Not wanting to dredge up past | 6 (9%) | 1 (4%) | 4 (14%) | 1 (8%) |
| Not known doctor long enough | 5 (8%) | 1 (4%) | 3 (10%) | 1 (8%) |
| 'Deterred by doctor' reasons | | | | |
| Feels the doctor is not interested | 16 (25%) | 2 (9%) | 5 (17%) | 9 (75%) |
| What doctor said or did previously | 8 (13%) | 3 (13%) | 1 (3%) | 4 (33%) |
| 'Other' | 31 (48%) | 10 (43%) | 13 (45%) | 8 (67%) |

followed by the perception that there is nothing the doctor could do to help with the emotional problem.

The interviewer evaluated 23 (36%) patients as having primarily realistic reasons for not discussing emotional problems, 29 (45%) patients as being deterred primarily by psychological embarrassment or internal hesitation to trouble the doctor, and the remaining 12 (19%) patients as being deterred chiefly by some aspect of the doctor's present or past behaviour. Table 1 also shows the individual reasons for not presenting emotional problems given by each of these three groups of patients, which were the source of the interviewer's ratings.

### *Group differences*

Table 2 provides information on demographic, clinical, and other characteristics of the three groups of patients with differing rated, primary reasons for not presenting emotional problems. No significant differences were found between groups on age, sex, GHQ score, or consultation length. Patients considered to have primarily realistic reasons for not presenting emotional problems were more likely to report in interview that they were coping with their emotional problems, to have recent onset emotional problems (within the past month), and to be evaluated by the interviewer as having emotional problems secondary to a physical illness. Patients rated as primarily deterred by the doctor's present or past behaviour were more dissatisfied with their consultations. Patients rated as holding back primarily because of psychological concerns had more chronic emotional problems than those in the other two groups.

Overall, 34 (53%) patients indicated that they would have liked the doctor to have taken the initiative and asked how they felt emotionally. Patients rated as having realistic reasons for not presenting emotional problems were less likely to want this.

## Discussion

In this preliminary study it was found possible to categorize patients, on the basis of their reasons for not presenting psychological problems, into meaningful face-valid subgroups with potentially different management needs. The three subgroups were patients with primarily realistic reasons for not presenting emotional problems (e.g. able to cope with distress), those giving reasons related to psychological embarrassment or hesitation to trouble the GP, and those mainly deterred by the doctor's interview behaviour. However, there are several limitations to the study and caution is needed in generalizing from the results.

First, with the small sample size of patients interviewed, it is possible that significant distinctions were missed. Secondly, the GPs were not a representative sample of normal practice — being approached on the basis of interest in psychological management and being aware of the purposes of the study — and patients also may have been primed to consider emotional problems by completion of the GHQ prior to seeing the GP. Thirdly, use of the GHQ rather than a standardized psychiatric interview makes it possible that a proportion of patients interviewed had subclinical syndromes[21,25] for which the therapeutic implications may be different than for those meeting diagnostic criteria.[26-28]

The most common reasons given by patients for not presenting psychological problems were that doctors do not have sufficient time, followed by the perception that there is nothing that the doctor could do to help with the emotional problem. Dissatisfaction about constraints on consultation time is common to both patients and doctors in general practice,[8,29] and there is evidence that psychosocial discussions result in longer consultations.[29,30] Similarly, doctors as well as patients often doubt the doctor's ability to respond effectively to psychological problems.[20,31] Despite this, many patients do initiate discussions of psychological problems and, hence, although time constraints and doubts about doctors' abilities to respond are understandably a factor for all patients and doctors in the current context of general practice, they are not of themselves sufficient to deter patients from presenting psychological problems. Other factors are likely to also be necessary.

**Table 2.** Factors associated with three patient subgroups differing in primary reasons for not presenting emotional problems.

| | Group A: Reality (n = 23) Mean (SD) | Group B: Patient hesitation (n = 29) Mean (SD) | Group C: Deterred by doctor (n = 12) Mean (SD) | Significance of difference between groups F (df = 2,61) |
|---|---|---|---|---|
| Age (years) | 39.4 (15.6) | 42.8 (14.9) | 34.5 (11.6) | 1.4 |
| GHQ score | 12.1 (4.2) | 14.2 (6.0) | 14.1 (5.5) | 1.0 |
| Consultation length (minutes) | 6.8 (4.7) | 7.1 (4.4) | 4.5 (2.4) | 1.6[a] |
| Patient satisfaction | 76.3 (15.2) | 70.1 (15.7) | 40.9 (15.5) | 21.5[b,e] |
| | n (%) | n (%) | n (%) | $c^2$ (df = 2) |
| Female | 16 (70) | 18 (62) | 6 (50) | 1.3 |
| Emotional problems secondary to physical illness | 9 (39) | 3 (10) | 1 (8) | 7.9[c] |
| Patient reported coping | 13 (57) | 6 (21) | 2 (17) | 9.7[d] |
| Chronicity of emotional problems | | | | |
| Month or less | 12 (52) | 3 (10) | 2 (17) | 12.2[d] |
| Over six months | 7 (30) | 18 (62) | 4 (33) | 6.0[c] |
| Patients wishing for GP to ask how they felt emotionally | 7 (30) | 18 (62) | 9 (75) | 8.0[c] |

[a]df = 2,60; [b]df = 2,59; [c]$P<0.05$; [d]$P<0.01$; [e]$P<0.001$.

The subgroup of patients identified as having primarily realistic reasons for not presenting psychological problems, perceived themselves as not needing to discuss their emotional problems with the GP because of being able to cope with their distress or because their medical needs were too pressing. Although their GHQ scores were not significantly lower, they reported their emotional distress as less disabling and less chronic, and their emotional distress was also more likely to be evaluated by the interviewer as secondary to a physical illness. A number of studies have reported subclinical and mild cases of psychiatric disorder to be more common in patients presenting with physical symptoms[6,9] and for patients whose emotional disturbance remains unrecognized by the GP,[1,8] as compared with patients presenting psychological problems and with detected cases. It has been suggested that non-detection of such cases by the GP may be adaptive given the likelihood of such problems remitting without treatment, and that neither psychological nor pharmacological treatments have generally been evaluated for efficacy in milder cases.[32] However, an association of somatization with presentation of milder psychiatric symptoms has also been noted in general practice,[6,10,11] so it is possible that some patients classified as having realistic reasons for not presenting emotional problems in this study were in fact minimizing self-perceived distress through somatization.

Evidence that some patients may be deterred by doctors' interview behaviours from presenting emotional problems has been reported by Goldberg *et al*.[12,13] The 18% of patients in the present study classified as being deterred primarily because of the doctor's present or past interview behaviour were more likely to be dissatisfied with the consultation. No analysis was possible, given the small numbers of patients involved, as to whether such consultations were more common among particular GPs, and it is possible that these patients were more prone to dissatisfaction generally rather than that the interview behaviours of the doctors were deficient and that the GPs were in need of training.[12,13,33,34]

Psychological barriers to seeking help for emotional problems have been studied in a number of contexts other than general practice.[35,36] Difficulties in self-disclosure, shyness or embarrassment, low self-esteem and threats to self-esteem have been found to contribute to difficulties in help-seeking.[35,36] These are consistent with the reasons given by patients classified in the present study as hesitating to present emotional problems primarily as a result of psychological concerns. Almost two-thirds of these patients in the present study had experienced emotional problems of over six months' duration. Such patients may need encouragement through direct questioning in order to facilitate presentation of emotional problems, and most reported that they would welcome the doctor taking the initiative and asking how they felt emotionally.

The identification and management of psychological problems in general practice in the face of multiple competing demands is increasingly being seen as a far more complex task then previously appreciated.[37] An understanding of patients' reasons for presenting or not disclosing psychological problems may assist in identifying subgroups of patients with different management needs, and facilitate the targeting of GPs' time and therapeutic efforts to patients who would most benefit.

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