What factors organise a GP’s aptitude to elicit the disclosure of psychological distress in men and how do they utilise this information?

Yajnah Neomi Bheenick

Submitted for the Degree of

*Doctor of Psychology*
(Clinical Psychology)

School of Psychology
Faculty of Health and Medical Sciences
University of Surrey
Guildford, Surrey
United Kingdom
September 2016
Abstract

Objective: Existing research suggests that men are less likely to be diagnosed with common mental illnesses, but are more likely to drink to hazardous levels and attempt and complete suicide, suggesting that mental illness is prevalent among men, but how they express their distress can be externalised. The need to attend to men’s help-seeking behaviour has been recognised and is extensively researched; but, the role of the medical system in supporting this access is less researched. However, the role of General Practitioners (GPs) in supporting men’s access is recognised. This study explored how GPs encourage their patients to disclose symptoms of psychological distress, and how they make decisions regarding treatment. The results with a specific focus on men were highlighted.

Design: A qualitative inductive Thematic Analysis was undertaken to identify themes emerging from the data.

Method: Nine GPs (mean age = 35) were recruited. Data was collected using semi-structured interviews about their consultations with patients presenting with psychological distress.

Results: Three themes emerged; 1) “Facilitating Techniques” which captured factors assisting consultations, encompassing five subthemes; Interpersonal Skills, Masking and Unmasking, Specific methods used to Gather Information, Mental Health Awareness and Organisational Influences; 2) “Recognition of the Patient’s Treatment Preferences”, which captured how GPs are guided by their patient’s preferences, men’s preference of medication, and the immediate availability of medication; and 3) “Cultural Prism”, which captured cultural factors through which help-seeking is governed from the GPs’ perspectives.

Conclusions: This research has improved the understanding of how GPs elicit men’s disclosure of psychological distress, and their decision-making processes about treatment. It
also highlights the benefits of inviting men to attend regular health checks, which has important implications in reducing some of the barriers of help-seeking in men. However, the clinical implications and conclusions are drawn tentatively given the perceived limitations of the study.
Acknowledgements

I would firstly like to thank all of the General Practitioners (GPs) who willingly gave up their time to participate in my research. They have each made an invaluable contribution to the study, by improving the understanding of how GPs elicit men’s disclosure of psychological distress, and how they utilise this information when deciding what treatment is most appropriate for their patient. Generally, the GPs have also raised awareness and understanding of how mental illness is recognised, diagnosed and treated for all patients, both men and women. Personally, I would like to say that the GPs have provided me with a better understanding of their role and responsibilities, for which I now have increased empathy, appreciation and respect.

I would also like to thank my research supervisors; Mary John and Linda Morison, for their invaluable guidance and support in the development and completion of this research, but also for their feedback and continued encouragement throughout the writing process.

In addition, I would like to extend my appreciation to all of my placement supervisors, who have provided me with a wealth of experience and knowledge that has prepared me well for my first job as a clinical psychologist.

Finally, I would like to say a sincere thank you to my family, my partner and my friends, for all of their patience, support and understanding over the last three years.
Contents

MRP Empirical Paper and Appendices  Page 1 – 60
MRP Proposal  Page 61 – 77
MRP Literature Review  Page 78 – 121
Overview of Clinical Experience  Page 122 – 124
Assessments  Page 125 – 126
Empirical Paper: What factors organise a GP’s aptitude to elicit the disclosure of psychological distress in men and how do they utilise this information?

Abstract

Objective: Existing research suggests that men are less likely to be diagnosed with common mental illnesses, but are more likely to drink to hazardous levels and attempt and complete suicide, suggesting that mental illness is prevalent among men, but how they express their distress can be externalised. The need to attend to men’s help-seeking behaviour has been recognised and is extensively researched; but, the role of the medical system in supporting this access is less researched. However, the role of General Practitioners (GPs) in supporting men’s access is recognised. This study explored how GPs encourage their patients to disclose symptoms of psychological distress, and how they make decisions regarding treatment. The results with a specific focus on men were highlighted.

Design: A qualitative inductive Thematic Analysis was undertaken to identify themes emerging from the data.

Method: Nine GPs (mean age = 35) were recruited. Data was collected using semi-structured interviews about their consultations with patients presenting with psychological distress.

Results: Three themes emerged; 1) “Facilitating Techniques” which captured factors assisting consultations, encompassing five subthemes; Interpersonal Skills, Masking and Unmasking, Specific methods used to Gather Information, Mental Health Awareness and Organisational Influences; 2) “Recognition of the Patient’s Treatment Preferences”, which captured how GPs are guided by their patient’s preferences, men’s preference of medication,
and the immediate availability of medication; and 3) “Cultural Prism”, which captured cultural factors through which help-seeking is governed from the GPs’ perspectives.

**Conclusions:** This research has improved the understanding of how GPs elicit men’s disclosure of psychological distress, and their decision-making processes about treatment. It also highlights the benefits of inviting men to attend regular health checks, which has important implications in reducing some of the barriers of help-seeking in men. However, the clinical implications and conclusions are drawn tentatively given the perceived limitations of the study.
Introduction

Research has highlighted a burden of psychological distress in men combined with lower rates of help-seeking and treatment. In the UK, GPs play a crucial role in the care pathway, by diagnosing and signposting patients to mental health services. This study explores how GPs elicit disclosure of psychological distress, and how they make decisions regarding treatment.

Men’s unmet mental health needs

In England, men are less likely to be diagnosed with anxiety disorders compared to women (Martin-Merino, Ruigomez, Wallander, Johansson & Garcia-Rodriguez, 2009), but when figures are examined for substance misuse the trend is reversed. Men are more likely to drink to hazardous levels (38% versus 15%; Singleton & Lewis, 2003), where drinking may be used to manage symptoms of a mental illness (Singleton, Bumpstead, O’Brien, Lee & Meltzer, 2001; Mental Health Foundation, 2006). 27% of men have given alcohol as a reason for self-harming (NHS Quality Improvement Scotland, 2008), and being alcohol dependent increases the possibility of attempting suicide, especially in men (Mental Health Foundation, 2006). Of the 14% of alcohol dependent adults accessing treatment for mental illness, men were less likely to be receiving treatment (9% versus 26%; Statistics on Alcohol, 2015).

Women are more likely to receive treatment (29% versus 17%), which has been linked to women’s increased likelihood of disclosing symptoms (Singleton & Lewis, 2003). Depression is diagnosed more frequently in women, (National Institute for Health and Clinical Excellence, NICE; 2003), but men may be under-diagnosed as they somatise and mask their emotional distress. They are more likely to present with physical symptoms or alcohol misuse to their GP (NICE; 2003).
increased rates of mental illness are observed in the discrete prison population. 72% of male prisoners were found to have at least one mental illness (mental health foundation, 2007), whilst 63% of male remand prisoners have antisocial personality disorder, compared to 0.3% of the general population (nice, 2009).

the samaritans (2015) indicated that men between 19 and 45 years are at the highest risk of committing suicide. of 6,233 suicides recorded in the uk in 2013, amongst people aged 15 and above, 78% were men (bromley et al., 2014), suggesting that mental illness is prevalent among men, but how they express their distress can be externalised. this highlights an important need to address the mental health difficulties men experience.

why are men’s mental health needs unmet?

there are a number of complex and contributing factors; moller-leimkuhler (2002) suggests that lower treatment rates in men cannot be explained by “better health”, but may be caused by a difference in their awareness of need and/or help-seeking behaviour. they posited that men’s help-seeking may be hindered by “inhibition of emotional expressiveness” and societal norms of “traditional masculinity”. galdas, cheater and marshall (2004) found that white middle-class men’s delay in seeking help was explained by “traditional masculine behaviour”.

the diagnostic classification system may inadvertently contribute to the lower rates of diagnosis in men. for example, depression can be recognised by “persistent sadness or low mood and/or loss of interests or pleasure” (international classification of diseases-10; icd-10). as mentioned, men tend to be more aware of and able to report their physical symptoms. harvey et al., (2013) reported that men may have less experience of discussing their internal mood states, and 50% of men described feeling too embarrassed to discuss their health with anybody, whilst others reported not having the vocabulary to discuss “sensitive” issues. this
was supported by 73% of GPs who reported that many of their male patients demonstrated limited vocabulary to discuss sensitive issues.

In a report titled “Delivering Male” (Wilkins & Kemple, 2010), the authors reported that some men thought that professionals “lack understanding of men’s complex needs” and that it is “difficult to find a GP who takes it seriously”. Men felt they did not have enough time to “get it off [their] chest” during a 10-minute consultation, and highlighted a need for extended opening hours. Men’s Health Forum (2016) highlighted that men prioritised seeking help for physical problems over mental health problems, and over half identified perceived negative stigma related to absence from work for mental illness. Therefore, service configuration and employers’ culture may be barriers to accessing support.

**What has been done about this?**

Organisations that address mental illness stigma such as “Campaign Against Living Miserably” (CALM), aim to prevent suicide amongst men, and reported a 45% increase in “male suicide awareness” following their “Bigger Issues” campaign (2015).

Many GP surgeries now have extended opening hours, helping to reduce the barrier of men not seeking help during working hours, alleviating potential loss of earnings (Harvey et al., 2013).

Mental health services are accepting self-referrals. Some men may prefer this if they have limited time to make a face-to-face appointment, or find it difficult to describe their symptoms to the receptionist.
A review of the evidence on recognition, diagnosis and treatment of mental illness by GPs

Examination of the impact of conforming to masculine norms and its role in hindering access to services has been extensively researched. The point of access is also critical, as adults access mental health services primarily via a GP. Men’s experience of this process and their interactions with GPs are central to understanding challenges posed to men.

A recent UK-focused review (Bheenick, unpublished) identified various factors influencing the recognition, diagnosis and treatment of mental illness by a GP, in which six themes emerged.

The most common theme was the “GP’s Communication Skills”. Patients reported not feeling understood, and described a lack of empathy by their practitioner (Buston, 2002). Webster (2013) highlighted communication as an important factor in recognising symptoms of emotional distress in men, where the GP’s communication style facilitated their disclosure.

Another theme was the “GP’s Interest in Psychiatry”. Higher interest increased the use of psychosocial questions and identification of symptoms (Marks, Goldberg & Hillier, 1979). A related theme was “GP’s Completion of Additional Training and Expertise in Mental Health”. Registrars in Railton, Mowat and Bain (2000) highlighted that whilst further training in psychiatry is not required post-graduation, it was viewed as imperative to ensure that mental and physical health needs are recognised; supported by Marks et al., who reported that GPs with prior experience in psychiatry were better at recognising symptoms.

An additional theme was “Gender Role Scripts of GPs” (Hale, Grogan and Willott, 2010). They noted some GPs being “men first, doctors second”. If a GP had certain values around “traditional masculinity”, this appeared to influence their perception of a male patient.

Another theme was “Influences on GPs’ Decision-Making Processes”. GPs’ decision-making was influenced by their personal treatment preferences; GPs who were “organically
orientated” were more likely to prescribe medication over psychotherapy (Dowrick, Gask, Perry, Dixon and Usherwood, 2000). Furthermore, two referral processes emerged from Nandy, Chalmers-Watson, Gantley and Underwood (2001); “proactive referrals to”, which occurred when GPs referred patients to other services because the input from secondary services was seen to be of benefit to the patient, and “reactive referrals away”, which occurred when GPs experienced emotions such as anger and frustration in response to their work, or if they had a lack of time. In these cases, GPs tended to refer to other services because they needed assistance due, in part, to their own emotional needs.

Finally, the theme “Demand versus Resources” emerged, where GPs reported a lack of time in obtaining a thorough understanding of a patient’s difficulties, for patients with depression in particular (Railton et al., 2000).

The findings above indicated various factors related to the recognition, diagnosis and treatment of mental illness. However, in most of the studies the findings are not separated out by gender. There is a lack of clarity about the specific needs of men when seeking help, or receiving treatment, limiting the conclusions that can be drawn for the male population.

Whilst the importance of a GP’s communication style was highlighted by Webster (2013), there is still a clear gap in understanding how a GP’s communication may be adapted and what specific strategies they perceive as useful in encouraging patients to disclose symptoms of psychological distress. With regards to men, this is particularly important given that men are more likely to report physical symptoms, somatise their symptoms or mask their symptoms. Additionally, as GPs have reported that men can have limited vocabulary to discuss sensitive issues, it is imperative to explore how a GP’s communication style facilitates their disclosure.
Rationale for Research Study

As there is a clear gap in the literature about the strategies and communication style that GPs use to encourage their patient’s disclosure of psychological distress, the main aims of this study were:

a) to explore what self-reported strategies a GP uses to encourage patients to disclose symptoms of psychological distress,

b) to explore how GPs make decisions about their patient’s treatment.

Across each of these aims, any differences that emerged between male and female patients were highlighted.

It was anticipated that this would have implications for medical training for GPs, in potentially developing additional communication styles. This would provide an insight into how to improve the recognition of mental illness in men, with the hope of continuing to normalise these experiences for men. In turn, it would be expected that men would experience fewer barriers in seeking help, leading to earlier treatment, in turn reducing sickness absence due to mental illness for this population, as well as helping to reduce its economic burden, estimated to be between £70-100 billion each year in the UK (Davies, 2013).

Given that GPs are traditionally the gateway to the provision of more specialist mental health services, it is important to explore the impact of GPs’ consultations in the process of supporting men’s access to these services; however the current literature is lacking. This is especially important given the increased use of drugs and alcohol as coping strategies in men, the increased prevalence of mental illness in the male prison population, and the higher rates of suicide in men.
Method

Design

A qualitative approach was considered to fit with the nature of the exploratory study in answering the open-ended research question. Thematic analysis (Braun & Clarke, 2006) was deemed to be most appropriate, due to its flexible approach, enabling the researcher to “identify, analyse and report patterns within the data”.

Due to the paucity of existing research, an inductive thematic analysis was adopted (Frith & Gleeson, 2004), whereby the themes identified were closely linked to the participants’ original thoughts and ideas (Patton, 1990). The data was coded without trying to fit it into a pre-existing coding frame and the analysis was data driven. The themes were identified at a semantic level, using the clear “surface meanings” of the data. Emerging patterns in semantic content were identified, and interpreted with the aim of trying to understand their broader significance and implications (Patton, 1990).

Epistemological Position

The researcher adopted a critical realist position. Whilst the participants spoke about their real-life interactions with their patients, the data required interpretation to help uncover some of the hidden mechanisms, to better understand the underlying processes involved (Willig, 2012). The researcher did not adopt a “knowing” stance; the interpretations described in the analysis are seen as “possibilities rather than certainties” (Frosh & Young, 2008).

Participants

Male and female trainee and qualified GPs were recruited to obtain data that would span a considerable timeframe in the working lives of GPs. Participants needed to have seen
patients with psychological distress. Opportunity sampling was used, followed by snowball sampling. In addition to contacting the Royal College of General Practitioners (RCGP) and General Medical Council (GMC), and advertising on social media, 44 GPs were e-mailed. Twenty of these expressed an interest, however only nine responded to arrange an interview. No response was received from the remaining GPs.

Nine participants were recruited across London (North, East and South), Canterbury, Kent, Somerset, Birmingham and Manchester. Please see Table 1 below for information about each participant.

Table 1

<table>
<thead>
<tr>
<th>Participant</th>
<th>Gender</th>
<th>Age range</th>
<th>Trainee/Qualified</th>
<th>Part-time/Full-time</th>
<th>Post qualification experience in medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Female</td>
<td>20-40</td>
<td>Qualified</td>
<td>Part-time</td>
<td>Qualified &lt; 5 years</td>
</tr>
<tr>
<td>B</td>
<td>Female</td>
<td>20-40</td>
<td>Trainee</td>
<td>Undisclosed</td>
<td>-</td>
</tr>
<tr>
<td>C</td>
<td>Female</td>
<td>20-40</td>
<td>Trainee</td>
<td>Part-time</td>
<td>-</td>
</tr>
<tr>
<td>D</td>
<td>Female</td>
<td>20-40</td>
<td>Qualified</td>
<td>Full-time</td>
<td>Qualified &lt; 5 years</td>
</tr>
<tr>
<td>E</td>
<td>Male</td>
<td>41-61</td>
<td>Qualified</td>
<td>Full-time</td>
<td>Qualified &gt; 5 years</td>
</tr>
<tr>
<td>F</td>
<td>Male</td>
<td>20-40</td>
<td>Trainee</td>
<td>Full-time</td>
<td>-</td>
</tr>
<tr>
<td>G</td>
<td>Male</td>
<td>Undisclosed</td>
<td>Qualified</td>
<td>Full-time</td>
<td>Qualified &gt; 5 years</td>
</tr>
<tr>
<td>H</td>
<td>Male</td>
<td>41-61</td>
<td>Qualified</td>
<td>Full-time</td>
<td>Qualified &gt; 5 years</td>
</tr>
<tr>
<td>I</td>
<td>Female</td>
<td>20-40</td>
<td>Qualified</td>
<td>Part-time</td>
<td>Qualified &lt; 5 years</td>
</tr>
</tbody>
</table>

Data Collection

The data was collected using semi-structured interviews with an interview schedule (Appendix A). Before commencing the interview, the participants were asked about their medical and GP training, the length of their consultations, and whether they had attended additional training in psychiatry.

Although the research question is related to male patients, it was deemed not appropriate to ask about men specifically as this could have created positive bias. Instead, the
questions were followed up with “How might this vary by gender?” to allow the participant to freely provide their views. Additional prompting questions were asked to gather more information where necessary, which provided the framework to be flexible and to follow the participant’s line of thinking.

**Reflexivity**

My interest in the mental health needs of men has emerged over time both in my personal and professional experiences (Appendix B).

**Interview process:** I decided that the questions should not have any mention of men’s mental health needs to avoid positive bias, but also so that my view of this issue was not forced upon the participants; instead the aim was to see what the participants naturally raised in relation to both men and women’s mental health. Following each interview, I made notes of my initial reactions and any emotions that were evoked, so that I could be mindful of these. For example, if participants did not highlight any particular differences between how men and women may firstly seek or not seek help, and secondly differences in how men and women can present, it was important for me to record my surprise and worry about this, so that I was aware of my own opinion in this area. Additionally, prior to commencing this research I was aware of psychiatry placements being non-compulsory for GP trainees. I have been aware of my strong beliefs about this being adapted for GP training, given the importance and value of psychiatry placements that has been highlighted in previous research. As a result, I did not include specific questions about this in the interview schedule, as it was important to see if this was a topic that appeared significant for the GPs interviewed, and to see if it naturally arose. When GPs did mention psychiatry placements, I ensured not to ask any leading questions around this.
Therefore, writing reflections after each interview enabled me to identify any “blind spots” that I might have, so that I could ensure not to impose my own assumptions and line of thinking onto the subsequent participants, but instead ensure that I abided by the original interview schedule and appropriate prompting. This ensured that the data was reflective of the participants’ thoughts and views.

**Analysis:** My research supervisor reviewed my initial coding for all transcripts and development of the themes, to ensure that the analysis remained closely linked to the data and did not include any interpretations based on my assumptions and beliefs.

Memos were used to identify any patterns that emerged from the data, and it was a valuable tool to reflect on my interviewing style. I frequently discussed the appropriateness of the prompting questions with my supervisor to ensure my approach was sound. I highlighted examples where questions might have been leading early in the process and was subsequently guided on how to obtain additional information in a non-leading manner.

**Procedure**

Ethical approval was obtained from The Faculty of Arts and Human Sciences; The University of Surrey (Appendix C).

If a person expressed interest in taking part, the information sheet (Appendix D) and consent form (Appendix E) were e-mailed so that they could make an informed decision. Once consent was obtained, the interview was arranged. The interview was recorded using a Dictaphone and transcribed by the researcher. Data analysis was completed within a thematic analysis approach where themes emerging from the data were identified and developed. In line with Yardley’s evaluative criteria (2007), the researcher shared the results with the participants to provide them with an opportunity to feedback.
Analysis

Thematic analysis of the transcripts was conducted using the guidelines of Braun and Clarke (2006), highlighting six phases:

Data Familiarisation: The researcher transcribed each interview to immerse herself in the data and to ensure familiarity with the depth and breadth (Riessman, 1993). The transcripts were repeatedly read to search for meanings and patterns. Memos were used to record initial ideas.

Generating Initial Codes: Initial codes were produced, consisting of semantic content that appeared interesting and important to the participant. This is where the data was beginning to be organised into meaningful groups (Tuckett, 2005). The researcher coded for as many potential themes and patterns as possible (Appendix F). Memos helped to identify similarities and differences across the data.

Searching for Themes: Memos were examined to identify which of the initial codes best captured what was emerging from the data, which were then sorted into potential themes. All of the relevant extracts contributing to each theme were collated, providing specific and subordinate themes.

Revising the Themes: The themes were reviewed and refined with other researchers to ensure a) consistency between the researchers, b) the themes were representative of the data, and c) the researcher’s assumptions were not imposed. It also enabled the researcher to identify instances where some themes could be merged, and exclude themes that were not well supported.

Defining and Naming Themes: The themes were refined and defined, ensuring that each theme could be described concisely.

Producing the Report: A concise and coherent story of the findings was reported, with sufficient evidence for each theme.
Credibility Checks

The researcher made an effort to ensure integrity in the participants (Shenton, 2004). By providing each with the opportunity to refuse taking part or to withdraw their data, only those who were genuinely willing to participate and offer data freely were recruited. The researcher developed a rapport from the beginning, and informed the participants that there were no correct answers, providing them with a safe space to speak. The participants’ responses were clarified with them to ensure that their ideas were understood.

The analysed interviews were shared with the research supervisors, and frequent debriefing sessions were held. These widened the researcher’s perception of the data as alternative understanding and connections were made, providing a richer appreciation of the content. These meetings allowed the researcher to have an interactive experience of testing and developing ideas and interpretations (Shenton, 2004).

The researcher kept a “reflective commentary” using memos, whereby the initial impressions, emerging patterns and theories were documented throughout data collection and analysis, in order to monitor the researcher’s developing constructions, considered as crucial in assessing credibility (Guba & Lincoln, 1989). This ensured that the researcher remained mindful to the context within which the research was being completed, and aware of the effects that her own positioning could have on data collection and analysis.

Following analysis the researcher debriefed the participants about the full nature of the study, and shared the results (Appendix G). This provided an opportunity to provide feedback and to ensure it was meaningful for them (Yardley, 2007). The participants did not express any disagreement or wish to embellish the findings; hence the themes developed were unchanged.
Results

This study aimed to explore the self-reported strategies that GPs use to encourage their patients to disclose symptoms of psychological distress, with a particular focus on men, and to explore the GPs’ decision-making processes regarding their patient’s treatment. Three themes emerged from the data; Facilitating Techniques; Recognition of the Patient’s Treatment Preferences and Cultural Prism. Each theme will be presented in order of what was perceived to be important to the participants.

Table 2

<table>
<thead>
<tr>
<th>Representation of themes</th>
<th>Facilitating Techniques</th>
<th>Recognition of Patient’s Treatment Preferences</th>
<th>Cultural Prism</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sub-themes relating patients generally</td>
<td>Immediate availability of medication versus talking therapy</td>
<td>Females attend due to “normal” life</td>
</tr>
<tr>
<td>Interpersonal Skills</td>
<td>Specific methods used to gather information</td>
<td>Age not Gender</td>
<td></td>
</tr>
<tr>
<td>Mental Health Awareness</td>
<td>Organisational Influences</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Masking and Unmasking    | Sub-themes specifically relating to male patients | Patient’s Preferences | Macho-culture |

Facilitating Techniques

Across all interviews, different factors assisted consultations with patients presenting with psychological distress. These facilitating techniques encompassed five subordinate themes; GP’s interpersonal skills; masking and unmasking; specific methods used to gather information; mental health awareness; and organisational influences. Each of the subordinate themes discussed related to factors that enabled the GPs to put their patients at ease and build a rapport, and establish the nature of their patient’s problem. Contrastingly, the main
constraining factor in the consultation process and development of relationships was 10-minute appointments, deemed insufficient in some cases. Each of the subordinate themes which provided a rich and expansive understanding of the overarching theme will be discussed.

**Interpersonal Skills:** For many GPs, there was an emphasis on communication skills, which included a repertoire of techniques. The importance of using open-ended questions was highlighted, captured by a trainee GP who said “I would say ‘is there anything in particular that’s been bothering you’...‘how are you doing’...open ended questions” (Participant F), supported by a qualified GP, Participant G, who said “sometimes you just need to use a few more open ended questions take your time allow them to talk”.

A majority of GPs also spoke about their awareness of a patient’s mood, body language and tone of voice, and how these influence their own physical and verbal communication, captured by Participant C, a trainee GP, who reported “I definitely try and match their body language...their voice...you have to create an environment where they’re gonna be open”, whilst Participant G highlighted how a patient’s body language and engagement can indicate symptoms of a mental illness; “body language...if they’re quiet if they’re not making good eye contact...this person’s troubled”.

Two trainee GPs highlighted the value of acknowledging and labelling a patient’s mood or emotion based on their behaviour. The impact of adopting these strategies was considered to have a positive effect for GPs and patients. Participant C observed her consultant using this approach in a joint session with a patient, and said “my consultant just intervened...‘why are you so angry?’ [to the patient]...he weirdly was like ‘just really angry because’...everything came out and actually the consultation was a lot better” and reflected “I think if you don’t acknowledge the way that someone’s behaving...you don’t really get anywhere” and spoke about how she subsequently used this technique.
Trainee and qualified GPs also acknowledged “taking a step back” and letting their patients talk often resulted in the patient describing the problem in their own time. There appeared to be a subtle undertone that, continuing to ask questions or to put forward the GP’s own thoughts could prevent the patient from opening up. This directive stance could otherwise be disrupting, interrupting the patient’s train of thought. The time available for these consultations also appeared to organise the GPs as they attempt to extract the necessary information to determine the problem in one 10-minute appointment. This is demonstrated by a trainee and qualified GP who reported “I think often if you just take a step back and allow people to speak they’ll tell you...I think that’s probably the main helpful thing that you can do...be quiet and let people speak” (Participant D), and “take your time allow them to talk...not pressurise...not fire as many questions...just allow time...allow the important symptoms to come forth” (Participant G).

Combined with “taking a step back”, some of the participants phrased their approach as “non-intimidating” or “non-confrontational”. Comments made by a trainee and qualified GP, Participants F and H exemplify this. Participant F draws out the need to provide softer signs to engage patients; “trying to not be intimidating...smiling at the beginning and making sure there is little intimidation effect...I would like to think I’m not particularly aggressive or intimidating” whilst participant H highlights the importance of pacing the session and how removing a perceived barrage of questions can facilitate patients’ disclosure; “you can do it in a way which isn’t confrontational...try and tease out without it sounding like...‘question 1 question 2 question 3’ that doesn’t tend to work”. These behaviours may have been a subtle recognition that a doctor-patient relationship may be intimidating, and perhaps the acknowledgement of a power imbalance. The behaviours adopted could result in the patient being able to fully explain their difficulties. No specific differences in how GPs consciously spoke to male and female patients in this respect were highlighted.
**Masking and Unmasking:** Across most of the interviews, differences in how male patients present to the GP were highlighted. This theme captures how men’s psychological distress can be “hidden” and the GPs’ awareness of this; for example; by attending the surgery reluctantly, talking about a minor problem, being oblique or dropping hints, where Participant B, a trainee GP, stated “*men are generally more reluctant to come to their GP...have hidden agendas about why they’ve come...be pushed by a relative to actually come or a partner*”, “*they can be quite guarded...they can present with a minor problem but actually they’ve got something that’s quite significant that they’re worried about*”, “*they are sort of half finishing sentences...drop hints*”. Additionally, a qualified GP, Participant E, explained differences in eye contact; “*I think the male patients more likely to not look at me when they walk in if they’ve got a mental health issue*”, and highlighted the possibility of men focussing on a physical problem; “*they actually have a psychological or mental health problem...manifesting as a psychosomatic symptom...they can be completely focusing on a physical symptom*”.

To accommodate for these differences the GPs identified how their communication differed when seeing a male patient. Some participants recognised that they change their style of questioning and explanation of mental illness, to “unmask” or break down some of these barriers, captured by Participant B who explained “*sometimes you need to do a bit more probing for men...ask more direct questions to men ‘is this what’s worrying you’...specific questions about their sleep or their work*”. Male patients are also seen as needing an explanation for their problems to help contextualise their difficulties and to understand the mechanisms that can maintain and overcome them. Participant H reported “*men want an explanation...if I’m going into the biochemistry of why they’re getting depressed they like it more because they can say ‘well OK it’s a bit like not having enough oil in your car engines’*”. Use of metaphors was a technique adopted to provide accessible explanations that
could be understood. The process appeared to allow the men to become less fearful in engaging with their mental illness.

Two qualified GPs also described methods to encourage men to access the surgery, acknowledging that this can be a significant barrier to help-seeking. Participant G reported “we have a range of appointments that we offer...early morning...probably help men in particular because they're keen to stay in to work”, whilst Participant H described “I might have a wife or a partner of somebody come in and say ‘look I’m very worried about Fred’...we’ll write him a letter to say ‘...we are undergoing a bit of a wellman check your name’s come up would you like to come’”. This participant acknowledged how some practitioners may not agree with this approach, as there is some subterfuge involved, but explained; “if you’ve actually got somebody with a serious problem and they won’t face it and that serious problem happens to be picked up and treated how can that possibly be a bad thing”.

Whilst many GPs provided a tailored stance that was organised by the patient’s gender, one qualified GP inferred that they treat all of their patients the “same” and that their approach does not vary by gender; “I must admit I wonder if it may have been different when I was younger...I treat them all the same” (Participant G). Another intimated that their approach was defined by relationships rather than by gender; “No no it [my approach] doesn’t [vary]...I mean I’m very lucky because I know my patients so I’m gonna say it’s so much easier when you do that’s why I like the small model” (Participant H). These GPs provided some reasoning for these differences; their maturity in practice and having worked with their community for a long time within small practices, affording them the opportunity to know their patients well. Participant E also relates his maturity in practice to the ability to recognise illness; “the more experience you get you have more of a feel what might be what might not be”.
Specific methods used to gather information: A variety of methods were described; firstly, the importance of taking a comprehensive history. Both a trainee GP and a qualified GP acknowledged how history taking can be different for mental health patients. It could be inferred that perhaps a more comprehensive and holistic history taking is required, due to it being a “mental” examination and not a “physical” one, captured by a trainee GP who said “mental health history taking would be a lot longer...more to explore, examination is different...there isn’t sort of a doing examination...it’s what you’re observing as you’re taking the history” (Participant C).

An “ICE” (Ideas, Concerns, and Expectations) framework, learnt during medical school, was mentioned by some of the participants as a method to gather information. This approach seemed to be very familiar to the GPs, and it appeared to be a tool that the GPs felt very skilled in using. ICE seemed to provide the GPs with a useful structure to show the patient that their views and preferences are taken seriously and to demonstrate empathy. The framework encourages the GPs to think and decide collaboratively with their patient about the preferred outcome and management of their difficulties, demonstrated by Participant G who stated “underpinning that whole process is to obviously explore patient’s concerns ideas expectations...what they hope to gain from the consultation...what their fears and concerns are...a useful process to go through to make sure you’re on the same page”.

Mental Health Awareness: Throughout the data, it became apparent that psychiatry placements are not compulsory during GP training. This subtheme reflects the perceived value of psychiatry placements and how it has shaped some GPs’ clinical practice in facilitating their consultations with patients with mental illness, in relation to management of their medication, conducting risk assessments, and referring to other services; “I feel I’m much more well equipped at knowing how to manage people’s medication” (Participant B) and Participant I; “I’m definitely much better at assessing risk in terms of suicidal risk harm
to self harm to others”. There was a recognition that earlier training, whilst helpful in developing the skills, are not consolidated in subsequent years of practice; Participant I continues “I’m probably better at that I know what’s involved you learn that in medical school but really you don’t use it in F1 and F2”. The psychiatry placement appears to provide a helpful re-engagement with processes and procedures as well as self-care; Participant D described how it improved her ability to manage the emotional impact of engaging with some patients; “I find people who are very depressed the most difficult and most challenging...you can take it all upon yourself it can get quite depressing...it’s made me learn to manage that a bit better...to hear people’s stories without taking it all to heart”. It should be noted that in this GP’s practice, a consultant from a local Community Mental Health Team visits the practice once a month to discuss patients that GPs are concerned about.

Two participants who had a rotation in psychiatry spoke about the importance of following up with patients; “if they’re a bit fragile in terms of their mental state...we just want to make sure they’ve not got worse...it’s a safety thing...to make sure the patient hasn’t deteriorated” (Participant I) and “if we’re very worried about someone we’ll phone them” (Participant D). Participant C also expressed “I think [psychiatry] should be part of nearly all GP training I think it’s a really useful job”. However, within this subtheme, no gender differences were highlighted.

Organisational Influences: This theme captures how organisational structures facilitate the development of relationships. Small practices were seen to offer a different type of service with a central element being the continuity of care which could not be delivered in larger practices. The organisational constraint of the consultation time was also seen to have a major impact in developing relationships between patients and GPs.
Small practice models were spoken about very positively and seemed to contain many advantages. Participant H, a qualified GP, described how he has been treating some of his patients for many years and how it has enabled him to get to know his patients well; “we’re not a big practice...we know all our patients so it’s quite a privileged position because you’ve got a lot of history with that patient you know a lot what the drivers are you know what family issues are. We in some cases look after three generations”. There was no mention of differences between men and women in this respect, which may mean that the patients feel able and comfortable in talking about their difficulties regardless of their gender.

It was inferred that in larger (by patient volume) practices it can be very difficult to see the same GP twice; “A lot of them are saying you can’t either get an appointment or worse still you never see the same doctor twice and patients just don’t like it” (Participant H). In larger practices the patient may find it difficult or frustrating to repeat their story to multiple doctors.

Furthermore, it was clearly reported that a 10-minute appointment is not sufficient, especially for the exploration of mental illness. One trainee GP spoke about the difficulties that arise if a patient becomes emotional; “If someone’s crying then there’s no way you can say ‘oh time’s up get out’...very much constrained by time” (Participant A), whilst a qualified GP explained how 10 minutes may not be enough to ascertain if there is a mental illness, hence a follow-up session is required. There was a recognition of how unsatisfactory this was as it fractured the examination and left the GPs uncomfortable as the process can lead to the patients not being in receipt of the care that they need in a timely manner; “some of them you only find out later...there’s a mental health issue...it’s not an easy thing to do...with ten minutes it’s even harder...if it does go on I probably have to ask them to come back with time pressures” (Participant E). This issue did not appear to be influenced by the gender of the patient.
Recognition of the Patient’s Treatment Preferences

Patient’s Preferences: Across the data, the GPs decision-making generally appeared to be guided by their patient’s preferences in relation to their treatment. Participant A said “I guess it depends if someone’s very insistent, if they’ve already decided they’d heard their friend had been somewhere or they wanted to try medication”. The GPs’ decision-making did not appear to vary by gender, as captured by Participant H “I think it’s very equal...as long as you put your cards on the table with a patient explain what part drug therapy plays explain what part talking therapies plays I think they’re all open to I don’t think there’s a gender thing there”.

However, whilst the GPs described not treating female and male patients differently, they reported that some men may prefer medication over talking therapy. A qualified GP said “men also tend to just want a quick fix so a lot of them in my area are a lot less likely to want counselling” (Participant E). Participant G expanded upon this by highlighting that men living in a more deprived area might want this “quicker fix” even more; “certainly in the deprived area it’s pretty much the same...perhaps a little bit more for the men I think again because of the lower threshold to go down the medication line they probably want even quicker fixes”. It is also important to note that one qualified GP, Participant I, explained “I have a lower threshold for referral for men” due to the higher risk they present.

Immediate availability of medication versus talking therapy: An important factor which appeared to impact upon this process was the immediate availability of medication versus the waiting times for talking therapies. It is possible that if waiting times for talking therapies were shorter, fewer patients might be prescribed medication. One qualified GP explicitly admitted that he would not be prescribing antidepressants as often if his patients could access talking therapy quicker, stating his rationale as “it’s no good me saying...I won’t treat you with an antidepressant, talking therapies is needed, if at the end of the day in 3
months time that patient’s even worse, lost their job and spiraling into even more depression” (Participant H).

**Age not gender:** It is important to note that two participants highlighted how their decision-making may be guided by a patient’s age rather than gender; “No I guess age would be more than gender, just in terms of if someone is very young I would be less inclined to start them on something straight away” (Participant A), whilst Participant D expanded upon this by including the lack of provision for talking therapy for the younger population “it’s really hard because I don’t like putting them on anti-depressants and there’s no CBT there’s no counselling...annoying because the services should be there”.

**Cultural Prism**

**Macho-culture:** There appeared to be cultural factors through which help-seeking by men and women is governed from the GPs’ perspectives. Primarily, the “macho-culture” that some men experience, leading them to perceive help-seeking as a sign of weakness, raised by three male qualified GPs; “they’re a very macho culture in my area” (Participant E), “the cultural aspect for males...is this a sign of weakness and can I admit that I’m going through a difficult time” (Participant G), “I’m saying males are not very good at talking about stress...coming to see me is a sense of failure” (Participant H). The GPs also highlighted differences for older men; “especially elderly men...they don’t really recognise anything to do with mental health there’s quite a lot of stigma” (Participant B) and “older men tend to be more reserved and tend not to present so much and tend to present later” (Participant D).

**Females attend due to “normal” life:** Two GPs indicated that women see their GPs more often as they attend for reasons which are considered part of ‘normal’ life, which may make them more familiar with the consultation process and the surgery environment, explained by Participant G; “I think that’s largely cultural a lot of women will go...they’re
used to going to their GP for things like contraception smears...if they’re pregnant take their kids bit sexist I know...they’re largely more open to the idea of presenting with a psychological complaint”.

**Willingly versus encouraged:** Both trainee and qualified GPs highlighted how women tend to attend the surgery willingly, whereas men appear to be encouraged by others, captured by Participant A; “women are much more forthcoming, whereas nearly every single man that comes in will say...’I’ve only come because someone else has told me I should come’...the majority of them would not come of their own accord”.

**Discussion**

This study investigated the self-reported strategies that GPs use to encourage their patients to disclose symptoms of psychological distress, with a particular focus on men, and their decision-making processes regarding their patient’s treatment. The themes developed are related to both male and female patients, where sub-themes that have a specific focus on men are highlighted.

Whilst the participants discussed various facilitating techniques in enabling their patients to disclose their distress, and a general recognition of their patient’s treatment preferences, it is important to acknowledge the cultural context captured by the third theme, as this explains differences in attendance and help-seeking behaviour by male and female patients in the first place. The discussion will explore the themes that are related to both genders, whilst ensuring to highlight the themes that relate to male patients specifically.
Neutrality

It is important to firstly note the neutrality in the participants’ responses; the GPs had not spoken spontaneously about differences in the ways in which male and female patients can present, nor how their own approach might differ, until they were prompted with questions like “How might this vary by gender?” This question appeared to surprise some participants, as they reported having been trained to treat all of their patients the “same”, which contributed to a culture of wanting to provide equality in their treatment. The GPs appeared to consciously consider equality as meaning to treat everyone the “same”. However, this was in contrast to their reported efforts to provide a bespoke consultation, in turn providing a better outcome for the patient.

It is important to reflect on why there were limited findings specifically relating to male patients. A methodological explanation could be the nature of the questions asked; by not asking questions specifically about men, this may have naturally limited the amount of male-specific findings emerging from this study.

Additionally, it is important to acknowledge a wider culture. As highlighted in Rooney (2016, unpublished), many men that visit their GP have been encouraged by their female partners. It is possible that these men are acculturated to a more “feminine” perspective, and therefore may be more primed to discussing sensitive issues, which may reduce the perceived differences between how men and women can present.

Discussion of Themes

Communication Skills: It is clear that the GPs have a repertoire of skills to enable their patients to talk about their difficulties, and to begin building a rapport to make their patients feel at ease and to develop a trusting relationship. In particular, training in the use of open questions has been sustained with participants integrating these questions into their
practice, and are identified as a useful approach in the GP Consultation in Practice statement (2010).

Importantly, the GPs demonstrated recognition of their patient’s presentation during a consultation, such as tone of voice and body language, and how their own body language is adapted in response to this. Interestingly, a (non-participating) trainee GP who completed an Erasmus exchange in Denmark highlighted the significance of people’s body language, whereby he acknowledged that “Being unable to speak the language meant focusing on body language, tone of voice and other non-verbal cues that I might usually be distracted from or may be hidden by the content of the language used.” (Thornton, 2015).

A patient’s body language is acknowledged across primary and secondary care services, and this awareness and own adaptation of body language have been highlighted as part of core communication skills in mental health nursing. Egan (2010) suggests the SOLER acronym (sitting facing the patient, open posture, leaning in occasionally, good eye contact, and a relaxed posture) creates a comfortable and open space for the patient to communicate. The ability to read non-verbal communication is key in establishing and maintaining a relationship with a patient (Carton, Kessler & Pape, 1999).

In conjunction with this, an increased awareness of a patient’s tone and body language can lead to GPs acknowledging and labelling a patient’s mood; one GP referred to this as “confrontation as a technique”. This appears to be a relatively new expression, and highlights a method that GPs can use in their consultations to encourage disclosure of psychological distress, addressing some of the gaps in this area of the literature. Whilst the GP used this expression, it can perhaps form part of validating and empathising with the patient’s experiences, whereby their mood, thoughts and behaviour are recognised and accepted. This is also important given that empathy has been associated with improved outcomes for doctors and their patients (Carmel & Glick, 1996; Hojat et al., 2001; Hardee, 2003).
Another technique that enabled participants to demonstrate empathy for their patients’ difficulties was the ICE framework (Pendleton, 1984). This appeared to enable the GPs to ascertain the patient’s views, and to validate and explore their worries, in turn making the patient feel heard and taken seriously. This is important to acknowledge, given Buston (2002), who reported that patients with a mental illness expressed not feeling understood or taken seriously, and described a lack of empathy by their practitioner. Given the challenges of general practice, using ICE in conjunction with labelling and validating a patient’s mood may be useful tools in demonstrating empathy. ICE may also be helpful to draw upon should a GP become unsure of how to explore a patient’s presenting problem, as the model provides clear guidelines. The framework also assists the GP in being non-confrontational, and taking their time, which were other important factors highlighted in the current study.

A study conducted by Matthys, Elwyn, van Nuland, van Maele and Sutter (2009) found that the presence of exploring a patient’s concerns and expectations was associated with less prescribing. Given that ICE appeared to be highlighted as a valuable technique in the current study, it is important to encourage its wider use as it may reduce the number of prescriptions that are made for medication (Matthys et al., 2009). It can also enable GPs to understand their patients’ motivations, and improve general patient satisfaction and compliance with medical advice (Tate, 2005).

It is important to acknowledge other consultation methods used by GPs to facilitate their conversations with their patients; the Helmann’s Folk Model (1981), focussing on the patient’s perspective and empathising, and The Inner Consultation Model (Neighbour, 1987), recommending GPs to summarise frequently to ensure a shared understanding. These consultation methods share some of the beneficial traits of ICE. However, they do not appear to include recommendations concerning which approach may be more effective for different genders.
In relation to male patients, the GPs identified various ways in which men may “mask” their distress. The GPs subsequently expressed ways in which their communication and approach differed when consulting with men to help “unmask” the true nature of their difficulties. The need for more direct questions and “probing” was described, which is supported by Webster (2013), who found that mental illness can be undiagnosed in men within primary care services if the GP’s communication does not include specific and direct questions about their mental health.

Unique to the current study, a GP explained how some men may prefer a metaphoric explanation of their biochemistry. This may support the findings of Harvey et al., who found that some male patients appeared to have limited vocabulary when discussing sensitive issues. Using metaphors appears to engage men, as the language is more accessible, which can replace the use of medical jargon. This in turn could reduce fear that a patient might have about their mental illness. This strategy is particularly helpful in addressing some of the gaps in the literature about how GPs can encourage and facilitate a man’s disclosure and understanding of mental illness.

Whilst many of the techniques were learnt throughout medical training, the GPs appeared to learn new strategies during clinical practice and with increasing experience. This can be explained by Kolb’s experiential learning style theory (1974), whereby a GP might try a new strategy (Concrete Experience), leading them to review how successful this strategy was (Reflective Observation). Subsequently, the GP may learn from this experience (Abstract Conceptualisation), and proceed to use it in future sessions with their patients (Active Experimentation). It is possible that this process occurred with the use of metaphoric explanations.

In addition, this study introduces a relatively novel concept which addresses some of the gaps in the literature about how to encourage men to access the GP surgery in the first
place, by inviting men to attend for a “wellman” check. This can enable men to be seen earlier and receive treatment quicker, acting as a proactive and preventative approach, imperative in the recognition and treatment of mental illness. This is supported by Harvey et al., where NHS professionals have suggested for men to undergo a yearly body “M.O.T”, which would include a general health check to treat any minor problems and to prevent the development of diseases, along with increasing men’s attendance.

**GPs’ completion of additional training:** It emerged that psychiatry placements were not compulsory during GP training, perhaps due to the scarcity of availability. Consistent with the findings of Marks et al., GPs in the current study felt better equipped with the recognition, exploration and management of mental illness if they had prior experience. An improvement in conducting risk assessments was highlighted, which is imperative given the increased risk of suicide for men. The findings of the current study are consistent with Railton et al., highlighting that although training in psychiatry is not required post-graduation, many registrars viewed this as vital to make sure that both the mental and physical health needs of patients are met.

**Influences on GPs’ decision-making processes:** There was a consensus that the GPs’ decision-making with regards to treatment did not vary by gender, but they appeared to be guided by their patients’ preferences. This is in contrast to Dowrick et al., who found that GPs were influenced by their own intervention preferences. However, what did not emerge across the current study were any particularly challenging or frustrating presentations, contrary to Nandy et al., who highlighted the frustration and anger that some GPs can experience in this area, leading them to refer to other services. With this in mind, it is important to consider whether GPs have much opportunity to reflect on their clinical practice. The GPs in this study generally demonstrated a thoughtful awareness of the psychological needs and wellbeing of their patients within the limited time that they have available. It is
possible that GPs may frequently find themselves in “The Doing Mindset” due to the demands of their role, and have little opportunity to reflect on their work with other GPs or colleagues. Whilst the GP Curriculum highlights the need to reflect during training, it is not clear how this is facilitated post-qualification.

Some of the GPs acknowledged men’s preference of medication over talking therapies. This was interpreted as men wanting a “quicker fix”. Existing researchers have acknowledged that doctors and patients can view medication as a “quick fix” (Thompson, 2007). This term is interesting, as many medications for mental illness do not work quickly, or may be prescribed long-term. However, even where the patient expresses a preference for medication, the long waiting times for talking therapy could be a deciding factor for GPs to prescribe medication.

**Organisational Influences**: The role that organisational structures can play in patient care is highlighted. With the increase in larger GP practices, it is important to acknowledge the benefits of small practice models. The small practice model was seen to facilitate the development of trust and relationships between a GP and their patient, and improve continuity of care. Patients do appreciate seeing a doctor they know well and trust (Cowie, Morgan, White & Gulliford, 2009; Ridd, Shaw, Lewis & Salisbury, 2009). The value of continuity of care and how GPs can promote this are both essential parts of GP training (Hill & Freeman, 2011). It was suggested that having continuity of care and a good relationship with your GP encourages disclosure of psychological distress irrespective of gender. This study therefore highlights the influence that organisational structures can have, and questions the suitability of large practice models, due to the difficulty in seeing the same GP twice. Furthermore, consistent with Railton et al., GPs mentioned that the 10-minute duration was too short, in particular for patients presenting with psychological distress. This is important for men who may mask their difficulties, and therefore require more time.
**Cultural Prism:** Cultural factors emerged in relation to help-seeking by men and women, captured by the third theme. These factors have been extensively researched and supported; for example, “macho-culture” has been identified as a common barrier to men seeking help (Good, Dell & Mintz, 1989; Moynihan, 1998; Rogers & Pilgrim, 2003; Saladin, Back & Payne, 2009).

The concept of “Gender Role Conflict” also appears to be upheld in the current study, in that some men may experience “Gender Role Strain”. As posited by Pleck (1995), men may experience a “discrepancy strain” if they perceive themselves as not meeting the “traditional” standards of their gender role, which can occur if a man with strong beliefs of “traditional masculinity” is experiencing a mental illness and seeks help, and perceives this as a weakness or as being a failure. The GPs in the current study appeared to have a good awareness of this culture, and it is possible that this awareness leads them to adapt their approach with a male patient; firstly, adapting their communication style and questions when trying to ascertain if there is a mental illness; and secondly, when providing an explanation of their difficulties by using metaphors. This is a tentative framework (Appendix I), which future research could explore further.

There is also recognition that women attend the GP surgery more naturally, due to issues such as contraception and pregnancy (Harvey et al., 2013), and may be more familiar and comfortable with the consultation process. Perhaps the invitation for men to attend for regular “wellman” checks would increase their familiarity with this process so that it could become more of a routine experience. The change in men’s parenting roles could also lead to more men bringing their children to the GP, which may also aid this process.
Clinical Implications

This study has provided support for existing literature from the perspective of GPs on the barriers to men seeking help for mental illness, but it has also expanded upon ways in which men can present differently to their GP when seeking help. This has important implications for training and awareness-raising of not only GPs, but all primary health care professionals, as common signs or typical diagnostic criteria may not be relevant for some men, or may not be visible.

However, it should be noted that “Men’s Health” is included in the GP curriculum, where an acknowledgement of how men’s mental and emotional health problems can present in different ways to women is made as a learning outcome (RCGP, 2016). Nonetheless, it is not clear how this learning is translated into GP training, as this was not explicitly mentioned by the participants. It is important to ensure its inclusion in all training programs, in line with promoting equality and valuing diversity (RCGP, 2016).

It is also important to recognise a novel strategy of inviting men to attend regular “wellman” checks, which would familiarise them with both the surgery environment and consultation process, for men who find it difficult or are reluctant to seek help. Harvey et al., acknowledged that this method is used in the United States and Germany, and therefore this could be incorporated into the UK.

Given that a GP is usually the first port of call for mental and physical health, and given the value attached to psychiatry placements by the GPs in this study, consideration needs to be given to offering such placements on a compulsory basis. This is particularly important given the knowledge that “poor physical health can cause poor mental health, and vice versa” (Highland Users Group, 2008). For example, 30% of people who have a long-term physical condition also have a mental illness (Barnett, Mercer, Norbury, Watt, Wyke & Guthrie, 2012), whilst the impact of “poor mental health” on physical conditions has been
estimated to cost approximately £8 billion a year (Naylor, Parsonage, McDaid, Knapp, Fossey & Galea, 2012).

It is also important to acknowledge the concerns raised with regards to the long waiting times for talking therapy. This has important implications for the funding and commissioning of secondary mental health services, especially as some patients may not be prescribed medication if there were sufficient resources available for talking therapy. This suggests that medication may not be the best treatment for some patients, but is chosen because there is not an accessible alternative, thus GPs could be put in a difficult position by managing patients in primary care, when timely secondary mental health services might be more appropriate.

Limitations

This study included participants from nine different areas of the UK, which was intended in order to capture diverse experiences of the GPs. In addition, there was a relatively wide age range amongst the participants, and years of experience, enabling the data to span a considerable timeframe in the working lives of the GPs.

However, it is important to acknowledge the difficulty in recruiting both trainee and qualified GPs for this study. Whilst GPs expressed an interest, one of the main reasons that limited taking part was their time availability. To address this ethical approval was subsequently gained for telephone interviews to occur alongside face-to-face interviews. GPs were more prepared to take part if it could occur outside of the working day. It is therefore highly recommended for future research to use telephone interviews with GPs. Whilst rich information was still gathered from the nine interviewed participants, this study has raised awareness of GPs’ roles and responsibilities and how there may be challenges to take part in research.
The participants were recruited via opportunity and snowball sampling. Whilst these methods of sampling mean that participants were willing, it introduces bias as the participants were self-selected. The participants recruited may have already had an interest in mental health, demonstrated by the fact that these participants generally appeared to have psychological awareness of their patient’s needs. If this were the case, it would be important to further the research with GPs who do not necessarily have a specific interest in this area.

**Future Research**

Whilst the study explored the GPs’ views of how they encourage patients to disclose symptoms of psychological distress, it would be interesting to further explore the views of men themselves who have sought help, been diagnosed with a mental illness and received treatment, to ascertain what they found helpful during the consultation with their GP. In addition, whilst sexuality was not raised in the current study, existing research has found that homosexual men are more likely to seek help compared to heterosexual men (Sanchez, Bocklandt & Vilain, 2013). It would be valuable for future research to explore the views of homosexual men in what enables them to talk about their psychological distress.

It would also be important to further the research in relation to men from different cultural backgrounds, as people who declare themselves to have a White heritage have been found to be 60% more likely to be offered treatment, whilst GPs are less likely to detect mental illness in Black African Caribbean and South Asian patients (Centre for Social Justice, 2007). In addition, whilst only one GP expressed that men from more deprived areas may have a lower threshold for medication, it is important to further the research in relation to men from different socio-economic backgrounds. The Mental Health Network (2014) reported that “men in the lowest household income group were three times more likely to have a common mental disorder than those in the highest income households”, demonstrating
the increased risk of mental illness that these men may experience. Furthermore, it seems that a person’s age may influence help-seeking and treatment, which was raised by two participants; however this requires further exploration.

**Conclusion**

This research has improved the understanding of how GPs elicit disclosure of psychological distress from their patients, and their decision-making processes regarding treatment. It has indicated various strategies that GPs might use to enable their patients to talk about their difficulties, some strategies which have been taught during medical training, whilst others have been developed throughout their clinical practice with increasing experience. The research also highlights the benefits of inviting men to attend regular health checks, which has important implications in reducing some of the barriers of help-seeking in men. In addition, the research contributes to the wider literature and clinical implications by identifying the advantages of small practice models versus large practice models; however it is important to interpret this tentatively given the small sample size.

Furthermore, a factor which appeared beneficial in mental health training for GPs was the opportunity to complete a psychiatry placement, which appeared to facilitate the development of inter-relational awareness, psychological mindedness and communication skills. The incorporation of these placements into GP training is recommended to ensure that training is consistent for all GPs. It is hoped that this would increase all future GPs’ skill and knowledge in recognising, diagnosing and treating mental illness in men and women.
References


Bheenick, Y.N. (2014). Literature Review: The role of a General Practitioner in recognising, diagnosing and treating mental illness and supporting access to mental health services. *Submitted to form part of a portfolio. University of Surrey*


Campaign Against Living Miserably (2015). *45% increase in male suicide awareness between October and December YouGov polls*
Carmel, S. and Glick, S. M. (1996). Compassionate-empathic physicians: personality traits and social-organizational factors that enhance or inhibit this behavior pattern. *Social science medicine, 43*(8), 1253-1261


Marks, J. N., Goldberg, D. P. and Hillier, V. F. (1979). Determinants of the ability of general practitioners to detect psychiatric illness. Psychological Medicine, 9(2), 337-353


Men’s Health Forum (2016). *Statistics on Mental Health and Men*


Neighbour, R. (1987). The Inner Consultation, Lancaster, MTP


Royal College of General Practitioners (2010). *GP Consultation in Practice statement*, RCGP Curriculum

Royal College of General Practitioners (2016). Promoting Equality and Valuing Diversity, *Curriculum Statement, 3, 4*


http://doi.org/10.1037/a0029529


Appendix A: Interview Schedule

The contextual questions asked at the beginning of the interview:

- How long the participant has to see clients
- How many years of experience they have as a qualified GP/GP in training
- When they completed their initial training
- When they started their GP training
- When they completed their GP training/are due to complete
- If there are any additional training courses they have attended

The subsequent open-questions asked as part of the interview guide:

1) What kind of practice do you work in?

2) When you have an appointment with a patient, what is typical about the process of a consultation?

3) When a patient comes to see you, how do you find out what they would like to talk about?
   - How might this vary by gender?

4) What do you think enables you to elicit appropriate information to help you establish whether the patient is experiencing psychological distress?
   - How might this vary by gender?

5) If you think that a person is experiencing psychological distress, how do you decide what to do next?
   - How might this vary by gender?
Appendix B: Interest in mental health needs of men

Firstly, in relation to my own friendships with men who have experienced mental health difficulties, they have provided me with a greater awareness and insight into some of the challenges that can arise in relation to seeking and receiving help, from being diagnosed with a mental illness to knowing how best it should be treated. In both cases, whilst these men did seek and accept some forms of help, there was a reluctance to, for example, continue to take medication or to engage in talking therapy, where a narrative of managing “on their own” as best they could appeared to emerge, which seemed to be in line with “traditional masculinity” and “gender-role scripts”.

Professionally, my position as a trainee clinical psychologist means that I have become increasingly aware of the mental health needs of men in this context, as it is naturally a profession and environment in which we frequently reflect on the populations whose needs are not being met. This has led me to further reflect on this in different ways, for example, by choosing to write an essay about promoting psychological services to minority groups in my second year of training, but also having attended the Male Psychology Conference where both the physical and mental health needs of men were recognised and emphasised.
Appendix C: Ethical Approval

Faculty of Arts and Human Sciences
Ethics Committee

Chair’s Action

Proposal Ref: 1119-PSY-15
Name of Student/Trainee: YAJNAH BHEENICK
Title of Project: What factors organise a GP’s aptitude to elicit the disclosure of psychological distress in men and how do they utilise this information?
Supervisor: Mary John, Linda Morison
Date of submission: 28th April 2015
Date of re-submission: 04th June 2015

The above Research Project has been re-submitted to the FAHS Ethics Committee and has now received a favourable ethical opinion from the Faculty of Arts and Human Sciences Ethics Committee on the basis described in the protocol and supporting documentation.

The final list of revised documents reviewed by the Committee is as follows:

Protocol Cover sheet
Summary of the project
Detailed protocol for the project
Participant Information sheet
Consent Form

This documentation should be retained by the student/trainee in case this project is audited by the Faculty Ethics Committee.

Signed and Dated: [Signature]
Professor Bertram Opitz
Chair

Please note:
If there are any significant changes to your proposal which require further scrutiny, please contact the Faculty Ethics Committee before proceeding with your Project.
Appendix D: Information Sheet

My name is Yajnah Bheenick and I am currently a final year Trainee Clinical Psychologist at The University of Surrey in Guildford. As part of our three year doctoral training we are required to complete a major research project.

I have recently completed a literature review about the recognition, diagnosis and treatment of mental illness in the UK. As the gateway to mental health services is primarily through a General Practitioner (GP), I was specifically looking for research into GPs’ experience of working with individuals presenting with psychological distress; however, I found for there to be very little research in this area. For this reason, my two research supervisors and I would like to explore the experiences and views of GPs of working with people experiencing psychological distress, including any potential challenges that can arise. In turn, it is anticipated for this research to have implications for further support and/or training in mental health and psychiatry for practitioners in the future.

The research will be a qualitative study using an interview guide with a series of open questions and further prompting where appropriate. The interviews will be conducted face-to-face and may take approximately 45 minutes. However, depending on your availability and responses, these can take anytime between 30 minutes to 1 hour. I will also be flexible in terms of timing and location of the interviews, and will travel to your work base if this is the most convenient place to complete the interview. I will also ensure to contact the appropriate Research and Development Departments and will have completed all ethics procedures as necessary.

The interviews will be audiotaped and the data will be kept confidential in accordance with the Data Protection Act (1998), by storing these on an encrypted USB stick which only the researcher, two research supervisors and transcriber will have access to. The transcriber will be required to sign a confidentiality agreement and a number will be allocated to each transcript to maintain its anonymity. The USB will be kept in a locked cabinet at the University of Surrey and the data will be stored for 10 years and then destroyed.

Once the research has been completed, you will be debriefed fully about the nature of the study. You have a right to withdraw your data should you wish and can do so by letting the researcher know in person or by telephone. If you experience any psychological harm or distress, please let the researcher know and this will be dealt with appropriately by signposting you to your local health service provision.

Thank you for taking the time to read this.
Yajnah Bheenick, Trainee Clinical Psychologist, y.bheenick@surrey.ac.uk
Supervised by Dr Mary John, Programme Director, m.john@surrey.ac.uk
Research Integrity and Governance: Dr Sophie Wehrens, sophie.wehrens@surrey.ac.uk
Appendix E: Consent Form

- I the undersigned voluntarily agree to take part in the study on ……………………….

- I have read and understood the Information Sheet provided. I have been given a full explanation by the investigators of the nature, purpose, location and likely duration of the study, and of what I will be expected to do. I have been advised about any psychological harm or distress that I may experience and have been advised how this will be dealt with accordingly should this occur. I have been given the opportunity to ask questions on all aspects of the study and have understood the advice and information given as a result.

- I agree to comply with any instruction given to me during the study and to co-operate fully with the investigator. I shall inform them immediately if I suffer any deterioration of any kind in my health or well-being, or experience any unexpected or unusual symptoms.

- I understand that all personal data relating to volunteers is held and processes in the strictest confidence, in accordance with The Data Protection Act (1998). I agree that I will not seek to restrict the use of the results of the study on the understanding that my anonymity is preserved.

- I understand that I am free to withdraw from the study at any time without needed to justify my decision and without prejudice.

- I confirm that I have read and understood the above and freely consent to participating in this study. I have been given adequate time to consider my participation and agree to comply with the instructions and restrictions of the study.

- I am aware that this research is conducted by Yajnah Bheenick (Trainee Clinical Psychologist) and supervised by Dr Mary John (Programme Director) whose contact details I have been provided. I have also been provided with the contact details for the Research Integrity and Governance Officer.

Name of volunteer (block capitals): ………………………………………………………...
Signed: ………………………………………………………………………………………
Date: ………………………………………………………………………………………
Appendix F: Example of coded extracts

Participant A
Participant D
Participant I

OK. Thank you. So moving on to the next question, I know you touched on this already, when a patient comes to see you, how do you find out in particular what they would like to talk about when it’s to do with mental health, so if a patient is finding it a bit difficult to talk about these symptoms?

OK. And you mentioned that it depends on how you ask. But is it OK to give an example of what type of questions you might ask to make them feel a bit more comfortable in disclosing how they’re feeling?

OK. And what do you look for in terms of the person’s body language?

OK, thank you that’s really helpful. And just thinking again when a patient comes to see you, how might it vary by gender?

Ermm I think that men are generally a little bit less reluctant to talk about how they’re feeling in general but the ones that come to the doctors are obviously the ones that are there to talk about it so there are probably people that are not seeing and who are not discussing their mental health problems and are just with them alone or with the support of their friends and family but it’s the ones that come and see us are generally prepared to talk about them. Ermm I mean sometimes you notice if a patient is anxious and you ask them if they want to explore that more with you and they...
Appendix G: Debrief

Dear <insert participant name>,

Thank you for taking part in my research. I would like to take this opportunity to debrief you about the nature of the study and to provide you with a brief summary of the results.

Background
I had recently completed a literature review about the recognition, diagnosis and treatment of mental illness in the UK. As the gateway to mental health services is primarily through a GP, I was specifically looking for research into GPs’ experience of working with individuals presenting with psychological distress; however, I found for there to be very little research in this area.

Aims
For this reason, we aimed to explore the experiences and views of GPs of working with people experiencing psychological distress, including any potential challenges that can arise. Existing research has reported differences in the attendance rates of men and women; that men may visit their GP less frequently, that men may be more reluctant to seek help for mental health problems, and that men may present differently to a GP when presenting with psychological distress. With this in mind, the researchers aimed to explore the GPs’ experiences of consulting with both male and female patients, and to see if any differences arose or not. In addition, the researchers aimed to explore the factors that facilitate men’s disclosure of psychological distress. This was done by asking participants questions like “How might this vary by gender?”, which you may remember.

The interview schedule did not have explicit questions about male or female patients, as the researchers did not want to make any assumptions, cause any bias or be leading in any way, but instead provided the participants with an opportunity to talk freely about this. Your contribution to the research has been extremely valuable in increasing the understanding of the recognition, diagnosis and treatment of mental illness for both male and female patients.

Method
The interviews were audiotaped and transcribed by the main researcher. The data was kept confidential in accordance with the Data Protection Act (1998) by storing them on an encrypted USB stick. The recordings were deleted and the transcripts were anonymised.

The data has been analysed using a Thematic Analysis approach, where emerging patterns were identified from the data and developed into themes. The themes were repeatedly revisited, refined and reviewed to ensure that they truly reflected the participants’ data.

Results
Across the data, three themes emerged.

1) Facilitating Techniques
Across all of the interviews, different factors assisted consultations with male and female patients presenting with psychological distress. These facilitating techniques seemed to encompass five subthemes:
- Firstly, the **GP’s interpersonal skills** (e.g. open questions, awareness of body language, tone of voice and mood, acknowledgement and labelling of a patient’s mood, taking a step back, and being non-confrontational and non-intimidating)
- Secondly, **masking and unmasking** (e.g. male patients may “mask” their psychological distress by attending the surgery reluctantly, by talking about a minor problem, by being oblique, by dropping hints or by focusing on a physical problem). In response to this, some participants identified ways in which they may adapt their communication (e.g. more “probing”, more direct questions, and using metaphors to explain mental illness). It was also suggested that some men could be sent an invite for a “wellman check” to encourage accessing help, for both mental and physical difficulties. However, it was also acknowledged by some participants that their approach did not vary by gender.
- Thirdly, **specific methods used to gather information** (e.g. taking a comprehensive history and using the ICE (ideas, concerns, expectations) framework)
- Fourthly, **mental health awareness** (e.g. completing a placement in psychiatry as part of training)
- and lastly, **organisational influences** (e.g. the impact of small model practices versus large model practices and the constraints of time on the development of relationships)

2) **Recognition of Patient’s Treatment Preferences**
Across all of the interviews, the participants generally appeared to be guided by their patient’s preferences in relation to their decision-making when thinking of the best treatment pathway. However, whilst the participants described not treating male and female patients differently, they reported that male patients may prefer certain treatments over others; for example, some may prefer medication over talking therapy as they may perceive it as a “quicker fix”. Nonetheless, an important factor which appeared to impact upon the decision-making process generally for male and female patients, was the immediate availability of medication versus the waiting list times for talking therapies.

3) **Cultural Prism**
There appeared to be some cultural factors through which help-seeking by men and women are governed from the GPs’ perspective. The main cultural element that arose was the “macho culture” that some male patients can experience, where they can perceive help-seeking as a sign of weakness. There was also the idea that women can see their GPs more often as they can attend for reasons which are considered part of ‘normal’ life; e.g. contraception and pregnancy, which may make some women more familiar with the process of a consultation and the surgery environment. In relation to this, participants highlighted how women tend to attend the surgery willingly, whereas men appear to be encouraged by others.

**Dissemination**
The write-up is now being finalised as part of my doctoral thesis. This will be submitted in July, and examined via an oral viva examination in September. Following completion, it is hoped that the research will be disseminated via publication in a journal.

Thank you again for taking part in my research and for making a valuable contribution to the wider literature on the recognition, diagnosis and treatment of mental illness. I wish you all the very best in your career. Please do not hesitate to contact me if you have any questions.

With Best Wishes,
Yajnah Bheenick
Appendix H: Sub-themes specifically relating to male patients

In summary, please find below the sub-themes relating to male patients specifically.

**Facilitating Techniques**

*Masking and Unmasking:* Across a majority of the interviews, differences in how male patients present to the GP were highlighted. This theme is titled “Masking” as it captures how men’s psychological distress can be “hidden” and the GPs’ awareness of this; for example; by attending the surgery reluctantly, talking about a minor problem, being oblique or dropping hints, where Participant B, a trainee GP, stated “men are generally more reluctant to come to their GP...have hidden agendas about why they’ve come...be pushed by a relative to actually come or like a partner”, “they can be quite guarded...they can present with a minor problem but actually they’ve got something that’s quite significant that they’re worried about”, “they are sort of half finishing sentences...sort of drop hints”. Additionally, a qualified GP, Participant E, explained a difference in eye contact; “I think the male patients more likely to not look at me when they walk in if they’ve got a mental health issue”, and also highlighted the possibility of men focussing on a physical problem; “they actually have a psychological or mental health problem...manifesting as a psychosomatic symptom...they can be completely focusing on a physical symptom”.

To accommodate for these differences the GPs identified how their communication differed when seeing a male patient compared to a female patient. There was recognition by some practitioners that they changed their style of questioning and explanation of mental illness, in order to “unmask” or break down some of these barriers. Whilst providing space for the patient to convey their concerns, a greater structure was required for male patients, captured by Participant B who explained “sometimes you need to do a bit more probing for men...you have to ask more direct questions to men ‘is this what’s worrying you’...specific questions about their sleep or their work”. Male patients are also seen as needing an explanation for their problems to help contextualise their difficulties and to understand the mechanisms that maintain them, as well as help them overcome them. Participant H reported “men want an explanation...if I’m going into the biochemistry of why they’re getting depressed they like it more because they can say ‘well OK it’s a bit like not having enough oil in your car engines’”. Use of metaphors was a technique adopted to provide accessible explanations that could be understood. The process appeared to allow the men to become less fearful in engaging with their mental illness.

Two qualified GPs also described methods to encourage men to access the surgery in the first place, acknowledging that for some men this is a significant barrier to help-seeking. Participant G reported “we have a range of appointments that we offer...early morning...probably help men in particular because they’re keen to stay in to work”, whilst Participant H described “I might have a wife or a partner of somebody come in and say ‘look I’m very worried about Fred’...we’ll write him a letter to say ‘...we are undergoing a bit of a wellman check your name’s come up would you like to come’”. This participant acknowledged how some practitioners may not agree with this approach, as there is some subterfuge involved, but explained; “if you’ve actually got somebody with a serious problem and they won’t face it and that serious problem happens to be picked up and treated how can that possibly be a bad thing”.

Whilst many GPs provided a tailored stance that was organised by the patient’s gender, one qualified GP inferred that they treat all of their patients the “same” and that their approach does not vary by gender; “I must admit I wonder if it may have been different when I was younger...I treat them all the same” (Participant G). Another intimated that their approach was defined by relationships rather than by gender; “No no it [my approach]
doesn’t [vary]...I mean I’m very lucky because I know my patients sooo I’m gonna say it’s so much easier when you do that’s why I like the small model” (Participant H). The GPs provided some reasoning for these differences; their maturity in practice and having worked with their community for a long time within small practices, affording them the opportunity to know their patients well. Participant E also relates his maturity in practice to the ability to recognise illness; “the more experience you get you have more of a feel what might be what might not be”.

Recognition of Patient’s Treatment Preferences

**Patient’s Preferences:** Across the data, the GPs decision-making generally appeared to be guided by their patient’s preferences in relation to their treatment. Participant A said “I guess it depends if someone’s very insistent, if they’ve already decided they’d heard their friend had been somewhere or they wanted to try medication”. The GPs’ decision-making did not appear to vary by gender, as captured by Participant H “I think it’s very equal...as long as you put your cards on the table with a patient explain what part drug therapy plays explain what part talking therapies plays I think they’re all open to I don’t think there’s a gender thing there”.

However, whilst the GPs described not treating female and male patients differently, they reported that some men may prefer medication over talking therapy. A qualified GP said “men also tend to just want a quick fix so a lot of them in my area are a lot less likely to want counselling, well not even wanting to take forward counselling” (Participant E). Participant G expanded upon this by highlighting that men living in a more deprived area might want this “quicker fix” even more; “certainly in the deprived area it’s pretty much the same...perhaps a little bit more for the men I think again because of the lower threshold to go down the medication line they probably want even quicker fixes”. It is also important to note that one qualified GP, Participant I, explained “I have a lower threshold for referral for men” due to the higher risk they present.

Cultural Prism

**Macho-culture:** From the GPs’ perspectives, there appeared to be cultural factors through which help-seeking by men and women is governed. The main cultural element that arose in three interviews was the “macho-culture” that some men experience; the perception of help-seeking as a sign of weakness. This was raised by three male qualified GPs; “they’re a very macho culture in my area” (Participant E), “the cultural aspect for males...is this a sign of weakness and can I admit that I’m going through a difficult time” (Participant G), “I’m saying males are not very good at talking about stress...coming to see me is a sense of failure” (Participant H). The GPs also highlighted differences for older men; “especially elderly men...they don’t really sort of recognise anything to do with mental health there’s quite a lot of stigma” (Participant B) and “older men tend to be more reserved and tend not to present so much and tend to present later” (Participant D).
Appendix I: A tentative framework

MACHO-CULTURE

GENDER-ROLE CONFLICT

GENDER-ROLE STRAIN

DYSFUNCTION STRAIN

A man who experiences physical and/or mental symptoms of distress, and does not seek help

Methods to encourage help-seeking:
- Adapted opening times (early morning and evening)
- Invite men for regular “wellman” checks to normalise attendance at GP surgeries

DISCREPANCY STRAIN

A man who experiences physical and/or mental symptoms of distress, and does seek help

Masking:
Attend reluctantly, talk about a minor problem, being oblique, dropping hints, reduced eye-contact, focusing on physical symptoms

Unmasking:
- More probing, ask more direct questions
- Using metaphoric explanations
Appendix J: British Journal of Clinical Psychology: Author Guidelines

The British Journal of Clinical Psychology publishes original contributions to scientific knowledge in clinical psychology. This includes descriptive comparisons, as well as studies of the assessment, aetiology and treatment of people with a wide range of psychological problems in all age groups and settings. The level of analysis of studies ranges from biological influences on individual behaviour through to studies of psychological interventions and treatments on individuals, dyads, families and groups, to investigations of the relationships between explicitly social and psychological levels of analysis.

The following types of paper are invited:

• Papers reporting original empirical investigations

• Theoretical papers, provided that these are sufficiently related to the empirical data

• Review articles which need not be exhaustive but which should give an interpretation of the state of the research in a given field and, where appropriate, identify its clinical implications

• Brief reports and comments

1. Circulation

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

2. Length

Papers should normally be no more than 5000 words (excluding abstract, reference list, tables and figures), although the Editor retains discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length.

3. Submission and reviewing

All manuscripts must be submitted via http://www.editorialmanager.com/bjcp/. The Journal operates a policy of anonymous peer review. Before submitting, please read the terms and conditions of submission and the declaration of competing interests.

4. Manuscript requirements

• Contributions must be typed in double spacing with wide margins. All sheets must be numbered.

• Manuscripts should be preceded by a title page which includes a full list of authors and their affiliations, as well as the corresponding author's contact details. A template can be downloaded from here.
• Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript with their approximate locations indicated in the text.

• Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate sheet. The resolution of digital images must be at least 300 dpi.

• All papers must include a structured abstract of up to 250. Articles which report original scientific research should also include a heading 'Design' before 'Methods'. The 'Methods' section for systematic reviews and theoretical papers should include, as a minimum, a description of the methods the author(s) used to access the literature they drew upon. That is, the abstract should summarize the databases that were consulted and the search terms that were used.

• For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full and provide DOI numbers where possible for journal articles.

• In normal circumstances, effect size should be incorporated.

• Authors are requested to avoid the use of sexist language.

• Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc. for which they do not own copyright. For guidelines on editorial style, please consult the APA Publication Manual published by the American Psychological Association.
Research Proposal: What factors organise a GP’s aptitude to elicit disclosure of psychological distress in men and how do they utilise this information?

Introduction

1.1. Background and Theoretical Rationale

The prevalence rate of mental illness within the UK’s adult population is one in four individuals over one year (The Office for National Statistics Psychiatric Morbidity report, 2001). The needs of men’s mental health is of concern as research has found that women are more likely to receive treatment for a mental illness in comparison to men (29% versus 17%), which may be explained by women’s willingness to disclose difficulties (Better Or Worse: A Longitudinal Study Of The Mental Health Of Adults In Great Britain, 2003). Women receive a diagnosis of depression more frequently than men, but it may be that men are under-diagnosed as they can present with alternative symptoms to their General Practitioner (GP) (National Institute for Health and Clinical Excellence, 2003).

The available evidence shows that men have a higher rate of ending their lives. A document titled “Preventing suicide in England: A cross-government outcomes strategy to save lives” by The Government in 2011, reported that men are three times more likely to commit suicide than women, and those between 35 and 49 years have the highest rate; figures supported by The Samaritans (2004).

Haste, Charlton and Jenkins (1998) investigated the potential for suicide prevention in primary services by examining 339 cases of suicide. They found that 80% were men, and concluded that women are more likely to be diagnosed with a mental illness and treated, such as for depression and schizophrenia. They proposed that men who have a mental illness and are at risk of committing suicide may be under-diagnosed and under-treated by GPs.
However, it is important to acknowledge that suicide is only one outcome that draws attention to the possible under-reporting of men’s mental illness.

Considering the barriers to men seeking help and accessing mental health services a review was completed by Moller-Leimkuhler (2002) with a focus on depression. It was suggested that “better health” cannot explain the lower treatment rates for men, but instead this may be accounted for by a difference in their awareness of need and help-seeking behaviour. Moller-Leimkuhler stated that men’s help-seeking may be hindered by an “inhibition of emotional expressiveness” and societal norms of “traditional masculinity”. Galdas, Cheater and Marshall (2004) found that in particular white middle-class men delay to seek help, explained by “traditional masculine behaviour”, with masculinity and gender-role conflict being particularly influential (Addis and Mahalik (2003). However, there is an absence of knowledge concerning men from different socio-economic and ethnic backgrounds.

The existing research suggests that men experience mental illness but frequently do not seek help. Conformity to masculine norms and theories of gender-role conflict have been explored as barriers to accessing services and has been extensively researched. Alongside this factor the point of access is important, with adults accessing mental health services in the UK primarily via a GP. Therefore men’s experience of this process and their interactions with a GP are central to understanding challenges posed to men.

A recent review (Bheenick, unpublished; Appendix 1) found various factors influencing the recognition, diagnosis and treatment of a mental illness by a GP. The review included studies completed in the UK which offers some understanding of this healthcare system. The factors include the GP’s communication skills, an interest in psychiatry, completing additional training in mental health and a GP’s personal characteristics. In
addition, differences were found among GPs in their decision making and referral processes. These are outlined below.

**Communication skills:** Male and female patients with a mental illness reported not feeling understood or taken seriously, and described a lack of empathy by their practitioner (Buston, 2002). Webster (2013) also highlighted communication as an important factor in recognising symptoms of emotional distress in men, where the GP’s communication style facilitated the men’s disclosure of their difficulties.

**Interest in psychiatry:** GPs’ interest in mental health was a factor which increased identification of symptoms indicating a mental illness and these GPs asked more psychosocial questions (Marks et al., 1979).

**Training and expertise:** Registrars in Railton, Mowat and Bain’s (2000) study highlighted that further training in mental health is not required post-graduation, but many viewed this as imperative in medical training. GPs that had prior experience in psychiatry were better at recognising symptoms of mental illness (Marks et al., 1979); however this study was completed over three decades ago.

**Personal characteristics:** The significance of GPs’ own gender-role scripts were highlighted by Hale, Grogan and Willott (2010). A theme that emerged was GPs being “men first, doctors second”. If a GP has certain values around “traditional masculinity”, this could influence their perception of a male patient. A GP’s own masculinity script may result in non-verbal behavioural responses to their male patient, which could lead to implicit messages regarding their willingness to engage in discussions about psychological distress. Hale et al., argue that men may be less likely to visit their GP if they think they are being perceived negatively.

**Decision making and referral processes:** GPs’ decision making was influenced by their intervention preferences when seeing patients with symptoms of a mental illness; they
were more likely to prescribe anti-depressants for depression if they preferred these, rather than referring patients to other services such as psychotherapy (Dowrick, Gask, Perry, Dixon and Usherwood, 2000).

Two referral processes emerged through Nandy, Chalmers-Watson, Gantley and Underwood (2001); “proactive referrals to” and “reactive referrals away”. “Proactive referrals to” occurred when GPs referred patients to other services for addiction or phobias for example, because the input from secondary services would benefit the patient. It therefore appeared that the GP held their patient’s interests in mind. Contrastingly, “reactive referrals away” occurred when GPs experienced emotions such as anger and frustration in response to their work. In these cases GPs tended to refer to other services because they needed assistance due to their emotional reactions, hence appearing to hold themselves in mind.

The research findings above indicate various factors related to the recognition, diagnosis and treatment of mental illness. However, in most of the mixed gender review papers, the results were not disaggregated by gender hence it is unclear how many of the participants were men, which limits the conclusions that can be drawn concerning the recognition, diagnosis and interventions for this group of participants.

The literature on the impact of GPs in the process of supporting men’s access to mental health services is lacking. This is crucial to explore as GPs are traditionally the gateway to the provision of more specialist services at a time when there is increasing concern about how men look after their well-being particularly given the high levels of suicide in men.

The research therefore aims to find out more about the specific factors that enables a GP to elicit men’s disclosure of psychological distress, and the GPs decision making processes regarding treatment. It is anticipated that this will have implications for clinical
practice and medical training for GPs, in turn having an additional benefit upon our society and economy.

1.2. Research question

Following on from the existing literature outlined above, the research question is “What factors organise a GPs aptitude to elicit the disclosure of psychological distress in men and how do they utilise this information?”.

2. Method

2.1. Design

A qualitative approach will be used as this is considered to be more appropriate for an exploratory study in answering the open-ended research question. The qualitative method chosen is grounded theory (Charmaz, 2006), as this studies “action and interaction and their meaning” (Frost, 2011); this is suitable for the research question due to its focus on GPs’ action and interaction when seeing patients with psychological distress. Grounded theory also “seeks to construct theory about issues of importance in peoples’ lives” (Glaser, 1978; Glaser & Strauss, 1967; Strauss & Corbin, 1998). As existing research about how GPs elicit disclosure of psychological distress in men and how they make use of this information is limited, the study aims to develop a theory to explain this process. Semi-structured interviews will be used with guided questions and prompting throughout. The researcher can maintain focus on the research question, whilst remaining flexible by following the participant’s line of thinking. The researcher will remain sensitive to the potential subtleties in the data, known as theoretical sensitivity (Singh, 2003).
Constant comparison will “generate and discover new categories and theories by juxtaposing one instance from the data with another” (Covan, 2007), allowing differences and similarities to be identified across the data. Initial codes will be developed from each interview and emerging themes will be identified across the data. Subsequently, following more focused coding categories will be formed, leading to a conceptual model.

Theoretical sampling will be used in line with grounded theory, where further sampling of participants occurs based on the categories identified from earlier stages of analysis and considering any subsequent concepts that appear to be important (Willig, 2008). If differences (negative cases) are identified, the analysis is extended to consider its importance in the research question, which may challenge or enhance an emerging theory (Covan, 2007). This tests developing theory against reality by continually collecting information that may dispute or expand upon its suggestions. The researcher will aim for theoretical sufficiency (Dey, 1999), where new data does not appear to contribute to the developing model.

Due to the time constraints and resources available, abbreviated grounded theory will be followed (Willig, 2008). The study will be abbreviated by restricting the sample of participants to male or female qualified and/or trainee GPs in and around London who have seen patients with psychological distress. The processes of coding and constant comparison apply; however negative case analysis, theoretical sampling and theoretical sensitivity can only be applied to the original interview data.

**Ontology and Epistemology:** Charmaz’s (2006) grounded theory is of a constructivist approach, asserting that “reality is constructed by individuals as they assign meaning to the world around them (Appleton & King 2002)” (Breckenridge & Elliott, 2012), and “challenges the belief that there is an objective truth that can be measured or captured
through research enquiry (Crotty, 1998). An assumption is made that the participants have constructed their own realities, dependent upon the meanings they attach to their actions and interactions, which are affected by their past experiences. Therefore reality is variable and is considered within the context it occurs. The “data and analysis are created through an interactive process whereby the researcher and participant construct a shared reality” (Frost, 2011), thereby adopting a constructivist position.

2.2. Participants

The aim is to recruit 10 to 12 participants to gather rich data, in line with existing research by Webster (2013) when using abbreviated grounded theory. The participants will include male and female trainee and/or qualified GPs working in and around London. Trainee and qualified GPs will be recruited due to the potential differences in their training. The participants will be of any age and ethnicity to capture a range of views.

To recruit participants, advertisements will be published in the British Journal of General Practice (BJGP), an international journal that publishes research each month, and on the online bulletin for Clinical Commissioning Groups (CCG). The researcher also has a database of 70 research active practices in Surrey, Sussex, Kent and London who will be contacted directly by phone or email to speak to the practice managers to enquire if they would like to take part. The database includes names of the relative CCGs, who the researcher will contact to obtain the appropriate information regarding Research and Development boards for approval if this is required.

2.3. Data Collection

The data will be collected using semi-structured interviews. To put participants at ease and to gather contextual information six factual questions will be asked first, followed
by four broad questions around a GP’s consultation with patients. Please see Appendix 2 for the interview schedule.

During the interviews appropriate prompting questions will be asked. This could be concerning any other clues that the participant is alert to during their consultations to indicate psychological distress, such as a patient’s body language.

The interview schedules will be adapted throughout data collection based on the emerging themes and to ensure that areas of interest and uncertainty are explored.

2.4. Procedure

1. Ethical approval gained from The University of Surrey

2. Advertisements will be published in the BJGP and bulletin for CCGs for practice managers and individual GPs. The researcher will also contact GP practices directly by phone call or email. In both cases the researcher’s email address and phone number will be provided

3. If a practice manager or individual GP is interested in taking part, they can contact the researcher by phone or email. The appropriate Research and Development departments will then be contacted if required

4. In the case of a practice manager expressing interest, the researcher will request permission to contact individual qualified and trainee GPs as part of that team by phone call or email

5. The information sheet and consent form will be sent to individuals who would like to take part by post or email to read and provide their informed consent

6. A suitable time and place will be agreed to complete the interview

7. The interview will be recorded using a Dictaphone and then transcribed by a transcription service. To ensure accuracy the researcher will listen to the recording
and check over the transcript, whilst including additional information such as the participant’s body language, tone of voice and expression. The transcriber will be asked to sign a confidentiality agreement.

8. Data analysis will be completed within an abbreviated grounded theory approach

9. A conceptual model will be shared with the participants via email to provide them with an opportunity to feedback, and to ensure it is meaningful for them (Yardley, 2007)

Please see Appendix 3 for a Gantt chart outlining the study timeline.

2.5. Ethical considerations

Every effort will be made to ensure that participants are fully aware of the purpose of the questions asked so that they have all of the information required to make an informed decision when choosing to take part or not. The participants will be informed of their right to withdraw should they wish not to complete the study once they have started.

The data will be kept confidential by storing these on an encrypted USB stick which only the researcher, two research supervisors and transcriber will have access to. A number will be allocated to each transcript to maintain its anonymity. The participants will be informed of this in the information sheet at the point of recruitment.

It should be noted that although all data will be kept confidential, the researcher will be required to consult other professionals should a participant raise any risk issues. The participants will be made aware of this at the point of recruitment and again before the interview commences. Should any issues of risk be raised, the researcher will follow protocol of informing the appropriate person and this procedure will be finalised with the practice managers.
An ethics application will be submitted to the Faculty of Arts and Human Sciences ethics committee for approval. No NHS ethics is required for this research.

2.6. Research and Development Considerations

As the research will include recruitment from different CCGs, the relevant Research and Development departments within Surrey, Sussex, Kent and London will be contacted about the nature of the study to obtain their approval and any relevant documents will be submitted if required.

3. Project costing

The costs within the project include:

- Printing of materials e.g. information sheets and consent forms
- Travelling costs between sites
- Transcription services of £1.20 per audio minute

Any cost which is not covered by the university budget of £200 will be covered by the researcher.

4. Data Analysis

The following grounded theory approach will be followed:

1. Line-by-line coding will be conducted as soon as possible after the interview
2. The interview schedule will be adapted based on the themes and to ensure that newly arising areas of interest, contradictions and uncertainty are explored
3. Focused coding, the second phase of the coding process will be implemented.
4. Categories will be developed based on the initial codes identified

5. Theoretical coding will be applied whereby the focused codes are combined into a conceptual model

6. The conceptual model will be shared with the participants via email to provide them with an opportunity to feed back, and to ensure it is meaningful for them (Yardley, 2007).

The researcher will remain rigorous in their approach and will adopt a reflexive stance. Memos will be written to record reflections after each interview and to highlight any emerging themes. They will also be used to record the similarities and differences emerging across the data to inform the development of the interview schedule. Throughout the initial stages of data analysis it may be that theoretical frameworks come to mind; however it is important to ensure that these are not imposed onto the data at this stage. The researcher will write memos to record these ideas to link back to the data at a later stage (Frost, 2011).

5. Involving/consulting interested parties

Other trainees and friends have been asked for contacts of trainee or qualified GPs that would be interested in discussing the research so that the researcher can get some feedback about the design and conduct of the research. The researcher has contacted a qualified GP and is awaiting their response.

6. Contingency Plan

The aim is to complete face-to-face interviews with the participants. However, due to the nature of a trainee or qualified GPs role and responsibilities, their availability may be limited.
In this case the interviews can be completed over the phone or Skype, with the appropriate technology to ensure it is being recorded and kept confidential.

7. Dissemination

The findings of the research will be disseminated through presentations at a Division of Clinical Psychology conference and to the recruitment sites. A submission will also be made to the British Journal of General Practice and British Journal of Clinical Psychology.
References


Bheenick, Y.N. (2014). *The role of a General Practitioner in recognising, diagnosing and treating mental illness and supporting access to mental health services*. Unpublished doctoral literature review, University of Surrey, Guildford, United Kingdom


Marks, J. N., Goldberg, D. P. and Hillier, V. F. (1979). Determinants of the ability of general practitioners to detect psychiatric illness. *Psychological Medicine, 9*(2), 337-353


Railton, S., Mowat, H. and Bain, J. (2000). Optimizing the care of patients with depression in primary care: the views of general practitioners. *Health & Social Care In The Community, 8*(2), 119-128


Literature Review: The role of a General Practitioner in recognising, diagnosing and treating mental illness in men and supporting access to mental health services

Abstract

Studies have reported that women access mental health services more frequently than men. It has also been reported that men are more likely to end their own lives. The literature also suggests that in some cases, men who have a mental illness may choose not to seek help, under-report their symptoms to their General Practitioner (GP), or present with physical symptoms, which could have an impact on whether a mental illness is recognised. Barriers to men accessing services have been extensively researched; however, the point of access to mental health services is also important, with access primarily being via a GP. It is therefore important to review factors related to the role of a GP in the recognition, diagnosis and treatment of mental illness in men.

Medline EBSCOHOST and PsycINFO were used to search for articles using a combination of the search terms doctor, communication, mental health, patient, GP, mental illness, referral, men, help seeking, General Practitioner, detect, psychiatric illness, recognise, diagnose, treat and treatment. 445 articles were initially identified. Each paper was assessed for their quality and exclusion criteria were applied. 13 papers were included in the review.

Themes were extracted from the review papers and the results section summarises six themes related to the research question. These are; “good communication skills”, having an “interest in psychiatry”, “training, knowledge and skills”, “personal values and beliefs”, “demand versus resources” and “decision-making and referral processes”.

The findings of the review are summarised and critiqued, with wider implications on clinical practice, services and society outlined.
**Introduction**

**Mental Illness and Treatment Pathways**

The prevalence rates of having a mental illness is one in four individuals in the UK over a year, whilst approximately one in six will experience this at some point during their life (The Office for National Statistics Psychiatric Morbidity report, 2001). Men are less likely to have received treatment for a mental illness compared to women (17% versus 29%), which may be attributed to women’s disclosure of mental health problems (Better Or Worse: A Longitudinal Study Of The Mental Health Of Adults In Great Britain, National Statistics, 2003). For example, depression is diagnosed more frequently in women, but men may be under-diagnosed as they can present physical symptoms to their General Practitioner (GP) (National Institute for Health and Clinical Excellence, 2003).

Differences in the pathways to accessing mental health treatment by men and women have been acknowledged (Horwitz, 1977). Horwitz interviewed 120 individuals from a community mental health centre and found; 1) women were more likely to recognise psychiatric problems, 2) women were more likely to talk about this with others and 3) women were more likely to enter treatment voluntarily. In support of this Gove and Tudor (1973) found that women access psychiatric treatment more often. However these studies are dated and conducted in the United States of America, hence it is important to consider how the social and cultural climate is different in the UK and how these have changed.

**Suicide and GP Contact**

The Government in 2011 released a document titled “Preventing suicide in England: A cross-government outcomes strategy to save lives”, which stated that the likelihood of men committing suicide is three times higher than women in the UK, and men who are between
35 and 49 years old have the highest suicide rate. Across the UK, the suicide rate in males across all ages is approximately three times higher than females (Samaritans, 2004).

Haste, Charlton and Jenkins (1998) looked at the potential for suicide prevention in primary care. They examined 339 cases of suicides, and found that 80% were men. They reported that women were more likely to have a history of mental illness, and for these women to be treated in the year leading up to their death. They concluded that men are less likely to have been diagnosed with a mental illness and subsequently treated. Haste et al., (1998) suggested that GPs may be under-diagnosing and under-treating men at risk of suicide across mental illness conditions generally.

In relation to the above, Crawford et al., (1998) found that GPs recognised depression in 36 of 70 patients with depression. Individuals who were more challenging to diagnose included men and those with “high levels of physical handicap”. Diagnostic overshadowing may occur if individuals present with physical difficulties; their symptoms of a mental illness may be wrongly accounted for by this, supported by Jorgensen et al., (1997) who found that most people with a mental illness visited their GP about physical symptoms.

Salib and Green (2003) examined gender differences in 200 cases of suicide by an elderly person between the years of 1989 and 2001. Men were less likely to be known by psychiatric services, and those who were deceased from ethnic minorities were all men, again not known to services. In younger men, Stanistreet (2004) found that few men between the ages of 15 and 39 visit their GP in the period before their death. Both of these studies therefore raise awareness of the role that primary health services can play in encouraging men to do so when they are experiencing mental distress.
Barriers to Help-seeking

The existing literature has highlighted barriers to help-seeking by men, which was explored by Moller-Leimkuhler (2002). She reported that societal norms of “traditional masculinity” may hinder help-seeking, due to an “inhibition of emotional expressiveness” which may impact upon symptom recognition. This is supported by Galdas, Cheater and Marshall (2004) who found that for men of a white middle class background in particular, delay to seek help is accounted for by “traditional masculine behaviour”. Expanding upon this, Addis and Mahalik (2003) indicated that two reasons which may account for non-attendance to mental health services by men is masculinity and gender-role conflict. However, there is an absence of knowledge concerning men from different socio-economic and ethnic backgrounds.

Young men visit their GP less often than women and are more reluctant to do so. Jeffries and Grogan (2012) interviewed young men about self-referral to primary healthcare services. They asked questions about their attendance at the GP surgery, their attention to healthcare and their behaviours related to help-seeking. The men were seen to be “strong, in control and not needing help from doctors”; however it is not clear whether this was for mental or physical health, or both. In support of other research, they found that the men appeared “tough” (Noone & Stephens, 2008; O’Brien et al., 2005), delay to seek help, appear self-reliant and can solve their problems by themselves. This is supported by Courtenay (2000), who concludes that men may dismiss their health needs and take risks, to legitimise themselves as the “stronger” sex. Similar to other studies (Mason & Strauss, 2004; Richardson & Rabiee, 2001), having an illness was seen as weak and by consulting the GP this was seen as a failure. For men who adopted a “hegemonic masculine discourse of independence” this seemed to justify not visiting their GP.
“Traditional masculinity” appears to be of great importance when considering barriers to men accessing health services. Vogel et al., (2011) investigated the “links between endorsement of masculine norms, self-stigma and help-seeking attitudes for men from diverse backgrounds”. They found that men who endorse dominant masculine values more, possess “less favourable attitudes about seeking psychological help”. This correlation was mediated by men’s experience of self-stigmatisation, which emphasises the impact of “internal judgement in relation to help seeking for men”. For example, men who have beliefs about “dominant masculine behaviours” may regard seeking help as having failed to fulfil principles of masculinity.

Alcohol and Mental Illness

Individuals with a severe mental illness are more likely to experience a problem with alcohol. It has been found that drinking too much alcohol can be a means to manage psychological distress, or be a symptom of distress. Men are more likely to experience a drug or alcohol problem compared to women (The Office for National Statistics Psychiatric Morbidity report, 2001); 80% of people in the UK who are dependent on alcohol and 67% of the population who drink at “hazardous levels”, are male. Drinking to manage difficult emotions or symptoms of a mental illness can sometimes be referred to as “self-medication”; this may be a manner in which some men cope with their psychological distress. Furthermore, 27% of men and 19% of women gave alcohol as the reason for harming themselves (Understanding alcohol misuse in Scotland, 2007).

Males’ Experiences

The Men’s Health Forum in partnership with Mind published a document titled “Delivering Male” (Wilkins & Kemple, 2010) addressing the question “What can be done to
make sure we meet the mental health needs of men and boys more effectively in the future?”.

Within this document, a chapter titled “Males Experiences and Views” encompassed the views of 74 people about men’s mental health and access to services. A theme which emerged referred to a perception that professionals can “lack understanding of men’s complex needs” and that it is “difficult to find a GP who takes it seriously”. Men also highlighted a need for extended opening hours in the evenings and weekends for GP surgeries, as they felt they are not encouraged to take time off to seek help. The men also felt they did not have enough time to “get it off your chest” during a consultation with a GP.

**Rationale for the Review**

The existing research suggests that men access mental health services less frequently and that men have a higher likelihood of ending their own lives. The author acknowledges that suicide is only one outcome that draws attention to mental illness, and it is stressed that the author is not proposing that all men who commit suicide have done so for this reason, as people can choose to end their lives for other reasons, for example in the cases of terminal illness (Jankowski & Campo-Engelstein, 2013). However, the literature above suggests that in some cases, men who experience symptoms of a mental illness may; 1) choose not to seek help, 2) under-report their symptoms, or 3) present with physical symptoms, which could all introduce difficulties in a mental illness being recognised by professionals.

The available evidence highlights some reasons for men under-reporting symptoms, such as “traditional masculinity” and gender-role conflict, which have been extensively researched. The available evidence therefore indicates that men experience mental illness but frequently do not seek help.
Alongside this factor the point of access is important, with adults accessing mental health services in the UK primarily via a GP. As described above, some men have alluded to a lack of understanding by their GPs and not having enough time to talk about their distress. Men’s experience of this process and their interactions with a GP are therefore central to understanding challenges posed to men. The aim therefore of this review is to explore the role of GPs in the recognition, diagnosis and treatment of a mental illness in men, and how they support access to mental health services.

**Method**

The databases used to search for relevant articles were Medline EBSCOHOST and PsycINFO. The search combinations were developed collaboratively by the researcher and supervisors, ensuring to include frequently used terms in mental health services and any alternatives to these to maximise the results. These were:

- “doctor AND communication AND mental health AND patient”
- “GP AND mental illness AND referral”
- “GP AND mental health AND men AND referral”
- “GP AND mental illness AND men AND referral”
- “GP AND mental health AND men”
- “GP AND help seeking AND men”
- “general practitioner AND detect AND psychiatric illness”
- “general practitioner AND recognise AND mental illness”
- “general practitioner AND recognise AND mental illness AND men”
- “general practitioner AND diagnose AND mental illness AND men”
- “general practitioner AND detect AND mental illness AND men”
- “GP AND recognise AND mental illness AND men”
- “GP AND diagnose AND mental illness AND men”
- “GP AND detect AND mental illness AND men”
- “general practitioner AND detect AND psychiatric illness AND men”
- “GP AND detect AND psychiatric illness AND men”
- “general practitioner AND diagnose AND mental illness”
- “GP AND diagnose AND mental illness”
- “GP AND treat AND mental illness”
- “general practitioner AND treat AND mental illness”
- “general practitioner AND treatment AND mental illness”
- “GP AND treatment AND mental illness”.

The searches were completed in May 2014 and were not restricted to a particular time period.

**Inclusion and Exclusion Criteria**

Once duplications were removed, articles in the English language and research conducted in the UK were included, as access to mental health services may be very different in other countries. Both qualitative and quantitative research were included as long as the authors reported data and used a formal methodological design. The articles that were specifically about a GP’s role in the recognition, diagnosis and treatment of a mental illness were included, including articles which examined patients’ views of their interactions with GPs and mental health services. However, the existing research including only adult men appeared extremely limited and therefore articles with both adolescent and adult men and women were included. In doing so the researcher hoped to identify factors related to the role
of GPs in the recognition, diagnosis and treatment of a mental illness generally, and to relate this back to the research question appropriately.

Exclusion criteria were applied, which included studies being outside of the UK, and if they did not have a focus on mental health, where articles were excluded because they were about; physical health, terminal illness and palliative care, dental care, genetic testing, dementia, prisoners, pregnancy and pharmacology. The remaining papers were then assessed for eligibility. The method is summarised in the flowchart in below.

Figure 1. Diagrammatic representation of the method.
Results

The studies outlined in this part of the review include ten with a qualitative design and three with a quantitative design. Five qualitative studies explored patients’ views of their interaction with GPs and mental health services. The remaining five qualitative and three quantitative studies explored doctor-related factors related to the recognition, diagnosis and treatment of a mental health illness where GPs were the participants. The paper titles may appear not to map onto the topic of the review explicitly (Tables 4, 5 and 6), however they were assessed as being eligible for inclusion once the research aims and results were read in detail and were deemed applicable to the question.

Quality Criteria

The quality criteria applied to assess the research was from The Standard Quality Assessment Criteria for Evaluating Primary Research Papers from a Variety of Fields (Kmet, Lee and Cook, 2004), as it enables a researcher to evaluate dissimilar sources of evidence. It provides criteria for evaluating qualitative studies (Table 1 and Table 2) as well as different criteria to evaluate quantitative studies (Table 3) in the left hand columns.

Outcome of Quality Assessment

Five qualitative studies exploring patients’ views of mental health services (Table 1): These studies explained their research questions adequately and used appropriate qualitative methodology. Two of the studies provided detailed information about the stages in their data collection and data analysis process, enabling replication if required, whilst the remaining three studies only provided partial information.

Five qualitative studies exploring doctor-related factors in the recognition, diagnosis and treatment of a mental illness (Table 2): The questions explored in these
studies were described sufficiently and each study employed appropriate methodology. Four of the five studies used purposive sampling which is appropriate in qualitative research as suitable participants relevant to the research question are sought. However, explicit information about the recruitment process was not provided hence making replication difficult. Furthermore, only one of the studies provided a clear diagrammatic representation of their analysis, whilst the remaining four mentioned the method of choice (e.g. thematic analysis) but did not provided a systematic account.

**Three quantitative studies exploring doctor-related factors in the recognition, diagnosis and treatment of a mental illness (Table 3):** The questions were described adequately and the appropriate methodology was used. However each study introduced bias in their sampling method by using snowball sampling, self-selecting sampling and opportunity sampling of recruiting GPs. In addition none of the studies reported effect sizes of their findings. However they appeared to use appropriate outcome measures and methods to analyse the data, and explained these in detail.

The findings reported below have been separated into the three areas of research outlined above. A summary of the qualitative and quantitative studies can be found in Table 4, 5 and 6 for detailed information.

**Summary of Findings**

Studies using only male participants were scarce and therefore the majority of studies have included both men and women. The researcher has therefore commented on themes relating to men and women, and has extracted those that are specifically related to men where appropriate. The eight themes that have emerged through the studies in relation to the research question are highlighted. These are GPs having; “good communication skills”, having an “interest in psychiatry” and having “adequate knowledge and skills” and
“training”. Their “personal values and beliefs” also appear to be a factor. In addition, GPs highlighted an imbalance between “service demand and resources” and information about their “decision-making and referral processes” and “treatment preferences” is provided.
<table>
<thead>
<tr>
<th>Quality Criteria</th>
<th>Study: Buston</th>
<th>Study: Gask et al.</th>
<th>Study: Lester, Titter and Sorohan</th>
<th>Study: Johnson and Welch</th>
<th>Study: Webster</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question / objective sufficiently described?</td>
<td>Yes - semi-structured interview; qualitative</td>
<td>Yes - semi-structured interview; qualitative</td>
<td>Yes - focus groups audiotaped and transcribed</td>
<td>Yes - in-depth interviews</td>
<td>Yes - semi-structured interview; qualitative</td>
</tr>
<tr>
<td>Study design evident and appropriate?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Context for the study clear?</td>
<td>Partial - not a lot of wider knowledge acknowledged</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Connection to a theoretical framework / wider body of knowledge</td>
<td>Partial - convenience sampling and not described in detail</td>
<td>Yes - purposive sampling</td>
<td>Yes - purposive and snowball sampling</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Sampling strategy described, relevant and justified?</td>
<td>Partial - reader would not be able to replicate without requesting further information</td>
<td>Yes</td>
<td>Partial - reader would not be able to replicate without requesting further information</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Data collection methods clearly described and systematic?</td>
<td>Yes - grounded theory approach</td>
<td>Partial - analysed for themes but what approach did they</td>
<td>Partial - researchers mentioned using thematic coding but did not provide a systematic account</td>
<td>Yes</td>
<td>Partial - no systematic account provided</td>
</tr>
<tr>
<td>Data analysis clearly described and systematic?</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Use of verification procedure(s) to establish credibility?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Conclusions supported by the results?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Reflexivity of the account?</td>
<td>Partial - spoke about potential biases but did not mention personal characteristics</td>
<td>Partial - spoke about potential biases but did not mention personal characteristics</td>
<td>Partial - spoke about potential influences but did not mention personal characteristics</td>
<td>Partial - spoke about potential influences but did not mention personal characteristics</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Table 1. Quality assessment for qualitative studies exploring patients’ perspectives.
Table 2. Quality assessment for qualitative studies exploring doctor-related factors.

<table>
<thead>
<tr>
<th></th>
<th>Study: Hale et al.</th>
<th>Study: Ralston et al.</th>
<th>Study: Nandy et al.</th>
<th>Study: Hinrichs et al.</th>
<th>Study: Chew-Graham et al.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question / objective sufficiently described?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Study design evident and appropriate?</td>
<td>Yes - semi-structured interview, qualitative</td>
<td>Yes - semi-structured interviews, qualitative</td>
<td>Yes - semi-structured interview, qualitative</td>
<td>Yes - semi-structured interview, qualitative</td>
<td>Yes - semi-structured interview, qualitative</td>
</tr>
<tr>
<td>Connection to a theoretical framework / wider body of knowledge</td>
<td>Yes</td>
<td>Yes</td>
<td>Partial</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Sampling strategy described, relevant and justified?</td>
<td>Yes - purposive and snowball sampling</td>
<td>Yes - purposive and self-selecting sampling</td>
<td>Yes - purposive sampling</td>
<td>Partial - convenience sampling</td>
<td>Yes - purposive sampling</td>
</tr>
<tr>
<td>Data collection methods clearly described and systematic?</td>
<td>Partial - reader would not be able to replicate without more information</td>
<td>Partial - reader would not be able to replicate without more information</td>
<td>Partial - reader would not be able to replicate without requesting further information</td>
<td>Partial - reader would not be able to replicate without requesting further information</td>
<td>Partial - reader would not be able to replicate without requesting further information</td>
</tr>
<tr>
<td>Data analysis clearly described and systematic?</td>
<td>Yes - clear diagrammatic representation</td>
<td>Partial - researchers mentioned extracting themes</td>
<td>Partial - researchers mentioned using grounded theory with no further detail</td>
<td>Partial - mentions thematic analysis but does not provide a systematic account</td>
<td>Partial - mentions thematic analysis but does not provide a systematic account</td>
</tr>
<tr>
<td>Use of verification procedure(s) to establish credibility?</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Conclusions supported by the results?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Reflexivity of the account?</td>
<td>Partial - spoke about potential influences</td>
<td>Partial - spoke about potential influences</td>
<td>Yes</td>
<td>No</td>
<td>Partial - spoke about potential influences but did not mention personal characteristics</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>----------------------</td>
<td>------------------------</td>
<td>----------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Design evident and appropriate?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Method of subject selection or source of information/input variable is described and appropriate.</td>
<td>Partial – snowball sampling – bias</td>
<td>Partial – self-selecting sampling – bias</td>
<td>Partial – opportunity sampling – bias</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subject characteristics sufficiently described?</td>
<td>Partial</td>
<td>Partial</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If random allocation was possible, is it described?</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If interventional and blinding of investigators was possible, is it reported?</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If interventional and blinding of subjects was possible, is it reported?</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcome measure(s) well defined and robust to measurement bias?</td>
<td>Partial</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sample size appropriate?</td>
<td>Partial – no mention of power</td>
<td>Partial – insufficient power</td>
<td>Partial – sample is “small”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Analysis described and appropriate?</td>
<td>Yes – spearman’s rho</td>
<td>Yes – spearman’s rho</td>
<td>Yes – chi square</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some estimate of variance is reported</td>
<td>Yes</td>
<td>Yes – standard deviations</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Controlled for confounding?</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Results reported in sufficient detail?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Results support the conclusions?</td>
<td>Yes</td>
<td>Yes</td>
<td>Partial</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Table 3. Quality assessment for quantitative studies exploring doctor-related factors.*
<table>
<thead>
<tr>
<th>Author</th>
<th>Title</th>
<th>Aim</th>
<th>Date</th>
<th>Gender</th>
<th>Participants</th>
<th>Age range</th>
<th>Measures</th>
<th>Analysis</th>
<th>Sampling</th>
<th>Main findings</th>
<th>Themes</th>
<th>Limitations</th>
<th>Strengths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buxton</td>
<td>Adolescents with mental health problems: what do they say about health services?</td>
<td>Explore adolescents' views with the aim of facilitating help seeking</td>
<td>2002</td>
<td>21 female, 11 male</td>
<td>Patients with a diagnosis of a mental illness</td>
<td>14 - 20 years</td>
<td>Semi-structured interviews</td>
<td>Grounded theory approach</td>
<td>Patients were invited by their healthcare professional</td>
<td>Focus on empathic communication skills</td>
<td>&quot;Good communication skills&quot; by practitioner</td>
<td>Majority female. Only adolescents</td>
<td></td>
</tr>
<tr>
<td>Gask, Rogers, Oliver, May and Roland</td>
<td>Qualitative study of patients’ perceptions of the quality of care for depression in general practices</td>
<td>Explore depressed patients’ perceptions of the quality of care received from GPs</td>
<td>2003</td>
<td>19 female, 8 male</td>
<td>Patients receiving treatment for depression</td>
<td>Not stated</td>
<td>Semi-structured interviews</td>
<td>Coding of themes however, approach not clearly defined</td>
<td>Purposive sampling according to age, gender and type of practice</td>
<td>Quality of care depends greatly on good communication between the practitioner and the patient supports Buxton (2002)</td>
<td>&quot;Good communication skills&quot; by practitioner</td>
<td>Method of analysis is not written in detail</td>
<td></td>
</tr>
<tr>
<td>Johnson and Welch</td>
<td>Consultation, referral and ethnicity: the role of primary care in accessing mental health services</td>
<td>Describe and compare early experiences of help-seeking for serious mental health problems among young men of white and black ethnicity</td>
<td>2010</td>
<td>7 men, 4 white, 3 black</td>
<td>Male patients</td>
<td>18 - 30 years</td>
<td>In-depth interviews</td>
<td>Grounded Theory</td>
<td></td>
<td>&quot;Good communication skills&quot; by practitioner</td>
<td>Method of data collection and analysis not written in detail</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lester, Titter and Sorohan</td>
<td>Patients’ and health professionals’ views on primary care for people with serious mental illness: focus group study</td>
<td>Explore the experiences of providing and receiving primary care from the perspectives of primary care health professionals and patients with serious mental illness respectively</td>
<td>2005</td>
<td>Mixed gender, quantity of each not stated</td>
<td>45 patients with a serious mental illness, 39 GPs and 8 nurses</td>
<td>Not stated</td>
<td>Focus group meetings and transcription</td>
<td>Themes generated however approach was not clearly defined</td>
<td>Purposive sampling and subsequent snowball sampling</td>
<td>Professionals perceived the care for individuals with SMI to be too specialised for primary care services and did not feel they had adequate knowledge and skills</td>
<td>&quot;Insufficient knowledge and skills&quot;</td>
<td>Good number of GPs for a qualitative study</td>
<td></td>
</tr>
<tr>
<td>Webster</td>
<td>A Grounded Theory Approach: Exploring Men’s Access to IAPT Services and Accounts of Psychological Help Seekers</td>
<td>Explore the accounts of psychological distress and the pathways into IAPT services for men</td>
<td>2013</td>
<td>11 male</td>
<td>11 male patients</td>
<td>35 - 49 years</td>
<td>Semi-structured interviews</td>
<td>Grounded Theory approach</td>
<td>Self-selecting</td>
<td>Some men who sought help from their GP focused on physical difficulties. Style of communication by the GP led to a more comprehensive disclosure</td>
<td>&quot;Good communication skills&quot; by practitioner</td>
<td>White British backgrounds</td>
<td>Clear, systematic methods outlined</td>
</tr>
</tbody>
</table>

Table 4. Summary of qualitative studies of patients’ views.
<table>
<thead>
<tr>
<th>Author</th>
<th>Title</th>
<th>Aim</th>
<th>Date</th>
<th>Gender</th>
<th>Participants</th>
<th>Age range</th>
<th>Measures</th>
<th>Analysis</th>
<th>Sampling</th>
<th>Main Findings</th>
<th>Themes</th>
<th>Limitations</th>
<th>Strengths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chew-Graham, Slade, Montana, Stewart and Gasic</td>
<td>Loss of doctor-to-doctor communication: lessons from the reconfiguration of mental health services in England</td>
<td>Explore the tensions across the primary-secondary interface and to inform service developments in other specialties</td>
<td>2008</td>
<td>Mixed gender, quantity of each not stated</td>
<td>35 GPs, 5 psychiatrists, 12 managers of CMHTs</td>
<td>Not stated</td>
<td>Semi-structured interviews</td>
<td>Thematic analysis</td>
<td>Purposive sampling to ensure variability</td>
<td>Referring to the CMHT for two main reasons; 1) to obtain specialist knowledge 2) to make a request for their input for the care of the patient</td>
<td>'Decision-making and referral processes' two types highlighted</td>
<td>No systematic account of data analysis</td>
<td>A large sample recruited considering it is a qualitative study therefore views of many professionals were captured</td>
</tr>
<tr>
<td>Hale, Grogan and Willett</td>
<td>Male GPs’ views on men seeking medical help: A qualitative study</td>
<td>Explore male GPs’ experiences of their male patients’ patterns of self-referral</td>
<td>2010</td>
<td>10 males</td>
<td>GPs</td>
<td>35 - 53 years</td>
<td>Semi-structured interviews</td>
<td>Interpretive Phenomenological Analysis (IPA)</td>
<td>Snowball sampling</td>
<td>Emerging theme: ‘Men first, doctors second’</td>
<td>'Personal values and beliefs'</td>
<td>Good age range of GPs</td>
<td></td>
</tr>
<tr>
<td>Hinchliffe, Owens, Dunn and Goodyear</td>
<td>General practitioner experience and perceptions of Child and Adolescent Mental Health Services (CAMHS) care pathways</td>
<td>Investigate GPs’ perceptions and experiences in the referral of mentally ill and behaviourally disturbed children and adolescents</td>
<td>2012</td>
<td>4 female, 3 male</td>
<td>7 GPs</td>
<td>Not stated</td>
<td>Semi-structured interviews</td>
<td>Thematic analysis</td>
<td>Recruited by email – conversion sampling</td>
<td>Requirement for specialist information and knowledge. Emphasised a need for continuous training for GPs in this area</td>
<td>'Adequate knowledge' and 'Training in mental health'</td>
<td>No systematic account of data analysis</td>
<td>Relatively balanced sample of male and female GPs</td>
</tr>
<tr>
<td>Nandy, Chalmers-Watson, Gantley and Underwood</td>
<td>Referral for minor mental illness: a qualitative study</td>
<td>Describe and analyse GPs’ decision-making processes when considering who should be treating patients with minor mental illness</td>
<td>2001</td>
<td>Mixed gender, quantity of each not stated</td>
<td>23 GPs</td>
<td>30 - 61 years</td>
<td>Semi-structured interviews</td>
<td>Grounded Theory approach</td>
<td>Purposive sampling</td>
<td>Two types of referral methods; referrals to and referrals away</td>
<td>'Decision-making and referral processes' two types highlighted</td>
<td>No systematic account of data analysis</td>
<td>Good age range and number of GPs for a qualitative study. The researchers felt they had reached saturation</td>
</tr>
<tr>
<td>Rallison, Morant and Bain</td>
<td>Optimising the care of patients with depression in primary care: the views of general practitioners</td>
<td>Explore how GPs view their roles and their capacity to cope with their patients’ mental health needs</td>
<td>2000</td>
<td>2 females, 13 males</td>
<td>15 GPs</td>
<td>35 - 56 years</td>
<td>Semi-structured interviews</td>
<td>Themes using a constant comparative approach</td>
<td>Purposive and self-selecting sampling</td>
<td>GPs reported a lack of time to work with patients who have depression and to obtain a comprehensive understanding</td>
<td>'Demand versus Resources'</td>
<td>No systematic account of data analysis</td>
<td>Good age range of GPs</td>
</tr>
</tbody>
</table>

Table 5. Summary of qualitative studies of doctor-related factors.
<table>
<thead>
<tr>
<th>Author</th>
<th>Title</th>
<th>Aim</th>
<th>Date</th>
<th>Gender</th>
<th>Participants</th>
<th>Age range</th>
<th>Measures</th>
<th>Analysis</th>
<th>Sampling</th>
<th>Effect sizes</th>
<th>Main findings</th>
<th>Themes</th>
<th>Limitations</th>
<th>Strengths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Donrick, Gask, Perry, Dixon, Underwood</td>
<td>Do general practitioners' attitudes towards depression predict their clinical behaviour?</td>
<td>To explore associations between attitudes and clinical behaviour</td>
<td>2000</td>
<td>Mixed gender, quantity of each not stated</td>
<td>40 GPs and 1,436 patients</td>
<td>Age of GPs not provided, Age of patients 18 - 65</td>
<td>Depression Attitudes Questionnaire (DAQ), 12-item General Health Questionnaire</td>
<td>Spearman's rho; correlation analysis</td>
<td>Self-selecting</td>
<td>Not stated</td>
<td>Their preferences of antidepressants over psychotherapy influence clinical behaviour</td>
<td>GP “Treatment preferences” affects “Decision-making and referral processes”</td>
<td>Self-selecting: only GPs who were willing to take part were recruited. Effect sizes not stated</td>
<td>A considerable amount of patient data was available and also covered a wide range of ages; representative of adult mental health services in the UK who see people above 18 and below 65 traditionally</td>
</tr>
<tr>
<td>Marks, Goldberg and Hilier</td>
<td>Determinants of the ability of general practitioners to detect psychiatric illness</td>
<td>To explore what enables a GP to detect psychiatric illness</td>
<td>1979</td>
<td>35 male, 16 female</td>
<td>55 GPs</td>
<td>Not stated</td>
<td>Observations of doctor-patient interviews General Health Questionnaire (GHQ)</td>
<td>Spearman's rho; correlation analysis</td>
<td>Snowball sampling</td>
<td>Not stated</td>
<td>Those with a “high identification index” appeared to have more concern and show more interest in the patient but also have an interest in psychiatry and possess higher qualifications</td>
<td>'Interest in psychiatry'</td>
<td>Sampling bias: Effect sizes not stated. Study conducted over thirty years ago</td>
<td></td>
</tr>
<tr>
<td>Millar and Goldberg</td>
<td>Link between the ability to detect and manage emotional disorders: a study of general practitioner trainees</td>
<td>To explore the relationship between the ability to detect and manage emotional disorders</td>
<td>1991</td>
<td>Mixed gender, quantity of each not stated</td>
<td>6 trainee GPs and 10 patients</td>
<td>Not stated</td>
<td>28-item General Health Questionnaire (GHQ-28)</td>
<td>Chi-square</td>
<td>Recruited from a previous study - convenience sampling</td>
<td>Not stated</td>
<td>Emphasise the importance of GPs to receive training in communication skills supports findings by Boston and Gask</td>
<td>”Training in Mental Health”</td>
<td>Relatively small sample and previously taken part in another study. Study conducted over twenty years ago. Effect sizes not stated</td>
<td></td>
</tr>
</tbody>
</table>

Table 6. Summary of quantitative studies of doctor-related factors.
1. Qualitative research – Views of mental health services from patients’ perspectives

Buston (2002) examined the views and experiences of health services by male and female adolescents with a mental illness. Most of the participants had positive and negative comments, concerning the doctor-patient relationship and their treatment.

With regards to the doctor-patient relationship, 37 comments were positive; participants described their practitioner as being able to understand them. However 45 comments were labelled as negative where they expressed dissatisfaction and talked about a lack of understanding by their GP and/or psychiatrist. These patients felt their symptoms had not been taken seriously and that they were not believed. With regards to treatment, the same themes had arisen around a lack of empathy and understanding and the importance of being listened to. The authors concluded that services and practitioners need to focus on developing communication skills that are empathic to enhance the development of the doctor-patient relationship.

It should be noted that those recruited in this study would have been willing to discuss their experiences, and therefore the views of those who would not be as comfortable to do so, or those who were not currently accessing services, cannot be captured. Furthermore, the majority of patients were female adolescents hence this limits the conclusions that can be drawn for the experience of adult men and their interactions with a GP, thereby limiting what can be applied to the research question. Empathic communication skills may therefore be particularly important for adolescents generally. In addition, the researchers did not report whether their findings had reached saturation hence other themes may have emerged.

Gask, Rogers, Oliver, May and Roland (2003) investigated the views of male and female patients of the quality of care in general practice for depression. The transcripts were analysed for themes and the results indicated, in support of Buston (2002), that the quality of care depends greatly on good communication between the practitioner and the patient,
however it was acknowledged some individuals with depression may find it difficult to disclose their difficulties. Gask et al., (2003) concluded that a person with depression may feel that a doctor might not be able to listen or comprehend, thereby requiring doctors to be more proactive in following patients up. However, it should be noted that less than 50% of the participants were male, hence it is not possible to conclude that good communication skills play a particularly important role in the recognition and treatment of mental illness in men.

A limitation of the study was the recruitment strategy; participants were recruited by their GPs which may have introduced response bias. Furthermore, the researchers did not state their method of analysis explicitly, making it difficult to ascertain how themes were developed.

Lester, Tritter and Sorohan (2005) explored the views of patients with serious mental illness (SMI) receiving primary care and the views of the health professionals that provide this. It was a qualitative focus group study which used six patient groups, six health professional groups, and six combined groups.

Themes were generated and it was found that most of the professionals perceived the care for individuals with SMI to be too specialised for primary care services and did not feel they had adequate knowledge and skills. Nonetheless, most of the patients in the study said that they would rather talk to their GP to enable continuity of care, instead of seeing somebody else with more specialist knowledge.

As with Gask et al., (2003), it is not possible to conclude that adequate knowledge and skills are a significant factor in the recognition and treatment of a mental illness in men, as the researcher recruited both men and women but did not disaggregate the results by gender.

A more recent study by Johnson and Weich (2010) aimed to “compare early experiences of help-seeking”, in which seven men of black and white ethnicity were asked
about their initial contact with the GP. Two men reported feeling like they were not listened to, and that the GP appeared not to understand. Six men were sent home without a referral to specialist mental health services and without a prescription for medication. Five men were later referred to mental health services only after their parents had either accompanied them to a subsequent appointment or made a phone call to the GP to express their concerns.

Importantly, this is the first study in the review to solely recruit men in relation to the research question, allowing an insight into the potential challenges that some men may face when seeking help for psychological distress. It provides further evidence that good communication skills are important, highlighted in Buston (2002) and Gask et al., (2003), but specifically to recognising a mental illness in men. A particular strength is the recruitment of both black and white men, obtaining experiences across the two ethnicities.

Webster (2013) also explored “men’s access to Improving Access to Psychological Therapies (IAPT) Services and accounts of psychological help-seeking” and provides support for the importance of a GP’s good communication skills when meeting with a male patient. She found that men who sought help via their GP could focus on their physical health instead. In this case, it was found that the GP’s communication method (for example being responsive and open) played a key role in enabling the men to disclose further information about their difficulties, which then led to the GP being able to recognise a mental illness. However all of the men who participated in this study were of White British backgrounds therefore these findings may not be representative of other cultures and ethnicities.

In summary of the above research, a theme which appears to be emerging is the importance of a GP having “good communication skills” when interacting with their patients to facilitate discussions concerning mental distress. Another theme is around GPs having adequate “knowledge and skills” in order to diagnose and/or treat a mental illness. With regards to supporting access to mental health services, one study also highlighted the
significant role that parents may play in a GPs “decision-making and referral processes” when referring a man to mental health services.

2. Qualitative research – Doctor-related factors related to the recognition, diagnosis and treatment for a mental health illness

Railton, Mowat and Bain (2000) explored the views of GPs about optimising the care for patients with depression and advertised the study to practices that had an interest in mental health. The questions asked concerned their own skills, organisational factors and any follow up and prescribing behaviour. Themes were developed from the transcript using a constant comparative approach (Miles & Huberman, 1994).

The analysis revealed four areas of interest; organisational issues, referral and the use of other professionals, treatment and management issues, and stigma. The GPs reported a lack of time to work with patients who have depression and to obtain a comprehensive understanding of their difficulties, in turn influencing their decision making and ultimately reduce the quality of the appointment; one GP stated “I think we miss quite a lot of depressive illness (...) because of the pressure of time”.

They reported that “postgraduate education in psychiatric care in general practice is extremely patchy”, and that there is no formal requirement for registrars to undertake any further training. Railton et al., (2000) also acknowledged an unpublished survey completed by Tayside Centre for General Practice in 1997, in which approximately 50% of the GPs wanted further training in this area, viewing this as one of the areas of medicine that requires more attention.

However, this study recruited from practices that were identified as being interested in mental health, and some GPs stated that they had agreed to participate because they do have an interest in this area. It is therefore important that these themes are considered within this...
context, where future research could aim to capture the views of GPs who do not have a particular interest in psychiatry. With regards to the research question, GPs were asked about their views regarding both male and female patients; hence it is not possible to conclude that having an interest in psychiatry would be particularly helpful in recognising mental illness in men.

Nandy, Chalmers-Watson, Gantley and Underwood (2001) aimed to analyse the decision-making process made by GPs in the treatment of minor mental illnesses. The researchers felt they had reached saturation by their final interview. Their results highlighted two referral types; “proactive referrals to” and “reactive referrals away”. The “referrals to” appeared to be for specific circumstances such as addiction and phobias. There was also a strong sense that the GPs felt the patients would benefit by being referred to other services. In contrary, the “referrals away” appeared to be frequently prompted by specific emotions felt by the GP, for example, if a GP felt frustrated or angry, these acted as “warning signs” that they required assistance, instead of a conscious decision that the referral would benefit the patient. As with Railton et al., (2000), the two referral types applied to both male and female patients, limiting the conclusions that can be made about the decision-making and referral processes concerning men with mental illness. It would be interesting to see if these referral types were upheld solely in relation to men, and whether one type is more or less applicable to men.

Chew-Graham, Slade, Montana, Stewart and Gask (2008) aimed to investigate the tensions between primary and secondary care when referrals are made to a secondary care team. The questions asked included the process of referral, and the GPs were asked about the type of patients they would refer to a Community Mental Health Team (CMHT). A particular strength of this study is the use of a large sample, hence the views of many professionals were captured and themes extracted from these.
The GPs described referring to the CMHT for two reasons; 1) to obtain specialist knowledge, and 2) to make a request for their input for the care of the patient. The GPs also talked about a personal “threshold” for referral with regards to their confidence levels and views of their competence. As with Nandy et al., (2001), it is not possible to conclude if these views and referral types are particularly pertinent in the treatment of men with mental illness.

Hale, Grogan and Willott (2010) examined the views of 10 male GPs in relation to help-seeking by men. The GPs were recruited via snowball sampling (Patton, 1990) and questions were asked about their views of men’s health needs and about why male patients decide to seek help and how. Secondary to this, they aimed to explore whether the health-related behaviours of the male GPs impacted upon their views and beliefs about their patients’ self-referral behaviour.

Interpretative phenomenological analysis (IPA; Smith, 1995, 1996) was used for the data analysis. Three themes emerged from the results; firstly “managing demand” where the GPs expressed a challenge in being able to manage the demands of their service. A second theme was “men in consultation”; the GPs highlighted that those who are less likely to refer themselves are working men who were perceived as “too busy getting on with their lives”, which appeared to be perceived positively by the GPs. In contrary, men who were not currently working but attended the practice often were seen as “hypochondriacs” and were seen as comparable to women who “over-attend” and have “too much time”. The GPs still expressed some sympathy towards these men, but perceived their use of services as unsuitable. The third and final theme was “men first, doctors second”, where the GPs’ own compliance with gender roles may impact upon their relationship with the patient. The GPs seldom visited their own GP, and had a preference to “treat” themselves.

This is the first study which has explored men’s help-seeking from a GP’s point of view, specifically male GPs. It may therefore be that a GP’s own personal values and beliefs
around masculinity may affect their perception of a male patient, in turn influencing their ability to recognise or treat a mental illness. However, this study used snowball sampling hence the results need to be considered within this context, as the GPs may have similar views if they know each other.

Hinrichs, Owens, Dunn and Goodyer (2012) examined the “perceptions and experiences in the referral of mentally ill and behaviourally disturbed children and adolescents”. Thematic analysis was used and findings were categorised under three themes; detecting symptoms of mental health, referral choices and communication with the sources of referrals. The GPs all mentioned the requirement for specialist information and knowledge, and cited other studies that have suggested that the undergraduate training that GPs receive may not be sufficient for primary care professionals in completing their assessments of mental health, which Hinrichs et al., (2012) support (Kramer, Iliffe, Gledhill et al., 2012, Merry, Stasiak, Shepherd et al., 2012, Iliffe, Gallant, Kramer et al., 2012, and Pfaff, Acres & McKelvey, 2001). Hinrichs et al., (2012) therefore emphasised a need for continuous training for GPs in this area to further assist their clinical assessment.

The sample of GPs recruited were contacted by email by the researchers in the same locality which would have been a quick and easy way to select people. In completing the research within one locality this would have enabled the researchers to gain a good understanding of the experience of GPs in their area, potentially enhancing local protocol. However, as with Gask et al., (2003), it is not possible to conclude that adequate knowledge and skills are a significant factor in the recognition and treatment of a mental illness in men as the GPs’ experiences related to male and female adolescent patients.

The above research continues to uphold the themes of “knowledge and skills” and “decision-making and referral processes” that take place for access to other services, influenced by the perceived benefit to the patient, the need for additional specialist
information and the GPs own emotional reactions. In addition, a theme of GPs expressing a need for further “training in mental health” has been identified. A theme of “demand versus resources” has also emerged, where GPs expressed not being able to manage the demands of their job and that a lack of time in consultation leads to cases of mental illness not being recognised. Finally, a GPs “personal values and beliefs” may be a theme which influences their view of a man seeking help.

3. Quantitative research – Doctor-related factors related to the recognition, diagnosis and treatment for a mental health illness

Marks, Goldberg and Hillier (1979) investigated doctor-related factors in their detection of psychiatric illness. Male and female patients were interviewed and completed the General Health Questionnaire (GHQ; Goldberg, 1972, 1979) and analysis compared the GPs’ assessments with these scores to examine their ability in detecting mental illness. The researchers acknowledged the difficulty in recruiting a large number of GPs, and therefore used snowball sampling. The GPs were not informed that their verbal and non-verbal behaviour were to be recorded, as this may have influenced their interview style. This information was later provided and none of the GPs withdrew from the study. The researcher recorded the types of verbal utterances that had been made by the GP across 11 different categories, such as “open-ended questions with a psychiatric content”, “reassurances” and “information”. The frequency of each type of utterance was totalled for each GP and correlational analysis was completed between their assessment and the patients’ scores on the GHQ. Alongside this, the researchers collected information regarding the GPs’ qualifications.

The findings suggested that the doctors assessed as having a “high identification index” were evaluated as “having more interest and concern for the patient, having a greater interest in psychiatry, and were more likely to be settled in their practice and to possess
higher qualifications”. These GPs had a different approach; they appeared to “better clarify the patient’s complaint, were better at picking up cues relating to emotional distress, were better able to deal with over-talkative patients, and asked more questions with a psychosocial content”. Most of the GPs had prior experience in psychiatry and it seemed that they had some interest in this area.

However, the use of snowball sampling meant that they potentially had limited control over those recruited, as participants referred others they knew to the study. This in turn queries the representativeness of the sample as the participants may have similar views if they know each other, hence the findings may represent a small group of people, limiting diversity (Taylor and Bogdan, 1998). This study was also conducted over thirty years ago and therefore the findings may be less applicable to the present day, considering the social, cultural and organisational changes that have occurred over this time in the UK. As with Railton et al., (2000), it is not possible to conclude that having an interest in psychiatry would be particularly helpful in recognising mental illness in men.

Millar and Goldberg (1991) investigated the relationship between the ability to identify and manage emotional disorders in trainee GPs. Five consultations with patients who scored “low” on the 28-item General Health Questionnaire (GHQ-28; Goldberg & Williams, 1988) and five consultations with patients who scored “high” were chosen to be rated for each trainee, recruited as part of a previous study by Gask, Goldberg, Lesser, and Millar (1988). They identified three trainee GPs as “able identifiers” and three as “poor identifiers” of mental illness, and these trainees were selected for further study. During the consultations the trainees were rated on the presence of different behaviours, such as “giving psychosocial information”, “explaining the link between symptoms and diagnosis” and “checking that information has been understood”.
The three “able identifiers” were better at providing patients with information and advice about their treatment. Those who were more confident in their ability to manage mental illness were more readily prepared to identify them, contrary to those who felt less confident. They acknowledged that these findings were dependent on a common factor; having good communication skills, and therefore emphasised the importance for GPs to receive training in communication skills. As this theme emerged in Johnson and Weich (2010) and Webster (2013) study of men, perhaps training in these skills would be beneficial for the recognition and treatment of a mental illness for men.

However, the sample recruited for this study is small and therefore one should be sceptical in generalising the findings from six trainee GPs to others of this population. These GPs had also taken part in a previous study by some of the same researchers, and therefore they may have agreed to participate as they knew them and perhaps felt more comfortable. This study was also conducted over twenty years ago and therefore caution must be taken as to how appropriate these results are for the present day if training of GPs has since changed.

Dowrick, Gask, Perry, Dixon and Usherwood (2000) evaluated whether GPs’ attitudes about depression predict their clinical behaviour. The GPs were requested to fill in the Depression Attitude Questionnaire (DAQ; Botega, Blizard, Wilkinson & Mann, 1992) which consists of 4 components; 1) attitudes towards treatment, 2) professional unease, 3) depression malleability and 4) identification of depression. The GPs were also asked for information on their prescribing. 1,436 patients between the ages of 16 and 65 and who attended their GP surgeries were asked to complete the 12-item General Health Questionnaire (GHQ; Goldberg et al., 1997). After their consultation, the GP gave each patient a score from 1 (no disorder) to 5 (severe disorder).

Through correlational analyses, by comparing the responses on the DAQ and the GHQ-12 with the ratings provided by the GP, Dowrick et al., examined their “identification
index”, “accuracy” and “bias”. They found that there was no relationship between the GPs’ view of their own ability to recognise depression (DAQ component 4 – identification of depression) and their actual observed ability (identification index). They also found that the GPs’ views about antidepressants and psychotherapy were congruent to their clinical behaviour; GPs who had a preference for antidepressants prescribed these more compared to GPs who preferred psychotherapy.

As the GPs were recruited on a voluntary basis, only those who were willing to take part were recruited. Considering that the research explored GPs’ attitudes and their clinical behaviour, the study may not have been pursued by some GPs if they had particular attitudes that they did not want to share, and therefore it is important to bear in mind the views of those that were not captured in this study. It is also not possible to conclude that the same pattern of behaviour would be found specifically in the treatment of men. However, a considerable amount of patient data was available and also covered a wide range of ages which is a particular strength.

Across the above research, the theme of “good communication skills” appears to be upheld and in particular a suggestion for GPs to receive training in this area. A certain level of “knowledge and skills” has also been implicated where the higher qualifications and experience in psychiatry appeared to increase identification rates of mental illness, thereby supporting the earlier theme. However, two additional themes appear to be emerging; the first of having an “interest in psychiatry”, which was implied as a factor which aids recognition and diagnosis of a mental illness, and the second of “treatment preferences” where if a GP preferred anti-depressants for example, these were prescribed instead of referring to therapy.
Discussion

The existing research revealed eight themes in relation to the recognition, diagnosis and treatment of a mental illness by a GP. The themes identified have been assimilated into six overarching themes, summarised below in order of their prevalence across the 13 studies. The methodology has also been critiqued accordingly throughout each theme.

**Good Communication Skills**

This theme emerged across one quantitative study and four qualitative studies. Positively, some of the patients reported that their practitioner was able to understand their difficulties. However, other patients expressed feelings of not being understood, taken seriously or being believed, and felt a lack of empathy on the part of their practitioner. These findings highlighted the importance of being listened to and emphasised a requirement for GPs and other health professionals to possess empathic communication skills (Buston, 2002). This appeared to be a particularly important factor in the development of the doctor-patient relationship, but also the recognition of emotional distress, where the communication style of the GP led to further disclosure about the difficulties and symptoms the patient was experiencing (Webster, 2013).

However, the quantitative study used a small sample of six trainee GPs in which this theme was raised and the findings were related to the recognition and management of mental illness in men and women. This limits the generalisability to other GPs and it was not possible to conclude that “good communication skills” are particularly pertinent to consultations with men. This was also the case in two qualitative studies which recruited both male and female patients, where the majority were female. However, the remaining two qualitative studies recruited only men, where the theme of “good communication skills” was
upheld, which implies that this can be an important factor for GPs when recognising and treating mental illness in men.

However, inconsistencies were present across the qualitative studies in that some provided detailed accounts of their data analysis whilst others did not; hence it is not clear how the researchers arrived at their themes.

**Training, Knowledge and Skills**

The level of training and knowledge that a practitioner has was raised as a potential factor across three qualitative studies. It was highlighted that registrars do not have to complete further training in psychiatry or mental health post graduating, but many practitioners saw this as a vital need. GPs also viewed the care of a serious mental illness to be too specialised for primary care services and reported not having adequate knowledge and skills. This was supported by other GPs who emphasised the importance of having specialist information to detect symptoms of a mental illness and acknowledged that their undergraduate teaching may not be sufficient, supported by Marks et al., (1979) who found that GPs who were more qualified were better at identifying symptoms. These findings could therefore have implications for further training requirements for practitioners in mental health and psychiatry to better equip them in the recognition, diagnosis and treatment of mental illness.

In one qualitative study exploring patients’ views, a large sample of 45 patients were recruited enabling rich data to be collected. However, the researchers did not state the age of the participants and how many were male or female, thereby omitting important demographical data. Again, this makes it difficult to conclude if adequate training, knowledge and skills are particularly important for GPs in the recognition, diagnosis and treatment of a mental illness in men.
Decision-making and Referral Processes

This theme emerged across three qualitative and one quantitative study. When GPs were presented with patients experiencing symptoms of a mental illness, their preference for medication or psychotherapy influenced their decision making (Dowrick et al., 2000). This has important implications for treatment, and one questions whether in these cases this is discussed collaboratively with the patient first in line with a person-centred approach, or if these decisions are made without considering what would be better for the patient. However this study used a self-selecting sample and therefore only GPs who were willing to talk about their attitudes were recruited.

The referral processes that emerged through the review included “proactive referrals to” where GPs tended to refer to other services if a need was clearly identified. However “reactive referrals away” were also implied, which depended on the emotions experienced by the GP, such as anger and frustration (Nandy et al., 2001). These referrals appeared to be more organised around the GP’s own self-preservation and where a need for a referral was less clear. However this qualitative study did not explicitly report the data collection and analysis procedures, reducing the transparency of the researcher’s methods and a lack of knowledge concerning how the themes were developed.

This therefore highlights the emotions that psychological work may trigger, and how this can impact on the GP personally. It may suggest that perhaps GPs do not have a medium through which they can reflect on their work of a psychological nature, with either peers or supervisors for example, which may assist in managing this.

Johnson and Weich (2010) found that men’s parents were particularly influential in treatment, where the GP only referred to other services upon hearing their concerns in person or over the phone, which may therefore have important implications for the recognition and treatment of mental illness in men. A particular strength of this study was the recruitment of
both black and white men enabling the researcher to capture views of both ethnicities, frequently absent in research.

**Demand versus Resources**

Hale et al., (2010) explored male GPs’ views of men’s help seeking, and reported that GPs expressed a challenge in being able to manage the demands of their service. Railton et al., (2000) found that GPs report having a lack of time to work with patients who have depression and to obtain a comprehensive understanding of their difficulties, in turn influencing their decision making and ultimately reduce the quality of the appointment. If GPs experience this with patients with depression generally, additional difficulties may arise if men do not openly disclose their distress, or if they present with physical symptoms.

Between these two qualitative studies, one recruited two female and 13 male GPs and the other recruited 10 male GPs, limiting the conclusions that can be made for both male and female GPs.

**Personal Values and Beliefs**

Hale et al., (2010) highlighted the importance of GPs’ own gender role scripts. For example, some of the GPs included in the study stated that they are “men first, doctors second”. Perhaps if they have certain beliefs of “traditional masculinity”, this may influence the way they perceive a male patient. The GPs may not make their views apparent to their patients; however it should be considered whether these views are portrayed through non-verbal communication or body language, which can influence the quality of a consultation and potentially lead to the patient feeling less understood. As considered in their study, if male patients think they are being viewed in a negative manner if they seek help, this in turn can reduce their likelihood of visiting their GP. Although this theme only appeared in one
study, it is particularly pertinent to the research question with its focus on men and can therefore be perceived as a critical factor warranting further exploration. Hale et al., (2010) also recruited a good age range of GPs and provided a detailed account of the data analysis.

**Interest in Psychiatry**

In relation to detecting symptoms of a mental illness, one important factor which assisted in better identification was a GP’s interest in psychiatry and mental health, where these GPs also differed in their approach, for example, being better at recognising cues of emotional distress and asking more psychosocial questions (Marks et al., 1979). This therefore indicates that a personal interest in mental health and psychiatry may lead to better and earlier recognition in primary care. However, the age range of the GPs was not stated therefore omitting important demographical data. In addition, snowball sampling was employed in this quantitative study which may limit the representativeness of the data.

**Implications and Recommendations for Future Research**

All of the studies were conducted in the UK which provides some understanding of this healthcare system. The research above has indicated various factors related to the recognition, diagnosis and treatment of mental illness. With the exception of Johnson and Weich (2010), Webster (2013) and Hale et al., (2010), research has recruited both women and men, where the results were not disaggregated by gender. In addition many of the studies omitted important demographical data such as age. It is therefore unclear how many participants were men and what age range they were, which limits the conclusions that can be drawn concerning the role of a GP in the recognition, diagnosis and treatment for this group of participants. Importantly, each of the quantitative studies did not state their effect sizes; hence it was not possible to know whether these were small, medium or large effects in their
analyses. Future research would have to ensure full transparency in research design and results.

The literature on the impact of GPs in the process of supporting men’s access to mental health services is clearly lacking. This presents a gap in the literature especially as GPs are usually our first port of call for our health, where research has indicated that men do visit their GP less frequently, can under-report their symptoms, can present with physical symptoms, and are more likely to end their own lives. These all highlight a clear need that men do experience psychological distress and future research should aim to address this discrepancy. The processes involved between a male patient and GP is crucial to explore as GPs are traditionally the gateway to the provision of more specialist services at a time when there is increasing concern about how men look after their well-being.

Therefore, if we are able to find out more about the specific qualities, skills and procedures that enable GPs to elicit men’s disclosure of psychological distress, and the GPs’ decision making processes regarding treatment, perhaps this can have implications for clinical practice in terms of further training in mental health to be included in medical training for GPs.

The investment in adult mental health services in 2011/2012 was £6.6 billion (The 2011/12 National Survey of Investment in Mental Health, 2012) and research has shown that approximately 2.3 million individuals experiencing mental health difficulties are receiving benefits or are not working (HM Government, 2009), with this being the main reason for claiming health-related benefits (approximately 42%). The research could therefore have a positive impact upon our economy and society.
References


Marks, J. N., Goldberg, D. P. and Hillier, V. F. (1979). Determinants of the ability of general practitioners to detect psychiatric illness. *Psychological Medicine, 9*(2), 337-353


Railton, S., Mowat, H. and Bain, J. (2000). Optimizing the care of patients with depression in primary care: the views of general practitioners. *Health & Social Care In The Community, 8*(2), 119-128


Overview of Clinical Experience

Adult Mental Health Placement: Community Mental Health Recovery Service

During this placement I worked with adults between the age of 18 and 65 years old with a severe or enduring mental health problem. I offered assessment and intervention for adults experiencing anxiety, depression, obsessive-compulsive disorder, post-traumatic stress disorder, emotionally unstable personality disorder, bipolar disorder, and anger management. The primary therapeutic approach offered was Cognitive Behavioural Therapy (CBT). In addition to one-to-one psychological intervention, I co-facilitated a transdiagnostic Coping Skills Group within a CBT framework. This consisted of six workshops, titled; managing difficult thoughts, managing difficult behaviours, stress and worry, managing difficult emotions, maintaining wellbeing and sleep management. I also developed and strengthened my skills in neuropsychological assessment with individuals who were referred following concerns around their cognitive functioning, using the Wechsler Adult Intelligence Scale – Fourth Edition (WAIS-IV) and the Wechsler Memory Scale – Fourth Edition (WMS-IV).

Older Adults Placement: Memory Assessment Service

Throughout this placement I worked with adults who were referred following concerns raised during a cognitive screening. As this placement was within a memory assessment service, it enabled me to further develop my neuropsychological assessment, formulation and intervention skills for adults who were showing signs of mild cognitive impairment, or dementia, such as Alzheimer’s or Frontotemporal dementia. Following assessment, I worked with individuals and/or their carers on a one-to-one basis following a diagnosis of dementia, for example, using a CBT framework. In addition to one-to-one psychological intervention, I co-facilitated a 10-week Living Well with Dementia group with the clinical psychologist, and assisted in the facilitation of Cognitive Stimulation groups with the occupational therapist.
Learning Disability Placement: Mental Health and Learning Disability Team

I provided assessment and intervention for adults over the age of 18 years old, with learning disabilities, autism and mental health difficulties such as anxiety, depression and obsessive-compulsive disorder. This placement provided opportunities for me to work within a wider range of models, such as CBT, systemic and behavioural approaches. For example, I worked systemically with four ladies with learning disabilities residing in a supported living house, and I worked closely with staff teams from residential care homes within a positive behavioural support framework for individuals that were presenting with behaviour that challenges. I also provided consultation about psychological therapies on a one-to-one basis, for example, with a trainee psychiatrist who was working with individuals using CBT. Furthermore, I completed a repeat dementia assessment with an individual with Down’s syndrome and their carer, and worked closely with a lady with an acquired brain injury, frequently meeting with her support staff to help develop communication aids. In addition to clinical work, I presented a case to the Learning Disability Psychiatry Forum and welcomed feedback and suggestions by the range of professionals who attended. I also assisted in completing a pilot audit for the service, looking at how many people who access the adult community mental health team also have a diagnosis of autism.

Children’s Placement: Children and Adolescent Mental Health Service

This placement was based within a community team, and consisted of providing assessment and intervention for children and young people up to the age of 18 years old. This included working with children and young people with experiences of anxiety, depression, body image disturbance, obsessive-compulsive disorder, bereavement and selective mutism, using CBT, narrative therapy, systemic therapy and compassion based approaches. Additionally, I completed assessments for individuals referred following concerns about autism or attention deficit hyperactivity disorder, which included completing appropriate
observations of a child in their school environment and observing the Autism Diagnostic Observation Schedule (ADOS). I also completed an assessment of a learning disability, which enabled me to develop my neuropsychological assessment skills further by using the Wechsler Intelligence Scale for Children – Fourth Edition (WISC-IV). This placement provided me with invaluable experience of multi-agency working, for example, with social services and educational establishments that were involved in a child or young person’s life.

Specialist Placement: Inpatient Neuro-rehabilitation Team

During my specialist placement I completed assessment and intervention for individuals who were referred following a neurological injury, primarily a head injury, which ranged from mild to moderate to severe. Following assessment, the primary intervention included CBT and/or supportive sessions for individuals who were experiencing adjustment difficulties or a mental health problem, such as anxiety or depression. The development and use of relaxation strategies and mindfulness was included in their treatment. I also co-facilitated a Cognitive Rehabilitation Group for individuals who were referred, to learn strategies to maintain and improve their attention, information processing and memory skills. Additionally, I worked closely with the wider multi-disciplinary team and nursing staff in developing behavioural guidelines, in line with positive behavioural support, for individuals that were displaying behaviour that challenges. I facilitated behavioural meetings to ensure that a holistic and consistent approach was used.

Throughout each of my placements, I completed comprehensive risk assessments with individuals who were at risk to themselves or others, and collaboratively developed risk plans with the individual, which were regularly reviewed and updated. I ensured to inform my supervisor and the wider multi-disciplinary team where risk management was shared. I have also worked with individuals of different abilities, racial, cultural, religious, educational, and sexual orientation backgrounds.
# PSYCHD CLINICAL PROGRAMME

## TABLE OF ASSESSMENTS COMPLETED DURING TRAINING

### Year I Assessments

<table>
<thead>
<tr>
<th>ASSESSMENT</th>
<th>TITLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>WAIS-IV</td>
<td>Short report of WAIS-IV data and practice administration</td>
</tr>
<tr>
<td>Practice Case Report</td>
<td>A woman in late adolescence, referred by the GP for assessment and intervention following concerns around chronic anxiety, low mood and low self-esteem.</td>
</tr>
<tr>
<td>Problem Based Learning – Reflective Account</td>
<td>PBL Reflective Account, Year 1</td>
</tr>
<tr>
<td>Major Research Project Literature Review</td>
<td>The role of a General Practitioner in recognising, diagnosing and treating mental illness in men and supporting access to mental health services</td>
</tr>
<tr>
<td>Adult – Case Report 1</td>
<td>A woman in late 60s, referred by the psychiatrist for assessment and intervention following symptoms of acute anxiety</td>
</tr>
<tr>
<td>Adult – Case Report 2</td>
<td>A woman in her late teens referred for assessment and intervention for chronic anxiety, low mood and low self-esteem</td>
</tr>
<tr>
<td>Major Research Project Proposal</td>
<td>What factors organise a GP's aptitude to elicit the disclosure of psychological distress in men and how do they utilise this information?</td>
</tr>
</tbody>
</table>

### Year II Assessments

<table>
<thead>
<tr>
<th>ASSESSMENT</th>
<th>TITLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional Issues Essay</td>
<td>“Successfully promoting psychological services to men, working class young people and cultural minorities present considerable challenges to clinical psychology where the majority of practitioners are white European females”. What challenges do you anticipate there will be for you as a clinical psychologist in attempting to reach out to these groups?</td>
</tr>
<tr>
<td>Problem Based Learning – Reflective Account</td>
<td>PBL Reflective Account, Year 2</td>
</tr>
<tr>
<td>Older People – Case Report 3</td>
<td>Neuropsychological assessment of a man in his early 80s, with a history of transient ischemic attacks and presenting with symptoms compatible with mild cognitive impairment</td>
</tr>
<tr>
<td>Personal and Professional Learning Discussion Groups – Process Account</td>
<td>PPLDG Process Account</td>
</tr>
<tr>
<td>People with Learning Disabilities – Oral Presentation of Clinical Activity</td>
<td>Working Systemically with People with Learning Disabilities</td>
</tr>
</tbody>
</table>
### Year III Assessments

<table>
<thead>
<tr>
<th>ASSESSMENT</th>
<th>TITLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service-Related Project</td>
<td>A service evaluation exploring clinicians’ and clients’ views of The Coping Skills Group</td>
</tr>
<tr>
<td>Major Research Project Empirical Paper</td>
<td>What factors organise a GPs aptitude to elicit the disclosure of psychological distress in men and how do they utilise this information?&quot;</td>
</tr>
<tr>
<td>Personal and Professional Learning – Final Reflective Account</td>
<td>On becoming a clinical psychologist: A retrospective, developmental, reflective account of the experience of training</td>
</tr>
<tr>
<td>Child and Family – Case Report</td>
<td>Using an integrative approach for the treatment of anxiety for a young boy referred to CAMHS</td>
</tr>
</tbody>
</table>