SOME OBSERVATIONS ON
PHYSICAL TREATMENT OF PSYCHOTIC
PATIENTS IN GENERAL PRACTICE *

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I think it is a sign of the times that at this conference general practitioners have been asked to speak at three meetings dealing with psychiatric problems, while a few years ago the subjects would surely have been thought of as concerning only psychiatrists. I do not claim greater skill for us as yet, but what is certainly true is, on the one hand, with the discovery of the antibiotics and greater improvement in the standard of living and health and, on the other hand, the increase of discharge rate from mental hospitals and the consequent lessening of fear on the part of the public, the family doctor can no longer justify a lack of interest in psychiatric problems.

Many figures have been given in recent years of the incidence of psychiatric disturbance in general practice, ranging from 5 to 50 per cent, and the divergence of these figures emphasizes the lack of agreement in the diagnostic criteria used. Most of these statistics are, of course, related to psychiatric disorders in the widest sense. If we limit ourselves to patients diagnosed as suffering from a major psychosis, we would expect a greater degree of uniformity, though even here I do not find myself in full agreement with such a careful observer as C. A. H. Watts (1956). He has suggested that in 60 per cent of the patients who present the symptom of depression, this symptom is of the endogenous type, while I would have put the percentage of the neurotic depressions higher, though I do agree with him that depression nowadays is an extremely common psychiatric symptom.

One of the speakers dealt with the problem of drug trials in the treatment of chronic psychoses (A. D. Harris, 1958). I have gone through my records to try to assess the size of the problem in general practice and find what appears to be the most beneficial therapy received by these patients. Of a total of 4,500 patients my partner and I have at present, nine who have had one or more schizophrenic attack, i.e., 0.2 per cent of the patients at risk. Of these, four received inpatient treatment and one is at present in a mental hospital. The remaining four have been seen at outpatient departments. Excluding the patient who is at present in hospital, two have rarely worked in the past five years.

In a period of three months, in which I estimated that 27 per cent of attendances at my surgery were for patients who presented

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emotional or psychiatric disturbances in the widest sense, four per cent of this figure, were for the diagnosed schizophrenic. With regard to other psychoses, those of old age and the involutional period were the most important. Two per cent of all attendances at the surgery were for patients suffering from involutional melancholia within these three months, i.e., 7.4 per cent of all psychiatric attendances.

In a single general practice it is, therefore, hardly feasible to carry out a statistically valid investigation about the relative value of drug treatment in psychoses. A collective investigation on this might be sponsored by the College of General Practitioners. There are, however, two serious drawbacks in general practice to experimental drug treatment of mental diseases which do not apply to hospitalized patients. In general practice the patient is not under constant supervision; therefore one is dependent on the patient's and his relatives' statements about alleged improvement; further, the dangers inherent in the use of some of the new drugs cannot always be adequately guarded against.

It follows, therefore, that the general practitioner tends to be conservative, and with this as an overall principle, the practitioner's individual bias will largely determine what treatment his patients receive.

Of the modern drugs, I have found the promazine group the most useful in severe acute psychotic agitation for any reason. The treatment of depressions seems to depend largely on the underlying pathology. Fifty per cent of my recent cases of involutional melancholia received E.C.T., and their improvement with this therapy was usually more dramatic than that experienced with any other physical treatment in any psychosis. Otherwise, if there is no marked restlessness or anxiety, the patients seem to derive most benefit from the amphetamine preparations and to a lesser degree from methyl phenidate. Where anxiety is a predominant symptom, I may prescribe benactyzine or mepobramate, but I have not found these preparations superior to the older sedatives. It does not seem to me that any of these substances have a specific effect, or alter basically the picture which the illness presents, but my experience is limited to patients who are not unmanageable at home. Some of my patients receive no drug treatment over long periods, some only a hypnotic at night, or a mild sedative in the day time—and from my observations I have found some of the old-fashioned mixtures containing phenobarbitone and bromide quite useful, in spite of what has been said about the danger of bromide intoxication.

One reason why I keep patients on regular medication—sometimes with only a placebo—is that I want them to come back for a fresh
prescription so that I can keep my eye on them, and I would even say of some of these patients that the cigarette which they may smoke with me during their visit is of as much therapeutic value as is the prescription I hand out. Even with E.C.T. one cannot always isolate the physical treatment as the only determining factor in improvement. One patient remarked to me: "The treatment at this hospital is quite different and much better than the one I got at the other hospital." In fact, he had the same form of E.C.T. at both hospitals, but he experienced the different care and attention he received at the second hospital as "different treatment," and he responded better.

As Dr Watts (1954) has so well described, when a patient comes out of the protected environment of a mental hospital, he feels apprehensive and inadequate. He often feels different from the average person, not only because he has been in a mental hospital, but also because of his awareness that he experiences things differently from his friends. It is up to the family doctor to give him a feeling of being accepted and thereby help to raise his self-esteem. The patient's regular attendance at the surgery also ensures that any intercurrent physical illness can be dealt with, as in my experience some of these patients, because of their poor ability for reality testing, are often unaware of organic illness, while on the other hand these same patients may show hypochondriacal anxiety. I have at least two schizophrenics, where this impaired judgment of physical condition is also apparent in other members of the family. (In one such family two sons are mild alcoholics, a daughter has had two schizophrenic breakdowns, the father has a large disfiguring lipoma in the face which I have often told him could easily be removed, and a fifth member of the family was accepted into the Army during a remission from a lymphadenoma, none of the family having thought fit to suggest otherwise or even to consult me. The patient herself suffered for years from large varicose ulcers, which I discovered by chance, when I called at the house for some other reason.)

In considering the problem of mental disease in general practice, we should remember that a patient will usually bring the physical manifestation of his illness first, as in our society physical symptoms are still regarded as more respectable than mental symptoms. We are familiar with this from the patient with the psychosomatic illness, but a patient may use any intercurrent minor physical symptom as a "cover" for seeking help with an emotional problem. A young man of 27 came to my surgery with a sprained wrist. While I was writing a note for him, he suddenly remarked: "By the way, doctor, there is something funny about my nose, can I have it
changed?" It emerged that the patient had delusions of a hypochondriacal nature, ideas of reference, and in fact, was in the early stages of a paranoid schizophrenia.

I have found this approach so frequent that I have given it the name "the by-the-way syndrome". It is often the task of the family doctor to steer the patient from this introduction to the insight which will enable him to seek psychiatric help.

Summary

Statistical information is given about the incidence of schizophrenia and involutional melancholia in a general practice, and the role of modern drug treatment is examined from the point of view of the family doctor. The difficulty of isolating physical treatment as the only determining factor in improvement is brought out. The importance of keeping in contact with the patient with a history of a psychotic breakdown is stressed. The impaired judgment of physical condition is brought as an example of the schizophrenic's poor ability for reality testing.

Attention is drawn to the fact that in general practice patients frequently use a minor physical illness as a "cover" for seeking help with an emotional problem.

REFERENCES


After giving an estimate of the proportion of stress disorder seen in his own practice (42.8 per cent of all patients seen) the author goes on to discuss minor psychoterapeutic procedures such as reassurance, placebo-prescribing, education, sympathetic listening, encouragement, and general guidance. The patient is helped to understand his problem and the action of his mind in relation to it Active questioning must be minimal so that the doctor will not interrupt what is coming forth. "If in doubt as what next to say—say nothing."

Special sessions of 30 to 45 minutes are needed so that the patient can feel relaxed, also the doctor.

Dr Hopkins gives 12 case histories which illustrate his methods and results.