Patient Factors Related to the Presentation of Fatigue Complaints: Results from a Women's General Health Care Practice

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ABSTRACT. The aim of this study was to examine which patient-related factors predicted: (1) fatigue, (2) the intention to discuss fatigue and (3) the actual discussion of fatigue during consultation with a GP in a women's general health care practice. Patients were asked to complete two questionnaires: one before and one after consultation. The patient-related factors included: social-demographic characteristics; fatigue characteristics; absence of cognitive representations of fatigue; nature of the requests for consultation; and other complaints. Some 74% of the 155 respondents reported fatigue. Compared to the patients that were not fatigued, the fatigued patients were more frequently employed outside the home, had higher levels of general fatigue, and a higher need for emotional support from their doctor. A minority (12%) intended to discuss fatigue during consultation. Of the respondents returning the second questionnaire ($n = 107$), 22% reported actually discussing their fatigue with the GP while only 11% had intended to do so. In addition to the intention to discuss fatigue during consultation, the following variables related to actually discussing fatigue: living alone, caring for young children, higher levels of general fatigue, absence of cognitions with regard to the duration of the fatigue, and greater psychological,

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neurological, digestive, and/or musculoskeletal problems as the reason for consultation. Fatigue was found to be the single reason for consultation in only one case. It is concluded that fatigue does not constitute a serious problem for most patients and that discussion of fatigue with the GP tends to depend on the occurrence of other psychological or physical problems and the patient's social context. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-342-9678. E-mail address: <getinfo@haworthpressinc.com> Website: <http://www.haworthpressinc.com>]*

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INTRODUCTION

This paper examines the health-care seeking behavior for fatigue complaints among the visitors to a women's general health care practice. We consider the distinguishing characteristics of women's health care in addition to the principles that have now become part of the regular medical care–consideration of the patient's gender-identity, gender-roles, and various personal and social factors (van den Brink & Bensing, 1996). In an earlier study, some 83% of the population sampled from the present general practice indicated having suffered from fatigue during the past two weeks (van den Brink & Bensing, 1996). In the general population only 37% of the women appeared to complain of fatigue (Bensing, Hulsman & Schreurs, 1999) while in an American sample 20.4% of the women reported suffering from fatigue (Chen, 1986). Somewhat higher percentages of fatigue are found among attenders of primary care: 25% in Australian settings (Hickie et al., 1996) while 57% of the female visitors of Dutch practices appeared to complain of fatigue in a recent study (de Rijk, Schreurs & Bensing, in press). Fatigue can be classified as a medical problem when people consult a doctor for their fatigue. In The Netherlands (and also in the United Kingdom and France, for example), the general practitioner (GP) is the first medical professional one turns to. It nevertheless appears that only a small part of those who report fatigue actually consult their GP for fatigue. Percentages between 7.6% and 15.6% are reported (Fuhrer & Wessely, 1995; Cathébras, Robbins, Kirmayer & Hayton, 1992; Lamberts, Wood & Hofmans-Okkes, 1993).

The aim of the present study was to explore those patient-related factors that link to the complaint of fatigue among general practice patients at three levels: (1) feeling fatigued; (2) having the intention to consult for fatigue; and (3) actually discussing fatigue during consultation. It is assumed here that consulting for fatigue is multi-determined. To distinguish the different factors

potentially involved, several theoretical approaches are applied. The most basic model of health-care seeking behavior involves a patient noticing that a health complaint is rather severe and seeking medical advice. This would suggest that only patients with severe fatigue consult for fatigue. In connection with this, it should be noted that feeling fatigued refers to a variety of subjective experiences, such as physical fatigue, reduced motivation and mental fatigue (see Smets, Garssen, Bonke & de Haes, 1995). Some types may be more related to health-care seeking behavior than others.

Social context characteristics intervene with health-care seeking behavior as well. In modern Western societies, help is often sought when the problem interferes with social relationships or working and caring duties (Helman, 1994). Such interference has been found to prompt the medical consultation for cough, for example (Cornford, 1998). Additionally, the opinions and help of the people around the individual may stimulate or preclude the need to seek medical care (Zola, 1966 and 1973, cited in Helman, 1994). On the other hand, Grimsmo and Siem (1984) suggested that married people receive help from their spouses rather than from their GP. With regard to fatigue, it is plausible that fatigue may interfere with work and care duties, which may stimulate the discussion of fatigue with the GP. Moreover, patients who live with a partner may be less inclined to consult their GP for fatigue.

Recently, there is increasing interest in cognitive factors determining health-related behaviors. For instance, general-practice patients can have different types of requests, such as requests for explanation and reassurance, for emotional support, and for investigation and treatment (Salmon & Quine, 1989; Valori, Woloshynowych, Bellenger, Aluvihare & Salmon, 1996). Consulting for fatigue may be related to specific wishes regarding the consultation. Additionally, consulting for fatigue is possibly related to particular ideas about the fatigue. When lay people experience symptoms, they construct "cognitive representations" with regard to identity, cause, timeline, consequences and cure of the condition (Leventhal, Nerenz & Steele, 1984; Leventhal & Diefenbach, 1991; Helman, 1994). These cognitive representations have been found to predict health-care use (Cameron, Leventhal & Leventhal, 1993). It is however generally assumed that people *have* cognitive representations of their illness. In cases of fatigue they may actually be quite *unsure* about the cause, course, etc., especially when turning to a medical professional for the first time (see e.g., Salmon & Quine, 1989; Valori et al., 1996; see also Ingham & Miller, 1986). This implies particularly the degree to which illness-related cognitions are absent may predict consultation of the GP for fatigue.

Finally, from the perspective of general medical practice, seeking care for fatigue may largely depend on the other complaints which patients present. In some 67% of the initial consultations for fatigue, the complaint has been

found to be accompanied by other complaints (de Rijk, Schreurs & Bensing, 1998).

METHODS

Procedure

The visitors to a women's general health care practice with four doctors in a middle-to-large city in The Netherlands were approached between 25 June and 9 July, 1996. The first author was sitting in the waiting room and asked every patient 16 years and older (based on the practice records) to participate in a study on fatigue. If the patient met the inclusion criteria (not just accompanying a child or other person and sufficient mastering of Dutch to complete the questionnaires) and agreed to participate, he or she was given two questionnaires. The first questionnaire had to be completed before consultation and be left at the practice. The second questionnaire could be completed at home after the consultation, and was accompanied by a self-addressed and stamped return envelope.

Sample

Generally speaking, the patient population in the present practice is mainly female and younger, more highly educated, and more urbanized than the most general practice patient populations in The Netherlands. The population has also been found to present more often with psychological and social problems than the populations in regular practices (van den Brink & Bensing, 1996). Of the 257 patients asked to participate in the present study, 215 met the above criteria; 170 of these patients (79.1%) agreed to participate. Reasons for nonparticipation were: too late and thus went directly to the GP (8); not interested in participating or too much trouble (24); other reasons (7); and no reason (6). Of these 170 patients, 115 also returned the second questionnaire (67.6%), which was completed 1.7 days later on average (SD 4.22). Only female respondents were selected, which resulted in 155 respondents for the first questionnaire and 107 for the second.

Measures

Questionnaire I

The first questionnaire contained the following measures:

One-item fatigue. Respondents were asked to indicate whether they had suffered from fatigue during the previous two weeks or not.

Intention to consult for fatigue and/or other complaints. An open-ended question about the complaints one intended to discuss with the GP was included and subsequently coded into categories based on the International Classification for Primary Care (ICPC) (Lamberts & Wood, 1987). The intention to consult for fatigue was operationalized as code A040.

Social context. Respondents were asked to indicate their age, whether they were living alone or not, employed or not, and caring for children under six years of age or not.

Absence of cognitive representations of fatigue. Only fatigued respondents completed this part, which was translated and adapted to fatigue from the Illness Perception Questionnaire (IPQ) (Weinman, Petrie, Moss-Morris & Horne, 1997). A "do not know" category was added to the original 5-point rating scale, that ranged from "not agree at all" (1) to "very much agree" (5). Principal Components Analysis (PCA) showed that the original origin/cause scale appeared to involve two factors: (a) physical factor (5 items) and (b) psychological factor (4 items). In order to compute measures for the absence of cognitions on fatigue, for every respondent, the number of "do not know" responses within a scale was divided by the number of items that comprised that scale. The absence measures thus reflect the percentage of "do not know" responses per scale. (The IPQ-scales that were rated on a 5-point scale did not predict any of the dependent measures and were not used in the present analyses).

Consultation requests. The nature of the requests for the consultation was measured using a translated version of the Patient Request Form (PRF) (Valori et al., 1996), which consists of three scales: requests for (1) explanation (5 items); (2) emotional support (4 items); and (3) examination (3 items). Alphas were: explanation $\alpha = .88$, emotional support $\alpha = .86$, examination $\alpha = .56$.

Questionnaire II

The second questionnaire contained the following measures:

Discussing fatigue. The respondent was asked to indicate whether fatigue was discussed during the consultation, whether the patient or the GP had introduced the problem of fatigue, and whether the first questionnaire had influenced the discussion of fatigue.

Severity of different types of fatigue. This was measured by using the Multidimensional Fatigue Inventory (MFI-20), a self-report instrument consisting of five scales. This inventory refers to the last few days. Each scale consists of four items rated along a 5-point Likert scale ranging from "Yes, that is true" (5) to "No, that is not true" (1). Examples of the items are: "I feel tired" (general fatigue); "Physically I feel only able to do a little" (physical fatigue); "I think I do very little in a day" (reduced activity); "I dread having to do things" (reduced motivation); "My thoughts easily wander" (mental fatigue). High scores reflect considerable fatigue (Smets et al., 1995). The alphas were

good: general fatigue: $\alpha = .86$; physical fatigue: $\alpha = .88$; reduced activity: $\alpha = .87$; reduced motivation: $\alpha = .85$; mental fatigue: $\alpha = .91$.

Statistical Analyses

Logistic regression analyses were conducted to examine the relations of each group of independent variables (social context, severity of different types of fatigue, absence of cognitive representations, consultation characteristics) to:

1. whether one felt fatigued or not, and for those who felt fatigued to
2. whether one intended to consult for fatigue or not and
3. whether one actually discussed fatigue during consultation or not.

In order to test the interaction between employment outside the home and caring for young children, an interaction term was entered in addition to the single terms. The interaction term was computed by multiplying "working" and "caring for young children." The role of other complaints was studied by comparing the top three of most prevalent ICPC-chapters (to which the other complaints belonged) for (1) not fatigued patients; (2) fatigued patients who did not intend to discuss fatigue with the GP and did not return the second questionnaire; (3) fatigued patients who did not intend to discuss fatigue with the GP and returned the second questionnaire; (4) and fatigued patients who discussed their fatigue with the GP.

RESULTS

Descriptives

In Table 1, the means and frequencies of the variables under study are presented. The mean age of the respondents was 35 years. Most of the women were employed outside the home, about 40% were living alone, 17% had children under six years, and 12% combined a job with caring for children under six years. The levels for the MFI-20 scales measuring the severity of different types of fatigue were low compared to levels found in soldier (training and barrack), junior physician, psychology student, and medical student samples (Smets et al., 1995). Some 74% of the respondents had suffered from fatigue in the previous two weeks, and 12.3% ($n = 19$) intended to consult for fatigue. Although 11.2% ($n = 12$) of the respondents returning the second questionnaire reported that they intended to consult for fatigue, some 22% ($n = 24$) actually discussed fatigue during the consultation. Two of

TABLE 1. Descriptives

Variable	Sample completing first questionnaire n	Frequency/ M (SD)	Sample completing second questionnaire* n	Frequency/ M (SD)
Age	152	34.77 (10.60)	107	35.36 (9.67)
Patient lives alone	152	38.8%	107	41.1%
(of which one parent family)	59	20.3%	44	20.5%
Working	140	65.0%	95	64.2%
Caring for children < 6 years	141	17.0%	97	17.5%
Working and caring for children < 6 years	139	12.2%	95	11.6%
Severity of fatigue	143	5.08 (3.43)	97	5.00 (3.58)
MFI-20 scales			107	
General fatigue	–	–		3.19 (1.19)
Physical fatigue	–	–		2.87 (1.21)
Reduced activity	–	–		2.60 (1.22)
Reduced motivation	–	–		2.37 (1.09)
Mental fatigue	–	–		2.91 (1.15)
Patient feels fatigued	155	74.1%	107	66.3%
Patient intends to consult for fatigue	155	12.3%	107	11.2%
Patient discussed fatigue during consultation			107	22.4%
Patient initiated discussion			24	91.7%
Degree of absence of fatigue-related cognitions on	109**		71	
Physical origin		.21 (.26)		.19 (.25)
Psychological origin		.04 (.15)		.04 (.14)
Time-line		.32 (.37)		.32 (.37)
Consequences		.04 (.11)		.04 (.12)
Control/cure		.11 (.24)		.09 (.22)
PRF scales				
Explanation	146	2.88 (.88)***	98	2.76 (.93)***
Emotional support	142	1.54 (.79)	97	1.50 (.74)
Examination	142	1.97 (.84)	97	1.88 (.80)

* All of the respondents also completed the first questionnaire.

**Only fatigued respondents completed this part of the questionnaire. A mean score of .21 on Physical origin means that on average 21% of the items of the Physical origin scale was answered with "do not know."

***p = .017 regarding differences between the two sets of respondents.

the women reporting an intention to consult for fatigue and returning the second questionnaire did not discuss fatigue in the end. Thus, 13% (n = 14) of the women actually discussed fatigue without having the intention to do so. Most of the women had introduced the topic of fatigue themselves (91.7%), and only one patient indicated that completion of the first questionnaire played a role in discussing the complaint of fatigue. With regard to the cognitive representations of fatigue, the timeline scale had the highest percentage of do not knows (32% of the items of the scale), followed by the physical origin scale (21%). Finally, the levels of requests for explanation were higher than the other requests.

Factors Related to Feeling Fatigued

In Tables 2 through 4, the characteristics of the social context, the severity of the different types of fatigue, and the requests for consultation are examined in connection with fatigue.

With regard to the social context, only employment was found to significantly predict fatigue. Of the MFI-20 scales, measuring the severity of different types of fatigue, only general fatigue was found to significantly contribute to the prediction of one-item fatigue. Of the PRF-scales, only the request for emotional support significantly contributed to the prediction of fatigue.

TABLE 2. Logistic Regression of Social Context Variables on Fatigue (n = 137) and Discussing Fatigue During Consultation (n = 67)

	Fatigue			Discussing fatigue		
Independent variable	**B (S.E.)**	**Exp (B)**	**R**	**B (S.E.)**	**Exp (B)**	**R**
1. Age	.01 (.02)	1.01	.00	.04 (.03)	1.04	.00
2. Living alone	−.27 (.42)	.76	.00	1.39 (.67)*	4.00*	.16*
3. Working	.62 (.30)*	1.85*	.12*	.72 (.42)#	2.06#	.11#
4. Caring for children < 6 years	1.68 (1.26)	5.39	.00	3.70 (1.58)*	40.39*	.20*
5. Working and caring for children < 6 years	−.72 (.75)	.49	.00	−1.06 (.79)	.34	.00
Percentage total predicted correct	73.0%			71.6%		
Percentage not fatigue predicted correct	0%			86.4%		
Percentage fatigue predicted correct	100.0%			43.50%		
Percentage fatigue observed	73.0%			34.3%		

*.05 > p > .01 **.01 > p > .001 ***p < .001 #p = .0797

Exp (B): If the predictor increases by one point, the *odds ratio* for the dependent variable increases by a factor equal to Exp(B).

TABLE 3. Logistic Regression of Severity of Different Types of Fatigue on One-Item Fatigue ($n = 99$) and on Discussing Fatigue ($n = 71$)

	Fatigue			Discussing fatigue		
Independent variable	**B (S.E.)**	**Exp (B)**	**R**	**B (S.E.)**	**Exp (B)**	**R**
1. General fatigue	3.53 (.90)*	34.16*	.34*	1.25 (.60)*	3.47*	.16*
2. Physical fatigue	−.44 (.55)	.64	.00	−.14 (.47)	.87	.00
3. Reduced activity	1 .20 (.80)	3.32	.04	.03 (.34)	1.03	.00
4. Reduced motivation	−1.29 (.72)#	.28#	−.10#	.26 (.42)	1.30	.00
5. Mental fatigue	−7.04 (1.78)	.78	.00	−6.31 (1.74)	1.13	.00
Percentage total predicted correct	89.9%			74.7%		
Percentage not fatigue predicted correct	78.6%			87.2%		
Percentage fatigue predicted correct	94.4%			50.0%		
Percentage fatigue observed	73.0%			33.8%		

*.05 > p > .01 **.01 > p > .001 ***p < .001 #p = .0733
Exp (B): If the predictor increases by one point, the *odds ratio* for the dependent variable increases by a factor equal to Exp (B).

Factors Related to the Intention to Consult for Fatigue

None of the factors examined here predicted the intention to consult for fatigue.

Factors Related to Actually Discussing Fatigue During Consultation

In Tables 2 through 4, the characteristics of the social context, the severity of the different types of fatigue, and the nature of the consultation requests are examined in relation to the actual discussion of fatigue during consultation. Of the social context variables, living alone and caring for children under the age of six appeared to prompt discussion of fatigue. Of the MFI-20 scales, measuring the severity of different types of fatigue, again only general fatigue contributed. None of the RPF-scales, indicating the nature of the consultation requests, predicted the discussion of fatigue, but an intention to discuss fatigue predicted actual discussion. Deletion of intention to discuss fatigue from the independent variables did not increase the predictive value of any of the RPF-scales.

In Table 5, the absence of cognitive representations of fatigue are examined in relation to the actual discussion of fatigue during consultation.

TABLE 4. Logistic Regression of Consultation Requests on Fatigue (n = 139) and Discussing Fatigue During Consultation (n = 71)

	Fatigue			Discussing fatigue		
Independent variable	**B (S.E.)**	**Exp (B)**	**R**	**B (S.E.)**	**Exp (B)**	**R**
1. Explanation	.11 (.23)	1.11	.00	.23 (.38)	1.25	.00
2. Emotional support	.83 (.36)*	2.29*	.14*	.03 (.41)	1.03	.00
3. Examination and treatment	−.08 (.27)	.93	.00	−.19 (.46)	.83	.00
4. Intention to consult for fatigue				2.71 (.85)**	15.04**	.31**
Percentage total predicted correct	74.1%			78.3%		
Percentage not fatigue predicted correct	0%			95.7%		
Percentage fatigue predicted correct	100.0%			40.9%		
Percentage fatigue observed	74.1%			31.9%		

*.05 > p >. 01 **.01 > p > .001 ***p < .001

Exp(B): If the predictor increases by one point, the *odds ratio* for the dependent variable increases by a factor equal to Exp(B).

TABLE 5. Logistic Regression of Absence of Fatigue-Related Cognitions on Discussion of Fatigue During Consultation (n = 71)

Independent variable	**B (S.E.)**	**Exp (B)**	**R**
1. Absence of cognition on physical origin	2.36 (1.42)#	10.60#	.09#
2. Absence of cognition on psychological origin	−1.69 (2.93)	.18	.00
3. Absence of cognition on timeline	1.69 (.82)*	5.40*	.16*
4. Absence of cognition on consequences	−3.28 (2.67)	.04	.00
5. Absence of cognition on control	.95 (2.02)	2.59	.00
Percentage total predicted correct	77.5%		
Percentage not discussing fatigue predicted correct	93.6%		
Percentage discussing fatigue predicted correct	45.8%		
Percentage discussing fatigue observed	33.8%		

*.05 > p > .01 **.01 > p > .001 ***p < .001 #p = .0974

Exp (B): If the predictor increases by one point, the *odds ratio* for the dependent variable increases by a factor equal to Exp(B).

Absence of fatigue-related cognitions with regard to timeline of the fatigue significantly contributed to the fatigue discussion.

Other Complaints

In Table 6 the top three of most prevalent ICPC-chapters (to which the other complaints belonged) for: (1) patients who were not fatigued; (2) fatigued patients who did not intend to discuss fatigue with the GP and did not return the second questionnaire; (3) fatigued patients who did not intend to discuss fatigue with the GP and returned the second questionnaire; (4) and fatigued patients who discussed their fatigue with the GP, were presented. For all those patients *not* discussing fatigue with the GP the top three ICPC-chapters were found to be (in varying orders): Female genital system and mamma; Skin/subcutaneous tissue; and Respiratory system. For those patients discussing fatigue with the GP, the top three ICPC chapters were found to be: (1) Psychological system; (2) Neurological system, Skin/subcutaneous tissue, and Female genital system/mamma; (3) Digestive system and Musculoskeletal system.

TABLE 6. Top Three of ICPC-Chapters with Percentage of Patients Reporting a Complaint Belonging to That Chapter

Not fatigued (n = 38)	Fatigued, did not intend to discuss fatigue with GP (and did not return second questionnaire) (n = 59)	Fatigued, did not discuss fatigue with GP (n = 47)	Fatigued, discussed fatigue with GP (n = 24)
1. Female genital system and mamma 39.5%	1. Female genital system and mamma 23.7%	1. Respiratory system 27.7%	1. Psychological 33.3%
2. Skin/subcutaneous tissue 21.1%	2. Respiratory system 22.0%	2. Female genital system and mamma 23.4%	2. Neurological system 20.8% Skin/subcutaneous tissue 20.8% Female genital system and mamma 20.8%
3. Respiratory system 18.4%	3. Skin/ subcutaneous tissue 20.3%	3. Skin/ subcutaneous tissue 19.1%	3. Digestive system 16.7% Musculoskeletal system 16.7%

DISCUSSION

The purpose of this study was to explore which patient-related factors appear to predict the presentation with fatigue among a sample of female patients visiting in a women's general health care practice. Fatigue was found to be a prevalent problem within the current sample. About 74% suffered from fatigue, which does not differ from earlier findings within the *population* (and not only the visitors) of the present general practice (van den Brink & Bensing, 1996). The percentage is, however, higher than the percentages found in regular general practices in The Netherlands (de Rijk et al., in press) and in Australia (Hickie et al., 1996). Fatigued women had more often employment outside the home, higher levels of what is known as general fatigue, and a higher need for emotional support from the GP when compared to non-fatigued women.

Only 11.2% reported an intention to consult for fatigue. This finding is nevertheless in line with findings in France, Canada and The Netherlands (Fuhrer & Wessely, 1995; Cathébras et al., 1992; Lamberts et al., 1993). The factors examined in the present study failed to explain the intention to present with fatigue. Nearly all of the patients that intended to consult for fatigue reported additional complaints as reason for consultation.

Some 22% of the respondents actually discussed fatigue during consultation. This was predicted by: living alone, caring for young children, a higher level of general fatigue, and less knowledge about the duration of the fatigue. Furthermore, those patients who actually discussed fatigue showed a different configuration of (additional) complaints: problems related to the psychological, neurological, digestive, and musculoskeletal system were more commonly reported.

Methodological Considerations

The prevalence of fatigue was not "artificially" heightened by the specific topic of the present study as the prevalence of feeling fatigued and fatigue as a reason for consultation were not particularly high for this population. Selective dropout was not expected to influence the results to any great extent. The drop-out rates were not particularly high. But we do not know whether the women who did not participate were a selective group. The sample completing the second questionnaire was somewhat biased towards a lower need for explanation. Seven of the patients who intended to consult for fatigue did not return the second questionnaire but this was not selective for an intention to discuss fatigue or not.

In contrast to Bensing et al. (1999), we did not find the combination of working and caring for young children to be particularly significant. As most of the women with young children were also employed outside the home, the

main effect of having young children may have masked any interaction effects.

With regard to the severity of the different types of fatigue, we found the one-item fatigue question to clearly tap the level of general fatigue. Although the one-item measurement of fatigue has received considerable criticism (Lewis & Wessely, 1992), the question used in the present study appeared to be a valid measure of fatigue in general.

Obviously, the inclusion of "do not know" or "no meaning" as a response option reduces the number of responses regarding the nature of the cognitive representation. Inclusion of such an option may nevertheless represent the reality of a fatigued patient.

The present sample of patients is not representative of all general practice patients but the study provides insight into the presentation of fatigue in a "modern" general practice (see van den Brink & Bensing, 1996). Moreover, women generally consult more often for fatigue than men do (Ridsdale et al., 1994; Elliot, 1999). Also, this is the first study so far known that examines the course from feeling fatigued to actually discussing fatigue with a GP.

From Feeling Fatigued to Discussing Fatigue with the GP

Although the majority of the women in our study reported feeling fatigued, only a minority had the intention of discussing the fatigue during consultation with the GP and/or actually discussed fatigue during consultation. Helman (1994) has suggested that the social context can legitimize complaining about a particular condition or not. Fatigue is of course a "natural" aspect of everyone's life. So many may report fatigue in this study because fatigue conflicts with the high standards of performance that probably exist among the highly educated, urbanized patient group examined here. The strong relation between job performance and feeling fatigue can be seen as an indication for such an explanation. On a different note, the number of patients actually discussing fatigue during consultation was higher than the number of patients reporting the intention to discuss fatigue. Not the intention but the actual discussion of fatigue was also successfully predicted by the variables examined here, which suggests that social roles may play an important role in the discussion of fatigue. Caring for young children, which was often paired with having a job in our study, predicted discussion of fatigue, which contrasts finding of Ridsdale et al. (1994). Our findings can be explained by caring for young children (combined with working) conflicting with feeling fatigued (cf. Helman, 1994). It is also quite possible that the fatigue experienced in connection with caring for young children is really the result of giving birth, interrupted sleep patterns and the demands of child care itself, as opposed to the combination of working and child care. This also seems to fit with the finding that caring for young children did not predict

feeling fatigued but actually discussing fatigue during consultation with a GP (e.g., possible childrearing problems that may lead to fatigue). Patients who live alone were more inclined to discuss fatigue with the GP than those who do not. It is very likely that the GP indeed helps solve a problem that would otherwise be solved within the social circle of the patient. The findings regarding social context are in line with the women's health care principle of paying attention to gender roles, personal factors, and social factors (van den Brink & Bensing, 1996); moreover, David et al. (1990) have found women to relate their fatigue to social context characteristics more often than men.

The absence of fatigue-related cognitions was highest with regard to the course of fatigue and appeared to predict discussion of fatigue with the GP. If the fatigue does not disappear spontaneously, one may get worried, and worry is known to be an important determinant of health-care seeking behavior (van de Kar, Knottnerus, Meertens, Dubois & Kok, 1992; van de Kar, van der Grinten, Meertens, Knottnerus & Kok, 1992).

The present study does not explain why patients who felt fatigued also had a higher need for emotional support than other patients. It may be that both saying one feels fatigued and saying one needs emotional support simply reflect a low threshold for the disclosure of feelings. With regard to the other complaints, those fatigued patients who did not discuss the fatigue with the GP showed quite similar complaints to those patients who were not. In contrast, those who did discuss fatigue with the GP tended to have not only more often psychological problems, but also neurological, digestive and/or musculoskeletal problems. As fatigue was the single reason for consultation in only one of the cases, fatigue is probably a consequence of these other problems or shares some underlying cause with the problems.

CONCLUSION

Although a vast majority of the patients in the present study felt fatigued, the fatigue did not constitute a serious problem for most of them. The fatigue that was discussed with the GP was not an "isolated" problem. Discussing fatigue appeared to be related to the social context, the absence of ideas about the duration and there are often other complaints. More sophisticated research methods (such as videotaping consultations) are needed to study just how fatigue is discussed, what subtle aspects of the communication stimulate discussion of possible sources, and just how such discussion influences the patient's coping strategies and the eventual course of the fatigue. Fatigue is nevertheless often handled without the care of a GP (Elliot, 1999; Lamberts,

1991). It should be noted that severe fatigue certainly affects the quality of an individual's life and that GPs are sometimes very puzzled by physically unexplained fatigue but that the magnitude of the problem within a general practice setting should not be overrated.

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