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The Concept of a Psychiatric "Case" in General Practice

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Summary. The paper describes a classification of psychological disorders occurring in primary care settings which is attuned to the needs of the doctor and his patient, and takes into account the non-specific nature of many of the disorders, the effects of diagnostic "labelling" and the need for intervention. Three groups of disorders are described. These are (i) major psychiatric illness, which broadly correspond to psychotic illnesses for which physical treatments have been shown to be of value. "Labelling" is seen to be necessary for correct treatment, and often helpful for the patient. (ii) Psychological distress syndromes not requiring intervention, which include subclinical illnesses, transient illnesses, distress unrelated to the presenting symptoms and some patients with unmodifiable dysphoric symptoms. Such patients may benefit from ventilation of problems at the time of consultation but an illness label should be avoided. (iii) Psychological distress syndromes which require intervention; they form a large group which may benefit from a variety of psychological, social and drug treatments. It may be important to help the patients to see themselves as emotionally ill, but specific labels are only justified by particular interventions. The need for future research is discussed in relation to triaxial classification and intervention studies.

In their classic study of psychiatric illness in general practice, Shepherd and his colleagues (1966) let general practitioners themselves decide what constituted a psychiatric case. For the purpose of their study, "any disorder, whatever the presenting complaint could be classified as 'psychiatric' if psychological or emotional disturbance was judged by the patient's doctor to play a major part in the illness". However, the doctors gave widely varying estimates of psychiatric morbidity, and these estimates bore no relationship to levels predicted by a screening test. This variability has since been demonstrated by many other studies (Goldberg and Huxley 1980).

The arrival of psychiatric screening questionnaires linked to standardised psychiatric interviews has meant that it is now possible to make estimates of psychiatric prevalence in general practice settings that are independent of the varying skills of family doctors in making such assessments (Goldberg and Blackwell 1970; Hoeper et al. 1979). However, when this is done we are in fact projecting a concept of a "case" which is thought realistic by hospital psychiatrists onto a very different setting. Such studies may be of great interest to epidemiologists, but they can hardly be of similar interest to those who work in primary care settings. The use of nosological systems which confine themselves to psychiatric syndromes leaves unanswered the question of the relationship of such syndromes to physical illness on the one hand, and social dysfunction on the other. Furthermore, the psychiatric "diagnoses" typically assigned in such settings give little clue to what should be done, by whom, or whether the patient should be told of his "label".

In his thoughtful article in the recent symposium, "What is a Case?" Copeland (1981) reminds us that the concept of a case is a chimera existing only in the mind of the investigator. Rather than regard the concept as a sort of Platonic ideal he suggests that investigators should ask – 'a case for what?' In the setting of present day general practice, with social workers, psychologists, community psychiatric nurses and lay counsellors all anxious to define their professional roles, one might also ask – 'a case for whom?'

Ingham (1981a) has suggested that investigators should consider three aspects of 'caseness', namely (i)

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severity and patterning of symptoms (ii) breakdown of usual coping mechanisms and (iii) help-seeking behaviour. He suggests that if coping mechanisms are intact patients are helpable *outside* a medical context, whereas if they have broken down patients 'are different in some way and in need of extraordinary forms of assistance'. Patients in the latter group can be considered to have psychiatric illnesses, while those still managing to cope might be referred to a clinical psychologist for preventive help in adjusting their attitudes and coping strategies so that breakdown becomes less likely (Ingham 1981 b).

The idea that psychiatric illnesses are those which occur in people whose coping strategies have broken down in the face of distressing symptoms presents a number of difficulties. In the first place, we cannot declare patients with major psychiatric syndromes such as schizophrenia or mania to be psychiatrically ill *unless* their coping strategies have broken down. Yet such syndromes may benefit from medical treatment even when the patient is still coping; psychiatry, as well as clinical psychology, must be allowed to have preventive strategies. Secondly, we are *obliged* to declare patients psychiatrically ill if they are failing to cope in the presence of distressing symptoms, even when we do not believe that the former is caused by the latter. Finally, non-medical workers in primary care settings may have much to offer in the treatment of those whose coping strategies have broken down – so the distinction does not really seem to offer much help in deciding who shall play a major role in treatment.

A Classification for Whom?

Special interest groups have their own reasons for manipulating classifications to their own advantage. Drug companies, for example, might wish for many distressed patients to be considered ill if that means they are likely to be prescribed psychotropics. Yet the two main protagonists are the general practitioner and his patient. The following classification is for them.

It is always important for doctors to recognise syndromes of psychological distress in patients who are consulting them. The ways in which this may be done are described elsewhere (Goldberg 1979). Having recognised the distress, the doctor should then ask himself whether it is making a significant contribution to the health problem for which help is being sought. If he decides that it does, he will then need to formulate a management plan which takes account of whether and how the distress is to be 'labelled'.

1. Major Psychiatric Illnesses

These are the major syndromes of disorders for which there is a medical treatment of proven value. They benefit from medical help whether or not coping strategies have broken down. They include syndromes such as acute schizophrenia, psychotic depression and hypomania, and correspond to the topmost levels of Wing's PSE-ID system of case identification. Therapeutic agents such as phenothiazines, butyrophenones, tricyclics, lithium and ECT are useful in treatment. We must now distinguish between the diagnostic label that the doctor uses to himself or in communication with other doctors, and that which he uses to the patient. He will need a precise idea himself if he is to choose an appropriate treatment, and he will need to explain to the patient that he is suffering from a nervous illness. In most cases patients should be told the psychiatric diagnosis; but experienced clinicians will recognise that there are exceptions to this. Major psychiatric illnesses account for less than 10% of patients with clinically significant distress (Goldberg 1979).

2. Psychological Distress Not Requiring Specific Intervention

Four groups of patients require no specific intervention beyond a short discussion of their problems during the initial consultation. Labelling these distress syndromes as "illnesses" may be harmful, since it may impair normal coping strategies. First are those patients whose distress is 'subclinical' in severity. They will not have enough symptoms for formal syndromal diagnosis, and may seek help for trivial complaints. Secondly, there is a group of transient, self-limiting reactions to some external event, such as an 'anniversary reaction'. If it is already clear that resolution is occurring, no treatment is required other than ventilation of the problem, and reassurance that the reaction is 'normal'. Thirdly, are patients whose distress turns out to be unrelated to the problem for which help is being sought, and who do not wish to discuss their problems. Their reticence should be respected, and the doctor should remind himself that repression is a valuable psychological mechanism for normal people. Finally, are patients whose distress is well established and is in understandable relationship to an external situation which cannot be modified. Many clinicians will wish to try to ameliorate these syndromes with drugs, but they should only be prescribed over long periods if the patient is undoubtedly better on drugs than off them. Patients may need to be told that their dysphoric symptoms are understandable reactions to circumstance and not an illness, and

for this reason drugs will not be given. A combination of supportive help – not necessarily by the doctor – and social interventions is often the most effective; while iatrogenic drug dependence on a barbiturate or benzodiazepine is the least desirable.

3. Psychological Distress Requiring Intervention

These patients form a large residual category. The most important group are those with depressive illnesses which are thought to require antidepressant medication either because of the constellation or intensity of the affective symptoms. In one recent study by Hoeper et al. (1979) RDC "diagnoses" were made in a general practice setting by researchers using Spitzer's "SADS-L"interview: the largest single group was "major depression". It is important that the doctor 'labels' the depression to the patient, since this will increase compliance with the treatment and may help dissuade the patient from making disastrous alterations in his personal life while his judgement is impaired. If the demands of the patient's environment exceed his ability to cope either at work or at home, the illness label may also serve to decrease the expectations of other people and allow the patient to function more effectively. Anti-psychiatrists usually forget – or perhaps never knew – that 'labels' are sometimes positively helpful. In my own work, the single largest group of patients are those with symptoms of both anxiety and depression accompanied by various neurasthenic symptoms such as anergia, fatigue, lack of concentration and irritability. These patients typically present to the doctor with somatic symptoms, and the accompanying psychological disorder may be missed. The doctor may see his role as that of excluding physical causes for the patient's somatic symptoms, and order a series of investigations which tend to reinforce the patient's hypochondriacal convictions. It does not really matter how the doctor 'labels' these illnesses to himself; what does matter is that he should recognise the distress syndrome, and ensure that the patient recognises it as well. We will assume that the patient has been physically examined and that there is no reason to suspect a physical cause for the presenting somatic symptom. The single most important thing for the doctor to do is to "label" the illness as a psychological one so that the patient comes to see that his symptom may be part of a wider disorder. Once this has been accepted, the doctor can move on to discuss the interpersonal and social setting in which the whole disorder is occurring. This leads to a treatment plan, which will itself be limited by the resources available in a particular practice.

Those who have not worked in the field will assume that it is a simple matter to distinguish the patients just described from patients with physical illnesses who have some secondary psychological disturbance. They would appear to be the converse of one another. In practice the distinction is often impossible. Patients frequently describe a series of physical illnesses and stressful life events which have gradually led up to the set of dysphoric symptoms which are present at the time of consultation.

The presence of a physical symptom *or* a physical disease makes it very much more likely that a patient's distress will not be recognised by his doctor, and that the patient will be one of the "hidden psychiatric illnesses" described by Goldberg and Blackwell (1970). It is therefore important that doctors consider the possibility of a psychiatric disorder when the patient's symptoms do not quite fit one of the recognised syndromes of physical disease, or where the patient provides verbal or nonverbal cues which suggest a possible psychiatric disturbance. It is important that assessments of psychological disturbance are not made by exclusion but are made by a positive and unequivocal description of symptoms which suggest such an illness. Doctors must avoid the "either-or" system taught to them at medical school: they must be prepared to diagnose physical illness *and* psychiatric disorder. Johnstone and Goldberg (1976) showed that detection of such "hidden psychiatric illness" by the doctor meant that patients both recover more quickly, and had fewer symptoms at follow-up one year later.

The other distress syndromes to be included in this group are patients with anxiety states, and those whose mood disorder is accompanied by obsessional, phobic or hypochondriacal symptoms. Patients who have presented with a psychological symptom will not need to be persuaded that their problems are psychological: having assessed the predominant symptoms the doctor will move on to assess the current life situation, and will once more formulate a treatment programme having regard to the resources that are locally available.

The role of diagnostic labelling is equivocal in this group of patients. With major disorders, the doctor should have a precise idea of diagnosis which alone justifies the exhibition of major physical treatments, and should ensure that the patient knows he or she is thought to be ill. In the group not requiring intervention it is important that the doctor indicates that he finds the patient basically healthy despite the distressing symptoms, and reinforces normal coping mechanisms. However, in the large group of distress syndromes requiring intervention the label given will be partly determined by the proposed treatment. If the severity and nature of depressive symptoms are thought to justify a trial of an antidepressant drug the patient should be told that he is thought to be de-

pressed, but in most other cases the main function of labelling is to persuade the patient that the presenting somatic symptom is part of an emotional disorder. In most cases the assigned 'label' is non-specific, but it has the important therapeutic task of helping the patient to redefine the nature of his distress.

Problems with the Proposed Classification

It would at first sight appear neater to include all depressions that are severe enough to justify antidepressant drugs with the "major psychiatric illnesses". This has not been done because many patients who present in general practice settings with undoubted depressive illnesses will in fact improve without drug treatments: a significant proportion of depressed patients receiving placebos will get better; and in some studies this effect is so marked that those on the real antidepressants are not at an advantage (Porter 1970; Raskin 1974). The sort of depressions which undoubtedly should be offered chemotherapy are those with psychotic features and those with pronounced neurovegetative or "biological" symptoms. However, in general practice settings the majority of depressed patients have no psychotic features, and neurovegatative features are often not pronounced, so such illnesses have therefore been relegated to the more amorphous group of "distress syndromes".

The proposed classification does have some implications for the role of other professional workers such as social workers and community nurses, but it is not suggested that they work with one group only. These workers may have an important contribution to make to the management of patients with major disorders, but the doctor must continue to shoulder responsibility for physical treatments, and this will mean seeing such patients from time to time, when they have been referred to another member of the team. Patients in the substantial group "not requiring intervention" will be seen only at initial consultation by the member of the primary care team providing triage. In Britain this is always the doctor, but in other parts of the world this may be a feldsher or specially trained health worker. Patients in the remaining group can be referred for their entire care to other members of the team if drugs are not prescribed or can be seen by both doctor and team member if drugs are part of a treatment plan.

Need for Further Research

The arrival of triaxial classification systems will facilitate research using the proposed model. Broadly speaking, patients with 'major psychiatric illness' will receive psychotic diagnoses on ICD codes 290–299, on Axis 1. Most patients with distress syndromes have either a neurotic code from ICD 300.0–300.8, or will have individual symptoms recorded, in the manner envisaged by the international classification of health problems in primary care (ICHPPC–2).

The important question of the relationship between distress syndromes and somatic symptom formation can be studied because not only physical disease, but also physical symptoms, are to be coded on Axis 2. The fact that social factors are to be coded on Axis 3 will enable researchers to investigate the relationship of social dysfunction to the various combinations of morbid phenomena on the first two axes. Several studies have shown the strong relationship between clinical Axis 1 and social morbidity Axis 3 in community samples (Cooper 1972; Huxley and Goldberg 1975; Hurry and Sturt 1981) but no study has allowed for the mediating effect of morbidity on Axis 2, or distinguished between established physical disease on the one hand, and isolated physical symptoms on the other.

It is necessary for the triaxial system to be adapted for intervention studies as well as the purely descriptive studies described above. To what extent can interventions be based on triaxial descriptions? If interventions by social workers are taken as an example, effective interventions have been shown by Cooper, Harwin, Depla and Shepherd (1975) in the management of chronic neuroses, presumably because of the long-standing Axis 3 disorders which had been shown to be associated with chronic neurotic syndromes (Kedward and Sylph 1974). More recent research has failed to show that social interventions are effective in patients with acute depressions, although those with "acute on chronic" depression who had major difficulties in their marriage or heterosexual role *did* benefit (Corney 1981). These results might fall into place with a triaxial system, although one suspects that it will be some time before a satisfactory system emerges for coding social problems on Axis 3.

A recent paper by Mann, Jenkins and Belsey (1981) has shown the predictive power of social factors in minor neurotic illness using the Social Stress and Support Interview. These workers also assessed personality factors as predictive variables, but found that neither physical illness nor personality were as powerful as social factors.

The major need in the coming decade will be for longitudinal studies and intervention studies. Which syndromes have a good prognosis, however they are treated, and which can be shown to be favourably influenced by treatment? Which syndromes are unaffected and can best be managed by supportive mea-

sures with minimal drug therapy? The classification offered by ICD-9 is not ideally suited to answering such questions, but some form of triaxial classification may prove to be very much more useful.

In order to be valuable, it is necessary for intervention studies to specify a particular intervention, and the particular group of patients to whom the intervention is addressed. Early studies have added professional workers to the primary care setting as though they were in themselves a treatment. The aim must be to specify the particular treatments which can usefully be given to particular groups of patients.

Emphasis on the possible contribution of other professional workers has tended to distract attention from the therapeutic effects of the doctor himself. What would be the effects of labelling patients as ill or not ill in the various clinical groups described in this paper? What are the effects of a non-specific illness label versus a psychiatric diagnosis? Within a particular group of patients, to what extent are the reported effects of a drug influenced by the effects predicted by the doctor? Finally, what are the effects of offering definite follow-up arrangements versus leaving the decision to the patient?

The arrival of triaxial systems of classification could greatly assist the further elucidation of problems in this area provided that it is used in an imaginative way and allowed to throw light on both the social correlates of illness and the scope for possible interventions.

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