

Psychiatry for the General Practitioner

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Introduction

Psychiatry in General Practice has been the subject of renewed interest among practitioners. Shepherd¹, Williams and Clare², Hankin³ and Goldberg⁴ have all pioneered in the understanding of the role of psychiatry in primary care. About a third of general practice patients have significant psychiatric symptoms.

Mental illness includes a large number of anxiety and depression related illnesses where patients are quite rational and relevant and quite different from the popularly held belief that all mental patients are mad. In fact non-psychotic (non mad) psychiatric illnesses outnumber psychotic illnesses by over 8 times. Yet even qualified medical and health professional continue to look on psychiatric illness as those relating to psychoses and nothing else. Doubtless this misconception has its origins in poor psychiatric education in many medical schools in the past and unfortunately even today in many developing countries.

The anxiety and depression related psychiatric illnesses and problems seldom present to the psychiatrist as the patients is convinced he is not mad and therefore he need not see a psychiatrist. The continuing myth that all psychiatric illnesses are psychotic illnesses has worked so well that over two thirds of all psychiatric illnesses remain undetected. The general practitioner often lacks the training to detect the less severe psychiatric and emotional problems and the psychiatrist does not see the less severe patients who goes to the general practitioner hoping for relief.

Common Problems in Diagnosis

The root of the patients' and the doctors' belief that the problem is non-psychiatric (and clearly not psychotic) is the frequency of somatic or physical complaints which emotional stress produces. These often relate to autonomic nervous system hypoactivity

or hyperactivity. Thus patients who have stresses related problems or problems related to work or relationships that they cannot overcome often complain of palpitations, gastric symptoms or insomnia. (Common symptoms of anxiety). The complaint of a physical symptom must always be considered without prejudice to be due to physical or psychological causes or both and not always a physical one as often is believed.

Similarly other patients with psychological stresses in their lives that defy resolution may haunt their family doctor with complaints of feeling "unwell", tired or worried they may have cancer or get a heart attack. Often these are investigated by the general practitioner. When all tests are negative the doctor happily tells the patient he is perfectly well. The patient rather than being relieved is disappointed at the lack of disease he was almost dying to get. He queries the doctors findings and often goes to another doctor seeking a disease he does not have.

Other patients may complain of lack of energy, loss of appetite constipation no interest in work, poor sleep or loss of weight. When once again the doctor finds no disease the patient is disappointed. Patients may, if questioned, reveal a recent disappointment or a loss of a personal kind that preceded the onset of these symptoms.

Once again the doctor who continuously looks for physical disorders will only be disappointed. Many such patients end up with no diagnoses or are prescribed a placebo. There then is the silent majority who suffer from an anxiety, depressive disorder or a psychiatric illness that occurs in about a third of all patients seen in general practice but which are not detected as such.

Common Presentations of Psychiatric Problems in General Practice

Patients with emotional problems in general practice

very seldom complain of emotional problems as such. They present in a variety of ways that may or may not alert the doctor to the underlying psychiatric problem. These include

Insomnia

Sleep is a fairly good barometer of mental health. Most people despite the pressures of every day work and family life sleep reasonably well most of the time. When this normal pattern is disturbed for more than a week for no obvious reason such as a physical illness, emotional problems may be the cause. The sleep disturbance may take the form of difficulty in falling sleep, waking up in the night, having difficulty falling asleep again or early morning awakening at 3 or 4 a.m. and inability to sleep the normal 7 or 8 hours of sleep.

The disturbance in the normal rhythm of sleep is obvious and very striking when asked for. Insomnia is not a disease and like fever is merely a response to an underlying problem.

Frequent requests for medical leave

In family practice, the medical leave request is not only common, but also a source of irritation for doctors especially when the request is for very common and relatively mild complaints like headache, backache, stomachache, feeling tired, feeling unwell which are not associated with obvious physical findings. The tendency is to lump all such requests as malingering. This is particularly so when the patient who requests medical leave has not done so previously and has been a good worker. Often those trivial complaints of a physical nature are the patient's way of expressing distress. A gentle exploration of his emotional problems in family, work or finances may reveal the real problem that underlies his request for medical leave.

Somatic complaints with no physical pathology

As mentioned earlier the autonomic nervous system is closely related to the psychological system of a person and somatic symptoms may be due to mental or physical disorders or both. Whenever a physical diagnosis is not present but symptoms continue, a psychological assessment of his problems are indicated to ascertain if the symptoms relate to psychological stress.

The patient with strange behaviour

Grossly abnormal behaviour such as talking nonsense, extreme suspiciousness, hearing voices, aggressive and restless behaviour for no apparent reason is often indicative of a severe psychiatric illness such as a psychotic disorder, schizophrenic, affective, paranoid or organic one. These are best referred to a psychiatrist for opinion and management.

Psychosomatic disorders

There exist a large number of so called physical disorders which have very strong psychological aetiological factors. Few doctors will look on myocardial infarct, recurrent gastritis, an eosophageal bleed or cirrhosis as anything but physical in origin. Yet the now popular "lifestyle" diseases caused by almost compulsive smoking, being overweight and high consumption of alcohol are often related to psychological urges, anxiety and depression that many do not know and few understand.

Managing Psychiatric Problem in General Practice

Counselling

It is unfortunate that counselling skills and techniques to uncover a patient's emotional problems are not included in most medical students curricula and yet counselling is a major skill in general practice and indeed in all medical practice.

How to talk to patients and their families about their illnesses, finding out their other worries and losses and helping them learn to cope are essential skills of a doctor.

Medication

The principles of psychotropic medication in general practice are

- use only pure medicines
- use low doses and work upwards
- be aware of common side effects and contraindications and educate patient about these.
- be confident on use of psychotropic medication

Anxiolytics

Benzodiazepines such as Lorazepam in the doses of

0.5 mg daily, BD or TID or with a 1mg ON dose helps most patients with anxiety and somatic symptoms with insomnia. Start with a lower dose and work upwards with the usual precautions on drinking, driving and dependence. However, always reassure patients on the benefits of a anxiolytics in short term use that very rarely causes dependence. Far too many very anxious patients, receive inadequate anxiolytics in the mistaken belief that they are dangerous medicines.

Antidepressants

The newer SSRI'S despite their higher costs are more tolerated due to their low side effect profile. The tricyclic antidepressants have more side-effects such as dryness of the mouth, thirst, constipation and blurring of vision but are far cheaper and equally effective and cost less than the new antidepressives.

Referral : All difficult problems and psychoses should be referred to a psychiatrist for opinion and management

Conclusion

There is currently a very low detection rate of emotional problems in general practice and inadequate treatment of the few that are detected as many of these patients may have to go to a psychiatric practice for their complaints. All general practitioners must learn to detect and treat these largely treatable disorders. To be able to do this general practitioners need to reorientate their skills to detect emotional problems and learn counselling and medication skills necessary to cope with emotionally distressed patients.

References

1. Shepherd M, *et al.* Psychiatric Illness in General Practice, Oxford University Press, 1966.
2. Williams P Clare A. Psychosocial Disorder in General Practice, Academic Press, London 1979.
3. Hankin J, Oktay J. Mental Disorder and Primary Medical Care – An analytical review of literature. National Institute of Mental Health, Rockville, USA, 1979.
4. Goldberg D, Hxley P. Mental Illness in the Community. The pathway to Psychiatric Care, Tavistock Publications, London 1980.

MCQs

- 1 Psychiatric problems in General Practice Care
- A are seen in less than 3% of patients
 - B are largely schizophrenics
 - C are rarely associated with stresses of day to day living
 - D may respond to counselling as outpatients
 - E are often managed with low dose anxiolytics
- 2 Anxiety disorders are
- A characterised by hearing of voices
 - B often associated with family problems
 - C not related to somatic symptoms
 - D seen in 1-2% of general practice patients
 - E best treated with antipsychotics
- 3 Depressive disorders
- A seldom have psychosomatic symptoms
 - B are usually genetic in origin
 - C may be associated with weight loss
 - D may present with insomnia
 - E may underlie requests for medical leave
- 4 Requests for medical leave
- A may be found in people with stress at work
 - B occurs usually among malingerers
 - C may be associated with unsomnia
 - D may be associated with depression
 - E may be associated with anxiety
- 5 Psychotropic medication used in patients in general practice
- A are generally addictive
 - B seldom has side effects
 - C should as far as possible be in pure form
 - D are usually antidepressants and anxiolytics
 - E should be used in the lowest dose and worked upwards