The role of general practitioners in treating psychological distress: A study of midlife Australian women

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Abstract

Background

Patient satisfaction with general practice (GP) care is important for treatment adherence, yet little is known about women’s satisfaction with GP care in relation to emotional problems.

Objectives

To explore women’s perceptions of the help provided by GPs for psychological distress.

Methods

Qualitative and quantitative data were gathered using semi-structured telephone interviews in NSW Australia. The respondents were 322 women aged 46-50 who participated in the baseline survey of Women’s Health Australia (WHA).

Results

Of the 309 women who had had a period of distress in the previous 12 months, 159 (52%, CI 46.4-57.6) had talked to a GP about their difficulties. Listening was the main help given by GPs (68%, CI 60.7-75.3), followed by a prescription for medication (55%, CI 47.2-62.8), and referral to specialist care (13%, CI 7.8-18.2). Few women reported specific behavioural interventions, such as counselling (4%, CI 0.9-7.1) or relaxation (1%, CI –0.6-2.6). There was a relatively high degree of satisfaction with referral, counselling and relaxation advice amongst those who received these treatments. In contrast, a fifth of women who received a prescription or were listened to found these treatments unhelpful (20%, CI 11.6-28.4, 21% CI 14.2-29.8)
respectively). Thematic analysis highlighted three main concerns for women, namely structural limitations of the GP-patient consultation, GPs’ limited interpersonal skills, and GPs’ limited interest, knowledge and skills in mental health.

**Conclusion**

While most women find their GP care helpful, many reported shortcomings in terms of both GP skills and structural limitations of the consultation. These findings are useful in informing the development of training programs for GPs.

**Key words: psychological distress, midlife, women**
Introducing

It is well established that general practitioners (GPs) in Australia and elsewhere see most people with psychological distress,¹ and that patients are offered a range of non-pharmaceutical treatments, including supportive listening, reassurance, lifestyle advice, meditation and relaxation techniques, as well as psychotropic medication and referral to specialist care.²,³ Studies suggest that GPs rarely offer specific psychotherapeutic interventions such as short or long-term counselling.

However, little is known about women’s satisfaction with GP care in relation to emotional problems. Patient satisfaction with GP care in general is largely determined by their perceptions of the GP-patient relationship and GPs’ interpersonal skills.⁴,⁵ Yet patients often report that they feel unable to discuss personal problems,⁴ discouraged from asking questions,⁶ and that their opinions are undervalued or disregarded.⁷ Many also report receiving inadequate information⁴ and complain about structural limitations such as lack of time in the consultation.⁴,⁶,⁷ Presumably patient satisfaction with GP care for emotional distress might similarly depend heavily on GPs’ interpersonal skills, as well as structural features of the consultation.

The present study was undertaken to explore women’s experiences in relation to GP treatment of psychological distress. Specifically, the study aimed to:

1. determine the proportion of women who talked with a GP about their psychological distress;
2. describe the type of help provided and its perceived helpfulness;
3. explore women’s perceptions regarding GPs’ role in the treatment of psychological distress.
Method

Design

Follow-up survey of a random sample of women who had poor mental health status (as defined) from a population-based cross-sectional survey of Australian women aged 45-50.

Setting and subjects

Baseline data for this study were collected as part of Women’s Health Australia (WHA), a federally funded interdisciplinary longitudinal research project designed to track the health of three cohorts of women over twenty years. Random samples of women aged 18-23, 45-50 and 70-75 years in 1996 were selected from the database of the Australian Health Insurance Commission (Medicare), the most up-to-date sampling frame available. This paper concerns only the mid-aged cohort, of whom 13,961 responded to the baseline survey.

From the mid-aged cohort of WHA, a random sample of 400 was drawn from those women living in NSW who scored $\leq 52$ on the Mental Health Index (MHI-5) of the SF-36 in the baseline survey. Trained interviewers administered a comprehensive semi-structured telephone interview that included questions about the experience of seeking professional help for psychological distress.
**Main outcome measures**

**Recent period of distress.** Respondents were asked whether they had had a period of distress, upset or worry in the past 12 months.

**GP help-seeking.** Women were asked whether they had a regular GP and, if not, whether they attended a regular group practice. Those who had had a recent period of distress were asked whether they had discussed their difficulties with a health professionals and, if so, who. Women who had discussed their difficulties with a GP were prompted to indicate the type of help provided. Based on previous studies of help-seeking, the prompts were: listening, counselling, relaxation advice, prescribing medications, and referral. Perceived helpfulness of each treatment offered was assessed on a 3-point scale: ‘very helpful’, ‘somewhat helpful’, and ‘unhelpful or made things worse’. Comments regarding GPs’ role in treating psychological distress were recorded verbatim.

**Analysis**

Quantitative data were analysed using the SAS software package. For each item, frequencies and 95% confidence intervals (CI) were calculated. Qualitative data were categorised thematically using constant comparison methods.

**Results**

**Respondents**

From the women randomly selected to participate in WHA, 13,961 women participated in the baseline survey giving a response rate of 53.5%, which compares favorably with other similar longitudinal studies. Details of respondents are available elsewhere. Respondents were similar to the Australian population of 45-50 year old
women in marital status, parity, and aspects of employment (except for unemployment). However, they had higher educational levels and fewer were unemployed, suggesting that women of higher socio-economic level are over-represented in the WHA sample.

For the follow-up survey reported in this paper, data were analysed on 322 completed interviews giving a response rate of 81%. Significantly more non-responders than responders worked at home or were retired, were of non-English speaking background, did not have private health insurance, took medication for ‘nerves’ and to sleep, and reported that, apart from family, they did not have anyone close by whom they could depend on.

Consultation with a GP

Of the 322 participating women, 290 (90%, CI 86.7-93.3) indicated having a regular GP and a further 16 (5%, CI 2.6-7.4) reported attending a regular group practice. In total, 309 (96%, CI 93.9-98.1) women indicated having had a period of distress in the previous 12 months. Of these, 215 (70%, CI 64.9-75.1) had talked to a health professional about their difficulties, with 159 (52%, CI 46.4-57.6) having consulted a GP. GPs were the health professional most commonly consulted for psychological distress.

Treatments offered and perceived helpfulness

The type of help provided by GPs is shown in table 1, together with ratings of helpfulness. Listening was the main help given by GPs, followed by a prescription for medication, and referral to specialist care. When broken down by single responses and combinations, the most common were: medication and listening combined (26.1%, 19.2-32.8), listening only (21.0%, CI 14.6-27.3), and medication only (16.6%, 11.1-
22.9). Few women reported specific behavioural interventions, such as counselling or relaxation.

Perceived helpfulness varied. There was a relatively high degree of satisfaction with referral, counselling and relaxation therapies. However, the low numbers and wide confidence intervals for these treatments suggest the need for caution in interpretation of these findings. Prescribing medication was least often rated as very helpful. Further it was regarded as unhelpful by around one fifth of women who received it, as was listening. Specific ‘other’ treatments seen as very helpful included helping with an apprehended violence order, giving praise and encouragement, and helping with family care.

[Table 1 about here]

Relevant comments from 247 (77%) of the 322 participating women were recorded. Thematic analysis indicated that three main themes underpinned these comments, namely: structural limitations of the GP-patient consultation; GPs’ interpersonal skills; and GPs’ interest, knowledge and skills in mental health.

**Structural limitations of the GP-patient consultation**

Time constraints were a major determinant in women’s dissatisfaction with the GP consultation. Women complained about lack of time to tell their story or even to detail their presenting physical problems: “The biggest thing is time. How to start explaining yourself? It’s hard to get to the point to say how you feel and this puts the doctor off. They feel you should say yes or no. It’s like a maze”. This restriction often undermined the GP-patient relationship: “I have a very hard time getting along with my doctor, getting into a conversation. She’s always in a rush”. Moreover, the fast throughput in some clinics made women feel dehumanised: “They just want to shove
you in and shove you out - like a sausage maker. If you haven’t finished then they make another appointment and tell you to come back”. Alternatively, some women adapted to the short consultation time by restricting their discussion to ‘medical’ issues: “I know he’s a busy man. I don’t think he’s got the time for this type of thing”.

Lack of access was another source of dissatisfaction, particularly amongst women from rural areas. Some indicated that they had to wait too long for appointments - four to six weeks “unless you were dying”. This was exacerbated in some towns where the ‘good’ GPs had closed their books and weren’t taking new patients, thus denying women the ability to change doctors when dissatisfied. Many women chose to travel long distances in order to consult with their preferred GPs.

**GP’s interpersonal skills**

Most women wanted a GP they could comfortably talk with, specifically someone who would listen. A woman who used the local GP for her children’s “bronchitis and things”, but drove 40 minutes to another town to see her GP of 20 years standing illustrated this. Highlighting the importance of the GP-patient relationship, she indicated: “She was the first person I talked to when I realised I was having a nervous breakdown”. However, provided GPs possessed the desired interpersonal skills, a long-term relationship was not necessary for rapport: “I changed last year after being unhappy with my GP. I talked to my new doctor about my relationship with my husband and I hadn’t talked to anyone else about that ever”. Effective interpersonal skills also encompassed the ability to explain the causes and treatments for a physical or psychological condition. “I like him a lot. He will sit and explain.”

**GP’s interest, knowledge and skills in mental health**
Women indicated the importance of GPs’ ability to recognise emotional issues that might underlie apparent physical symptoms. Some women would present to the GP with a physical problem hoping for recognition of their emotional needs: “You always think of GPs for physical problems, not social or emotional ones. I didn’t know where to go. I’d go on the pretext of headaches. I didn’t want to go and say ‘I need some sort of emotional assistance here’”. However, at times, GPs’ familiarity with their patients precluded recognition of their needs: “I’d talk to him about anything. He’s like a friend. But that can also be a problem: he thinks he knows me, thinks I can cope” and “He was not able to see past the facade. I told him I was feeling very, very stressed, that I had five major stresses at the same time. I didn’t feel as though he, or anyone, saw my pain because I looked as though I was coping”.

Indeed, women felt that many doctors were disinterested in their patients’ psychological difficulties: “I don’t think they really want to know about my emotional problems” and “GPs can’t get you out door quickly enough when it comes to emotions”. Some said that the GP “skirted around” the topic; one indicated that her GP said he did not believe in “that sort of thing” when she sought help for emotional difficulties and depression.

In addition, women talked specifically about GPs’ limited skills in dealing with the mental health problems: “Some doctors seem to have poor skills with emotional problems” and “I shopped around because some doctors belittle the problems”. Some women felt that GPs needed to update their knowledge and skills: “all GPs could benefit from further training in this area”. Indeed, there was a strongly held desire for a more holistic approach to health care and an acknowledgement by GPs of the issues underlying physical ill health: “Doctors don’t look beyond the initial problems. They
don’t look into why you feel the way you feel” and “They should explore emotions to see if this is the cause of medical problems”.

On the other hand, some women regarded mental health as a specialty area and felt that “ordinary GPs are not qualified” to deal with emotional issues. There was a small but adamant group of women who felt that it was inappropriate to expect emotional help from GPs: “Doctors are there for physical problems, not emotional problems”. Some women indicated that they consult a GP for physical problems and a psychologist for emotional difficulties, while others had turned to complementary therapists such as naturopaths: “I have found alternative therapies better. Once I got away from the doctors, I’ve felt better. Alternative therapies have done better for me”.

Dissatisfaction with GPs orientation to psychological distress was intertwined with women’s attitudes to psychotropic medications. Many women were of the view that “doctors are too quick to hand out pills” and some regarded a prescription for medication as “poor care” for psychological distress. Given the complexity of this issue, comments related to psychotropic medications have been reported and discussed separately elsewhere.

Discussion

Strengths and limitations

It has been suggested that when interviewers are writing interview responses they are more likely to record instances where respondents are specific about their grievances. Likewise, respondents are more likely to articulate negative rather than positive experiences and concerns. These factors might have inflated reporting of negative perceptions.
The strengths of the present study are its initial random community sampling and the use of both qualitative and quantitative methods. Qualitative methods have the capacity to illuminate the complexities and contradictions of quantitative reports of satisfaction and dissatisfaction. This is clearly borne out in the present findings.

**Help provided and perceptions of helpfulness**

Of women who had experienced psychological distress in the previous year, 52% had talked with their GP about their problems. This rate is higher than previously reported for mental health consultations amongst women generally and amongst those with a psychiatric disorder. This is presumably due both to the relatively high rate of GP visits amongst midlife women and to the likelihood that many women discussed emotional issues when presenting for physical problems. Indeed, consistent with previous studies, women’s comments highlight the importance of GPs’ ability to recognise emotional agendas hidden beneath presenting physical problems.

Listening and/or medication were the most commonly reported responses offered by GPs. The reported incidence of counselling and other behavioural interventions was even lower than found previously. This might be due partly to the different perspectives and terminology: what was described as listening by women in our study might have been described as non-directive counselling by GPs in previous studies.

Despite their commonality, listening and medication were perceived to be the least helpful of the treatments offered, with over one fifth women who received them regarding them as unhelpful or worse. In contrast, referral was seen by around 90% referred women as helpful. In a recent Australian study of public perceptions on mental health treatment, respondents similarly regarded referral as an appropriate response for GPs. Indeed, only 38% perceived the GP as an appropriate person to
administer treatment for psychological problems.\textsuperscript{17} Consistently, there is some evidence that GP treatment of psychological illness has limited effectiveness in terms of patient outcomes, particularly in the longer term.\textsuperscript{18}

Yet women in the present study clearly wanted to discuss emotional issues with and to be listened to by their GP. Only a small, albeit adamant, group of women regarded emotional care as outside the GPs’ realm. Qualitative comments suggest that, together with information provision, women regard listening as the key component of effective GP interpersonal skills. Previous research similarly suggests that those who feel most ‘helped’ by talking to a GP are those who have had a chance to say what is really on their mind and those who have been given information about their illness.\textsuperscript{19} That listening was not always regarded as helpful by women in the present study suggests that many did not actually feel heard or acknowledged.

GP\textquotesingle s’ helpfulness in responding to women’s emotional needs appears to be limited by their lack of interpersonal skills and interest in emotional issues, evidenced in the qualitative findings of the present study. This is consistent with previous studies of satisfaction with GP care in general.\textsuperscript{4,5} Women indicated that they shopped around for a GP with the desired interpersonal skills and, within the limitations of GP availability and access, most women were not afraid to change GPs if necessary, consistent with a consumerist model of health care.

Lack of time was also reported to limit women’s interactions with GPs, again consistent with previous findings regarding GP care in general.\textsuperscript{4,6,7} Time constraints can effectively make patients feel dehumanised and degraded, as evidenced in women’s comments reported here and elsewhere.\textsuperscript{13} The problem is exacerbated by the fact that emotional issues are left till late in the consultation and payment arrangements
encourage GPs to focus on presenting problems. Recent changes in Medicare schedules in Australia allow for longer consultations to be reimbursed, thus giving incentives for more appropriate consultation lengths.

Access difficulties were particularly high for women from rural areas, supporting previous research. Yet there is evidence of increased reliance on GPs for mental health treatment in rural compared with metropolitan areas. This underscores the need for additional training for rural GPs.

**Conclusions and implications**

The present study documents the needs and expectations of Australian women in regard to GP responses to psychological distress. While most women find their GP care helpful, many reported shortcomings in terms of both GP skills and structural limitations of the consultation. Importantly, much is currently being done in Australia to improve GP skills in treating psychological distress, including increased emphasis on mental health skill development in undergraduate, postgraduate and vocational training programs. The findings of the present study are useful in informing the development of such programs.

**Acknowledgements**

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References


GP treatment of psychological distress in midlife women


### Table 1

**Type of help given by GPs and perceived helpfulness**

<table>
<thead>
<tr>
<th>Help given by GP</th>
<th>n</th>
<th>% (CIs)</th>
<th>Perceived helpfulness</th>
<th>% (CIs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Listened</td>
<td>109</td>
<td>68.5 (60.7-75.3)</td>
<td>Very helpful</td>
<td>60.7 (51.8-70.2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Somewhat helpful</td>
<td>17.8 (10.7-25.3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Unhelpful</td>
<td>21.5 (14.2-29.8)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Don’t know</td>
<td>5.1 (0.4-9.6)</td>
</tr>
<tr>
<td>Medication</td>
<td>87</td>
<td>54.7 (47.2-62.8)</td>
<td>Very helpful</td>
<td>50.6 (40.4-61.6)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Somewhat helpful</td>
<td>24.1 (15.0-33.0)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Unhelpful</td>
<td>20.3 (11.6-28.4)</td>
</tr>
<tr>
<td>Referral</td>
<td>20</td>
<td>12.6 (7.8-18.2)</td>
<td>Very helpful</td>
<td>73.7 (54.3-93.7)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Somewhat helpful</td>
<td>15.8 (-0.5-32.5)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Unhelpful</td>
<td>10.6 (-3.1-25.1)</td>
</tr>
<tr>
<td>Counselling</td>
<td>6</td>
<td>3.8 (0.9-7.1)</td>
<td>Very helpful</td>
<td>83.3 (50.1-115.9)</td>
</tr>
<tr>
<td>Relaxation</td>
<td>2</td>
<td>1.2 (-0.6-2.6)</td>
<td>Very helpful</td>
<td>100 (100.0-100.0)</td>
</tr>
<tr>
<td>Other</td>
<td>26</td>
<td>16.4 (10.3-21.7)</td>
<td>Very helpful</td>
<td>42.3 (22.6-61.4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Somewhat helpful</td>
<td>19.2 (3.6-34.4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Unhelpful</td>
<td>35.4 (16.3-53.7)</td>
</tr>
</tbody>
</table>

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1 n > 159 because women could report more than one type of action. 2 Other = practical help including help with domestic violence and family support; praise and encouragement; reassurance; cuddle; acupuncture.