Psychosocial explanations of complaints in Dutch general practice

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Background. Dutch GPs are frequently consulted by patients presenting physical complaints which have a psychosocial cause. Until now, this type of complaint has often been the subject of study, but the way in which psychosocial explanations for complaints are broached and discussed has not yet been studied.

Objective. We aimed to analyse the way in which GPs and patients relate physical complaints to psychosocial causes and whether this affects the advice or treatment given in the course of the consultation. We hoped to provide insight into the actual behaviour of GPs and patients concerning these issues.

Method. From a corpus of 279 videotaped consultations, 24 consultations of eight GPs, four female and four male in different practices, were selected for analysis. The verbal behaviour of GPs and patients in the selected consultations was transcribed in detail and subsequently analysed, according to the qualitative methodology of conversation analysis.

Results. Patients present explicit, as well as implicit, psychosocial explanations. GPs respond confirmatively to the first kind and almost ignore the latter. GPs present two types of psychosocial cause-seeking questions. Verifying questions suggesting a psychosocial cause lead to an explicit response from patients; conversely, exploratory queries investigating potential psychosocial causes lead always to a denial. Subsequently, GPs initiate a checklist strategy to investigate potential psychosocial causes. This strategy hardly ever leads to establishing a psychosocial explanation. GPs nearly always focus on the somatic aspects of the complaint, notwithstanding the establishment of a psychosocial explanation. They will hardly ever give any psychosocial advice in the course of that same consultation.

Conclusion. GPs and patients are cautious in relating physical complaints with psychosocial causes. Psychosocial explanations are formulated and treated as delicate activities in the context of the consultation. GPs and patients both contribute to psychosocial explanations, but GPs contribute more to this delicate topic than their patients do.

Keywords. Doctor–patient interaction, general practice, psychosocial complaints, psychosocial explanations.

Introduction

One-fifth of the complaints voiced by patients of Dutch GPs consist of psychosocial problems. In most cases, these complaints are presented in physical terms. Different methods are used to measure the extent of psychosocial problems, but usually the GP’s opinion is used to determine whether the problems are psychosocial in nature. In The Netherlands, no research has been done on how psychosocial problems are voiced during consultations.

In the literature, various terms and definitions are used for the concept of psychosocial problems, comprising somatization, problem behaviour, psychosomatics and vague symptoms. GPs differ in their judgment about the amount of psychosocial problems they are confronted with. In this study we have chosen the term ‘psychosocial aspects’ for the often complex relationship between somatic and psychosocial aspects of a complaint. Psychosocial aspects are defined as to mean all those aspects of the complaint which are not physical, but related to the
patient’s living situation or history. Examples of psychosocial aspects are ‘stress’ or ‘relational problems’.

For assumed causal relations, such as a patient presenting the complaint ‘a headache’ caused by stress in their job, the term ‘psychosocial explanations’ is used. This article examines the way in which GPs as well as patients bring up psychosocial explanations for complaints.

**Method**

A total of 279 consultations with eight GPs, four female and four male, from various practices in the northern region of The Netherlands have been recorded on videotape. The eight GPs were approached through informal routes by using the contacts of the Professor of the Department of General Practice of the University of Groningen. All eight GPs agreed to participate and all patient visits at each GP practice during 2 days were recorded. GPs and patients were told that the purpose of the research project was to investigate communication between GPs and patients. After each consultation, the patients were asked to complete a questionnaire and the GPs filled out a standardized form giving information on the patient and the consultation. Twenty-four of the total corpus were selected for analysis. These consisted of the first three consultations of each GP in which a patient presented physical symptoms that were subsequently related to a psychosocial cause. This selection was carried out by studying the consultations and the information collected from the patient questionnaires. After the consultation, the patients were asked whether psychosocial aspects relating to the complaint had been a topic of conversation. If the researcher had selected a consultation but the patient did not indicate that psychosocial aspects had been a topic of conversation, the consultation was still included in the study. This sample of 24 consultations is not representative of the GP setting in The Netherlands. However, they give a first insight into how psychosocial explanations are discussed.

The 24 consultations have been transcribed in detail and analysed according to the qualitative methodology of conversation analysis. In conversation analysis, the objective is to describe the procedures by which parties participating in the discourse produce their own behaviour and understand and deal with the behaviour of others. This results in the formulation of the interactional procedures that conversational partners rely on when they talk to each other. This method has been used quite often in previous analyses of doctor–patient interactions.

**Results**

In 15 of the 24 selected consultations, GPs initiated a psychosocial explanation, and in nine cases the patient did so. In seven of the 24 consultations, patients concluded, however, that psychosocial aspects had not been a topic of conversation. It appeared that in these seven consultations the GP always took the initiative. At the end of the consultation, patients indicated correctly when they had taken the initiative themselves.

**Psychosocial explanations of patients**

During consultation, patients may present two types of psychosocial explanations. Explicit and implicit ones. In explicit explanations, the patient explicitly marks the causal relationship between the complaint and a psychosocial cause, as in Fragment 1: “I thought . . . it had something to do with . . . annoyances at school”. These explanations are nearly always formulated in a cautious way, in terms of ‘I think’, ‘maybe’ and ‘it could be caused by’. Patients present these explanations to be judged by their GP. GPs react confirmatively to these explicit explanations, but in cautious terms. The GPs’ judgement depends on two factors: a classification of the explanation by the patient, and the phase of the consultation in which the explanation is presented. When a patient does not elaborate on his explanation, the GP will prompt him to do so. Usually GPs give their judgement in a later stage of the consultation, e.g. in the phase when the diagnosis is being discussed.

In implicit explanations, patients describe psychosocial aspects or circumstances that may be considered the cause of their symptoms. In other words, patients present their symptoms and then report facts or circumstances, which imply a possible explanation for their health problems, as in Fragment 2. GPs can suggest an explanation from the patient’s report, but they very rarely discuss the potential implicit explanation from therein. They treat these implicit explanations as pure information.

**Psychosocial explanations of GPs**

GPs always use the interrogative form to raise psychosocial causes during consultations. In this respect, they differentiate between psychosocial explanations and somatic explanations, which are nearly always presented in an affirmative form. There are two types of psychosocial cause-seeking question that differ with respect to their formulation, their place within the consultation and the way patients react to these questions.

The first type of question is the verifying question, as in Fragment 3: “do you actually worry ... complaints”. Using such questions, GPs explicitly formulate a psychosocial fact as the cause of the complaint and present the causal relation to the patient for confirmation. These questions are often posed at the end of the consultation. In such cases, the GP uses a lengthy introduction to lead up to the question to justify it and to initiate a transition to the psychosocial explanation for the complaint, as in Fragment 3. Patients respond to this type of question with cautiously formulated confirmations or
TABLE 1  Fragments of transcribed consultations

Fragment 1:
P:→ Well I thought by myself it, (1.1) had something to do with, I mean, there are some annoyances at school it is,
GP: yes?
P: yes, it is my first year, (1.0)
P: and it is off course …
Fragment 2:
P:→ Last sunday I had a fight, (1.4)
P: yes a fight, he rushes at me at once, and then he came with his knee there. (0.7)
P: knee in the back, (0.3)
P: at once (0.7)
GP: another person
P: yes
Fragment 3:
GP: Well it is, known that eh, when you are tense, (0.7)
P: h hm
GP: you get this sort of neck complaints and headaches too, (0.8)
P: yes
GP:→ my question is, do you actually worry about that throat, (1.7)
that is why you felt tense, and that is also the reason for these neck complaints. (0.6)
P: yes, actually is
GP: would that be possible, (0.7)
P:→ that could well be actually yes.
Fragment 4:
GP: And, (1.1)
GP:→ you have often these complaints but then they last short, but do you have a[ny idea why
P: [yes
GP: you have so often these complaints, (1.3)
P:→ no I actually don’t know that.
GP:→ what is your profes[sion?
P: [maybe it is my, well the care of the mentally handicapped
GP:→ but it doesn’t involve a lot of lifting [or something
P: [no
GP:→ is it heavy? (1.8)
P: you mean physical or [mental
GP: [yes if it is [a hard job for you
P: [no
GP:→ no?
P: no no
GP:→ do you like it
P: yes
GP:→ there are no problems at your work, that could be involved
P: no, [no not at all
GP:→ [or things which bother you or something, in your private situation maybe
P: no really not
denials, e.g. “no, I do not think so” or “that could be” (Fragment 3).

The second type of cause-seeking questions are the exploratory questions, as in Fragment 4: “do you have any idea why … “. Using such questions, the GP explores the knowledge and insights of the patient concerning possible causes of the complaint. With the very subtle beginnings of these questions, GPs demarcate in cautious terms the transition to the explanation-seeking activity. Patients always respond to these questions with denials: “no I actually don’t know that”. The subsequent actions of the GPs show that they use these exploratory questions to investigate potential psychosocial explanations of the complaint. After listening to the patient’s negative response, the GP initiates a domain checklist strategy. They pose a series of questions in which various psychosocial domains concerning job, home situation and relationship are checked. With those they investigate potential psychosocial causes (Fragment 4). The GP then tries to relate the patient’s answers to the complaint. Patients often respond negatively to checklist questions, which makes it impossible for the GP to reformulate their responses as an explanation for the complaint. This strategy seems hardly effective for establishing a psychosocial explanation.

Consequences of psychosocial explanations in regard to advice and treatment

Both GPs and patients appear to initiate psychosocial explanations. Sometimes these explanations are confirmed, sometimes they are not. However, they hardly ever lead to an explicit psychosocial advice or to a referral of the patient to mental health care. However, the consultations themselves can contain extensive psychotherapeutic episodes. This means that part of the treatment of the psychosocial causes probably occurs during the consultation. There is no one-to-one relationship between the type of explanation offered for the complaint and the type of advice or treatment that follows.

Although GPs investigate and try to establish a psychosocial explanation for complaints using cause-seeking questions, they apparently do not transfer these into advice or treatment, not even when patients bring up such an explanation themselves. GPs focus mainly on somatic aspects of the presenting complaint.

Conclusion

GPs and patients are cautious in their formulation of psychosocial explanations, which are formulated and treated as delicate activities within the context of the consultation. GPs and patients, however, apply different kinds of delicacy. The delicacy of patients is mainly caused by the fact that explanations are verbal activities which are by definition carried out by the GP and for which patients turn to their GP. The delicacy on the GP’s side is mainly caused by uncertainty, for it offers knowledge that the GP does not posses and on which the patient is the expert. The delicate nature is not only created by the way the explanations are presented: it is also confirmed by the way GPs and patients respond to the explanations. Patients present explicit and implicit explanations, showing a gradual increase in delicacy. The implicit explanations are formulated in very cautious terms, and GPs hardly ever discuss the potential explanation. Patients subsequently do not take the initiative to bring forward again the explanations. It remains to be seen whether patients will clarify their potential implicit explanation more extensively. On account of their cause-seeking questions, GPs contribute more to this delicacy than do their patients, by applying an extensive checklist strategy. However, hardly any psychosocial explanations result from this non-directive
action. Moreover, it consumes a lot of time. The consultations show a patent relationship between the degree of explicitness displayed by the GP, on the one hand, and the degree of agreement or denial in the patient’s response to cause-seeking questions on the other.

GPs and patients appear to depend on one another to determine a particular fact or event as a psychosocial cause of a complaint. In other words, psychosocial explanations are evaluated and accomplished within the interaction through mutual efforts, unlike somatic explanations, which are usually presented as an established fact by GPs. GPs are clearly engaged in seeking and establishing psychosocial explanations, but they rarely use their findings in terms of explicit treatment or advice. To study the purpose of determining psychosocial explanations in general practice and to look how representative the results of this explorative study are, further research seems advisable in a larger group of consultations and in a series of subsequent consultations relating to the same complaint.

References