POPULATIONS AT RISK

Conceptual Models of Psychological Distress Among Low-income Patients in an Inner-city Primary Care Clinic

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Although depression and anxiety syndromes are common in primary care, many depressed and anxious patients fail to receive effective treatment. Little attention has been given to the role of illness beliefs in shaping these patients' treatment preferences and decisions. Using semistructured interviews, this study examined conceptual models of depressive symptoms among patients in an inner-city clinic. A theoretical taxonomy of patients' conceptual models of distress was developed: each category was associated with a unique pattern of treatment preferences. We conclude that patients' models of distress may play an important role in treatment-seeking decisions, and deserve further investigation.

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Despite the high prevalence of depression and anxiety disorders in primary care settings, most depressed and anxious patients fail to receive effective treatment for their symptoms.^{1,2} Several barriers to care have been identified, including low rates of physician recognition,³ medication prescription, and referral.⁴ To date, however, few studies have examined the active role of the patient in interpreting and managing mental health problems. Little is known of how patients' decision-making processes relate to perceptions and beliefs about mental disorder and its treatment.⁵ This qualitative study investigates primary care patients' conceptual labels of depressive and anxiety symptoms, and builds a theoretical model linking these representations with attitudes toward treatment.

METHODS

Participants

Participants were recruited from a primary care clinic serving a multi-ethnic, low-income population in the Bronx. Consecutive patients presenting at the clinic were approached between May 15 and June 15, 2001 as they

waited for their appointments. Consenting participants were screened using the General Health Questionnaire (GHQ), a brief screening measure for psychological distress. The GHQ has been translated into a number of languages, including Spanish, and has been found to be valid and reliable in primary care settings.⁶ Individuals endorsing 5 symptoms or more were invited to participate in an interview.

The Interview

The qualitative, semistructured interview was designed to elicit patients' illness narratives in sufficient detail to discern their conceptual models of their illness. The interview began with open-ended questions about the illness experience that were followed by a series of prompts aimed at exploring patients' illness models. Prompts were based on a model of illness representation from the health psychology literature, the Illness Representation Model,⁷ which consists of 5 representational dimensions of illness: label, cause, timeline, consequence, and concepts of management or treatment. The interview also explored patients' attitudes and beliefs regarding 3 health-seeking strategies: disclosure to the physician, psychiatric medication, and psychotherapy. A Spanish version was prepared in advance. Interviews were conducted by telephone within a week of the clinic visit. They lasted 40 to 60 minutes.

The interviews were conducted in English or Spanish by a bilingual clinical psychology graduate student (NG). The interview was not taped, since initial efforts to include taping had slowed recruitment, but the interviewer took extensive, detailed, nearly verbatim notes, preparing a transcript of the patients' responses immediately following each interview.

Analyses

All 3 authors participated in the analysis. In a preliminary, descriptive phase, we reviewed transcripts and developed a coding system to identify key features of illness narratives. In a second phase, we developed a theoretical model for understanding links between conceptual representations of illness and attitudes toward treatment. Participants' narratives were classified into 5 representational categories reflecting contrasting models of the relationships between social reality, the body, and emotional experience. Further analyses revealed that each

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of the 5 representational categories was associated with a particular constellation of attitudes toward treatment.

RESULTS

Out of 105 (88 females, 17 males) individuals approached, 64 (58 female, 6 males) consented to be screened and 31 (30 female, 1 male) met symptom criteria on the GHQ. The ratio of male to female potential participants reflects clinic demographics. It is not clear why males refused at a higher rate or were less likely to meet study criteria. Twenty-two patients were reached and included in the study. The sample had a median age of 30, education of 12.5 years, and income of \$18,000. Fifty percent were born outside the United States. Six interviews were conducted in Spanish.

The Theoretical Model

A taxonomic model of illness representations was developed for classifying the 22 participants. The model consists of 5 taxons or categories. Participants were classified according to the representational models they described.

Biosocial Narratives. The first category we called *biosocial narratives* (Table 1). Like almost all participants, biosocial narrators ascribed their illness to events in the social world, describing multiple, long-term stressors. In biosocial narratives, the physical body was described as mediating between traumatic events or situations and the felt symptoms of depression. In each case, a traumatic experience damaged, strained, or exhausted patients' "nerves," resulting in a weakened, depleted condition that made the person vulnerable to both physical and psychiatric illness. For example, 1 woman attributed her depression to her father's violence when she was a little girl and to her son's recent criminal activity and jail sentence.

Because they viewed their distress as a medical or health problem, biosocial narrators had chosen to disclose their distress to their physicians. They saw doctors as an

Table 1. Biosocial Model

I can't pay my rent, I owe back rent. I don't make much money, that is why I worry. I don't know what I am going to do. I am very depressed. I try to relax, but I can't. I worry too much. I worry and think too much. That's how I am under stress.

The nerve in my neck gets tense when I get excited. I get a pain like I am paralyzed. I can't work too much, can't do any heavy job, I have to lie down to rest. When you think too much, that makes you more worried. When you think too much, you feel pressure in your eyes and head. Your head hurts because your brain is working too much and you get pain. When I think too much, my blood pressure goes up and I have a headache. If someone is yelling, I get nervous. My pressure is high.

Table 2. Psychological Model

I don't know what I'd call my state of mind. I would say it's depression. Well it is just basically, you get stuck in self-pity. It is comforting to feel like you are a low life. It justifies doing bad stuff to yourself. You want to be alone. I don't want to be around people. I don't want to be around others, because I know the effect that a bad aura has on others. But you want them to feel sorry for you. I feel hopeless. Sometimes it is hard waking up, because I am just waking up to another day of misery.

It's all related to self-esteem. I was an intense kid, school was my world. If I couldn't do a problem, I would get angry. If it wasn't a 100 score I got angry. I expected perfection. No one really pushed it on me. In some ways, I needed to be perfect, I still do. But as I get older I am less intense. I have learned to deal with school and I don't get as tense.

important source of medication and advice. They differed from other participants in viewing medication favorably, and 2 were taking it at the time of the interview. They were not interested in psychotherapy.

Psychosocial Narratives. The second category we labeled *psychosocial narratives*. Like the biosocial narratives, the stories in this category focused on social stressors. In this group, however, the stressors were often single instead of multiple, including specific problems of relatively recent onset, such as a broken hip, paralysis from an auto accident, or a death in the family. By contrast to the biosocial model of the body as a mediator between stressors and felt experience, psychosocial narrators placed mind or emotions in this mediating role, describing their symptoms as emotional reactions to stressors. Members of this group did not view their distress as an illness, several describing their symptoms as "normal reactions" to real events or situations.

Most psychosocial narrators had disclosed, or planned to disclose, their symptoms to their physicians. They did not believe medication would be helpful for their condition, but were favorably inclined toward psychotherapy. Therapeutic talk, especially support and advice, was viewed as the efficacious element in both psychotherapy and in conversations with the physician.

Psychological Narratives. The third category we called *psychological narratives* (Table 2). This group tended to emphasize interior, psychological causes of their distress and symptoms. Although social reality entered into these narratives, it was less salient than psychological reality. For example, one man attributed his unrealistic fears of HIV infection to his guilt at having illicit sex. One woman with severe, long-term depression lived alone in poverty with 2 small children, yet hardly mentioned the role that contemporary stressors might play in her illness. Psychological narrators often focused on themes of performance and failure, and issues related to social mobility, but these were often "psychologized" as

problems of "self esteem," "being a perfectionist," or "poor body image."

Most psychological narrators felt their problems were appropriate to discuss with their physicians. They were strongly opposed to psychotropic medication and were enthusiastic about psychotherapy. They placed high value on catharsis as a therapeutic element in therapeutic talk.

Situational Narratives. A fourth category was called *situational narratives*. In these narratives, symptoms had begun as a direct result of an acute, recent stressor that the participant anticipated would be of short duration. For example, one participant described her efforts to get insurance coverage for an infertility procedure, while another reported that her husband had just separated from her unexpectedly. Concepts of timeline differed from others in the sample, insofar as all three anticipated a speedy return to normal functioning. These participants tended to use "stress" to describe their symptoms, and to be concerned with finding ways of "calming" their nerves.

Similar to most other participants, situational narrators did not view psychiatric medication as appropriate for their problems. However, by contrast to others, they did not want psychotherapy and saw no reason to disclose their symptoms to their physicians. Disclosure seemed pointless to these participants because they viewed their problems as completely situational.

Somatic Narratives. The last representational type in the sample we labeled *somatic*. In this category, psychological symptoms are conceptualized as physiological in nature. One participant believed that her symptoms of distress were caused by hypertension. She said that the distress she had reported on the GHQ was due to the fact that she had recently run out of hypertension medication. She felt that neither disclosure of her distress, nor psychological or psychiatric treatment was appropriate for her condition.

DISCUSSION

Patients' conceptual representations of psychological distress have been little explored in the literature. Our results suggest that although patients' models of illness

and care may differ significantly from contemporary biopsychiatric models of depression, they are highly coherent and appear to be associated with attitudes toward treatment choices in primary care.

It has been noted by Kleinman et al. and others that providing good medical treatment entails reviewing patients' explanatory models and negotiating between professional and lay models to generate joint treatment plans.⁸ Our findings suggest how important such negotiations may be for providing mental health care that is acceptable to distressed primary care patients.

The taxonomic model we developed, although hypothetical in this study and specific to the particular ethnic background and sociocultural context of the patients we studied, suggests that patients' conceptual models of distress and illness may prove a useful key to understanding preferences and behaviors. Further research is needed to test the model in other settings and with other patient groups.

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