Patients' opinions of the use of psychiatric case-finding questionnaires in general practice

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Abstract

Background The common mental disorders of depression and anxiety often remain undetected in general practice. Psychiatric screening instruments have been recommended to assist detection.

Aim To assess patients' attitudes towards the use of psychiatric screening questionnaires for common mental disorders within general practice.

Design Twenty focus groups comprising 127 patients were conducted in Wales, UK. The groups were distinguished by age, sex and locality.

Results The majority of respondents felt that the use of a screening questionnaire was acceptable and would be willing to complete one within a general practice setting. However, a number of individuals expressed concern about the validity of the kinds of questions asked and the usefulness of the instrument in practice. Respondents also discussed their concerns relating to issues of confidentiality and the doctor's response to the assessment.

Conclusion The study indicates that lay beliefs towards mental illness, particularly relating to perceived stigma, will continue to pose problems for the routine use of psychiatric case-finding questionnaires within general practice.

Introduction

The detection of minor mental illness in general practice has been recognized as problematic.¹ Although general practitioners (GPs) successfully detect and treat a large number of depressed patients, it has been estimated that about 50% of consulting patients with depression do not have their illness recognized.² The problems facing GPs in diagnosing depression within a consultation are considerable³ and are

made more difficult by patients' reluctance to disclose the problem or indeed recognize that they have a mental health problem.⁴

Efforts to improve detection rates have focused on the interviewing skills of the doctor.⁵ Training of GPs in interviewing techniques using video-feedback is now widely used within the GP vocational training scheme. Another technique suggested to improve detection of depression has been the use of screening questionnaires such as the General Health

Questionnaire⁶ or the Revised Clinical Interview Schedule.⁷ The use of such instruments has mainly been as a research tool to compare the effectiveness of detection methods in identifying depressed patients and on the resulting outcomes.^{8–12} However, little research has been conducted on the relationship between the effectiveness of a screening instrument and the attitude of patients to such instruments, nor has there been much research on the routine use of screening instruments within general practice. Researchers within general practice have also questioned the value of screening given that the results of many assessments are not necessarily easy to interpret, and that the use of instruments may serve to medicalize what many would consider to be normal human distress.^{13,14} This paper reports on patients' opinions of the routine use of psychiatric case-finding questionnaires in general practice in Wales.

Methods

Having obtained appropriate local ethics committee approval, 10 GPs across rural mid-Wales, urban West and South-east Wales and in the industrial South Wales valleys were approached for help in accessing respondents through their age-sex registers. A random sample of patients in the three age groups of 18–25, 35–45 and 55–70 were then sent a postal invitation to participate in a focus group. In total 1424 letters of invitation were sent and 256 expressions of interest were returned, giving an overall response rate of 18%. However response rates ranged between groups from 3 to 54% depending on the age, gender and locality of respondents. Older female groups tended to produce the best response rates and young male groups produced the worst. Not all of the respondents expressing an interest in participating subsequently attended the focus group, as the groups were convened at a date and time that suited the majority, but by no means all, of the responders.

Twenty focus groups ($n = 127$ individuals) were conducted and the number of participants in each group ranged from three to 12 individuals. The focus groups lasted between 1 and 2 h

in length and were moderated by one of the authors (FW). Ten of the focus groups consisted of only males and 10 of only females. Six groups comprised of individuals aged 18–25; six comprised of participants aged 45–55 and eight groups of participants aged 55–70. The focus group discussions were audio-taped and later transcribed for detailed analysis. Participants were not required to have previously consulted for a mental health problem, although during the focus group it emerged that many had done. In the final part of the focus group participants were asked a standardized question specifically about how they might react if asked to complete a questionnaire about their emotional health whilst waiting to see the doctor. They were told that the questionnaire could then be taken into the consultation with them. An example questionnaire (the 12 item General Health Questionnaire)¹⁵ was provided to the groups to assist discussion, although it is considered that participants' comments would be relevant to other psychiatric screening instruments which are similar in nature.

Focus group methods have been variously advocated as a technique in general practice research,¹⁶ not least because they enable researchers to explore views that are constructed and expressed in public settings, and to study group norms, attitudes and priorities as they are expressed in the language of the researched. In focus group research, participants can act as co-researchers taking the research into new and often unexpected directions by engaging with each other in ways that are sometimes complementary (sharing common experiences, affirming similar beliefs) and argumentative (questioning and challenging each other). The research reported in this paper formed an element of a bigger project concerned with the disclosure of emotional problems in primary care which has been discussed elsewhere.¹⁷

The research team were mindful of the importance of the research context and process and therefore treated the data as respondents' 'accounts', recognizing that participants would be likely to produce arguments and opinions that they felt would be acceptable to voice in

public. For example, earlier disclosures of mental health problems by some focus group participants may have served to moderate the language and views expressed by others within the group. As with other qualitative analysis the key to the analysis process is the drawing together and comparison of similar themes and examining how these relate to variations between individuals and groups. A detailed analysis was carried out using the software package NUD*IST which is designed specifically to assist with the analysis of qualitative data.

Results

In line with the principles of focus group methodology, it was left to participants to specify the issues that concerned them most of all. On analysis of the audio-taped discussions these turned out to circle around (1) the validity of the questionnaire, (2) the importance of confidentiality, (3) the questionnaire's usefulness and (4) how they as patients would be perceived having completed it. Table 1 summarizes the number of groups that discussed each of these four issues. All 20 groups discussed the questionnaire's usefulness compared with only 14 of the 20 groups who discussed concerns about the validity of the questionnaire. Comparisons can also be made by age, sex and locality. For instance, older groups were more likely to express concerns about confidentiality and male

groups were more likely to declare their fears about how others would perceive them.

Validity

Some people stated that the answers to the questionnaire would not produce a fair reflection of people's psychological state. It was suggested that those individuals who were most emotionally distressed would be least likely to complete the questionnaire honestly, perhaps because they would be unlikely to admit an inability 'to cope'. Unlike physical health problems, where it was thought that there was a visible or testable proof of pathology, mental health was perceived as subjective and therefore possible to hide. It was suggested that affected patients might be 'crafty' in the way they answered key questions, although many respondents also thought that it might be possible to 'trick' people into answering the questions honestly by interspersing them with questions about physical health. Whilst there was recognition that mental health problems were a difficult thing to measure, some claimed that the questions were not 'concrete' enough and others claimed that they were too blatant. Some wished to simplify the questionnaire while others wanted to lengthen it. Quite often groups would suggest alternative questions and designs for the questionnaire. It was considered that a response would be more likely to be given if one felt

Table 1 The number of groups which discussed each of the four themes

	Total number of focus groups	Validity	Confidentiality	Usefulness	Perceived stigma
Male	10	7	9	10	10
Female	10	7	8	10	8
18–25	6	4	5	6	6
35–45	6	5	5	6	6
55–70	8	5	7	8	6
Urban	7	5	6	7	7
Rural	7	6	6	7	6
Valley	6	3	5	6	5
All groups	20	14	17	20	18

Box 1

Mike: But again its very subjective. You could fill this in today, it could be a different result a month ago. There are things on there...what 12 questions.

Christ, 9, 10, 11 of those could apply to me, probably all of us in this room over the last 2 weeks.

John: I think if you had a 100 of these scripts probably somewhere near half of them wouldn't be truthfully answered.

Maybe not all of us but a lot of us

Moderator: For what reasons?

Mike: You con yourself.

David: You have to accept it yourself. You know personally I would answer that correctly – you know honestly, but a lot of people wouldn't think that they have a problem at all. I think you would have to be a bit more crafty than this. I think that its too blatant, you would have to trick people to get it out of them.

Voice: Yeah.

David: I think you would have to incorporate it into a general health one, put in some physical things...

Jim: Mix it up a bit.

David: Yes basically, because that way then you might get a more truthful answer. Because general health questions give an overall opinion and you might get more chance of this being answered more truthfully. But as it is now it's too confrontational.

Voice: Yeah.

Rob: You would be looking for ways out of it.

David: Yes you wouldn't answer it basically truthfully.

Mike: I can't see anybody unless they have a very very serious problem which they intend dealing with I can't see anybody answering that one 'have you felt that life isn't worth living?' That's very very difficult to come to terms with yourself, and that's the last thing that you want someone else looking at. (Valley men 35–45)

assured about confidentiality and who might be interpreting the questionnaire. Furthermore, it was felt that a more honest response might be elicited from an individual who perceives that he wants help (see Box 1).

Concern was expressed that the questionnaire was only sensitive to how people felt during a short time period. Participants thought that this could be significantly influenced by a number of factors such as pre-menstrual tension, having a bad week and anxiety from being in the surgery. It was also felt that responses could be affected by the presence of physical illness that had brought the person to the surgery – suggesting that it would be physical illness that causes emotional distress rather than vice versa.

Confidentiality

Many groups raised issues relating to who would see the questionnaire and how it would be used. Some individuals stated that they would feel uncomfortable completing such a questionnaire in the surgery in close proximity to other patients. The older groups in particular were

adamant that the questionnaire was to be seen only by themselves and the GP and not by other researchers. Under these conditions most would be happy to put their name on the questionnaire, although some stated that they would only complete the screening questionnaire if it were anonymous. Some individuals were particularly concerned that surgery receptionists would see the completed questionnaires. Their concerns were not usually that receptionists would break a code of confidentiality, but rather that the receptionist would know too much about their personal health problems.

Concerns were also raised about how the questionnaire could be dangerous and used against one particularly if one felt that the questionnaire were not a true reflection of one's mental health (see Box 2). Participants felt that once information is held on medical records it can be used to inform future employers. Consequently one should be cautious of the repercussions and wary of such concrete information being held. Admitting to emotional problems on paper was considered to be more dangerous than discussing it verbally.

Box 2

Kate: We find it intrusive and it's almost as though they are insinuating that there might be something wrong with you. And personally I would say no, I'm not going to bother with that, thank you. I want me ankle strapped up or my ear-syringed or whatever [laughter] but I can't be bothered with all that.

Moderator: You feel the same do you Jane?

Jane: Yes I do. I would think if I go to the doctors with a bad ankle and that was produced in front of me I would be very wary. I don't know. Why do they want to know this information? Yes...And I would want to know why...

Kate: and what were they going to do about it if there were things they were worried about. I mean would they ring you up and say you've got this, and you've ticked that, and you've ticked something else, or would they just store that information for their own personal use and not do anything with it?

(Rural women 55–70)

Usefulness

While questionnaires on physical health were considered to be appropriate and helpful to the doctor, there was much less agreement about the value of questionnaires for emotional health. On the positive side many felt that the questionnaire gave the doctor an easy starting point and a clue as to the direction in which to take the consultation. There was a view that GPs tend to forget about psychological aspects of illness and hence the questionnaire could act as a useful reminder for the GP. Furthermore it could provide a patient with an opportunity to discuss a problem which he or she would not have otherwise mentioned. For some, ticking boxes seemed easier than broaching sensitive topics verbally. Hence the questionnaire was viewed by some as

legitimizing emotional problems as an appropriate use of the doctor's time (see Box 3).

Some individuals mentioned other benefits that the questionnaire might bring such as a prompt to remind oneself about symptoms to mention to the doctor, a means of passing the time in the waiting room and as a research tool to survey the practice population's health. Others thought that the questionnaire would distract the doctor from his real job of diagnosing and treating the physical complaint of the patient. Consequently the questionnaire would be impractical for busy doctors who do not have time to look at it and would frustrate patients who wanted the doctor's attention to focus on their physical health problems.

Whilst some of the younger groups seemed very familiar and comfortable with questionnaires to the point that a few admitted that they enjoyed completing them, others seemed far less comfortable. Some individuals warned that questionnaires could lead to situations where the consultation could be replaced altogether and were critical of the abundance of paper-work generated in the NHS leading to wasted resources. Some argued that a good GP should not need the questionnaire as he should be able to build up a relationship of trust and gain the patient's confidence to disclose an emotional problem.

Concerns of perceived stigma

Some participants stated that they would feel uncomfortable answering very personal ques-

Box 3

Martin: I wouldn't have a problem, I think it should be done.

Paul: I think that's a good insight then to see just roughly how you are then, really isn't it.

(Urban men 35–45)

Sarah: I think it could be a good thing.

Moderator: In what way?

Sarah: Because it would tell him in a glance of the things that perhaps you wouldn't bother to tell him.

Moderator: and why wouldn't you tell him?

Sarah: Well you would feel that they were too trivial to mention wouldn't you.

Helen: That's a point I suppose yeah. Things are too small to mention.

(Rural women 55–70)

tions about their emotional and psychological health. They found the questionnaire intrusive and unnecessary. Others expressed their concern that their doctor would think badly of them in the light of the questionnaire and therefore would attempt to answer it in a manner that would present them as 'a good person'. One's relationship with the doctor would not be helped if the doctor had doubts about one's psychological health. There were also suggestions that the questionnaire was stigmatizing and would have the effect of categorizing patients (see Box 4). One individual commented that he would complete the questionnaire because he would want to present himself as helpful and compliant and that possibly he would be fearful that his refusing to co-operate could effect his future treatment.

Discussion

Diagnosis of minor mental illness within primary care has often focused on the GPs capacity to detect and treat the illness. In theory, screening questionnaires could help improve levels of detection, but we have little idea as to how patients might respond to them. This research has focused on the patients' perspective. The sociological theory of interactionism suggests that in qualitative research the interviewee actively constructs some version of the

world. Therefore focus group participants' impressions of the questionnaire's validity and usefulness were linked with their own interpretations of what the purpose of the questionnaire was. The questionnaires provoked mixed responses amongst potential patients both within and between focus group sessions. Whilst the majority of focus group participants stated that they would be willing to complete a psychiatric case-finding questionnaire a significant minority felt uncomfortable with its purpose and perceived consequences. It was not our aim to provide a count of the respondents who were 'for' or 'against' completing the questionnaire but rather to explore the participants' reasonings about the use of the questionnaires. Generally speaking the younger groups (18–25 years) had a more positive response than the older groups, perhaps because they had experienced less psychiatric morbidity and therefore felt they had less to fear from a screening instrument. Men and middle-aged groups (35–45 years) were particularly concerned about the consequences of completing the questionnaire on their employment opportunities. Older women were more likely to feel the questionnaire intrusive, inappropriate and reinforcing stigmatizing labelling. Professional reluctance to use psychiatric screening instruments appears to centre on the relative merits of medicalizing distress and the extent to which the results of such questionnaires may be usefully employed to alter management options.^{13,14} As such, professional concern about the utility of making a firm diagnosis of depression would seem to in part to reflect those of patients.

Recent sociological analyses of population surveillance and screening have been dominated by the ideas and writings of Foucault.¹⁸ Thus Armstrong,¹⁹ for example, in full Foucaultian mode, argues that the gaze of the clinician creates a power relationship between doctor and patient that can in turn provoke resistance in the form of concealment. It is apparent from the data reported in this study that many patients hold beliefs about mental illness as a stigmatizing condition which should be hidden from public view. In our work, a considerable amount of

Box 4

John: and you would be worried, well if I do fill it in honestly what is the doctor going to think of me, you know.

(Valley men 35–45)

Gary: You know, you don't want people to think you are a nutter. You know what I mean, it's that sort of stuff isn't it. If you admit to it then...

(Rural men 18–25)

Lyn: We don't want to be classified as our illness.

We are afraid that...It's going to be put on this, you know, as women, as women, and I would feel resentful.

Claire: Yes.

Lyn: and I wouldn't fill this in. Full-stop.

(Urban women 55–70)

patient discussion therefore revolved around how the techniques of surveillance could be subverted. Such thinking is likely to pose a considerable hindrance in the routine use of psychiatric screening questionnaires in general practice.

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