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Qualitative Research

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The first consultation for low mood in general practice: what do patients find helpful?

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Background: Recent evidence suggests that the first consultation with a general practitioner (GP) for symptoms of depression may be more than just a vehicle for assessment and management planning (as current guidelines imply).

Objectives: To identify what patients find helpful, or otherwise, in their first consultation for low mood with a GP.

Methods: A cross-sectional questionnaire and interview study of patients with low mood who had recently consulted their GP, in the North of England. Patients were asked to complete a questionnaire regarding the consultation, and a Patient Health Questionnaire-9 (PHQ-9), within 2 weeks. They were also invited to take part in a face–face interview with a researcher. Both sources of data were subjected to qualitative thematic analysis.

Results: Thirty-seven questionnaires were returned; 5 interviews took place. The majority of participants felt better after consulting a GP for the first time for low mood. The factors most commonly cited as helpful were "being listened to" and "understanding or empathy from the GP." Others included "admitting the problem," "being reassured of normality," and "being provided with optimism or hope for change." The most commonly reported difficulty was the patients' struggle to express themselves. Patients often felt that GP follow-up was inadequate.

Conclusions: These results suggest that the therapeutic benefit of the GP consultation is under-recognized in current guidelines. The results of our study will provide crucial information as to how such consultations can be tailored to improve patient satisfaction.

Lay summary

Although patients often tell their general practitioner (GP) that they feel better after a first consultation with symptoms of depression, the degree of patient satisfaction after such consultations seems to vary greatly. In this questionnaire and interview study, patients were asked to state which aspects of the consultation they had found helpful, or otherwise. The results showed that well-recognized factors of patient-centredness (where patients are involved in all decisions about their healthcare) such as "having time to talk" and "being listened to" were highly valued in the current setting. In addition, several aspects of the GP consultation that are more specific to depression were also highly rated, namely: "Admitting the problem," "being reassured of normality," and "being provided with optimism or hope for change." Overall, most patients felt better after the first consultation for low mood—a therapeutic effect that is not well recognized in current guidelines for depression. However, patients consistently reported that they felt GP follow-up after their first consultation for low mood was insufficient. These results should help us to optimize GP consultations for patients presenting for the first symptoms of depression.

Key words: consultation, depression, general practice, low mood, patient perspective, qualitative research

Background

Many people with low mood in the United Kingdom will present to their general practitioner (GP) as their first point of professional contact. Current guidelines[1,2] appear to suggest that this initial consultation is simply a vehicle for assessment and diagnosis, and for the formulation of a collaborative management plan. However, recent evidence suggests that the first consultation for depression has additional value.[3]

Despite the recognized challenge of having sufficient time to listen, analyse, and explore feelings in emotionally distressed patients in general practice,[4] there is some evidence supporting the assertion that the primary care consultation may itself be therapeutic.[5] GPs use a variety of nonspecific "psychological management" techniques within consultations, including listening, showing empathy, support, reassurance, or influencing the patient to change.[6] When asked to recall consultations about depression, many patients reported discussion of practical problems and problem-solving.[7] Patients also recalled discussion of changing thinking patterns, addressing relationships, or talking to loved ones. Patients felt that coming to a personal understanding of their own condition was important.[8] Depressed patients valued understanding and

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Key messages

- Most patients with low mood felt better after a first consultation with a UK GP.
- Patients valued previously well-recognized factors of patient-centredness.
- Highly valued consultation factors that were more specific for low mood were identified.
- Patients often felt that GP follow-up after their first consultation was inadequate.
- The therapeutic benefit of the GP consultation for low mood is not well recognized.

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listening skills from the GP[9,10] and a sense of optimism and hope[11] as important.

These studies demonstrate that patient-centredness—factors such as listening and empathy—are considered by patients to be valuable in consultations for depression, similar to other conditions in the general practice setting.[12–14] However, none of the previous studies have been structured such that the influence of specific management strategies, such as antidepressant use or psychological therapies outside the GP consultation, can be excluded from any benefit(s) perceived by the patient.

Therefore, we aimed to investigate whether, from a patient perspective, the first consultation with a GP for low mood could itself be therapeutic. We also aimed to identify factors that might influence the success or otherwise of such consultations.

Methods

Setting and participants

The study took place at 11 general practices in Northumberland and Cumbria, United Kingdom, between January and October 2018. Patients between the ages of 18 and 65, who had presented to their GP with symptoms of low mood for the first time (within the previous 12 months), were identified by weekly searches of Read code (coded clinical terms, used in UK general practice electronic records) performed by administrative staff at each participating practice. The terms searched were "low mood," "depressed mood," "depression," and "anxiety with depression" as these were identified as the most commonly used in such consultations in a pilot study. All patients and GPs spoke English as their first language. A diagnosis of depression was not required. Patients already on psychotropic medication were excluded. The clinical record of each patient identified was then reviewed by a member of GP clinical staff to confirm eligibility or otherwise.

Data acquisition

A mixed-methods study design was used incorporating an initial questionnaire to reach a wider range of participants, followed by interviews (after questionnaire analysis) to add depth and detail to the emerging themes. Potential participants were sent a "study pack" including: (i) a patient information sheet (PIS) incorporating an invitation to participate; (ii) the study questionnaire; (iii) a copy of the Patient Health Questionnaire-9 (PHQ-9); (iv) an invitation to participate in an interview. The study questionnaire was developed by the study team and is presented in Table 1. It incorporated 4 questions from the General Practice Assessment Questionnaire (GPAQ) which has been used extensively to assess patient satisfaction in a wide variety of GP consultations.[15] In addition, it included questions devised by the study team to elucidate whether the consultation was perceived to be therapeutic and also the factors within the consultation which contributed to its success. The study questionnaire was designed to encourage free text responses and had been tested in a previous pilot study and found to produce appropriate data.

Participation or otherwise in the study was *not* recorded in the GP record so as not to influence ongoing GP care. Completion of the questionnaire was accepted up to 2 weeks after the first consultation. Return of the completed questionnaire was taken as consent, and capacity to consent was assumed (all as per ethics approval). The participants were also asked to complete a PHQ-9 to (retrospectively) report the severity of their symptoms at the time of the consultation.

The participants were not directly identifiable from the returned questionnaire and PHQ-9. Each return was given a unique numerical code. Only the site investigator at each general practice and the PI (IJM) were able to use this code to identify the patient in order to compare demographic features of responders vs. nonresponders.

The participants were also invited to take part in an individual face–face interview with the PI to discuss the questions and emerging themes from the questionnaires in more detail. Separate, written consent was obtained for this part of the study. A topic guide was used (Table 2). The interviews took place in nonclinical settings of the participant's choice (e.g. home; a quiet café) and lasted from 30 to 45 min. They were subjected to audio recording and professional transcription.

Analysis

The Likert-style responses from questions 5 and 7 of the questionnaire were scored[1–5] and analysed with simple descriptive statistics appropriate for ordered, categorical data. The open-ended responses from the remaining questions were subject to qualitative, thematic analysis[16]: Comments and themes that occurred prominently and/or consistently in the responses were identified and labelled with (primarily inductive) codes. The codes were refined continuously to produce a final set of themes and subthemes. The transcribed interviews were subjected to similar thematic analysis.

Thematic analysis was used. All interviews were recorded with permission and fully transcribed. A preliminary coding frame that was informed by questionnaire responses was developed. Transcripts were read by 1 researcher (IM, a GP) and codes were then applied to all transcripts. A series of key themes including aspects of the doctor patient relationship, the value of a trusted environment and fear of wasting the doctor's time were evident. One additional theme on follow-up also emerged.

Table 1. The questions included in the study questionnaire (this does not illustrate the *layout* of the questionnaire).

1. How old are you?
2. What is your gender?
3. How were you feeling before the consultation?
4. Were you given a diagnosis? If so, what was it?
5. Were you prescribed any medication as a result of this consultation? If so, please specify which.
6. Were you referred, or advised to refer yourself, to any provider of psychological (i.e., talking) therapies? If so please specify which.
7. How did you feel overall, after the consultation? (Circle the most appropriate & add comments)
   Much better Better No different Worse Much worse
8. What was it about the consultation that made you feel better or worse?
   Better? (Please specify) Worse (Please specify)
9. We are interested to know whether any of the following factors, if applicable, made a difference to how you felt after the consult. (Please tick under the appropriate heading for each factor and add comments if required).

	Much better	Better	No different	Worse	Much worse	Not applicable
Talking about work/studies						
Having enough time in consultation						
Talking about hobbies/interests						
The offer of treatment						
Talking about relationships						
Knowing how I feel is normal						
Feeling that you were listened to						
Talking about family						
Talking about physical health						
Being treated with care and concern						
Talking about money						
Other (please specify)						

10. Have you ever seen a GP in the past about low mood or depression?
11. Have you ever been prescribed an antidepressant in the past? If so, do you know which one(s)?
12. Have you ever been diagnosed with any other mental health condition? If so, which one(s)?
13. Is there anything you wish to add which could assist us in our aims for this study?

Results

Questionnaires

Participants Seven hundred and thirty potential participants were identified by Read code search, of whom 351 were invited to participate after manual checking of eligibility. Thirty-seven completed questionnaires were received—a return rate of 10.5%. There was no significant difference in age (t-test, $P = 0.51$) or sex distribution (Chi^2, $P = 0.81$) between participants and nonparticipants. Sixty-eight percent of participants were female; the average age overall was 41 (range 19–61) (Table 3).

Thirteen participants (35%) reported low mood or depression in the past (prior to the previous 12 months), whilst only 5 (14%) reported any other previous mental health diagnoses;

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Table 2. Topic guide for interviews with individual participants.

Aims

- Is the consultation itself therapeutic?
- What is or is not helpful in the consultation?

Questions

- How did you feel about coming to see a GP?
- Overall, how did the consultation go in your opinion?
- Could you tell me what worked well/what you found helpful in the consultation?
- And what did not work well/was less helpful?
- Overall, did you feel better or worse after the consultation; and what made a difference?
  - How long did that benefit last?
- Did you feel the consultation itself had therapeutic value?
- OK, so now imagine you were giving (anonymous) feedback to the GP you saw—what would you say?
- Finally, is there anything else you would like to say to help us to help other patients in similar circumstances in the future?

most commonly anxiety disorder (3; 8%). Twelve participants (32%) had taken an antidepressant in the past, most commonly (where known) fluoxetine (5; 42%) or citalopram (4; 33%).

Before the consultation All participants reported a PHQ-9 at the time of the consultation of 7 or more; the average being 16 (range 7–27) (Table 3). Mild symptoms were reported by 14% of participants whilst those reporting severe symptoms were the largest group, comprising approximately one-third of participants.

The most common feelings experienced by the participants at the time of the consultation were:

• Unhappy/low	19 participants	(51%)
• Anxious	16	(43%)
• Tired	9	(24%)
• Tearful	9	(24%)

Patient quotes, in response to being asked how they felt:

"*Confused, depressed, stressed out, tired, lost and alone*"	Male, 30 years.
"*Low, panicky, out of control, unable to concentrate, waking during night, desperate*"	Female 58 years
"*Low overburdened, incompetent. Unable to cope*"	Female, 56 years
"*Tired, stressed, down, hopeless, a failure*"	Female, 41 years

Management in the consultation The majority of participants (20, 55%) reported that they had not received a clear diagnosis from this, their first consultation with a GP for low mood. Of those that did, the most commonly received was depression (10 participants, 28%). Fourteen participants (39%) were prescribed an antidepressant—either sertraline (9 participants, 24%) or fluoxetine (5, 14%); no other antidepressants were prescribed (Table 4). Prescribing did not appear to be related to diagnosis—only 6 of the 14 participants given a diagnosis were also prescribed medication. However, there was a small but significant difference in PHQ-9 between those prescribed an antidepressant and those who were not (average PHQ-9 = 18.3 and 15.0, respectively; P = 0.031 [t-test]). None of the participants with mild depression (PHQ-9 <10) were prescribed an antidepressant. Thirty-one (86%) participants reported that they were referred or advised to self-refer for psychological therapies.

Table 3. Characteristics of study participants.

PHQ-9	Symptom severity	Number (%)	Median age	Gender (F:M) %
5–9	Mild	5 (14)	41	60:40
10–14	Moderate	9 (25)	35	75:25
15–19	Moderately severe	10 (28)	50	80:20
20+	Severe	12 (33)	36	58:42

After the consultation Twenty-three participants (64%) reported that they felt better or much better after the consultation; 12 (33%) felt no different and only 1 (3%) felt worse or much worse (1 did not reply) (Table 4). This perceived benefit was most commonly reported in participants with a PHQ-9 of 5–9—suggesting mild depression (5, 100%)—and least commonly reported in those with the most severe symptoms (6, 50%). Feeling better after the consultation was reported in 8/14 (57%) of those prescribed an antidepressant compared with 16/22 (73%) in those who were not; this difference was not significant ($X^2(2,37) = 1.1$, $P = 0.31$).

The aspects of the consultation that were found to be most helpful by participants were:

No reply	8	22%	
Being listened to	10	27%	(36% of those that replied)
Admitting the problem/relief	8	22%	(32%)
Optimism/hope for change	8	22%	(32%)
Normality/validation	7	19%	(21%)
Understanding/empathy	5	14%	(18%)

"*After talking to the doctor I felt a lot better. Just having someone to talk to and understand my situation in confidence.*"	Female, 46 years
"*The first hurdle had been breached. I had been reassured I was not unusual. I was taken seriously & not dismissed.*"	Female, 38 years

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Table 4. Outcomes of the first consultation for low mood.

PHQ-9	Symptom severity	Prescribed antidepressant, no. (%)	Referred for talking therapy, no. (%)	Feeling after consultation, no. (%)		
				Better	No different	Worse
5–9	Mild	0 (0)	5 (100)	5 (100)	0 (0)	0 (0)
10–14	Moderate	3 (33)	9 (100)	5 (56)	4 (44)	0 (0)
15–19	Mod. severe	5 (50)	7 (70)	7 (70)	3 (30)	0 (0)
20+	Severe	6 (50)	10 (83)	6 (50)	5 (42)	1 (8)
All		14 (39)	31 (86)	23 (64)	12 (33)	1 (3)

There was a small but significant difference in PHQ-9 between those prescribed an antidepressant and those who were not (average PHQ-9 = 18.3 and 15.0, respectively; $P = 0.031$ [*t*-test]). The aspects of the consultation that were found to be most helpful by participants (more than 1 option per participant allowed) were: No reply 8 (22%); Being listened to 10 (27%) (36% of those that replied); Admitting the problem/relief 8(22%) (32%); Optimism/hope for change 8 (22%) (32%); Normality/validation 7 (19%) (21%); Understanding/empathy 5(14%) (18%).

"*Speaking about condition and being listened to sympathetically and it was quite usual to feel like that. Being understood.*"	Female, 61 years
"*I felt supported, validated.*"	Female 39 years

Aspects about the consultation that were perceived as less helpful were: the difficulty in talking about personal feelings (6 participants, 16%); lack of time (3, 8%), and management uncertainty (3, 8%).

"*Although there is so much more openness about depression and feeling low, it is still hard to talk about it.*"	Female, 19 years
"*I think more time to explain how I was feeling to the GP would've been beneficial as I don't think I covered everything. I would also have liked a definitive diagnosis.*"	Female, 21 years
"*I feel the doctors/nurses need more training on how depression/anxiety affects a person. How much it takes someone to make that step to get help. I feel on this occasion a lack of empathy left me feeling worse than I did.*"	Female, 44 years

Interviews

Of the 37 participants that completed the study questionnaire, 11 also gave initial consent for interview. Of these, 5 (4 female, 1 male, age 33–57, PHQ-9 7–18) completed interviews; failure to respond to subsequent contact and opting out due to time pressure being the most common reasons for noncompletion. Of the 5 interviewees, 4 described a clearly positive experience during their first consultation with the GP, 1 was clearly negative. Overall themes emerged that were quite similar to those from the questionnaires; the strongest being:

- Fear of wasting the GP's time.
- That the setting—talking to a stranger in a safe environment—was helpful
- Feeling that the GP:
  - Allowed plenty of time.
  - Interested/listening.
  - Sympathetic and not judgemental.

However, 1 theme that emerged consistently from the interviews, that had not featured in the questionnaires was regarding follow-up. All of the interviewees mentioned that they would have liked more follow-up; to have had their progress reviewed more often:

"*To be honest, I don't think he {GP} really took how I was feeling seriously.*"	Female, 33 years.
"*She said one of the other GPs would contact me, which didn't happen…but I didn't follow it.*"	Female, 57 years.
"*I've meant to have two since…but that hasn't happened, so it seems I'm sort of falling away.*"	Male, 50 years.

Discussion

This study suggests that the GP consultation may itself provide significant benefit to the patient: The majority of participants stated that they felt better after consulting with a GP for the first time for low mood. The perceived benefit of the GP consultation was most evident in those with milder symptoms and least common in those with severe symptoms—though even in this group it was reported by approximately 50% of participants.

The factors most commonly cited as contributing to the perceived benefit of the consultation were "being listened to" and "understanding or empathy from the GP." These are well-recognized components of patient-centred care by GPs over a range of clinical conditions.[14] However, the present study also identified several other helpful aspects of the consultation that are more specific to low mood or depression: admitting the problem, being reassured of normality, and being provided with optimism or hope for change. The most common difficulty within the consultation was the patients' (self-reported) problem in expressing themselves. After the first consultation, regardless of its perceived benefit, patients often felt that GP follow-up was inadequate. As Kay McCall, both a GP and (mental health) patient stated back in 2001. "See us frequently at first. A week is a long time…three weeks almost unimaginable."[17]

The present study, analysing as it did "normal" GP consultations for low mood (see below) also provided some other findings of interest. Firstly, that symptoms of low mood were not well recognized by patients. All participants displayed low mood according to the GP—this was the principal inclusion criterion for the study. Indeed, all participants had a PHQ-9 score of 7 or more—in keeping with at least mild depression—and one-third of participants had a PHQ-9 of 20 or more, indicative of severe depression. However, when asked to describe how they were feeling before the consultation, only half of participants described themselves as low or unhappy.

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Secondly, that GP treatment of depression was largely in keeping with current guidelines. Antidepressant are known to be most effective for those with moderate or severe depression and therefore guidelines suggest antidepressants be avoided in those with mild disease, at least initially. None of the participants of the present study with mild symptoms (PHQ <10) were prescribed an antidepressant at the first consultation, whereas 47% of participants with moderately severe or severe symptoms (PHQ-9 >14) were given medication. In contrast guidelines state that talking therapies may be appropriate for all severities of depressive illness: 84% of participants in the present study were referred or advised to refer themselves for psychological therapies.

The idea that the consultation with a doctor may itself be therapeutic for the patient has been recognized since (at least) Balint's concept of "the doctor as the drug."[18] However, in a review of the literature of GP management of emotional problems, it was found that empirical data for such consultation benefit was limited and was "*…less when rated by external observers than when evaluated by GP self-report*."[5] More recently, Collinson and Gask similarly concluded that evidence of the patient's experience of mental health care that primary care provides is still limited.[19] The present study's conclusion that patients do find benefit from consulting their GP with low mood adds to such evidence. Being "listened to" and "GP empathy" have previously been shown to be important to quality of care in GP management of depression[8,9]; the present study found similarly. However, being "able to admit to the problem" and being "reassured that the problem is normal," have not previously been highlighted as an important part of the GP consultation for low mood. We speculate that these factors reflect patients' negative perceptions of mental health problems and are less likely to be a prominent aspect of patient-centred care for physical health conditions. The other main positive aspect of the consultation identified, i.e. "optimism or hope for change" is again perhaps more associated with mental health problems and has previously been recognized as important in GP management of depression.[7,20,21]

Strengths and limitations

The present study, seeking to determine whether the consultation itself was of benefit to patients, asked them directly. We chose only to analyse the first consultation to eliminate the influence of previous management but more importantly because we considered that its success or otherwise may be a key determinant in whether a patient will re-attend and (hopefully) embark on a pathway towards recovery.

This is a novel and workable model to study the first consultation as it avoids selection bias by the consulting GP: At the time of the consultation, neither the GP nor the patient was aware that this might be the subject of subsequent analysis. We can therefore be confident we analysed "normal" care. (An earlier pilot in which the GP recruited the patient at the time of the consultation resulted in significant GP selection bias). However, study participants were therefore effectively self-selecting, with a risk of being nonrepresentative of the patient population (those presenting to their GP with low mood). Simple demographics were similar between participants and nonparticipants, but we lack the data to compare symptom severity. Other disadvantages of our "post hoc" recruitment and analysis were recollection bias and the possible influence of newly commenced medication. We sought to minimize these by only accepting completed questionnaires within 2 weeks of the first consultation. That the frequency of reported benefit was not different between those who were prescribed an antidepressant and those who were not, reassures us that we were successful in this regard.

Our sample sizes (37 questionnaires, 5 interviews) were smaller than hoped primarily due to the low recruitment rate of 10.5%. There are many features inherent to depression that make it less likely that people will opt into clinical research of this nature. Nevertheless, themes emerging from the study were consistent and therefore, we believe, of value. The degree to which the retrospectively collected PHQ-9 score accorded with depression severity at the point of consultation cannot be accurately ascertained.

Conclusions

We have shown that the consultation with a GP is frequently perceived as beneficial by patients with low mood. This benefit is not adequately recognized in modern guidelines for depression which consider the initial consultation to be simply an opportunity to obtain information and to develop a management plan. In these guidelines it is the treatment—medication and/or psychological therapies—that is expected to provide the therapeutic benefit. The present study does not however allow us to determine the duration of the reported benefit, nor its magnitude relative to other components of recovery. This would be fertile ground for future research.

The results of our study will provide crucial information as to how such consultations can be tailored to improve patient satisfaction and benefit. The aspects of the consultation that were most popular with patients should be incorporated into patient-centred GP care for depression. The first consultation for low mood can easily be dominated by distress, for example by a history of multiple social stressors and by patients' negative perceptions of themselves and their illness. The present study demonstrates the importance of providing reassurance and optimism for improvement and recovery, and the value to the patient of ongoing GP management.

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Ethical approval

Ethical approval for the study was granted by the HRA North West—Haydock Research Ethics Committee (17/NW/0475) 10.08.2017.

Conflict of interest

None declared.

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Data availability

The qualitative data obtained from individual participants in the study cannot be shared due to confidentiality issues. Amalgamated and/or processed data, both qualitative and quantitative, will be shared on reasonable request to the corresponding author.

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