Current Practice

PRACTICAL PSYCHIATRY

Psychiatric Interviews in General Practice

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The scheme for psychiatric history-taking found in current textbooks and taught in medical school is quite inappropriate to conditions in present-day general practice. The family doctor's objectives and resources differ from those of the psychiatrist, and so accordingly must the methods he employs.

A trained psychiatrist in an outpatient department allows at least half an hour to assess each new patient, while the busy general practitioner can spare only five to ten minutes to attain this end. The structured psychiatric interview starting with the family background and moving on through a personal history with its educational, occupational, and sexual sections, to a survey of the previous personality is therefore unsuitable under these conditions: it outlasts the time available and alienates the patient.

The basic problem confronting the hospital psychiatrist and the general practitioner differs in a number of important respects. The general practitioner is less concerned with diagnostic classification, since the overwhelming majority of his patients have mild or moderate affective illnesses, many of which present with physical complaints. These illnesses include anxiety states, neurasthenia, and mild depression. While most textbooks indicate rigid distinctions between these clinical syndromes, in practice they mingle inextricably with one another. The major psychoses with delusions, hallucinations, or socially disruptive behaviour are rare but generally unmistakable and may require referral to a psychiatrist.

The common task in general practice is therefore to apprehend the affective disorder behind a presenting physical complaint, to elicit confirmatory and uncomplained-of symptoms or causes, and then to explain the illness to the patient in a manner which ensures his co-operation in treatment. The patient may resent the first hint of emotional causation, and reject the unspoken but implicit accusation that he "imagines" his symptoms. The psychiatrist does not usually have these problems, since the patient's presence implies an awareness that psychological factors are involved. Under these conditions the patient will expect intimate and detailed inquiries, and is more likely to accept the proffered treatment.

If all this seems to make the general practitioner's task hard he has many compensating advantages that the psychiatrist lacks. These include first-hand knowledge of the family and its social background (often gained in the home setting), ready access to all members of the family, and an existing relationship with them which makes it easier to obtain additional information and makes them willing to co-operate in treatment.

Because of the continuing relationship with the patient the general practitioner need not disturb the interview by writing laborious notes. A few important points jotted down towards the end are better than recording it whole. A brief interview need not be a hurried one; an impression of leisure can be created if the poised pen and prescription pad are pushed to one side and the doctor turns in his chair to face the

patient. The patient should be allowed to relate his complaint in his own way, but the use of comments and leading questions can both save time and make the patient feel that his problem is recognized and understood. For example, a complaint of unusual irritability might be met with the remark, "I expect you get cross with your children, and feel guilty about it afterwards." Using this general technique of free discussion with timely interjections the family doctor has to keep three objectives in mind during his brief interview. These are the interpretation of the complaint, the planning of management, and the explanation of treatment.

Interpreting the Complaint

Even nowadays it is rare for a patient in general practice to complain of "depression." Perhaps increasing sophistication and diminishing stigma will one day produce a change in the pattern of complaint, but at present patients usually present with somatic symptoms. The interview often opens with a comment that the patient feels "anaemic and rundown," has been "fighting off 'flu,'" "thinks it must be the change" or suffers from "low blood pressure." Lassitude or fatigue is often the cardinal symptom with a tendency to procrastinate over actions and decisions, leaving the housework undone or business untended. These feelings lead to requests for iron tablets, vitamins, or a tonic, and the patient's resolve to get them may be strengthened by previous placebo responses.

It is helpful at this point to ask directly about irritability, since it commonly goes hand-in-hand with fatigue in minor affective illness, while fatigue on its own occurs more often in cases of organic disorder. The patient becomes increasingly sensitive to minor stress, so that the most trivial upsets seem intolerable and minor obstacles appear insuperable. He may fly off the handle at the office or resent his children's demands for attention. Because patients are ashamed of these feelings they are usually learned only by inquiry, after which there is relief that the feelings have been shared, and a strengthening of rapport. Another presenting symptom can be sleep disturbance—which may not conform to classical descriptions of difficulty in dropping off or early waking. Instead the patient may wake unrefreshed, have restless disturbed sleep, or say that while his sleep is all right he just doesn't seem to get enough of it. This strengthens the conviction that something is needed to buck him up or shake him out of his physical malaise.

Over-indulgence in food is as common as is loss of appetite, and produces added guilt with concern about appearances and despair over ill-fitting clothes. Various bodily manifestations of anxiety are common and tend to be over-emphasized in the initial confrontation. They range from palpitations, sweats, breathlessness, paraesthesiae, and tinnitus to headaches, back-aches, and abdominal pain.

A 67-year-old housewife said she felt "jittery." Having described palpitations she went on to say that she was always tired, adding that she'd just had a holiday and didn't feel any better:

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"One worries about the heart at my age." On being reassured she went on to describe pains in her ankle that followed a sprain some years before. Brief examination was negative, but her notes showed similar episodes over the past 20 years which cleared up with mild sedation.

In general it is not too difficult to probe beyond these initial bodily complaints that stem from lassitude or anxiety to reveal an underlying emotional change. In some cases numerous and trivial physical complaints can be quite infuriating unless the basic mood disorder is recognized.

A 69-year-old spinster said she occasionally noticed a twinge in her back when she bent down. After examination and reassurance she drew attention to a small spot on her face. Told that this was not serious she asked if she could have a blood test: "I wondered whether I might perhaps have an ulcer or diabetes." When told that this didn't seem necessary, she described a vague abdominal pain which she related to wind which "seems to come up and choke me." Questions revealed that she had noticed fatigue and irritability: "I was going to ask you for some Amytal tablets." Before she left she added: "I get so depressed, living alone."

Another equally common type of somatic façade which may present greater problems is an unrelated but genuine physical symptom, which the patient presents for inspection while the underlying emotional disturbance goes unremarked. Patients with longstanding complaints (such as tinnitus) may complain because their tolerance of them has given way under an additional, and perhaps unrecognized, emotional burden. Alternatively, the physical complaint may be so urgent and tangible that it overshadows the emotional disturbance, which will not come to light unless the patient is encouraged:

A 36-year-old housewife complained of a large boil on the bridge of her nose. While the prescription for antibiotics was filled in she remarked: "It's because I'm run down." Asked what this meant, she explained that her husband was sick to death of her, she was irritable and unkind to the whole family, and though sleeping well she was waking tired. These symptoms antedated her boil. After only three weeks' treatment with antidepressants she was "back to nearly normal" and "doing loads more."

There is a whole range of reasons why a patient may not report an underlying emotional disturbance. In the above examples the patients were aware of their anxiety and depression but were reluctant to volunteer information about it, preferring to formulate their problems in somatic terms. They may have accepted the emotional change as part of their lot in life—"you just have to get on with it"—or be unwilling to talk about their feelings, which they are accustomed to keeping to themselves; to discuss them would be a sign of weakness.

But there remains a group of patients whose defensive denial of mood disturbance takes place at a deeper level; they manage to conceal their feelings even from themselves.

A middle-aged business man complained of a sore throat. His complaint seemed trivial, and after examination had revealed no abnormality he observed that he feared it "might be cancer." With great reluctance he admitted being restless at night and of having become increasingly intolerant of his friends. Some long-standing habits of his wife were now irritating him unduly, and he was feeling continuously tired. He confessed to being reticent since a deprived childhood and of having little time for personal or emotional problems: even to talk about these now would be to "gossip."

Such patients may maintain a total denial of all psychiatric symptoms, and only the passage of time with the gradual accumulation of negative investigations and opinions arouses suspicion. Regional pain in all parts of the body comes into this category, but only pain in the face has so far acquired the status of a syndrome, perhaps because it cannot be explored by surgery or investigated with barium. It is significant that it responds to treatment with antidepressants.

Planning Management

Criteria of Referral

After an emotional illness is detected the general practitioner must consider whether he can handle it himself. Most can

and do treat a wide variety of psychiatrically ill patients, but it would be helpful to enumerate the principal indications for referral to a psychiatrist. The most pressing indication is that the patient has serious suicidal intentions. The risk of suicide should be assessed in every patient suspected of affective illness. All new episodes of psychotic illness should be referred, as well as patients requiring special forms of treatment such as electroconvulsive therapy for depression, or behaviour therapy for specific phobias (such as dogs, insects, or air-travel). Patients with chronic disabilities affecting their social and occupational adjustments should be referred for assessment and possible rehabilitation. Finally, patients who fail to respond to treatment, and those who make importunate demands and whose management cause the doctor anxiety or distress, may justifiably be referred. Allowing people to talk about themselves is not without its hazards, and it is better to ask for specialized help than to feel, like the sorcerer's apprentice, that there is more on one's hands than can possibly be coped with.

Suicidal Risk

Some doctors are embarrassed to ask patients about suicidal feelings, while others fear that doing so may make suicide more likely. Both these views are unjustified. If the subject is handled tactfully patients never resent it, and are often relieved to be able to discuss ideas about which they feel guilty. The topic is best approached by questions such as: Does life seem hopeless at times? Do you sometimes wish that you were dead and away from it all? If positive replies are received to this sort of question the patient should be asked directly about suicidal thoughts, particularly whether actual plans have been made: Have you ever considered how you might end it all?

In completing an assessment of suicidal risk it is useful to ask whether the patient feels useless or worthless, and to ask how he feels about the future. Patients often express lesser degrees of despair, saying that they wish they could go to sleep and never wake, that they wouldn't kill themselves because of the children, or that they lack the courage to carry things through.

The presence of active plans is an indication for an urgent psychiatric opinion, and the old saying that "people who talk about suicide never do it" is certainly untrue. In cases of doubt or difficulty the opinion of someone else—the spouse, relative, or a close friend—can be sought. The family doctor is in a good position to assess the severity of this risk, and it should not be necessary to refer a patient solely for this assessment to be made.

Background Information

Once this has been done a rapid exploration should be made of the patient's marital and interpersonal relationships, occupational activities, and leisure interests in order to reveal whether further discussion will prove fruitful or necessary.

Sexual problems are common but are rarely mentioned spontaneously. A neutrally phrased question such as "How about the physical side of your marriage?" will break the ice, and an inquiry about change in interest or capacity will provide an opportunity to reassure the patient that loss of sexual drive is often a symptom of emotional illness which is early in onset but slow to return. Patients are surprisingly reluctant to link such change with their other feelings; they see it more as a cause of their illness than a consequence, and removal of this guilt may help.

Questions relevant to the selection of an appropriate course of chemotherapy should be asked. The wide spectrum of tranquillizers and antidepressants available permits variable degrees of sedation or stimulation, and combinations of antidepressants and anxiolytics may be required. To facilitate this

choice inquiry should be made into tension, agitation, retardation, lassitude, and apathy.

Social Agencies

The interviewer can also assess the possibilities for intervention by ancillary social agencies—the health visitor, old people's welfare, mental welfare officers, home helps and meals on wheels, disablement resettlement office ("D.R.O.") of the Ministry of Labour, or psychiatric social workers. Some patients prefer to cope with their personal problems unaided, but others welcome outside assistance. When advice about work is sought, or given, it must be borne in mind that not everyone benefits from a holiday and that for some patients occupation may be more therapeutic than inactivity. Patients should generally be dissuaded from giving up their jobs while they are depressed. In general it is best to adopt an interested but passive role, and in particular one should avoid giving glib advice such as "have another baby" or "get a part-time job."

Special Interviews

If there is clearly more than can be discussed in the available time, if there are puzzling aspects to the case, or if the patient is not well known to the doctor, an appointment for a longer interview can be made at the end of surgery or at an afternoon clinic. Such a special interview need not be esoteric: the patient is asked who there is at home, and how he gets on with them. Often the apparent causes are immutable (a sick spouse, an aged or dependent relative, or an uncongenial occupation), and it is more realistic to repair the patient's ability to cope by offering a sympathetic ear, aided by psychotropic drugs if indicated, than it is to attempt a reconstruction of their lives by time-consuming and complex psychotherapy. A brief inquiry about problems at home and at work will quickly indicate the patient's need to confess or desire to conceal, and either of these should be respected. The aim should always be to help patients to cope with their problems more effectively, and this is not necessarily achieved by insisting that a patient tells all. It is best not to point out an individual's shortcomings unless something can be done to repair the defect: some attics are best kept locked. If the doctor thinks that he has a flair for dynamic interpretations it is well to remember that they are often painful in direct proportion to their truth, and that they should therefore be made only in a setting of regular psychotherapy by a doctor who has received some formal training in the field.

Since all members of the family are likely to be his patients, it is specially important that individuals feel that their confidences are respected. One must be prepared to hear more from another member of the family, but never to pass on what has been told in confidence. This is specially true of adolescents, who may be afraid that what they say will get back to their parents.

It is often difficult to know in retrospect just how such an interview has been of help, but a discussion that seems inconclusive to the doctor can have beneficial effects on the patient's symptoms:

A 23-year-old youth demanded plastic surgery to remove a skin blemish on his neck. Because his manner and his complaint seemed odd he was invited to discuss this in more detail at an afternoon clinic. Here he revealed that he had always felt an odd man out, and was living unhappily at home with a strict elderly father and a younger mother. He was a clerk with frustrated ambitions to be a journalist or to write "a good book." He hoped to emigrate to Canada to escape his discontent, but meanwhile all his dissatisfactions centred on the small skin blemish. At the same time he often felt depressed and suicidal.

At the next interview he said he felt as if a cloud had been lifted, and added, "I'm as settled now as I'll ever be." It was tempting to suppose that his improvement was due to the antidepressants prescribed, until he laughingly confessed that he hadn't been able

to afford the prescription charge: "I felt so much better after talking to you that I didn't need them."

Continuing Care

Whatever the length of the interview, the general practitioner must cultivate a skill that will have been neglected during his medical training: the ability to tolerate his patient's symptoms without feeling that each one should automatically elicit an investigation or a pill. The opportunity to talk about and ventilate symptoms, combined with a display of concern by the doctor, may in itself be therapeutic. By the same token it is useful to ask the patient to come back for another visit to report progress, and not leave the onus on the patient to reattend. This not only displays the doctor's continuing concern, but allows a series of short discussions to gradually blend into one sequential interview while rapport with the patient strengthens in the intervals between.

Explaining Treatment

At least a third of the available time at the first interview needs to be spent on this task, since patients generally shun the stigma of mental illness and are reluctant to be thought "in need of a psychiatrist." It is commonly felt that general-practitioner psychiatry consists in large part of chronic neurotic patients who have drifted away from psychiatric out-patients. In fact many are mildly obsessional personalities who are vulnerable to minor affective illness but ashamed to be in need of psychiatric treatment. Chronic neurotics certainly do exist, but they tend to over-represent themselves by repeated attendances, and do not pose the same problem in history-taking as the other type of patient.

Time should be spent reassuring them that their problem is common, curable, and not in the least culpable. These patients are often perplexed that they have fallen ill, and spend much time fruitlessly asking themselves why it should have happened. It is often helpful to say that these conditions can arise "out of the blue," or that rather than being a sign of weakness the liability to mild affective illness is the price paid for a conscientious personality, since striving for perfection inevitably brings disappointments and a sense of failure.

The patients may be surprised that treatment is even possible: "it would be far nicer if it were anaemia, at least you can treat that." When offered treatment these patients also find difficulty in accepting it, saying that they ought to overcome the illness themselves. For several reasons they dislike taking tablets, specially for long periods, preferring to "pull themselves together." They are afraid of losing control and of coming to rely on drugs. Fortunately such patients will usually accept an explanation which anticipates possible side-effects and predicts the likely duration of treatment. It is difficult for lay people to understand that affective illness has a lengthy time scale necessitating treatment which lasts for weeks and months rather than days. It is important to warn patients against stopping treatment abruptly once they feel well, and to suggest a gradual weaning off tablets until full confidence has been restored. An encouraging and optimistic manner helps a great deal; pessimism is very easily communicated to the patient. Finally, the patient who feels that he needs a tonic is perplexed if he receives a tranquillizer or antidepressant with a sedative effect, and may speedily discard it unless it has been explained that it is prolonged tension that produces lassitude, and that sedative effects and lassitude will wane together as the full therapeutic effect asserts itself during the first week or two of treatment.

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