Lay attitudes to professional consultations for common mental disorder: a sociological perspective

Roisin Pill*, Lindsay Prior† and Fiona Wood‡

*Department of General Practice, University of Wales College of Medicine and †Cardiff School of Social Sciences, Cardiff, UK

How, why, and under what kinds of circumstances lay people consult for symptoms of emotional distress are topics that have commanded various degrees of attention from secondary and primary care professionals. We argue below that many of the responses made by such professionals to these issues carry within them a set of very important assumptions about how members of the lay public view psychiatric symptoms. Whether such assumptions are justified by the evidence is, however, a matter of some debate. In what follows we draw on some recent, sociologically informed research on lay attitudes to emotional distress so as to highlight the debates and to suggest some ways in which they might be resolved.

The professional perspective

Understandably, most of the papers written about depression and its management in the UK are by psychiatrists, although there is a small but growing literature by general practitioner (GP) researchers. The majority of the latter tend to follow the lines laid down by the specialists though, increasingly, the approaches used and interpretation of findings are being queried by some researchers and commentators coming from a primary care background1,2.

Certain themes found in much of the psychiatric literature on mental illness occur repeatedly in papers about depression in the UK: the seriousness of the condition; the need to ensure that sufferers receive the most effective treatment available; the existence of an unacceptable amount of ‘under-treatment’; the importance attached to the role of stigma in contributing to under-treatment; the increasing recognition of the key role that the GP, rather than the specialist, must play in resolving this gap.

Thus we are told that diagnoses of anxiety and depression have a prevalence of about 16% in the UK3,4. Moreover, 15–30% of sickness absence can be attributed to these disorders and the associated disability

Correspondence to: Prof. Roisin Pill, Department of General Practice, Llanedeyrn Health Centre, Maelfa, Llanedeyrn, Cardiff CF23 9PN, UK
is comparable to most chronic medical conditions. As far as psychiatrists are concerned, there is now good evidence that effective pharmacological and psychological treatments exist for more severe cases of depression and anxiety. This is generally accepted among health professionals though some doubt has been expressed about the efficacy of treatment for the mild/moderate cases often seen in primary care or indeed whether it is appropriate to attempt to screen or case-find. While about 90% of people regarded by psychiatrists as having symptoms of depression and anxiety are treated within primary care, it has been estimated that possibly as many as 50% of cases go undetected in the GPs surgery.

To date, research has concentrated on exploring the perceived failure of GPs to recognise psychiatric disorder with less attention being paid to the reasons why patients may be reluctant to disclose symptoms to their GP. Most psychiatric work on this topic has invoked the concept of ‘somatisation’. This is a complex construct, with several different definitions though most require the physical complaint to be ‘caused’ by the psychiatric disorder. Somatisation defined in this way is relatively uncommon and is found in about 3% of attendees in UK primary care. In contrast, it is relatively common in patients with physical complaints who also have psychiatric disorder and has been estimated as up to 25% of those consulting. It has been suggested that this can be called ‘somatic presentation’, i.e. the patient has a psychiatric disorder (as defined by the specialists) and consults about physical symptoms that may or may not be related to their psychiatric disorder.

Most studies have concentrated on the interviewing skills of the doctor and on developing and testing interventions designed to improve detection. There is, indeed, evidence to show that such interventions designed to teach more effective interviewing skills can improve detection rates, but it is clear that if patients were readier to discuss emotional problems with their GP this could also dramatically increase the likelihood of recognition. For example, Weich et al showed that GPs detected about 20% of the cases of psychiatric morbidity who presented with physical symptoms, 53% of those presenting with both emotional and physical symptoms, and 100% of those who complained of emotional problems. Another recent study has found a strong association between detection by the GP and the psychological style of attribution employed by the patient. In particular, those who ‘normalise’, i.e. find common-sense explanations for their symptoms, are less likely to be detected. These findings suggest that more attention could usefully be paid to exploring people’s attitudes to their symptoms and their views about the appropriateness of the services available to them in primary care in order to understand their behaviour in consultations with their GP. In the following section, we examine the work has been undertaken on this topic in the mental health field.
Lay attitudes to professional consultations

How professionals interpret lay responses

Lay (and professional) attitudes towards mental illness have received greater attention in medical journals in recent years. The context of discussion has usually concerned difficulties surrounding the delivery of effective and timely treatment to those who could benefit. As noted above, ‘under-treatment’ is seen as the key problem, and lay attitudes are perceived as potential barriers needing to be changed. Thus one of the activities of the 1992 Defeat Depression Campaign, supported by both the Royal Colleges of Psychiatrists and General Practitioners, was a survey\(^\text{16}\) of public attitudes ‘to know which attitudes needed to change and to measure the effectiveness of the campaign in promoting those changes’. The opinions singled out as problematic were the association of stigma with depression, the ambivalence about consulting a family doctor (possibly on account of stigma), and the view that antidepressants were addictive and not particularly effective.

More recently in 1998, the Royal College of Psychiatrists launched another 5-year campaign aimed at the public in general called Changing Minds; Every Family in the Land. This was designed to reduce the stigmatisation experienced by people with mental problems and to close the gap between professional and public assessment of treatment by ‘de-mythologising’ six categories of common mental disorder, including depression\(^\text{17}\). As with many other medical specialities, the perception is that any discrepancy between professional and lay attitudes and beliefs about symptoms, diseases, appropriate behaviour by the sufferer and treatment is generally due to ignorance, prejudice and misunderstanding on the part of the patient. The solution is seen in re-education through the provision of information. Thus, in a recent review article, Jorm summarises his findings as follows\(^\text{18}\):

Many members of the public cannot recognise specific disorders or different types of psychological distress. They differ from mental health experts in their beliefs about the causes of mental disorders and the most effective treatments. Attitudes which hinder recognition and appropriate help-seeking are common. Much of the mental health information most readily available to the public is misleading. However, there is some evidence that mental health literacy (defined as ‘knowledge and beliefs about mental disorders which aid their recognition, management and prevention’) can be improved.

In relation to the common mental disorders, such as depression, it is very striking how few data there are on the perceptions, beliefs and help-seeking behaviour of people within the UK. Research within Britain has been largely stimulated by concern with the clinical problems that arise
in diagnosis and treatment of common mental disorders when professionals and patients come from different cultures – and particularly different ethnic groups\(^1\). A more recent example can be found in the, as yet, unpublished work of Lloyd and colleagues that has investigated explanatory models of Afro-Caribbean patients in British primary care.

Much of the published work has focused on trying to understand the reasons for not consulting the GP rather than describing beliefs about illness and symptoms. This is perhaps understandable given the fact that only about 5% of those recognised in primary care as emotionally distressed are referred on to mental health services\(^2\) – a figure that has apparently changed little over the years\(^1\).
the fact they had high GHQ scores. The most frequently cited reasons that patients gave for not mentioning psychiatric problems to their GPs were: ‘Doctors have insufficient time’ and ‘That there is nothing the doctor can do’.

The relationship between research methods and research findings

In the examples quoted above, the data have come from cross-sectional surveys on patients. Generally, they have employed highly structured questionnaires. While such studies allow data collection from large numbers of people on a variety of indicators thus facilitating the use of sophisticated quantitative approaches, they provide very little opportunity for inquiring about how subjects actually interpret the issues that are placed before them. To gather data on how lay people (rather than professionals) interpret the world and its problems, qualitative methods are required. Such methods enable people to speak in their own terms and to order discussion in their frame of priorities.

A sociological perspective

Research on lay attitudes to mental illness

Having criticised the professional psychiatric literature for the relative lack of attention paid to exploring why individuals in the community are not only apparently so reluctant to seek medical help but also to disclose emotional symptoms/problems to their GP once in the consulting room, it has to be admitted that there is very little in the sociological literature either – at least from the point of view of the general public.

Work on mental illness has been mainly concerned with various aspects of secondary care: for example, such topics as patient experiences and views about services, aspects of professional practice including studies of relationships between health professionals in psychiatry, and studies of the diagnostic process and its consequences. Work has also been published on what is seen as gender issues in mental illness. What sociology can offer is a body of research on lay and professional encounters and professional and lay beliefs about health and illness. Such studies offer insights into ways in which topics such as this could be most fruitfully explored.

Sociologists and anthropologists start from the position that each culture (norms, beliefs and behaviour of particular social groups) provides its members with ways of becoming ‘ill’, of shaping their suffering into a recognisable illness entity, of explaining its cause and of
getting some treatment for it. Thus cultures influence the ‘language of distress’, i.e. the means by which personal distress is communicated to other people. Both the presentation of illness and others’ response to it, are largely determined by sociocultural factors.

Over the last 30 years, medical sociologists have traditionally examined and described the social patterning of beliefs about illness in Britain. They have looked at the ways in which these are related to help-seeking behaviour, and examined the crucial role of the medical profession in defining, legitimating and treating illness. For example, they have introduced concepts that distinguish between illness (the subjective experience of symptoms), and disease (the objective pathological entity). They have further distinguished between clinical and lay ‘explanatory models’, and have analysed the process of help-seeking. This body of work can provide a useful counterpoint to the purely professional view of the world.

For example, it is well-known that only a small proportion of those in the community experiencing either mental or physical symptoms, that a doctor would consider indicative of disease and requiring medical treatment, ever actually present them to their GP. An even smaller percentage of these individuals are then referred on to specialists in secondary care. Mental health problems, including depression, are no exception to this pattern. A number of studies confirm the existence of a clinical iceberg; the organised, legally-sanctioned professional health services treat only the tip of the sum total of ill-health.

Within any modern urbanised society such as Britain, there will also be a large number of therapeutic options potentially available to people. These will range from self-treatment, folk-remedies, advice from family and friends, and increasingly the Internet, over-the-counter pharmaceutical preparations, unofficial and alternative healers, and healers from other non-Western traditions. People make choices about what to do, and who to consult, on the basis of such factors as perceived availability, whether payment has to be made, and the explanatory models (EMs) that they hold, i.e. the particular set of beliefs marshalled in order to deal with the current episode of illness. Such EMs are typically rather idiosyncratic and changeable, heavily influenced by both personality and cultural factors, and need to be understood by examining the circumstances in which they are employed. The concept of EM has proved a useful tool for looking at the process by which lay people organise and manage episodes of impaired well-being.

Lay views on disclosure of emotional problems in primary care: an illustration

The lack of any previous body of work on this topic was the stimulus for our exploratory study of lay attitudes in Wales. We argued that there was a need to look at the beliefs and attitudes of the general public who may never have come into contact with psychiatry and psychiatrists and
who may or may not have presented any symptoms of common mental disorder in primary care. (These, after all, provide the background and the resources from which any one individual constructs his or her explanatory models, seeks to make sense of symptoms, and does or does not take remedial action.)

We wanted to see what beliefs are held in common, the extent to which people feel it is appropriate to disclose emotional distress to a professional, and their assessment of the likelihood of any improvement of their symptoms as a result.

Our purpose here is not to give full details of our findings but, by concentrating on the choices made in the study design, and illustrating the kind of data collected and the way it was analysed, to give the reader some concept of the possibilities of qualitative research, and its potential for increasing understanding of complex processes and developing and testing hypotheses.

An outline of the project
The findings are derived from an all-Wales study of community-based groups stratified by age and sex. Researchers based in University of Wales College of Medicine and Cardiff University asked 20 groups of people (n = 127) to discuss issues relating to reluctance or failure to consult the doctor. Groups were recruited in rural mid Wales, urban West and Southeast Wales, and in the South Wales valleys through a network of general practices associated with the Department of General Practice. Ten of the groups comprised only females and 10 only males. Six groups contained people aged 18–25 years, 6 contained people aged 35–45 years, and 8 contained people aged 55–70 years. Participants were not required to have consulted for emotional symptoms at any point in their lives (though some had done). Focus group techniques were used to generate data, and the data were analysed according to established principles of qualitative social science research.

Choice of method: focus groups
Focus groups\textsuperscript{37} were selected as the method for data collection because they are regarded as especially appropriate for the study of attitudes and experiences around specific topics and exploring the participants’ priorities, their language and concepts. Kitzinger\textsuperscript{38} argues that this method can ‘reach the parts that other methods cannot reach, revealing dimensions of understanding that often remain untapped by more conventional data collection techniques’.

The crucial distinction between focus groups (\textit{i.e.} group discussions organised to explore a specific set of issues) and the broader category of
group interviews is the explicit use of group interaction as research data. Compared to the two more well-known methods of data collection, questionnaires and one-to-one interviews, focus groups are better for exploring how points of view are constructed and expressed in public settings. Norms and priorities can be highlighted and differences in assumptions thrown into relief by the questions the participants ask of each other, the sources they cite and what explanations appear to sway opinions of other members of the group. Our interest was in understanding the reasoning behind the weight accorded to various factors suggested as influential in the choices people make about consulting, and then about disclosing emotional problems.

The choice of subjects
It was felt that a common background and similar life-cycle experience would facilitate interaction and maximum freedom of expression. Given our intention to compare the views of participants with potentially differing attitudes, behaviours and understandings of emotional problems and their treatment, this decision enabled us to utilise the powerful strategy of comparing and contrasting the perspectives of homogenous groups. Age and sex were already known to be significantly linked with readiness to consult from the OPCS morbidity surveys and we were anxious to tap people from different communities with very different cultural and socio-economic histories to see how far the experience of varied social groups was reflected in the discussion.

Conduct of the focus group
The meetings were conducted by a moderator and were audio-taped (with consent) for later transcription and analysis. The discussion was structured around a number of tasks designed to facilitate discussion. The first, and most important of these, was to respond to short descriptions of the basic demographic characteristics, current situation and symptoms experienced by three individuals. The purpose of these vignettes was to explore respondents’ recognition, diagnosis and response to a range of physical and emotional symptoms. Two were adapted from those previously created by the Institute of Psychiatry and have been used in this research project with their kind permission. The example of Miss Jones is of particular interest as it includes a constellation of symptoms and variables that many health professionals would regard as indicative of quite severe depression.

Miss Jones is a 29-year-old single parent with two small children. They live on a fairly run-down estate and rely on benefits. She
feels low in energy, has lost weight, is not sleeping properly and feels terrible in the mornings. She also feels that she has no self-confidence and that the future holds nothing for her. At times, if it were not for the children she wonders if it would be worth going on. Her relatives visit her from time-to-time, but they are not prepared to contribute to childcare.

Two main questions were added in relation to each vignette: What is wrong with the person? What (if anything) should they do about it? At this point our particular interest in emotional problems and disclosure had not been made explicit as we wished to explore to what extent the various groups recognised symptom patterns as indicative of common mental disorder. Our agenda was made explicit or confirmed after having obtained the initial spontaneous reactions to the three vignettes.

**Analysis**

As with surveys, the context in which data are collected inevitably affects the nature of the material collected and we treated the transcripts as ‘accounts’, recognising that participants would be likely to produce arguments or opinions that they felt would be acceptable to voice in public. Like other qualitative analyses, the key process is the drawing together and comparison of similar themes and examining how these relate to the variation between individuals and between groups. However, with focus groups, the researcher must start from an analysis of groups and seek to strike a balance between the picture provided by the group as a whole and the operation of the individual voices within it. Thus we tried to distinguish between the opinions expressed in spite of, or in opposition to, the group and the consensus constructed by the group.

Once the first few tapes had been transcribed, an initial coding frame was developed by the research team. Disagreements about emergent themes led to further clarification and refinement of the basic categories we were looking for, and helped to ensure reliability. The software programme NUD*IST which is designed specifically to analyse qualitative data was employed at the next stage. This enables the researcher to handle the unstructured data more effectively by managing documents (in an index system), supporting the process of coding (indexing), and asking questions, searching patterns of coding and building and testing theories (via index searches). Since multiple coding of any data segment is possible, more fine-grained coding could be introduced as analysis progressed.

**Main findings**

Two main reasons why individuals often fail to consult their GP for emotional problems emerged from the focus group discussions. First,
our discussants remained unsure as to whether the symptoms of emotional distress constituted legitimate ‘illness’. Second, even in those instances where emotional problems were recognised as illness, they remained unconvinced that GPs could deal with the problem in an appropriate manner.

Most people tended to view the symptoms of emotional disorder as ‘trivial’ and an inevitable part of normal human existence. It was felt that the individual should be able to deal with such symptoms themselves or with the help of their family and friends. Participants did, however, recognise suicidal thoughts as serious, but remained unsure as to how they ought to be dealt with. Emotional symptoms were often discussed by contrasting them with ‘real’ health problems – which were essentially physical. Physical complaints of all kinds were viewed as appropriate to ‘take to the doctor’; emotional complaints were not.

Even in those cases where symptoms of common mental disorders were recognised (such as with depression), consulting the GP was not necessarily seen as the answer. It was assumed that GPs were unable to devote sufficient time to patients with emotional problems. GPs were also seen as being able to offer only palliatives (such as antidepressants), and unable to deal with the ‘real causes’ of emotional distress. Participants tended to regard medication with suspicion and only those who had suffered from emotional symptoms and had taken prescribed medication spoke up for it.

Discussion

Many of these themes mirror the findings of surveys and other research. For example, the ‘normalising’ of symptoms was noted in the accounts of women suffering from severe depression, three-quarters of whom reported that their families gave little or no support and tended to ‘explain away’ marked changes in behaviour. Normalising was also observed in patients consulting by Kessler et al. Resistance to the idea of medication is also not peculiar to psychiatric patients. There is now a considerable body of work documenting and explaining lay attitudes and an increasing emphasis on ‘concordance’, i.e. a partnership between patient and doctor in which each respects the other’s point of view, rather than the traditional idea of compliance. It is also interesting to note that, in a recent general population prevalence study examining help-seeking behaviour, 86% of the African Caribbean and 90% of white European ‘cases’ sought no medical help for psychological problems, expressing the view that doctors would not be helpful for such problems. The patterns of belief described for the different ethnic groups were remarkably similar to the Welsh groups.
This overlap and consistency of themes in research conducted at different times and in different ways can be construed as evidence of the validity of our findings. It also suggests that these are important topics though, as we have seen, different interest groups, (such as psychiatrists, GPs and indeed potential patients) are likely to come to different conclusions about the implications for patient management and professional education and training.

Our research indicates that while most people are sensitive about disclosing facts relating to their mental health, sensitivity or stigma could not be said to have been the major reason for an apparent reluctance to declare emotional problems. Instead, two other kinds of barrier emerged. The first concerned an inability or an unwillingness to view what psychiatrists see as the symptoms of minor psychiatric disorder as illness. In short, the symptoms of emotional distress were seen as falling outside lay boundaries of the clinical and treatable. The second barrier to disclosure lay not so much in beliefs and views that members of the public held about minor mental disorder, but rather in assessments or evaluations of the services on offer. Our findings also point to a mismatch between what is on offer as far as GP services for people with common psychiatric disorders are concerned, and what people consider appropriate and worthwhile (even when they classify a problem as psychiatric).

Thus, most people felt that GPs had little time to devote to an analysis of personal problems, and some suspected that GPs might not be too tolerant of a presentation with emotional symptoms. Even if such expectations were confounded, then the GP was seen as having little option other than to prescribe an antidepressant. Unfortunately, the latter were regarded as being potentially addictive, or otherwise harmful, and, in any event, as mere palliatives in place of something that could really get to the root of a person’s problems. What members of the various groups would wish for – were they to have an emotional problem – was someone to talk to. ‘Counselling’, therefore, emerged as the preferred option for the management of minor psychiatric disorder.

Our contribution to the debate is to emphasize that patient viewpoints about (medical) help-seeking can have a reasoned basis. So the reluctance of people to see their problems as requiring medical intervention has to be distinguished from their capacity to evaluate the services on offer. It is the former that has been the focus of professional psychiatric concern rather than the latter. The lay appraisal of GP services that we have outlined may seem realistic and appropriate to some GPs and worrying to others. What is clear is that the clinicians in both the primary and secondary care settings need to be more aware of their own assumptions and those of colleagues working in very different contexts. Patients are not necessarily irrational in their assessments of what is on offer.
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