Katie Crocker
Anna Chur-Hansen
Jane Andrews

Interpersonal relationships for patients with irritable bowel syndrome: a qualitative study of GPs' perceptions

Background

Irritable bowel syndrome (IBS) is a common functional gastrointestinal disorder and general practitioners (GPs) are in the front line of care. Supportive interpersonal relationships are integral to successful management and prognosis of IBS. Yet GPs' perceptions of helping patients manage interpersonal problems are unknown.

Method

Thirteen GPs (3 women, 10 men) participated in semi-structured interviews. The data were analysed thematically.

Results

Three main themes were identified. Most GPs had not actively considered that living with IBS could contribute to patients' interpersonal problems. GPs viewed interpersonal relationships as potentially triggering or exacerbating IBS symptoms. Their approach was to proactively identify interpersonal problems in order to manage the related symptoms.

Discussion

IBS is a chronic illness that is difficult to manage for patients and doctors alike. Recognising the potential interpersonal impact of IBS and referring patients to appropriate services where necessary could improve patient health outcomes as well as the doctor–patient relationship.

Keywords

irritable bowel syndrome; qualitative research; general practitioners, interview; interpersonal relationships

Irritable bowel syndrome (IBS) is a common functional gastrointestinal disorder characterised by abdominal pain, altered bowel function and bloating. IBS ranges in severity from trivial to debilitating.[1] Symptoms exist in the absence of visible structural or biochemical abnormalities,[2] although recent research has uncovered some subtle abnormalities, hinting at possible organic underpinnings.[3] The community-based prevalence of people with symptoms consistent with IBS is most commonly estimated to be between 5% and 15% in Western countries, with a female predominance of approximately 1.5–4:1, depending on criteria and study location.[3] IBS is associated with a diminished health-related quality of life.[1]

General practitioners (GPs) are in the front line of care for patients with IBS. Estimates of primary care consultation rates for people with symptoms consistent with IBS in the community range from 33%[4] to 81%.[5] Consultation rates vary depending on symptoms, cultural and psychological factors, comorbidity rates and access to health care.[6–8] Annual estimates for the number of primary care encounters for IBS are 285,000 in Australia,[9] 2.4–3.5 million in the US[7] and almost 2 million in the UK.[10]

Challenges in diagnosis and treatment,[11] high rates of functional comorbidity, the interplay of psychological factors[12] and the dependence of successful outcomes on a positive doctor–patient relationship[13] often mean that managing IBS is a source of uncertainty or frustration for treatment providers and patients alike.[14] However, when such challenges are overcome, management of IBS can be rewarding.[15]

For patients with chronic, relapsing conditions, such as IBS, maintaining supportive interpersonal relationships is integral to successful management of long-term illness, and improving prognosis[16] and general wellbeing.[17] Relationships can be a source of stress or support, thus hindering or aiding illness adjustment.[18] The impact of life stress on IBS is well established[2,7,12,19,20] and relationship stressors may contribute to the worsening of symptoms.[21] Importantly, however, relationships can also be negatively affected by chronic illness,[22,23] potentially creating a feedback loop that exacerbates both relationship problems and symptoms.

IBS is associated with impaired interpersonal relationships across a range of measures, from the broad-based social domain of health-related quality of life (HRQoL)[1] to the more specific: increased partner burden,[24] social isolation,[25] interpersonal conflict,[26] perceived stigma,[27] intrusiveness into social relationships,[27] poorer perceived social support[28] and a lack of understanding from social supports of the impact of IBS on patients' daily lives.[23] Difficulties are thought to arise in relation to the socially taboo and embarrassing nature of the symptoms, and a lack of perceived legitimacy due to IBS being a non-life-threatening disorder without visible pathophysiology, associated with stress and psychological problems.

As IBS is a chronic illness with neither a cure nor consistently effective medical treatment, attention to the impact on quality of life factors is central to management,[29] as are efforts to control symptoms. GPs are well positioned to help patients with IBS manage illness-related interpersonal problems as a way to improve patient care.[13] Yet, despite the importance of healthy interpersonal relationships in successful illness outcomes and the association of IBS with

difficulties in this regard, GPs' perspectives on their patients' interpersonal lives have not been investigated. The purpose of this study therefore was to explore how GPs conceptualise both interpersonal relationships for patients with IBS, and their own role in identifying and managing interpersonal difficulties that patients may have.

Method

A qualitative approach was used, based on semi-structured interviews with GPs (*Table 1*), to allow for exploration of experiences, attitudes and beliefs.

Sample and setting

The first author recruited GP participants by approaching them directly and via practice managers, as well as a university department of general practice, and snowball sampling. Thirteen GPs agreed to participate and gave written informed consent. Reasons were not sought for non-participation. Participants were not offered remuneration.

Data collection

The first author conducted all 13 interviews. Each interview included prompts and questions (*Table 1*) related to experiences working with patients with IBS. Interviews were audio-taped with permission and transcribed verbatim by the first author. Transcripts were offered to all participants to check for accuracy and completeness; four participants asked for transcripts and one participant added further information. Participants were not asked to review a summary of findings. Thematic saturation of data, meaning that participants provided no new information,[30] was reached by the thirteenth interview and thus data collection ceased.

Analysis

The first author analysed the data using QSR NVivo 10 qualitative software.[31] The analytical process moved back and forth through the five stages of data analysis as outlined for the Framework approach:[32] familiarisation; identifying a thematic framework; indexing; charting; mapping and interpretation (*Table 2*). The second author analysed a subset of transcripts for consistency. All authors reviewed the findings and the final themes were agreed by consensus. An audit trail was maintained to document the interviewer's thoughts and reflections on each interview and the interview process, as well as the analytical process and subsequent findings.

Ethical approval

The University of Adelaide Ethics Committee approved this study (reference number H-044-2010).

Table 1. Interview schedule: key topics and questions

Topics	Questions
Diagnosis and treatment	• How do you generally go about diagnosing patients presenting with functional bowel symptoms, such as IBS? • How do you usually explain: a) a diagnosis; and b) treatment options to your patients with IBS?
Investigation of interpersonal problems	• How often do you find yourself asking or being told about interpersonal or relationship problems by patients with IBS? • Who usually raises these issues?
Identification of interpersonal problems	• What kinds of interpersonal relationship problems do: a) you ask patients with IBS about? b) patients with IBS tell you about? • Can IBS, or something to do with IBS, cause or contribute to relationship or sexual problems?
Management of interpersonal problems	• If you discover a patient with IBS has interpersonal problems, what is your preferred course of action? • Whose role is it to help patients manage interpersonal problems? • To what extent, if at all, do you see the management of IBS-related interpersonal problems as part of your role or responsibilities as a GP?
Other	• Do you have any further thoughts or comments on anything we have discussed today?

Results

Participants were three women and 10 men currently working as GPs in a capital city in Australia, aged 40–69 years, who had been in practice for 5 to more than 40 years. Demographic data are shown in *Table 3*.

Three major themes were identified in relation to how GPs conceptualise interpersonal relationships for patients with IBS: 1) the impact that IBS may have on relationships was not a focus for GPs during consultations with patients; 2) when considered, interpersonal relationships were seen to potentially trigger or exacerbate IBS symptoms; 3) consequently, GPs sought to identify interpersonal problems in order to manage the related symptoms.

Theme 1 – The impact that IBS may have on relationships is not a focus in encounters

GPs do not raise the question of whether IBS affects relationships

GPs reported not asking patients about any impact of IBS on their lives. Some GPs did not believe IBS could negatively affect patients' lives, whereas others had not considered that IBS might have any impact. When interviewed, GPs did not spontaneously consider the impact that IBS may have on patients' lives. However, when prompted by direct questioning, these GPs reflected that it was logical or understandable that IBS symptoms could impact negatively on patients' personal lives if, for example, patients became embarrassed or their partners were not understanding.

> "I suppose yes, it can but so can any chronic illness affect anyone's relationship, it depends on how the individual takes it and what the partner is like in terms of accepting that this person has got an illness. If they just think, 'Oh, they're just bloody carrying on again' well, it doesn't help. But that's how some people are, it doesn't really matter what they've got. There are plenty of people out there, if they haven't had the illness themselves, they really haven't got much time for someone else who's got it." (GP 2, male)

One GP took a more holistic approach to IBS. In addition to exploring the impact of psychosocial stressors on symptoms, he also routinely enquired as to the consequences of living with IBS or any chronic illness on interpersonal relationships and general quality of life.

"Yeah, often times I ask them, 'Does this bother you? How does this hinder you?' I can give you a number of patients that say, 'Yes, I tend not to go out much' – especially older patients, you know – 'I'm too embarrassed by it.' So we work on what strategies can we have, because they don't like the idea of, especially for those in their 40s or 50s or young 60s – 'I don't want to be wearing pads, I don't want to be wearing undergarments, I just, you know, stay home.'" (GP 13, male)

GPs also reported that patients themselves rarely or never discussed any impact of IBS on their interpersonal lives.

"Sure, well I guess anything which affects your sense of wellbeing has the potential to make your enjoyment of life and relationships more difficult. I must say I don't often find that people would specifically volunteer to me that they think their IBS is affecting their relationships. And I'm not sure if it's something I would routinely ask about. Perhaps I should, but I don't know that I do." (GP 10, male)

Table 2. Description of the five stages of data analysis using the Framework approach

Data analysis stage	Description
1. Familiarisation with data	Listening to audio recordings and reading transcripts to identify key ideas and recurrent themes.
2. Identifying a thematic framework	Identifying key issues, concepts and themes by drawing on a priori issues and questions derived from study aims and objectives, issues raised by participants, and recurring views or experiences in the data.
3. Indexing	Systematically applying the thematic framework to the data.
4. Charting	Rearranging the data into chart form, by theme or subject area.
5. Mapping and interpretation	Using the charts to define concepts, map the range and nature of the phenomena, and identify associations between themes in order to explain findings. This process is influenced by both the original research objectives and the emerged themes.

Adapted from Pope C, Zieblands, Maus N, Analysing qualitative data. BMJ 2000; 320: 114–116, with permission from BMJ Publishing Group Ltd.

Theme 2 – Interpersonal relationships trigger or exacerbate IBS symptoms

Relationships are a potential source of stress, which triggers or exacerbates symptoms

GPs described relationships or other people in their patients' lives as potential stressors, in addition to other life areas such as activities, work or finances. Patients' stress was seen to potentially trigger or exacerbate IBS symptoms directly or indirectly. Patients' stress was also referred to as 'emotions', 'feelings', 'feeling overwhelmed', 'mental health issues' such as 'anxiety' or 'depression', getting their 'bowels in a knot' or getting 'the shits' with another person.

"… there's often a strong link between how we're feeling about ourselves and about life and relationships and how our gut is. And most people are pretty familiar with the idea that if you're really frightened by something you can get a belly ache or even lose control, so most people are familiar at the extreme end of the concept that strong emotion or things that are happening can affect how our abdomen feels and how things function. I usually suggest that, you know, you take it back a little bit, all right you might not be scared to death but if there are tensions and things happening, it has a knock on effect." (GP 10, male)

Psychosomatic explanations underpin the causal relationship between interpersonal problems and symptoms

Psychosomatic processes, usually accompanied by specific underlying psychophysiological explanations, were offered for why and how stress resulted in the manifestation of symptoms. Psychophysiological explanations revolved around the brain–gut axis, including activity of neurotransmitters, an overactive autonomic nervous system, a dysfunctional temporolimbic system and hormonal imbalances.

"[IBS is] a condition related to the way that the brain and nerves interact in the body and how it interacts with the bowel and the gastrointestinal system." (GP 5, male)

Some GPs described the physical symptoms as manifestations of hidden or buried distress.

"…if you dig deep enough you'll often find that there's something there that needs treatment, regardless of the physical symptoms … it's a masquerade, I guess, that I often describe it as, hiding something that's deeper, the symptoms. No different from a headache, you know, a stress headache, it's hiding something that's deeper." (GP 11, male)

Theme 3 – Identify and manage interpersonal problems in order to manage the related symptoms

Help patients make the connection between interpersonal problems and symptom outcomes

As a consequence of the knock-on effect of stressors on symptoms, GPs reported that they sought to explore and identify any interpersonal problems that were sources of stress for their patients. This included actively facilitating patients making their own connection between stressful relationships, or other events, and symptoms.

"I guess we try and link it to some form of psychological distress or some sort of connection, try and make a connection, no different from trying to make a connection with stress headaches, to see if we can find an underlying connection." (GP 11, male)

Eliminate, reduce or manage interpersonal problems and consequently eliminate, reduce or manage related symptoms

Once interpersonal problems, or other sources of stress were identified, GPs expressed the view that if such problems were eliminated, reduced or managed, then the associated symptoms would

also be eliminated, reduced or managed.

> "Once you find out what else is going on you know that if you solve that the pain will get better, but really that's what's going to make a difference with the pain. … You know, it's surprising how, if people have confidence in you, how you can just have a talk to them and just say a few things and suddenly they're just not stressed anymore and suddenly the pain feels a lot better. And you haven't given them anything." (GP 2, male)

Complexity of interpersonal problems determines next steps

For some patients, GPs felt the identification of the relationship between problems or stress and symptoms was enough to help patients manage their related symptoms. For other patients, GPs chose discussion or basic counselling. For more complex presentations, GPs discussed barriers to helping patients, including time pressures and not possessing the required skill sets. They therefore referred these patients to other professionals, mainly psychologists, who had more time and the relevant skills. Several GPs mentioned the value of the Medicare public health care rebates that allowed them and their patients to make use of psychological services.

> "Sometimes making that connection for people can be enough, like sometimes that's, yeah, this sort of penny drops and you can see it. I tend to do a fair bit of counselling in that I think anxiety and depression are huge issues… and so I do a lot of, I suppose, supportive counselling as opposed to cognitive behavioural therapy, or those particular modalities. But sometimes as much as asking those questions, you can open a bag of worms and all this stuff comes out and so when that happens, often it's more appropriate to see a psychologist, because if they're dealing with, yeah, if it's anxiety and depression then that stuff needs to be dealt with in a more … in a better planned way that my supportive stuff is, I think. If it's a domestic violence issue then that's a whole different thing, and yeah, sending people to counsellors is very helpful for that." (GP 8, female)

Table 3. GPs' demographic information

Demographic characteristics	n	%
Gender		
Female	3	23
Male	10	77
Age bracket in years		
40–49	7	54
50–59	3	23
60–69	3	23
Years in practice		
<10	1	8
10–19	4	31
20–29	2	15
30–39	3	23
40–49	3	23

Discussion

This is the first in-depth, qualitative study exploring GPs' conceptualisations of interpersonal relationships for patients with IBS. Before being interviewed, most GPs in this study generally had not conceived of the relationship between IBS and relationship problems as bidirectional, in which symptoms may impact on patients' interpersonal lives. Patients did not raise this outcome and so GPs did not explore these outcomes with their patients, which is a novel finding. GPs conceptualised interpersonal relationships as important but modifiable sources of psychosocial stress, which could trigger or exacerbate patients' IBS symptoms. Stated management preferences driven by this conceptualisation included helping patients make the initial connection between stress and symptoms, delivering basic counselling and referral to psychological services.

With one exception, the GPs in this study indicated that they did not generally consider the potential detriment of IBS to interpersonal relationships for their patients and therefore did not explore these issues with their patients. Health-related quality of life research has established that IBS may have an equivalent or worse impact than many diseases such as diabetes mellitus, gastroesophageal reflux disease[1] and inflammatory bowel disease (IBD).[33] In one study, patients with severe-to-moderate IBS symptoms indicated they were willing to give up an average of 25% of their remaining life to achieve perfect health.[34] The burden often extends to individuals' families,[23,24,35] employers[29] and health care systems.[36] Important personal relationships are affected in a range of ways, such as greater burden and poorer relationship and sexual satisfaction experienced by partners,[16] and a perceived lack of understanding by others for common problems caused by IBS symptoms, such as toileting needs or an inability to travel.[27] Patients with IBS with poor relationships also tend to experience higher levels of stress,[21] which has been associated with poorer health and higher utilisation of health care.[37] Further, several studies point to social isolation as a long-term consequence of IBS,[8,38] which is a key risk factor for further physical and psychological illnesses. These psychosocial outcomes may additionally function as determinants of IBS.[39] IBS remains a lifelong condition without a cure and one that can be difficult to manage effectively. Thus, the lack of attention to these issues by GP participants is an important finding.

Recent recommendations call for health practitioners to recognise psychosocial burdens of IBS and tailor treatments towards reducing their impact.[16,29] However, such recommendations are still not routinely followed in practice. These recommendations are not targeted at GPs and are not currently supported in the majority of clinical guidelines, such as the National Institute for Health Care Excellence (NICE) guideline, which is targeted at symptom control.[40] Additionally, the current IBS research foci are primarily aetiology and pharma-driven symptom management. Research exploring quality of life, psychosocial burden and the patients' perspectives of living with IBS is limited, and is published primarily in gastroenterology, psychiatry and nursing journals. GPs' awareness of the interpersonal impact could be improved through more research in GP-specific publications.

Another explanation relates to the patients themselves. The GPs in this study reported that patients did not raise impact issues with them. Patients with IBS often tend to have complex agendas: more than one bothersome symptom, co-morbid conditions, fears of organic disease,[41] and concerns about stigma,[42] in addition to seeking a diagnosis, testing, symptom resolution, reassurance[41] and education.[43] Patients with complex agendas rarely voice all issues.[44] In the context of limited consultation time, a problem

referred to by the GPs in this study, it is not surprising that neither doctors nor patients raise interpersonal issues if other more pressing issues relating to diagnosis and treatment still remain. However, their lack of discussion does not mean these issues are not important to patients; they may contribute to patients' feelings that GPs have a limited understanding of how IBS affects their lives,[42,45] and the overall mutual frustration experienced by both patients with IBS and doctors.[11,14,15]

The GPs' concerns about the impact of psychosocial stress arising from interpersonal relationships on symptoms is reflected in much of the current research findings and treatment recommendations.[2,3,7,12,14–16,20,29] As part of a comprehensive approach to understanding and managing IBS, these publications emphasise the importance of identifying and managing a range of factors that influence psychosocial stress. Consistent with the GPs' subsequent treatment preferences, many publications recommend that psychosocial problems should be identified and addressed through education and counselling for simple life problems through to psychological intervention for more complex life events.

Study limitations

The majority of GPs in this study were men. IBS has a female predominance, and women are more likely to prefer female GPs in general. Female GPs are also reportedly more likely to manage psychosocial problems on average.[46] Thus, it is possible that interpersonal issues are raised when both parties are women. It should be noted though, that there is still individual variability within genders, and the accounts provided by female GPs in the present study were consistent with the main themes presented. Additionally, qualitative research is not based on representative sampling, but on depth of data from participants.

Conclusion

Through the use of qualitative methods, this study has captured and distilled themes describing GPs' conceptualisations about IBS and interpersonal relationships, and how these beliefs drive their management decisions. This study shows that GPs are willing to help patients identify and manage interpersonal problems, yet only insofar as these problems are seen to contribute to IBS symptoms. IBS is a lifelong illness, without a cure or consistently effective medical treatment, and with a known negative impact on patients' interpersonal lives that may reduce illness adjustment and exacerbate symptoms. GPs are in the frontline of care for people with IBS, and are well positioned to help patients manage interpersonal problems as part of regular care. Improving GPs' awareness of these issues through an increased research presence in GP-targeted publications may result in improved patient outcomes, and greater patient and doctor satisfaction.

Key points

- GPs are well positioned to help patients manage interpersonal problems, whether they contribute to or arise from their IBS.
- Incorporating management of the life impact of IBS into regular patient care, where appropriate, may have significant long-term health and adjustment benefits for patients, and improve both patient and doctor satisfaction.
- Future research recommendations include evaluating the acceptability and utility of recognition and management of life impact from both the patients' and practitioners' perspectives.

Authors

Katie Crocker B.Psych (Hons), PhD candidate, School of Psychology, The University of Adelaide, SA. katie.crocker@adelaide.edu.au

Anna Chur-Hansen BA (Psych Hons), PhD, FAPS, FHERDSA, Registered Psychologist, Professor and Head, School of Psychology, The University of Adelaide, SA

Jane Andrews MBBS, FRACP, PhD, AGAF, Head of IBD Service and Education, Department of Gastroenterology and Hepatology, Royal Adelaide Hospital, SA; Clinical Associate Professor, School of Medicine, The University of Adelaide, SA; Senior Lecturer, Faculty of Medicine, Flinders University, SA

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correspondence **afp@racgp.org.au**