

## Detection of Psychologic Complaints by General Practitioners

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Many complaints, which present as somatic illness at a medical visit, appear afterwards to be partly psychologic in origin. Not every general practitioner (GP), however, is equally sensitive to the psychologic aspects, and not every physician possesses the communication techniques required to detect them. In this respect, it has been considered important that a GP show attention, interest and concern; have a patient-centered attitude; clarify complaints; structure the interview; and have an active, seeking attitude. In this research project the effects of these factors on a patient's presentation of personal problems were investigated; the relationship between the GP's way of communicating and his or her sensitivity to the psychologic aspects of complaints was examined. It appeared that the features of physician-patient interaction, mentioned above are complementary; it was possible to identify one conversational style, expressed by a factorscore, based on measurements of the several distinct features. This conversational style appeared to be a good predictor of a physician's initiatives in asking for a patient's problems, but a negative predictor of a patient's initiatives in presenting them. Hence, when a physician communicated in an open, patient-centered way, the patient did not need to take those initiatives; if the patient did so, it was in most cases a sign of the physician's unresponsive attitude. The open conversational style of the physician was related to his sensitivity to the psychologic aspects of complaints. The consequences of these findings for vocational and postgraduate training are discussed. Key words: general practitioner; physician-patient interaction; psychologic complaints. (Med Care 1988; 26:1009-1020)

A patient who visits a physician usually will enter the consulting room with a physical complaint. Goldberg gives a number of reasons for this.<sup>1</sup> First, there are the expectations of the patient, who goes to a physician because of bodily sensations. Second, although the underlying problem may be psychologic, in most cases there also will be some accompanying physical signals which may become even more marked when the patient is under stress.<sup>2</sup> Finally, there is a

broad category of complaints where the physical symptom causes anxiety or guilt. In all these cases, it is less threatening for many patients to describe the somatic side of the complaint than to talk about the psychologic aspects, although many complaints appear to be essentially psychologic in nature. Psychologic factors also play an important role in many somatic complaints. In the mid 1960s, Shepherd and his colleagues<sup>3</sup> had already reported that psychiatric disorder comprise between 5% and 32% of all complaints. Most of the disorders are categorized as neuroses and personality disorders, as opposed to psychoses. Using the General Health Questionnaire, Marks, Goldberg, and Hillier<sup>4</sup> estimated the preva-

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lence of psychiatric morbidity in 91 practices to be between 15% and 69%. The same wide range of occurrence was reported in recent research in the Netherlands.

Although such prevalence usually reflected the bias of the reporting agency, in most cases GPs, it is not our intention to discuss the accuracy of these judgments. We are interested in the variation in sensitivity among GP's and the relationship that exists between this sensitivity and the physician-patient communication (in Goldberg and Huxley's<sup>5</sup> terminology: we talk about bias and not about accuracy). At present, our view is that many of the complaints presented to the GP are psychological in nature, in spite of the patient's tendency to present them as somatic. This causes problems for the GP.

A GP should develop interviewing techniques that will allow discovery of hidden psychologic and social problems, which are either primary or provide important background to the somatic disorder. In Holland this is particularly important because the GP, in most cases, is the first professional a patient seeking help will meet; the GP functions as the gatekeeper to more specialized agencies including social workers, psychiatrists, or psychotherapists, on the one hand, and somatic specialists on the other. The patient's future treatment, therefore, lies in the hands of the general practitioner.

Many authors have said that a physician should communicate with his patients to facilitate the search for a possible psychosocial background to complaints. Goldberg gives the following guidelines:<sup>1</sup>

1. Patients should be given the opportunity to describe early in the interview the nature of the disorder in his or her own words.
2. Before the physician elicits information regarding particular symptoms, the patient should have the opportunity to clarify the complaints, state the reason for his visit to the physician, and clarify what he wants.

After describing the proper way to commence the consultation, much could be said

about the way the physician should control the interview, about the emotional atmosphere during the consultation, and about the relationship the physician develops with the patient. Our emphasis is not on conducting a psychologic assessment interview for an established psychological problem. Instead, we stress interview techniques and attitudes that should enable the doctor to determine whether psychologic factors play any role at all. Many authors have stressed the importance of the affective behavior of the physician during the consultation. DiMatteo gave an overview of the required behavior in this respect.<sup>6</sup> A physician should show sensitivity to current feelings and be able to communicate this understanding in language attuned to the patient's feeling. He should give the patient nonverbal attention, such as making eye contact, assuming an attentive posture and restful attitude, and keeping attention on the patient rather than on writing, reading, or other activities. Affective behavior is a necessary condition for creating a relationship in which a patient is able to show his emotions and present his or her personal problems. It has also been shown by Ben Sira and others that patients initially judge a GP by his perceived interest and concern for the patient: when the patient's judgment is positive, the medical abilities of the physician are rated higher. Affective behavior adds much to patients' satisfaction.<sup>7-9</sup>

Additionally, a GP who wants to discuss the psychosocial side of a patient's complaints should be prepared to do this on equal terms with the patient. Szass and Hollender presented three models for describing the relationship between physician and patient 30 years ago.<sup>10</sup> They described the active physician and passive patient, a model appropriate in cases where the patient, due to his or her physical condition, was forced into passivity and where the physician's medical knowledge was needed. They also described the model of mutual understanding, a model appropriate in

sician should control the emotional atmosphere, and about how the physician develops with the patient. The analysis is not on consensus interview techniques and how the doctor to detect psychologic factors play a role. Authors have stressed the ineffective behavior of the physician during the consultation. Diagnostics of the required techniques.<sup>6</sup> A physician should be attuned to the patient's current feelings and communicate this understanding to the patient. The physician should be able to give the patient a sense of control, such as making eye contact, tentative posture and listening attentively. The physician should be able to show his or her personal interest in the patient. As shown by Benet, patients initially judge a physician's interest and concern for their health as a reflection of the physician's affective behavior and satisfaction.<sup>7-9</sup> The physician wants to discuss the patient's concerns and to do this on the patient's terms. Szass and Lee have models for detecting between physician and patient.<sup>10</sup> They described the passive patient, a patient whose physical condition, and where the knowledge was needed. The model of mutual understanding appropriate in

those cases where the knowledge and insights of the patient was as valuable as the medically-oriented views of the physician. This is, for example, the case when psychosocial factors play a role. The power shift model of Byrne and Long is a further elaboration of this way of thinking.<sup>11</sup> The idea is that the more a physician uses patients' ideas and knowledge to establish a diagnosis and treatment, the more room there will be for the patient to offer new information about the possible psychosocial character of the complaints.

Finally, there must be some remarks about the structuring of the consultation. It is important that the physician control the interview to prevent issues remaining unnoticed. Problems should be brought forward one at a time. The subject being discussed must be clear to the patient. Another important point in this respect is an active attitude on the part of the GP in seeking new information. Although the physician must facilitate communication, ask open-ended questions, and avoid making value judgments too soon, he or she also must take the initiative in raising new points. Purposeful probing, therefore, can be of great value in detecting the psychosocial origins of complaints.

### Research Questions

These are the limits of theory. In the next section an empirical approach is introduced to investigate the value of the different aspects of physician-patient communication. In this research project the aspects of physician's communication style mentioned above operation. The following research questions were posed:

1. How do the various elements of a physician's communicative style relate to each other?
2. Does frequent use of the interview techniques mentioned facilitate initiatives on the part of the patients in presenting their personal problems?

3. Is it true that a physician who behaves according to the rules mentioned, detects more psychologic problems?

### Methods

Data was collected from 30 GPs in the form approximately 50 videotaped interviews by each GP and questionnaires completed by the GP and patient about one another. From the questionnaire that the GP completed after each interview, we inferred his judgment about the extent to which psychosocial factors play a role. From the videotaped interviews, we inferred the interview style of the GP and also the method of treating complaints judged as psychiatric.

The GP's who took part in the video recording were approached by intermediaries connected with our research institute. In some cases the GPs participated as a group; there were individual decisions to participate as well. GPs were not selected for their interest in psychiatric illnesses or for similar reasons. However, the group was not as representative of the total population of Dutch GPs, as was hoped. The videogroup had a larger proportion of GPs working in health centers, and, on the whole, had attended more postgraduate training courses than a national sample. However, in all cases, the distributions over the two groups were the same.

Videotapes were made of all consultations until 60 recordings were obtained. About 15% of the patients refused to participate. There was no difference in mean age between participants and nonparticipants. Women refused to participate slightly more often than men (62% of the participants and 66% of the nonparticipants were women). Patients who refused to participate reported psychologic or social complaints relatively often. Although this results in a decrease in the variability of our material, we are primarily interested in the variation among doctors rather than a generalizable survey of psychiatric complaints in general prac-

tice, and do not, therefore, consider this loss of patients significant.

We listed the following features of communicative style, which should produce a positive bias with respect to psychosocial judgment:

- clarifying the reason for seeking help,
- affective behaviour,
- structure of the consultation,
- equality of the relationship, manifested in the amount of patient participation,
- purposive probing.

*Clarification* was indicated when the physician discussed the patient's motives for visiting the physician with this particular complaint before the examination. This was judged for each separate complaint. We used four measures for *affective* attitude (the physician's interest and concern; eye contact, number of empathic manifestations, and number of nonspecific utterances—e.g., hm-hm, ah,). The degree of *structuring* was measured by whether, for each consultation, the GP rounded off questions consecutively. *Patient participation* in deciding on the diagnosis and therapy was rated on two 5-point scales. *Probing* was measured by tallying the number of times the GP introduced a new subject in the discussion. All these measures were assessed by observation: different types of utterances (emphatic utterances, open-ended questions, closed questions, introducing new subjects, nonspecific utterances) were counted, the physician's attention to the patient and patient participation were measured on rating scales, duration of consultation and stages of the consultation were measured by means of a stopwatch.

Observation was carried out by five observers. After a joint training course, each individually observed a number of the consultations. Every month, one or two days were spent on joint observation. We based measurements of interobserver reliability on

these observations. Product-moment correlation varied from 0.43 to 0.89 for the variables that could be counted; *probing*, and "empathic utterances" were not reliably measured (interobserver reliability was 0.43 and 0.53, respectively). Variables that were judged on rating scales all had reliabilities of about 0.45.

We also collected test-retest scores by observing about 30 consultations 1.5 years later. These interobserver reliabilities were higher than those mentioned earlier. Nevertheless, we conclude that we were confronted by a considerable observer effect, which we attempted to neutralize by distributing the observers equally over the consultations of each GP. Our success was indicated by the fact that checking the observer effect did not change the mean score of any of the measured variables. Two dependent variables were used: the proportion of complaints that the doctor judged to be psychosocial, and the number of initiatives the patient took to introduce psychosocial items. For the first variable, the physician classified each complaint as belonging to one of the following categories:

1. Strictly somatic;
2. Mainly somatic, but with mental factors;
3. Presented in somatic terms, but with mental factors probably behind it;
4. Mainly mental, emotional, or social.

For each GP we obtained a distribution of approximately 90 judgments (one interview contained an average of 1.8 complaints), from which we deduced a general tendency to identify complaints as purely somatic, purely mental, or belonging to one of the other two categories.

When observing the consultations, each shift in the interview from somatic topics to psychosocial topics was assessed as being the initiative of the patient or the doctor. In this way, the initiative of the patient was measured.<sup>12</sup>



TABLE 1. Communication When Somatic Topics are Discussed and When Psychosocial Topics are Discussed<sup>a</sup>

|   | Somatic Topics |      |                | Psychosocial Topics |      |     |                    |
|---|----------------|------|----------------|---------------------|------|-----|--------------------|
|   | $\bar{X}$      | SD   | N <sup>b</sup> | $\bar{X}$           | SD   | N   | t                  |
| Clarifying  |                |      |                |                     |      |     |                    |
| Proportion of complaints for which the reason for encounter was discussed | 19%            |      | 1877           | 29%                 |      | 461 | 4.32 <sup>c</sup>  |
| Affective behavior  |                |      |                |                     |      |     |                    |
| Interest (5-point scale)  | 3.3            | 0.8  | 1446           | 3.6                 | 0.9  | 477 | 6.69 <sup>c</sup>  |
| Proportion of time GP looks at patient                                    | 48%            | 27.1 | 1430           | 70%                 | 35.2 | 469 | 12.36 <sup>c</sup> |
| Encouraging (utterances/min)  | 1.9            | 1.5  | 1441           | 2.8                 | 1.9  | 477 | 8.22 <sup>c</sup>  |
| Empathy (utterances/min)  | 0.2            | 0.3  | 1440           | 0.4                 | 0.4  | 477 | 9.22 <sup>c</sup>  |
| Structuring   |                |      |                |                     |      |     |                    |
| Proportion of consultations with structured approach                      | 65             |      | 482            | 54%                 |      | 324 | 3.13 <sup>d</sup>  |
| Patient-centered behavior   |                |      |                |                     |      |     |                    |
| During diagnostic phase (5-point scale)                                   | 2.7            | 1.1  | 1884           | 3.7                 | 1.1  | 496 | 17.67 <sup>c</sup> |
| During prescribing phase (5-point scale)                                  | 2.7            | 1.2  | 1866           | 3.3                 | 1.2  | 406 | 8.95 <sup>c</sup>  |
| Purposive probing   |                |      |                |                     |      |     |                    |
| Introduction of new topics  | 0.4            | 0.7  | 1441           | 0.8                 | 1.0  | 478 | 7.42 <sup>c</sup>  |

<sup>a</sup> *t*-values indicate the differences between values for somatic and psychosocial topics.

<sup>b</sup> It should be kept in mind that clarifying and patient-centered behavior are related to complaints, whereas the other variables are related to consultations. A second reason for different numbers is a difference in number of times that a variable was not applicable. (For example, *structuring* has been measured only when more than one complaint was discussed in the consultation.)

<sup>c</sup> *P* < 0.001.

<sup>d</sup> *P* < 0.01.

**Results**

Table 1 shows that physicians talk more openly to their patients when discussing psychosocial topics rather than somatic topics. This was true for all factors we considered except for *structuring*. In situations in which somatic complaints alone were discussed. In this case the course of the conversation was structured better than when psychosocial topics were also discussed. Other than for this single exception, when discussing psychosocial complaints, physicians were more interested in their patients, showed more empathy, were more patient centered, and tried more often to find out what the patient really wanted.

The physicians involved in our investigations differed substantially from one another in all aspects considered. This was statistically tested by means of variance analysis (Table 2), which yielded the same

results in each case except one: the variances among physicians considerably exceeded the variances among the cases of one physician, except for *structuring*, which yielded no significant differences among physicians. However, physicians who were rated high on one variable often received a high rating on other variables; in other words, a physician whose concern for patients was judged positively in many cases also tended to be rated positively on, e.g., the patient-centeredness of his or her behavior and the degree to which he or she clarified problems before taking the history. On the other hand physicians who seldom made inquiries about the situation at home or at work also showed little sympathy towards their patients and did not encourage them very much.

Measured at the level of the GP, there were high correlations between the measures that expressed the communicative

TABLE 2. Results of Variance Analysis: Variance of Several Communication Features Within One Physician Compared to the Variance Between Physicians

|   | F ratio | Probability | df |
|---|---------|-------------|----|
| Clarifying  |         |             |    |
| Proportion of complaints for which the reason for encounter was discussed | 5.66    | $P < 0.001$ | 29 |
| Affective behavior  |         |             |    |
| Interest (5-point scale)  | 16.37   | $P < 0.001$ | 29 |
| Proportion of time GP looks at patient                                    | 17.58   | $P < 0.001$ | 29 |
| Encouraging (utterances/min)  | 13.41   | $P < 0.001$ | 29 |
| Empathy (utterances/min)  | 7.94    | $P < 0.001$ | 29 |
| Structuring   |         |             |    |
| Proportion of consultations with structured approach                      | 1.25    | NS          | 29 |
| Patient-centered behavior   |         |             |    |
| During diagnostic phase (5-point scale)                                   | 9.97    | $P < 0.001$ | 29 |
| During prescribing phase (5-point scale)                                  | 8.54    | $P < 0.001$ | 29 |
| Purposive probing   |         |             |    |
| Introduction of new topics  | 5.42    | $P < 0.001$ | 29 |

style outlined above. Because of these high intercorrelations, all variables loaded high on the same factor when we carried out a factor analysis. This allowed us to express the conversational style of a physician in one factor score instead of nine separate measures. This factor score normally was distributed with zero as its mean and 1 as its standard deviation. Table 3 shows the loadings of the separate variables on the common factor. Figure 1 gives the distribution of the 30 physician. A high factor score indicates a so-called "open conversational style."

Another interesting finding is shown here. These factor scores allowed us to rank the 30 GPs. The scores that shown in Figure

TABLE 3. Loading of the Separate Measures on the Common Factor

| Measure                                 | Factor Loading |
|---|----------------|
| Clarifying                              | 0.72           |
| Interest                                | 0.77           |
| Proportion of time GP looks at patient  | 0.77           |
| Encouraging                             | 0.71           |
| Empathy                                 | 0.70           |
| Patient-centered behavior (diagnostic)  | 0.92           |
| Patient-centered behavior (prescribing) | 0.91           |
| Purposive probing                       | 0.72           |

1 were based on all the consultations. We calculated those factor scores on the basis of only those consultations where complaints were judged to be purely somatic. We did the same for consultations where physicians discussed psychosocial problems and for consultations with male patients, female patients, old patients, and young patients. Ranking on the basis of each of these subdivisions constantly yielded the same results. Although, as shown in Table 1, the mean conversational style was more open when psychosocial topics were involved, the ranking of physicians was the same in all these cases: a physician with a high score with respect to psychosocial topics also received a high score when somatic topics were involved. The conversational style, measured in this way, was a general feature of the physician that repeatedly surfaced.

We can summarize our findings in the following ways. When psychosocial topics were discussed, the conversational style in all respects was more open, friendly, and patient-centered than when somatic topics were discussed; when a physician was judged positively in one respect, judgment in other respects was positive too; and when a physician exhibited an open conversational style in the treatment of patients in

Features Within One

| Probability | df |
|-------------|----|
| $P < 0.001$ | 29 |
| $P < 0.001$ | 29 |
| $P < 0.001$ | 29 |
| $P < 0.001$ | 29 |
| $P < 0.001$ | 29 |
| NS          | 29 |
| $P < 0.001$ | 29 |
| $P < 0.001$ | 29 |
| $P < 0.001$ | 29 |

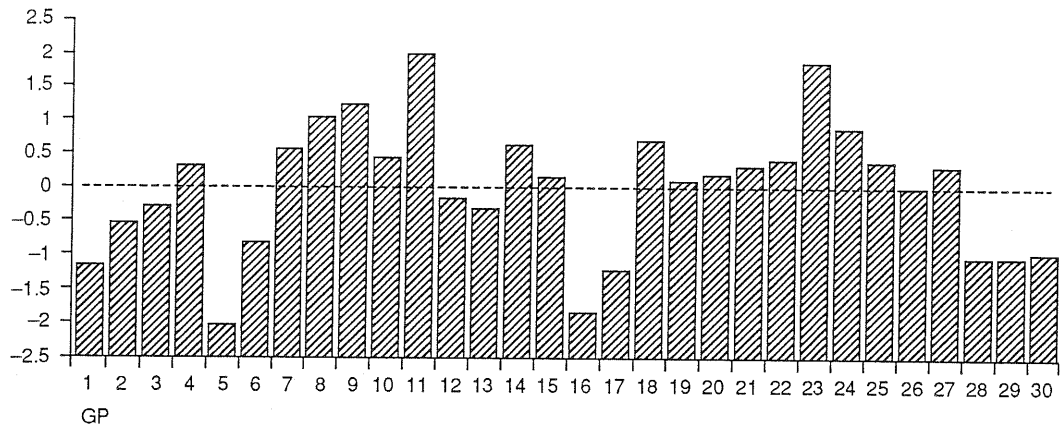


FIG. 1A. Conversational style of 30 GPs as indicated by the factor scores.

one category (as compared to his colleagues), he or she exhibited the same style when treating patients in other categories. We can speak about one conversational style.

Let us turn now to the second question: does the open style of conversation help the patients to uncover their more personal problems? To answer this question, we closely studied the consultations. For this purpose, we considered only the first somatic-oriented stage of the consultation in those cases where the complaint was not considered to be purely somatic and where the beginning of the consultation had a somatic character (consultations with purely somatic complaints as well as consultations where the psychologic complaint was presented immediately were not taken into

consideration). Initially a distinction was made between consultations in which the first stage was followed by a second, psychosocial-oriented stage and consultations that kept their somatic character during the whole consultation. The expected effect of the open conversation style was self-disclosure on the part of the patient. The presence of a stage in the conversation where psychologic problems were discussed was an indicator of self-disclosure. It was expected that the conversational stage preceding the psychologic-oriented stage would, therefore, be more open than a corresponding phase in a consultation where only somatic topics entered the discussion.

A second distinction was made within those stages that were followed by a psychosocial stage. The psychologic part of the

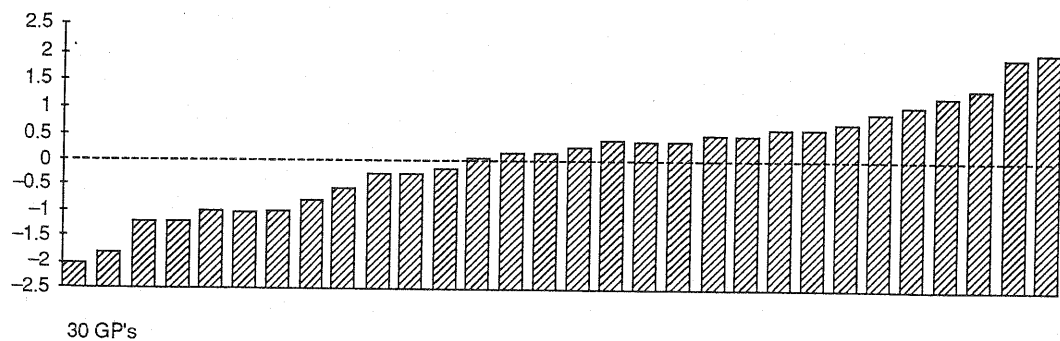


FIG. 1B. Ranking of the 30 GPs by factor scores.

consultations. We scores on the basis of where complaints by somatic. We did s where physicians problems and for atients, female pa- l young patients. each of these sub- ded the same re- m in Table 1, the e was more open s were involved, s was the same in 1 with a high score ical topics also re- en somatic topics versational style, s a general feature atedly surfaced. findings in the fol- ychosocial topics ersational style in en, friendly, and en somatic topics a physician was respect, judgment ive too; and when open conversa- ent of patients in

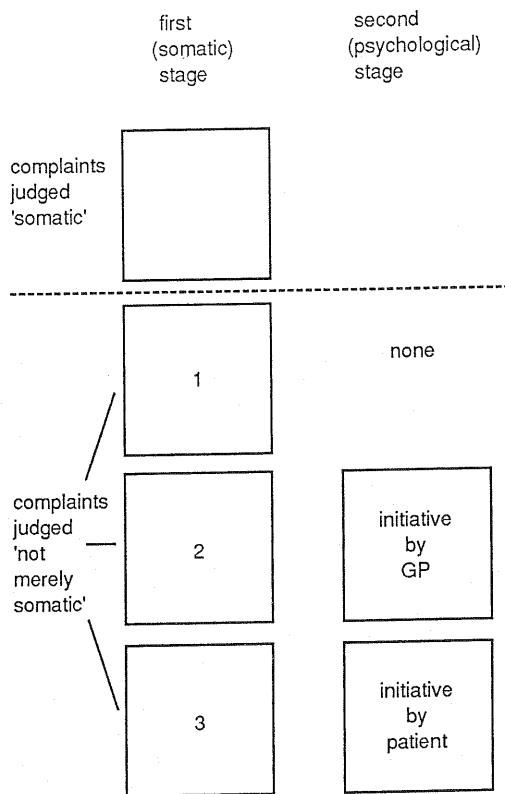


FIG. 2. Division of the research sample of consultations with no somatic complaints into three subgroups.

interview was initiated by the physician or by the patient. By comparing the preceding somatic stages we could analyze whether the patient's initiative was the result of a preceding open conversation (Fig. 2). We compared the following three kinds of initial, somatic stage in a consultation with regard to the conversational style presented:

1. Conversation style in somatic stages that were not followed by any other stage;
2. Conversation style in somatic stages that were followed by a psychologic stage at the physician's initiative; and
3. Conversation style in somatic stages that were followed by a psychologic stage at the patient's initiative.

Means and standard deviations of aspects of conversational style are shown in Table 4. Analysis of variance yielded significant dif-

ferences of group means for interest, eye contact, and patient-centered behavior (all significant below 0.001 level).

Paired comparisons by means of a *t*-test showed differences in the expected directions in some respects: the communicative style was in general more open in fragments that were followed by a psychologic stage than in interviews where the topic remained of a somatic character. When the two types of fragments, followed by a psychologic stage, were compared, however, it became clear that the more open the conversational style, the greater the probability that the physician rather than the patient would take the initiative to move to the psychologic stage. The low amount of interest, encouragement, and patient-centered behavior in the stages preceding a patient's initiative was particularly striking. It appeared that the patient's initiative was more an indication of the patient's need for attention than a logical reaction to an inviting attitude on the part of the GP. The fact that purposive probing by the physician occurred less in somatic stages, followed by psychologic stages on patient's initiative, illustrated the perceived lack of physician's attention.

The same conclusion can be drawn when we look at the GP level. For each of 30 GPs, a mean score regarding their communicative style was calculated for all the consultations used, i.e., the factor score mentioned. For each GP, the proportion of psychologic stages initiated by the patient and the proportion initiated by the GP was calculated. This produced the number of psychologic stages during the 50 consultations on an individual GP basis. The correlation coefficients between the proportion of patient initiatives and doctor initiatives and the conversational style (i.e., the factor scores) and number of psychologic stages are given in Table 5.

From these coefficients it appeared that the more open the conversational style of the GP, the more initiatives the physician took and the fewer initiatives the patient



TABLE 4. Communication in the First, Somatic Stage in Those Consultations Where One of the Complaints was Judged as not Merely Somatic, Divided According to the Content of the Second Stage

|   | 1<br>Somatic Stage<br>Only<br>(N = 362) |     | 2<br>Somatic Stage<br>Followed by<br>Psychologic<br>Stage (Initiative<br>GP)<br>(N = 185) |     | 3<br>Somatic Stage<br>Followed by<br>Psychologic<br>Stage (Initiative<br>Patient)<br>(N = 130) |     |
|---|---|-----|---|-----|--|-----|
|   | $\bar{X}$                               | SD  | $\bar{X}$   | SD  | $\bar{X}$  | SD  |
| Clarifying  |   |     |   |     |  |     |
| Proportion of complaints for which the reason for encounter was discussed | 30% <sup>a</sup>                        | —   | 40% <sup>a,b</sup>  | —   | 26% <sup>b</sup>   | —   |
| Affective behavior  |   |     |   |     |  |     |
| Interest (5-point scale)  | 3.3 <sup>a</sup>                        | 0.8 | 3.6 <sup>a,b</sup>  | 0.7 | 3.4 <sup>b</sup>   | 0.8 |
| Proportion of time GP looks at patient                                    | 48% <sup>a</sup>                        | 21  | 57% <sup>a</sup>  | 20  | 53%  | 24  |
| Encouraging (utterances/min)  | 2.0                                     | 1.4 | 2.3   | 1.8 | 2.0  | 1.4 |
| Empathy (utterances/min)  | 0.2                                     | 0.3 | 0.2   | 0.3 | 0.1  | 0.2 |
| Structuring   |   |     |   |     |  |     |
| Proportion of consultations with structured approach                      | 62%                                     | —   | 53%   | —   | 52%  | —   |
| Patient-centered behaviour  |   |     |   |     |  |     |
| During diagnostic phase (5-point scale)                                   | 2.7 <sup>a,c</sup>                      | 1.1 | 3.3 <sup>a,d</sup>  | 0.9 | 3.1 <sup>c,d</sup>   | 1.1 |
| During prescribing phase (5-point scale)                                  | 2.7 <sup>a,c</sup>                      | 1.1 | 3.0 <sup>a</sup>  | 1.1 | 3.0 <sup>3</sup>   | 1.2 |
| Purposive probing   |   |     |   |     |  |     |
| Introduction of new topics  | 0.5                                     | 0.8 | 0.4   | 0.7 | 0.3  | 0.7 |

<sup>a</sup> significant difference between 1 and 2 ( $P < 0.05$ ).  
<sup>b</sup> significant difference between 1 and 3 ( $P < 0.05$ ).  
<sup>c</sup> significant difference between 2 and 3 ( $P < 0.05$ ).  
<sup>d</sup> significant difference between 2 and 3 ( $0.05 < P < 0.10$ ).

ans for interest, eye entered behavior (all level).

by means of a *t*-test the expected direc- the communicative re open in fragments a psychologic stage e the topic remained When the two types d by a psychologic however, it became n the conversational probability that the e patient would take to the psychologic of interest, encour- entered behavior in patient's initiative 3. It appeared that 'as more an indica- d for attention than nviting attitude on fact that purposive n occurred less in d by psychologic tive, illustrated the an's attention.

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took. Patients took more initiatives when there were fewer psychologic stages. Our former interpretation—a patient initiative is a cry for attention—was confirmed by this. We cannot say that an open conversational style prevented initiatives on the part of the patient. From the high correlation between proportion of the GP's initiatives and the speaking time of the patient ( $r = 0.50$ ) we concluded that this was not the case. It would be more appropriate to say that an open conversational style removed the necessity for the patient to take initiatives.

The last question to be answered concerned the relationship between conversa- tional style and the detection of psychoso- cial complaints. As was explained in the in- troduction, psychosocial complaints are those complaints that a GP judges as such. The proportion of complaints judged to be

purely somatic was used as a measure to rate a GP's tendency in this respect. This proportion varied widely among the 30 GPs ( $F = 5.06$ ,  $df = 29$ ,  $P < 0.01$ ). Table 6 shows that this tendency was correlated with the

TABLE 5. Relationship Between Conversational Style and Proportion of Initiatives Taken by Patient and GP (N = 30)

|  | Proportion of Patient Initiatives | Proportion of GP Initiatives |
|--|-----------------------------------|------------------------------|
| Conversational style (factor score based on all consultations) | -0.37 <sup>a</sup>                | 0.47 <sup>a</sup>            |
| Number of psychologic stages                                   | -0.31 <sup>a</sup>                | 0.27 <sup>b</sup>            |

<sup>a</sup>  $P < 0.05$ .  
<sup>b</sup>  $P < 0.10$ .

TABLE 6. Relationship Between Conversational Style and Proportion of Somatic Judgments

|   | Proportion of Judgments (pure somatic) |
|---|--|
| Conversational style (whole consultations)      | -0.48 <sup>a</sup>                     |
| Conversational style (somatic complaints)       | -0.42 <sup>a</sup>                     |
| Conversational style (psychological complaints) | -0.47 <sup>a</sup>                     |

<sup>a</sup>  $P < 0.05$ .

GP's conversational style assessed in all interviews: in interviews with complaints judged to be purely somatic and in interviews with complaints judged to be not purely somatic.\* It was clear that physicians with an open, patient centered, clarifying attitude perceived more complaints to be not purely somatic than physicians with the opposite attitude.

This was not an artifact in the sense that the open conversational style was inherent in nonsomatic complaints; hence a physician who perceived many such complaints often used this style automatically. If the communication style was calculated on the basis of somatic complaints only, in fact, the same relationship was found. GPs who judged many problems to be not merely physical were GPs who communicated in all cases in a more open way than GPs who were somatically oriented.

Although outside the scope of the questions posed in this article, the relationship between conversational style and treatment of recognized psychologic complaints should be mentioned: the more open the conversational style, the more a doctor

\* In the same way that factor scores based on measurements of all available interviews were computed, factor scores based on interviews with patients with complaints judged as purely somatic, and based on interviews with patients with complaints judged as not purely somatic were calculated. In this way, we had measures of a somatic conversational style and a psychosocial conversational style, which were, as already mentioned, highly intercorrelated.

talked about those psychologic aspects ( $r = 0.69$ ), explored possible backgrounds, and gave the patient insight into those backgrounds ( $r = 0.80$ ).<sup>12</sup>

### Conclusion

The recommended interview techniques proved useful for the purpose of creating an atmosphere where personal problems could be discussed. It was not possible, however, to indicate one specific aspect of such a conversational style that prevailed above the others: the connection between the distinguished elements was too strong. The significance attached to the patient's initiative was somewhat different from the observed reality. In the ideal case, the problems of the patient easily became a subject of discussion. When the patient raised his problems explicitly, however, this, in most cases, resulted from an interview with a discouraging beginning, at least from the patient's point of view. When the physician took the initiative in discussing psychosocial topics, this was, in most cases, a natural follow-up to a preceding stage that was already open and patient-centered.

The activity of the patient seemed to be a good measure of independence or autonomy, but was not a good indicator of the beneficial effects of the doctor's behavior. These sort of measures had an ambiguous character: a high degree of activity (e.g., questioning, speaking time, bringing in new objects of discussion) on the part of the patient may have been an expression of the space a patient had or of the space to which a patient was trying to lay claim. Finally, a physician who communicated in the recommended open way more often attached the label not merely physical to a complaint.

In summary, it is possible to represent the conversational style of a physician on one dimension in which all the discerned elements show up together. Physicians who could be characterized on this scale as open, talked regularly, on their own initiative,

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about psychosocial aspects of complaints. These physicians had a tendency to make nonsomatic judgments. Physicians whose conversational style could be characterized as closed were more often corrected by their patients, i.e., after a not very inviting opening stage, the patient was the one who took the initiative to discuss psychosocial topics.

These findings, it must be remembered, concern a situation in the Netherlands. One typical feature of the Dutch health-care system (and also of the British system but not of the American) is that a Dutch GP has a fixed list of patients. Families have their own family physician, who may be the same person for a period of 20 years. Many patients, therefore, are well known by their physicians, which makes it easier for the physician to make tentative suggestions when he suspects something other than a common illness with a simple somatic background. Furthermore, knowing the patient, the physician is able to relate items that initially do not seem to have anything to do with each other. For these reasons, it is possible that an open conversational approach is more successful in medical settings where physician and patient know each other well than in settings with a more polyclinical character. On the other hand, however, the classical findings of Korsch and Negrete<sup>15</sup> and Ben Sira<sup>7-9</sup> showed the importance of being amiable in such settings too.

It is worthwhile to teach this general open approach to physicians if importance is attached to giving a broader interpretation of a patient's complaints. Such an approach contributes to a decrease in purely somatic judgements. Such training, however, should take place from the beginning of the medical education. Medical education exclusively stresses the clinical aspects of illness in the first years. The student is taught to perceive complaints within the framework of clinical pathology; questions such as "why is this patient visiting his GP at this moment with this complaint?" are of no importance within this framework. Patient

centered behavior is of little use when one is trying to write a perfect clinical anamnesis. It appears from our investigations that it is very difficult to change such a clinical attitude after an 6-year program of education where the attitude has been constantly reinforced. One should consider that in the Netherlands General Practice training takes place only after this 6-year clinical training.

Is it necessary, therefore, that a GP view the complaints of his patients in the context of a broad frame of reference where, e.g., not only the somatic aspects of the complaint, but also the feelings of the patients, the GP's own experiences, and the social consequences of the complaint are considered? The greatest differences between doctors, after all, are not caused by differences in their abilities to perceive explicitly psychologic or psychiatric complaints, but by a wide variation in perception of the psychologic background to complaints that are somatically expressed. Other research workers in the Netherlands have found reason to stress the importance of exploring this background. If this is not done, serious harm may be done to the patients through unnecessary diagnostic tests and treatment, and by creating a strong belief in the patient that he or she really is seriously ill. This phenomenon is called somatic fixation.<sup>13</sup> It may cause what Lamberts called "illness behavior without illness," a serious problem indeed.<sup>14</sup>

One way to prevent this problem may be the discussion approach by the physician. It will not cure the anxieties of the patient immediately, but it does allow him to keep his problems in perspective. This type of care may be all that many patients need.

Regarding the methodology of this study, it has already been stated that the investigated group cannot be called a random sample of physicians; furthermore, the complaints presented in the interviews form a rather heterogeneous group. The first objection can be met partly with the observation that the variation between physicians

appeared sufficiently large to show successfully the relevant relationships.

Heterogeneity of consultations is one of the problems with physician-patient interaction research, according to Carter and Inui.<sup>16</sup> Concerning this problem we wish to draw attention to our finding that the relationships remain the same for several, more homogenous subgroups. We have the impression that GPs show a remarkably constant conversational style, as Byrne and Long have demonstrated.<sup>11</sup>

Nevertheless, these results should be taken at face value as an outcome-based evaluation of our conversational style that is still lacking. The only outcome measure used until now was the treatment a patient gets: although that outcome was satisfactory (a more open conversational style does result in more counseling, more exploring, and more insight giving), the measure was too closely related to the conversational style itself. From now on effects such as reduction in complaints and reduction in frequency of consultations should be investigated. We hope that further research will fill these gaps.

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