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Communication Study

General practitioners' and psychiatrists' responses to emotional disclosures in patients with depression

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ABSTRACT

Objective: To investigate general practitioners' (GPs') and psychiatrists' responses to emotional disclosures in consultations with patients with depression.
Methods: Thirteen patient consultations with GPs and 17 with psychiatrists were video-recorded and then analyzed using conversation analysis (CA).
Results: Psychiatrists responded to patients' emotional disclosures by attempting to clarify symptoms, by rational argumentation, or by offering an interpretation of the emotions from their own perspectives. GPs responded by claiming to understand the emotions or by formulating the patients' statements, but without further exploring the emotions.
Conclusion: GPs displayed a greater engagement with patients' emotions than psychiatrists. Their approach could be described as empathic, corresponding to a mentalizing stance. The different approaches taken by psychiatrists could represent conceptual differences and might affect fruitful interdisciplinary work. Psychiatric nurses' responses to patients' emotions must also be studied to complete our knowledge from psychiatry.
Practice implications: Experiences from training in mentalization could be used to develop physicians' empathic or mentalizing approach. As most patients with depression are treated in primary care, developing GPs' mentalizing capacity instead of offering didactic training could have a substantial effect in the population.

1. Introduction

GPs and psychiatrists often appear to have different understandings of depression. GPs place more emphasis on patient-centered care [1,2] and their interactions with patients tend to be from a patient-driven perspective [3]. Guidelines for depression are often thought to be at odds with the complexity of the situation in primary care [2,4–10]. Some GPs regard depression not as a disease but as a reaction to adverse life circumstances [11–14] or other illness [15,16]; they view it more as a 'sub-text' [17]. For GPs, an empathic approach may be considered more appropriate than making a diagnosis or offering medication [18].

In psychiatry, understanding the patients and grasping the content of their minds are likewise recognized as important [19], but this approach is not always realized [20–23]. Focus on empathy is now often replaced by preoccupation with the therapeutic alliance, which consists of several facets in addition to empathy [24,25].

Moreover, empathy has been defined in different ways [26,27] with different weight on affective and cognitive dimensions. More recently empathy has, however, been defined to cover a wider range of understandings, including the ability to understand other people's thoughts and intentional states [28]. There is also a demand that this understanding is checked with the patient [29]. This wider definition means that empathy corresponds more closely with mentalization, a newer concept in psychological theory [30,31].

An increasing number of studies have investigated emotional communication in clinical settings outside psychiatry [32–37]. Many of them are more concerned with which physician behavior leads to patients expressing emotions, than with physicians' responses to patients' emotional cues [34].

Studies of physicians' responses to patients' emotional disclosures from oncology [37–39] show that patients may have intense emotional responses to serious disease, and also an increased risk of depression [40]. Some studies indicate that

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physicians move away from emotional communication [38,41,42] and initiate biomedical inquiry or non-specific acknowledgements [43]. A study of surgeons and primary care physicians showed that 'emotional opportunities' were often missed [36]. This was also seen in another primary care study [32].

Patients disclose their emotions either indirectly as cues or hints or more explicitly as direct 'empathic opportunities' [44–47] or 'concerns' [35,37,44,46]. Special instruments, for example the VR-CoDES, have been developed to measure different ways of responding to patients' emotional talk enabling quantitative studies of physicians' responses [33]. Responding well to patients' emotional disclosures has been shown to have a positive effect on outcome [48,49] and to increase patient satisfaction and self-efficacy [28,39].

To our knowledge, no study has explored physicians' responses to emotional disclosures in patients with depression. Part of the treatment for depression includes some form of psychotherapy, where working with the patients' emotions is important [24]. A study using conversation analysis (CA) showed that in psychotherapy emotional responsiveness is a prerequisite of the therapist's access to the patient's experience [50]. Patients with depression are usually treated in primary care, where physicians do not have specific psychotherapeutic training. GPs often use non-specific factors where empathy [51] or mentalization [52] play an important role. Collaborative treatment across sector borders is considered a future treatment model [53–56]. Successful collaboration could depend on the different professionals having a common understanding of the approach, which may not necessarily be the case now [7,11,57].

We investigated how GPs and psychiatrists, in consultations with patients suffering from depression, responded to patients' emotional disclosures and whether or not they explored these disclosures.

2. Methods

The study was qualitative. The data material consisted of video-recordings of consultations between GPs and psychiatrists and patients with moderate depression. We used CA to demonstrate how doctors responded when patients made emotional disclosures. CA studies the order of talk in interaction and the ways in which intersubjectivity is achieved. Intersubjectivity is considered inherent in the structure of conversation and is accomplished by the structures that underlie the organization of talk; interactants show in their next turn how they understand the co-interlocutors' preceding turn [58]. We applied the sequential perspective of CA and studied the conversation between doctors and patients with the analytic focus on doctors' responses to patients' disclosure of emotional states.

2.1. Participants

Twelve GPs and 11 psychiatrists from Denmark took part in our study. Five psychiatrists worked in specialist practice. GPs can refer patients to these psychiatrists without the patients having to fulfill special criteria. Treatment for patients is free of charge. Six psychiatrists worked in hospital-based outpatient departments where patients with moderate depression may be referred if there is no progress in treatment. The doctors were purposively sampled to cover the range of demographic differences [59,60]. Gender distribution was seven female GPs and five male; four female psychiatrists and seven male. Age range was comparable – psychiatrists 42–63 years and GPs 43–66 years. The mean age for each group was 54 years.

All patients gave informed consent. In Denmark, the Committee on Health Research Ethics is only applied in biomedical research. Nevertheless, all ethical standards were observed and the Danish Data Protection Agency was advised of the study.

2.2. Data material

Thirty consultations between doctors and patients with moderate depression were video-recorded between 2010 and 2012; 13 were with GPs and 17 with psychiatrists. The doctors were asked to recruit patients with moderate depression according to ICD-10 criteria. All but one were follow-up consultations. The videos from psychiatrists tended to be longer (30–60 min) than those from GPs (15–45 min), corresponding to normal consultation periods in the two sectors. Based on assessment of the videos, patients in both GP and psychiatrist consultations appeared comparable in terms of psychopathology.

2.3. Analysis

Working together, both authors (AD and CF) identified extracts from the consultations where patients explicitly designated their emotions; either saying that they had a particular feeling (i.e. 'I feel really sad', 'I actually feel really bad') or designating their experience by an emotional adjective (i.e. 'it is so tough', 'it is awful'). Taking a sequential approach, we studied how physicians responded to the 'empathic opportunities' [46], presented as emotional disclosures. The segments were transcribed according to the established conventions of CA [61,62].

CF, a language psychologist, completed the primary analysis of the extracts. Thereafter we discussed the analysis in a research group, and this led to a further refinement. The group consisted of AD, specialist in family medicine and psychotherapy, CF, and two other language psychologists.

In all, we identified just over 100 empathic opportunities. For both GPs and psychiatrists there were consultations with many opportunities and a few with none. Although consultations with psychiatrists were on average twice as long as consultations with GPs, the total number of empathic opportunities was the same for GPs and psychiatrists.

3. Results

Psychiatrists and GPs differed in their responses to patients' emotional disclosures. Psychiatrists often followed their own agenda without further exploring patients' emotions. In the majority of cases they either met the patients' emotional utterances with rational argumentation or by changing the subject. In the remaining cases they responded by trying to clarify the patients' disclosures in terms of symptoms or by offering interpretations of the patients' emotions from their own perspective. By these methods, they did not engage with or explore the patients' emotional disclosures.

In general, GPs tended to focus on the patient's emotional disclosures, but this was often limited to claiming that they 'saw' or 'understood' the emotions. Some GPs formulated [63,64] the patients' emotional statements and some encouraged the patients to reflect upon their emotions. These GPs displayed a wider engagement with the patient's emotions and showed interest in the patients' life experience. In addition, the GPs displayed an open, not-knowing stance [65]. The few psychiatrists who explored patients' emotional disclosures presented their interpretations as unconditionally true and related to their professional discourse.

We have illustrated the different forms of response with analyses of extracts from consultations.