

How general practice patients with emotional problems presenting with somatic or psychological symptoms explain their improvement

John Cape

SUMMARY

Background: The emotional problems of patients presenting only somatic symptoms are frequently not detected by general practitioners (GPs), yet clinical outcomes have often been found to be no different from emotional problems directly presented.

Aim: To compare clinical outcomes and attributions for improvement of patients with emotional problems presenting only somatic symptoms to GPs, with patients directly presenting emotional problems.

Design of study: Survey of patients with General Health Questionnaire (GHQ) scores in the symptomatic range, with follow-up after three months of a repeat GHQ and a questionnaire of patients' attributions for improvement.

Setting: A sample of 152 adult patients from nine general practices in North and East London.

Method: Consecutive patients were invited to complete an adapted GHQ prior to their consultation. The consultations were audiotaped and coded to indicate the extent to which psychological discussion took place, as against discussion of other issues. The GPs recorded whether they considered each patient to be emotionally disturbed or psychiatrically ill at the time of the consultation, to assess GP detection of emotional disturbance. To form the initial sample, interviews were conducted one to five days after the consultation with patients who intended to present with either psychological or somatic problems, with a follow-up questionnaire after three months.

Results: A total of 106 patients provided follow-up information, of whom 57 presented psychological problems directly at initial consultation and 49 presented only somatic symptoms. There were no differences in clinical outcome at three months between the two groups. Somatic presenters who improved were more likely than psychological presenters to attribute improvement to change in their physical health (68% versus 31%) while psychological presenters were more likely to attribute improvement to the GP's listening and counselling in the consultation (44% versus 18%). Other attributions for improvement, such as passage of time, change in life circumstances, support of family and friends, medication, and 'working through problems myself', were equally common in both groups.

Conclusions: Patients with emotional problems presenting only somatic symptoms have equivalent clinical outcomes to patients presenting psychological problems directly, but are more likely to attribute emotional improvements to change in their physical health. For some such emotionally disturbed patients it may be sufficient for GPs to treat the physical health problems and to reassure the patient, without attempting to treat the underlying emotional disturbance.

Keywords: emotional disturbance; somatic symptoms; psychiatric symptoms; general health questionnaire.

J Cape, BA, MPhil, PhD, head of psychology, Camden & Islington Mental Health NHS Trust, St Pancras Hospital, London.

Address for correspondence

Dr John Cape, Camden & Islington Mental Health NHS Trust, St Pancras Hospital, 4 St Pancras Way, London NW1 0PE. E-mail: j.cape@ucl.ac.uk

Submitted: 25 July 2000; Editor's response: 20 October 2000; final acceptance: 6 March 2001.

©British Journal of General Practice, 2001, 51, 724-729.

Introduction

A high proportion of patients with emotional problems present only somatic symptoms in general practice consultations¹⁻² and their emotional problems are not recognised by general practitioners (GPs).¹⁻⁴ Despite this, clinical outcomes of these patients are frequently found to be no different than those of patients presenting emotional problems directly^{5,6} or of patients whose emotional problems GPs recognise.^{7,8} Explanations for this include that patients presenting only somatic symptoms are frequently milder cases whose problems are more likely to remit without treatment.^{2,6,8,9}

While patients' attributions of the causes of their emotional and somatic symptoms have been investigated as a contributory factor in the way they present in primary care,^{10,11} patients' explanations as to why their emotional problems have improved have not been studied. Even in secondary care, studies have been limited to patient perceptions as to beneficial factors in the treatments provided.^{12,13} Research on lay beliefs indicates that people consider a number of factors, such as social support and personal self-control strategies, as helpful in overcoming personal problems, as well as seeking professional help.^{14,15} Life events or change in life circumstances are also important.^{16,17} An understanding of reasons given by patients for improvement, particularly for those presenting somatic symptoms only, may elucidate what is the most appropriate role for GPs in the treatment of such patients.

The aim of this study was to compare clinical outcomes and the reasons given for improvement in patients with emotional problems presenting only somatic symptoms to the GP, with patients who directly present emotional problems. It presents follow-up data not previously reported on a cohort of psychological and somatic presenters.^{18,19}

Method

Selection of the study samples is summarised in Figure 1. Consecutive adult patients attending the surgeries of nine GPs in North and East London were invited to complete a screening questionnaire. The questionnaire comprised the 30-item General Health Questionnaire (GHQ)²⁰ and a checklist of 34 common symptoms adapted from a survey of symptom prevalence in the community²¹ with an introductory question asking patients to tick the main problem or problems that they had come to see the doctor about. Two of the symptoms were 'depression' and 'anxiety, tension or nerves' while the rest were physical symptoms that could either be

HOW THIS FITS IN*What do we know?*

Many patients with emotional problems only present somatic symptoms. These emotional problems often improve even without detection or treatment by GPs.

*What does this paper add?*

Patients presenting only somatic symptoms attribute subsequent improvement in their emotional problems to improvement in physical health. Testing and providing reassurance for physical health problems may be sufficient treatment for emotional disturbance in some such patients.

indicative of possible emotional problems (e.g. 'faintness or dizziness', 'loss of appetite') or probably independent (e.g. 'sore throat', 'ear or hearing trouble'). The checklist was designed to distinguish patients with above-threshold GHQ scores, who intended to present emotional problems explicitly to the doctor (either alone or also with somatic symptoms) from patients who intended to present somatic symptoms only.

For each participating GP, approximately equal numbers of both types of patient were approached to be interviewed. Of these, 176 patients agreed to be interviewed (13 refused

and five patients with probable psychotic disorders were excluded), of whom 93 indicated they had come about psychological problems and 83 about somatic symptoms only. At the interview, which took place one to five days after the consultation, 88/93 (94.6%) of patients who had planned to present psychological problems reported that they had subsequently done so in the consultation and 64/83 (77.1%) of patients planning to present only somatic symptoms subsequently mentioned only somatic symptoms. These 88 psychological presenters and 64 somatic presenters formed the initial sample for the present study, and are henceforth referred to as the 'psychological' and 'somatic' groups. Full details of selection procedures and of characteristics of these initial samples are described in reports of the original studies.^{18,19}

In summary, the psychological and somatic groups both had above-GHQ scores but differed in whether they explicitly presented psychological problems in the consultation. Each group was mixed in other respects, with psychological presenters commonly also presenting with somatic symptoms and the somatic symptoms presented by both groups being heterogeneous (physical illness as well as somatic symptoms of emotional disturbance).

Consultations with GPs

The consultations with the GP of all patients who completed screening questionnaires were audiotaped (6.2% of patients refused). The audiotapes were coded using a system designed to assess the extent to which psychological discussion takes place in a consultation as against discussion of other issues.¹⁸ Psychological discussion was defined as any mention by patient or doctor of explicit psychological symptoms (depression, anxiety), feelings or emotions, and any discussions about events or areas in patients' lives that are causing or might be causing stress. The coded audiotapes generally confirmed the patients' reports from the research interviews, that the psychological group had explicitly brought up psychological problems in the consultation while the somatic group had not (see original reports^{18,19} and figures in Table 1 for the proportion of the consultation that comprised psychological discussion in patients successfully followed up). The audiotapes were also timed for consultation duration.

The GPs recorded whether they considered each patient to be emotionally disturbed or psychiatrically ill at the time of the consultation. This was to assess GP detection of emotional disturbance.

Interviewer ratings

As part of the interview with the patient after the consultation, the interviewer made an assessment adapted from Bridges and Goldberg⁶ of the relationship between psychological and somatic complaints. The interviewer also rated chronicity of emotional disturbance.

Follow-up questionnaire

Patients were sent a follow-up questionnaire three months after initial screening. The questionnaire comprised the GHQ-30, followed by a single-item question: 'Generally

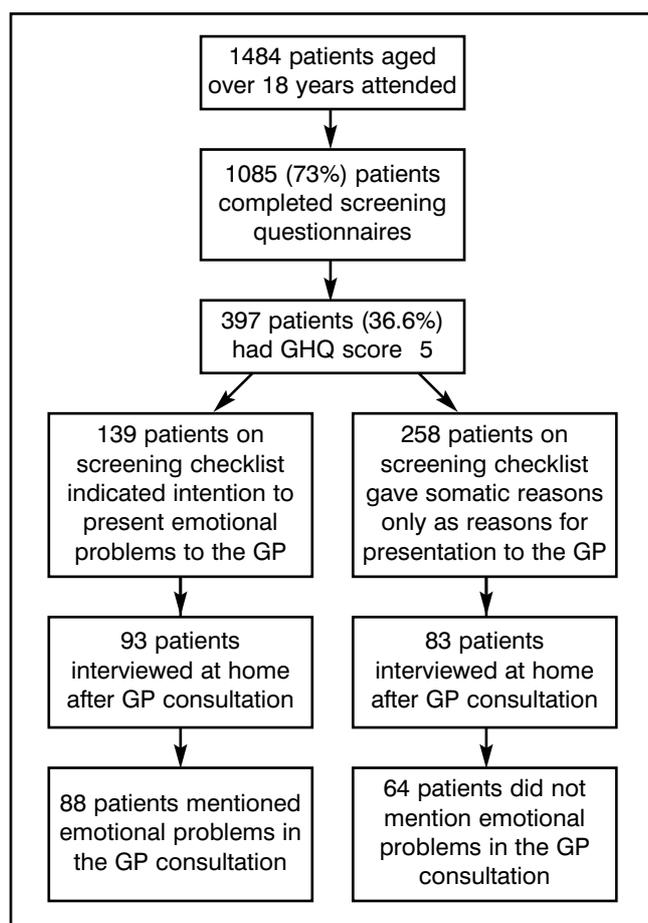


Figure 1. Selection of study samples.

Table 1. Demographic screening, consultation, and follow-up information for psychological and somatic groups. Figures are means (standard deviation in brackets) unless indicated otherwise.

	Psychological group (n = 57)	Somatic group (n = 49)	Difference between groups (95% CI)	P-value
Age (years)	43.7 (15.0)	39.0 (14.3)	4.7 (-1.0 to 10.4)	0.104
Number (%) female	46 (81)	33 (67)	13.4 (-3.1 to 30.0)	0.116
Number (%) emotional problems longer than six months	21 (37)	20 (41)	4.0 (21.9 to 14.1)	0.675
Number (%) assessed by GP with emotional disturbance	50 (88)	17 (35)	53.1 (37.2 to 68.8)	<0.001
Number of somatic complaints	2.4 (2.2)	2.6 (2.2)	-0.2 (-1.0 to 0.7)	0.720
Initial GHQ	17.8 (6.8)	13.4 (5.5)	4.4 (2.0 to 6.8)	<0.001
Consultation length in minutes	12.9 (8.4)	6.3 (4.4)	6.6 (4.0 to 9.3)	<0.001
Psychological discussion (% of consultation)	43.4 (25.7)	0.4 (1.4)	43.0 (35.6 to 50.4)	<0.001
Follow-up GHQ	8.1 (9.2)	6.6 (6.6)	1.5 (-1.6 to 4.6)	0.345

speaking, has there been any change in how you are feeling emotionally compared with three months ago? (Please tick one)', with response alternatives: 'feel better now', 'feel worse now', 'no change'. Patients who ticked that they felt better were then asked to indicate either 'yes' or 'no' for whether each of eight factors (worded exactly as in Table 3) had contributed to improvement in their emotional state. Two questions on follow-up appointments with the GP and use of psychotropic medication in the three months concluded the questionnaire.

Statistical analysis

Data analysis was undertaken in SPSS software. Differences between groups of patients were tested using χ^2 for categorical variables and *t*-tests for continuous variables (each with 95% confidence intervals). Change in GHQ was evaluated through repeated measures analysis of variance. Preliminary analyses indicated that the relevant continuous variables were approximately normally distributed and parametric tests were appropriate.

Results

Three-month follow-up questionnaires were returned by 57/88 (64.8%) of the psychological group and 49/64 (76.6%) of the somatic group. Owner occupiers were more likely to return questionnaires than patients renting accommodation (68.0% versus 51.1%, $\chi^2=3.7$, $P = 0.05$), but otherwise there were no differences between responders and non-responders in demographic or clinical characteristics or in characteristics of their initial consultations with the GPs.

Tables 1 and 2 give demographic, screening, consultation, and interview information on the two groups of patients who returned follow-up questionnaires. The psychological group had higher screening GHQ scores than the somatic group. Although visiting the GP for emotional problems, they also identified on the screening questionnaire equal numbers of somatic symptoms as reasons for their visit to the GP as patients presenting somatic symptoms only. The groups, however, differed significantly in the relationship between somatic symptoms and emotional disturbance (Table 2: $\chi^2 = 37.2$, degrees of freedom = 4, $P<0.001$) with the psychological group presenting somatic symptoms of emotional disturbance more commonly, while only the somatic group

had emotional distress secondary to physical illness. The consultations of the psychological group were longer and on average they spent about one-half of the consultation discussing psychological problems, compared with the negligible discussion of psychosocial issues by the somatic group. They were also more likely to be identified by the GP as emotionally distressed.

At three-month follow-up, there was significant improvement in GHQ across both groups ($F = 92.9$, $df = 1$, $P<0.001$) but no significant differences between the two groups in either GHQ change ($F = 2.9$, $df = 1$, $P = 0.09$) or in follow-up GHQ scores (Table 1). Similar proportions of the psychological (47.4%) and somatic (48.9%) groups had GHQ scores in the asymptomatic range at follow-up. Because of the initial GHQ screening difference in the whole sample, a matched subsample of 35 cases in each group was selected using randomised assignment where there were uneven numbers of cases with identical initial GHQ scores in the two groups. GHQ change for the two matched subgroups was similar (from 14.8 [standard deviation = 6.1] to 6.9 [SD = 8.7] for the psychological subgroup and from 14.8 [SD = 6.0] to 7.5 [SD = 7.1] for the somatic subgroup).

There was no difference in the reported number of visits to the GP in the three-month follow-up period between the psychological (2.0, SD = 2.1) and somatic groups (1.5, SD = 1.7), but the psychological group were more likely to have had visits in which emotional problems were discussed (58.2% versus 27.6%, $\chi^2 = 9.6$, $P<0.01$). A greater proportion of psychological presenters than somatic presenters reported receiving psychotropic medication in the follow-up period (52.7% versus 18.2%, $\chi^2 = 12.5$, $P<0.001$).

Thirty-two (56.1%) of the psychological and 22 (44.9%) of the somatic group rated themselves as feeling better emotionally at three-month follow-up. Patients rating themselves as feeling better had GHQ change scores of 12.7 (SD = 6.8) compared with 3.8 (SD = 8.5) for those rating themselves as unchanged or worse, validating the patients' reports of their improvement. Similar numbers of reasons as to why they felt better were endorsed by psychological (2.8, SD = 1.1) and somatic (2.5, SD = 1.3) presenters. Table 3 gives the reasons endorsed by each group. The somatic group were more likely to attribute improvement to change in their physical health. The psychological group were more likely to

Table 2. Relationship between somatic symptoms and emotional disturbance. Figures are numbers (percentage in brackets) of patients.

	Psychological group (n = 57)	Somatic group (n = 49)
Emotional state secondary to physical illness	0 (0)	11 (22)
Emotional problems with unrelated physical illness	14 (25)	18 (37)
Physical illness or symptoms exacerbated by emotional state	8 (14)	15 (31)
Emotional disturbance with somatic symptoms	20 (35)	5 (10)
Psychological symptoms only	15 (26)	0 (0)

Table 3. Reasons for improvement in emotional problems given by psychological and somatic groups. Figures are numbers (percentage in brackets) of patients giving each reason.

Reason	Psychological group (n = 32)	Somatic group (n = 22)	Difference between groups (95% CI)	P-value
Physical health better	10 (31)	15 (68)	-37 (-12 to -62)	0.007
Passing of time	14 (44)	6 (27)	17 (-9 to 42)	0.218
Change in life circumstances	11 (34)	6 (27)	7 (-18 to 32)	0.581
Support of family or friends	10 (31)	4 (18)	13 (-9 to 36)	0.282
Medication doctor prescribed	7 (22)	4 (18)	4 (-18 to 25)	0.741
Doctor's listening and counselling	14 (44)	4 (18)	26 (2 to 49)	0.050
Treatment by a mental health specialist	6 (19)	1 (5)	14 (-2 to 30)	0.127
'Worked through the problems myself'	12 (37)	7 (32)	5 (-20 to 31)	0.667
Other	7 (22)	3 (14)	8 (-12 to 28)	0.444

^a Patients could give more than one reason.

attribute improvement to the doctor's listening and counselling.

Discussion

While the patients presenting only somatic symptoms were found to have no different clinical outcomes to patients presenting directly with psychological problems, there were differences in attributions for improvement in the two groups. Patients presenting somatic symptoms only were more likely to attribute improvement to change in their physical health, while patients presenting psychological problems directly were more likely to attribute improvement to the GP's listening and counselling.

A lack of difference in clinical outcomes of psychological problems between somatic and psychological presenters, and between patients whose emotional problems are identified by the GP and those who are missed, is the modal finding in naturalistic studies, with some studies finding better outcomes for psychological and detected cases and other studies finding poorer outcomes.^{5-8,22,23} The present study replicates and extends this finding by confirming that similarity in outcome can occur despite no explicit mention by either the patient or the doctor (validated by independent data) of psychological symptoms or psychosocial issues in the consultations of somatic presenters. With the initial difference in GHQ scores between the two groups, the results are consistent with the suggestion that patients presenting only somatic symptoms are more frequently milder cases of emotional disturbance whose problems are more likely to remit without treatment.^{2,6,8,9}

This is the first study in general practice of patients' attributions of the factors responsible for their improvement. It is reassuring to report that the majority of patients who presented psychological problems directly to GPs did attribute their improvement in part to some aspect of the GP's inter-

vention. The GP's listening and counselling or psychological management²⁴ was more frequently rated as important than the psychotropic medication prescribed. This most likely reflects differences in the frequency with which medication and psychological management was provided by GPs, but also mirrors studies of lay beliefs on the relative efficacy of counselling and medication in treatment of depression.^{25,26}

Improvement in physical health, as well as being the reason for improvement in emotional problems most frequently endorsed by somatic presenters was also commonly endorsed by psychological presenters, most of whom also presented somatic symptoms. Whether the patients attributed improvement in their physical health to the doctor's treatment or to other factors was not asked. While the impact of physical health on psychological morbidity is well established^{27,28} and chronic ill health is known to predict persistence of psychological problems;^{29,30} the potential significance of treating or reassuring patients about physical health problems as a means of reducing emotional ill health is less often discussed.

Other reasons given by patients for improvement — change in life circumstances, support of family and friends, working through problems themselves, and passage of time — are consistent with other evidence of the importance of these factors. The significance of life events and social difficulties in the maintenance of problems, and of 'fresh start' events and social support in their amelioration, are well documented.^{16,17} Family and friends are a more common source of help and advice than professionals,³¹ even for patients in specialist treatment.³² Personal resources, such as resilience and coping styles, allow some patients to be more successful in overcoming problems than others.³³ Finally, passage of time has long been considered a factor in spontaneous remission.³⁴

There are a number of methodological limitations to the

study. First, the psychological presenters had higher initial psychological symptom scores than the somatic presenters. This is a common finding in naturalistic studies,^{2,6,9} but leads to difficulties in interpretation of change scores, only partly dealt with by retrospective creation of a matched subsample in this study. Secondly, the study was ultimately underpowered. Sample size calculations were based on size of groups to detect a GHQ difference of three points between groups at a power of 0.8 at the 5% significance level; however, both the standard deviation of GHQ change and loss of patients to follow-up were greater than anticipated. In addition, the significant proportion of patients lost to follow-up, despite the lack of differences found from those successfully followed up, could have differed in other ways not measured. Thirdly, the GHQ is primarily designed as a screening measure rather than as a measure to evaluate clinical change, although there is some evidence as to its sensitivity to change.³⁵ Finally, the sample size of improvers at follow-up for the analyses of attributions for symptom improvement was small and hence it is possible that significant differences were missed.

The treatment needs of patients with emotional problems presenting with somatic symptoms are likely to vary depending on the relationship between emotional distress and somatic symptoms. Patients whose somatic symptoms are a function of their emotional disturbance (somatisers) may require active discussion and treatment of their emotional problems,³⁶ while for patients whose emotional distress is secondary to physical illness, treating the physical illness and reassuring the patient about the secondary distress may be sufficient. The numbers of patients in the present study, especially of somatisers not presenting emotional problems, were too small to evaluate this adequately.

An understanding of patients' attributions for improvement can both help elucidate what may be therapeutic factors outside the immediate consultation and treatment and can help GPs target their own therapeutic efforts to best effect. This is important, given increasing awareness of the complexity of managing psychological problems in primary care in the face of multiple competing demands^{37,38} and increasing suggestions that not all psychological morbidity presenting in primary care may warrant treatment.^{7,9} If, for some patients, treating and reassuring about physical health problems is sufficient intervention also for associated emotional problems, then this would allow GPs to target their diagnostic and therapeutic efforts to those emotional problems where additional intervention is necessary. Confirmation of this would require a comparative treatment trial, comparing treatment of physical symptoms alone in such patients with treatment that also targeted emotional problems.

References

- Goldberg D, Huxley P. *Common mental disorders: a bio-social model*. London: Routledge, 1992.
- Weich S, Lewis G, Donmall R, Mann A. Somatic presentation of psychiatric morbidity in general practice. *Br J Gen Pract* 1995; **45**: 143-147.
- Wright AF. Unrecognised psychiatric illness in general practice. *Br J Gen Pract* 1996; **46**: 327-328.
- Tylee A, Freeling P, Kerry S, Burns T. How does the content of consultations affect the recognition by general practitioners of major depression in women? *Br J Gen Pract* 1995; **45**: 575-578.
- Verhaak PFM, Tjhuis MAR. The somatizing patient in general practice. *Int J Psychiatry Med* 1994; **24**: 157-177.
- Wright AF. A study of the presentation of somatic symptoms in general practice by patients with psychiatric disturbance. *Br J Gen Pract* 1990; **40**: 459-463.
- Goldberg D, Privett M, Ustun B, et al. The effects of detection and treatment on the outcome of major depression in primary care: a naturalistic study. *Br J Gen Pract* 1998; **48**: 1840-1844.
- Dowrick C, Buchan I. Twelve month outcome of depression in general practice: does detection or disclosure make a difference? *BMJ* 1995; **311**: 1274-1276.
- Coyne JC, Schwenk DL, Fechner-Bates S. Non-detection of depression by primary care physicians reconsidered. *Gen Hosp Psychiat* 1995; **17**: 3-12.
- Kessler D, Lloyd K, Lewis G, Pereira Gray D. Cross sectional study of symptom attribution and recognition of depression and anxiety in primary care. *BMJ* 1999; **318**: 436-440.
- Salmon P, Peters S, Stanley I. Patients' perceptions of medical explanations: qualitative analysis. *BMJ* 1999; **318**: 372-376.
- Elliott R, James E. Varieties of client experience in psychotherapy: an analysis of the literature. *Clin Psychol Rev* 1988; **9**: 443-467.
- Llewelyn SP, Elliott R, Shapiro DA, Hardy G. Client perceptions of significant events in prescriptive and exploratory periods of individual therapy. *Br J Clin Psychol* 1988; **27**: 105-114.
- Furnham A, Henley S. Lay beliefs about overcoming psychological problems. *J Soc Clin Psychology* 1988; **6**: 423-438.
- Furnham A, Hayward R. A study and meta-analysis of lay attributions of cures for overcoming specific psychological problems. *J Genet Psychol* 1997; **158**: 315-331.
- Brown GW, Adler Z, Bifulco A. Life events, difficulties and recovery from chronic depression. *Br J Psychiatry* 1988; **152**: 487-498.
- Leenstra AS, Ormel G, Giel R. Positive life change and recovery from depression and anxiety: a three-stage longitudinal study of primary care attenders. *Br J Psychiatry* 1995; **166**: 333-343.
- Cape J. Psychological treatment of emotional problems by general practitioners. *Br J Med Psychol* 1996; **69**: 85-99.
- Cape J, McCulloch Y. Patients' reasons for not presenting emotional problems in general practice consultations. *Br J Gen Pract* 1999; **49**: 875-879.
- Goldberg D, Williams P. *A user's guide to the general health questionnaire*. Windsor: NFER-Nelson, 1988.
- Hannay DR. Symptom prevalence in the community. *J R Coll Gen Pract* 1978; **28**: 492-499.
- Higgins ES. A review of unrecognised mental illness in primary care: prevalence, natural history, and efforts to change the course. *Arch Fam Med* 1994; **3**: 908-917.
- Coyne JC, Klinkman MS, Gallo SM, Schwenk TL. Short-term outcomes of detected and undetected depressed primary care patients and depressed psychiatric patients. *Gen Hosp Psychiatry* 1997; **19**: 333-343.
- Cape J, Barker C, Buszewicz M, Pistrang N. General practitioner psychological management of common emotional problems (I): definitions and literature review. *Br J Gen Pract* 2000; **50**: 313-318.
- Priest RG, Vize C, Roberts A, et al. Lay people's attitudes to treatment of depression: results of an opinion poll for Defeat Depression Campaign. *BMJ* 1996; **313**: 858-859.
- Churchill R, Khaira M, Gretton V, et al. Treating depression in general practice: factors affecting patients' treatment preferences. *Br J Gen Pract* 2000; **50**: 905-906.
- Kisely SR, Goldberg DP. Physical and psychiatric comorbidity in general practice. *Br J Psychiatry* 1996; **169**: 236-242.
- Dent OF, Waite LM, Bennett HP, et al. A longitudinal study of chronic disease and depressive symptoms in a community sample of older people. *Ageing Mental Health* 1999; **3**: 351-357.
- Kisely SR, Goldberg DP. The effect of physical ill health on the course of psychiatric disorder in general practice. *Br J Psychiatry* 1997; **170**: 536-540.
- Kennedy GJ, Kelman HR, Thomas C. Persistence and remission of depressive symptoms in late life. *Am J Psychiatry* 1991; **148**: 174-178.
- Barker C, Pistrang N, Shapiro D, Shaw I. Coping and help-seeking in the UK adult population. *Br J Clin Psychol* 1990; **29**: 271-285.
- Cross DG, Sheehan PW, Khan JA. Alternative advice and counsel in psychotherapy. *J Consult Clin Psychol* 1980; **48**: 615-625.
- Lambert MJ, Anderson EM. Assessment for the time-limited psychotherapies. *Ann Rev Psychiatry* 1996; **15**: 23-47.
- Lambert MJ. Spontaneous remission in adult neurotic disorders. *Psychol Bull* 1976; **83**: 107-119.
- Ormel J, Koeter MWJ, van den Brink W, Giel R. Concurrent validity of GHQ-28 and PSE as measures of change. *Psychol Med* 1989; **19**: 1007-1013.
- Morriss R, Gask L, Ronalds C, et al. Clinical and patient satisfaction outcomes of a new treatment for somatized mental disorder taught to general practitioners. *Br J Gen Pract* 1999; **49**: 263-267.

37. Klinkman MS. Competing demands in psychosocial care: a model for the identification and treatment of depressive disorders in primary care. *Gen Hosp Psychiat* 1997; **19**: 98-111.
38. Rost K, Nutting P, Smith J, *et al*. The role of competing demands in the treatment provided to primary care patients with major depression. *Arch Fam Med* 2000; **9**: 150-154.

Acknowledgements

I am indebted to the participating doctors whose commitment made this study possible, and to the former North Thames Regional Health Authority and to the Psychosomatic Research Trust for financial support.