MENTAL ILLNESS IN GENERAL PRACTICE

(Report of a symposium arranged by the Welsh Faculty of The College of General Practitioners for Students of the Welsh National School of Medicine on 11 November 1964)

THE SYMPOSIUM WAS OPENED by DR ROSENTYL GRIFFITHS, chairman of the Undergraduate Education Committee. She expressed her pleasure in welcoming the chairman and speakers and the large number of students and doctors who had come to discuss this interesting subject. She impressed upon the audience that the purpose of the symposium was to give an insight into the type of case that could be encountered in general practice. A high proportion of patients seek advice from the general practitioner on account of mental ill health and its understanding is vital to the economy of the nation. It was important for the general practitioner to recognize illness in its early stages. She said that the chairman, in his role as consultant psychiatrist, and teacher together with the three general practitioners, who were to introduce the topics, had laboured hard in the vineyard and we should now reap the harvest of their experience. DR J. P. SPILLANE, M.D., B.SC., M.B., B.CH., D.P.M., physician superintendent of Whitchurch Hospital then took the chair and reminded the audience of the size of the problem. He pointed out the difficulty of assessment but indicated as a guide that approximately 5,500 people per annum successfully committed suicide in Great Britain and the attempted suicide rate was probably eight times this. We had come this afternoon to look for hard clinical facts and our first speaker would no doubt produce these.

Depression

DR C. A. H. WATTS, M.D., M.B., B.S., D.OBST.R.C.O.G. (Ibstock) introduced the subject. Endogenous depression had three features. It was a commonplace illness in every sphere of medicine, was frequently overlooked and could be a devastating experience for the patient. Other factors causing depression were physiological, social, physical and psychological and a combination of all the various factors could be met. Only a small number of the total cases of depression were recognized. He then showed charts to illustrate this. Only 12 to 15 per thousand of those who consulted a doctor were suffering from depression but this did not include a vast reservoir of those who did not consult their doctor. Capstick had shown that 85 per cent of suicides were not under the care of a doctor at the time of the attempt. The suicide rate in this decade was higher than at the beginning of the century. There were six ways in which endogenous

depression could present:

1. The typical unmistakable depression accounted for only five per cent of the cases.
2. An obvious depression but the type needing to be identified
3. Disguised as an anxiety state
4. Disguised as an organic illness
5. A depression added to an established organic disease
6. A behaviour problem out of keeping with the patient's usual way of life

Many acts of licence and stupidity were in fact due to endogenous depression. Dr Watts then suggested five points that might help as a guide:

1. There was an unexplained loss of energy
2. There was an upset of the sleep rhythm which might either take the form of insomnia or of sleeping too much
3. There was a swing of affect
4. There were habit changes
5. There was a falling off in the *joie de vivre*

The speaker then referred to endogenous depression as the forgotten diagnosis, and he quoted the tragedy of a certain patient referred to a physician who finding no physical illness reassured the man and the patient went home and hanged himself. He quoted an example of one patient seen by no less than 42 doctors on whom £140 was spent in drugs, £700 in hospital care and who was in fact suffering from an undiagnosed endogenous depression. He then gave further illustrations of the great sufferings of the depressed patient. He stressed the importance of assessing the suicidal risk, a skill which should be known by every practising doctor. It demanded a tactful approach to the subject. If the patient admitted to suicidal thoughts he should be referred to a psychiatrist though it might be advisable to delay reference for a few days during which time the family doctor developed a good rapport situation. If the patient was referred after a single interview he might feel rejected. Dr Watts then showed three paintings by Goya which indicated the progressive change in the painter from normality through to depression.

In thanking Dr Watts for his excellent talk Dr Spillane suggested that in assessing the suicidal risk a useful question to ask the patient was ' what do you feel about the future? '. He thought the fear of being alone was often significant and he emphasized the importance of the relationship between the patient and his doctor.

PROFESSOR K. RAWNSLEY then expressed his opinion that depression could be a symptom as well as a disease and this could occur for example in schizophrenia and early organic dementias. He had found a useful question to ask in determining the suicidal risk—' Have you any morbid thoughts? ' He also supported the view that the general practitioner could use his relationship with the patient in order to obtain a promise that he would not do anything foolish while arrangements were being made.

MR. ROGER MASON asked how we could persuade the patient to visit a psychiatrist when he was unwilling to accept that his disease was not physical. Dr Watts thought that the stepping stone to persuading the patient was the help that we could now offer in the way of drugs. He

regretted that ECT could only be given in a mental hospital.

DR GERALD PETTY pointed out that it was always worth-while making time for the depressed patient and he asked Dr Watts how much time he found he had to put aside for his work. He had found himself that patients who woke up depressed and tended to improve during the day were probably suffering from an endogenous depression. The reverse story indicated depression due to an environmental state. He thought that the endogenous depressive unlike the neurotic did not threaten suicide. Dr Watts replied that he gave about eight hours out of 52 hours per week for psychiatry.

DR R. T. STAMPS asked in what way could the local authority doctor help. Dr Watts thought the service was very good. He thought that a contact once a month between the general practitioner and the welfare officer perhaps over a cup of coffee could be of help.

DR J. N. M. PARRY reminded the audience that the endogenous depressive was a dangerous patient. He arrived at the end of a busy surgery and must be given time even though the symptoms might appear trivial.

Senile mental illness

Dr Spillane then introduced DR GERALD PETTY, *T.D.*, M.R.C.S., L.R.C.P., (Llandaff) and said that he had travelled extensively and studied the subject of senile mental illness both in this country and abroad. Dr Petty pointed out that the symptomatology of the ageing person had not altered throughout the entire world's knowledge. The problem had only been increased recently because of the increase in the expectation of life. Although officially old age comes on the 65th birthday it can occur any time between 50 and 90 years. He then introduced quotations from Ptam-Hotep who lived 4,000 years ago, the book of Ecclesiastes and William Shakespeare which adequately illustrated old age. He thought that the chief objective of the geriatrician and general practitioner was to care for his charges and to make them grow old young. He thought there were three therapeutic categories:

1. Untreatable, and requiring hospital admission
2. Alleviated types which could be cared for within a home or a hostel
3. Adequately treatable at home

He thought that in the first group the diagnosis of senile dementia was frequently made and was often wrong. It consisted of a steady progressive deterioration in the personality together with the onset of infantile habits, lack of co-ordination of movements, confabulation, muttering and inappropriate emotional outbursts which often needed admission to avoid wrecking the home. In the second group there were patients with senile amnesia. These people could often remember things long past incredibly lucidly but could turn on the gas and forget to light it. Their conversation consisted of repetitions of the same question. The condition was due to a general degeneration of the cerebral cortex and resembled the state of concussion. ' The wandering sickness ' was a problem which sometimes needed custodial care in a hospital.

Senile confusion. The diagnosis was often difficult. The treatment was

adequate and the results were good. He pointed out the need to distinguish it from senile dementia and mentioned the usual sudden onset. He said that complete examination and investigation of the patient was essential. We should not ask for symptoms but look for signs. The causes included infection, postoperative state, carcinoma, anaemia, infarct, malnutrition, emotional disturbances and depression which were common in the aged often because of loneliness and other social factors. Treatment was largely a national social problem. To deal with it we must deal with the lack of a sense of social responsibility. He reminded his listeners of the present and proposed arrangements for care of a mentally disturbed patient. He himself had found that amongst drugs stelazine in the dose of 2–3 mg. per day was satisfactory. He thought it a mistake to oversedate the elderly who after all often had cat-naps during the day and did not require prolonged sleep during the night. The relatives could help by appreciating the nature of the second childhood and encouragement or an occasional ticking off could be helpful. He gave some amusing accounts of his experiences with these patients and of the satisfaction obtained from successful treatment. He thought that there was some value in regular examination of the elderly but preferred to leave out discussion of euthanasia since he himself was rapidly approaching his statistical old age.

DR STEPHEN GANG asked whether Dr Petty would agree that the demented patient must be recognized early and he would be wise to control his temper even when these patients cause him inconvenience. He gave an interesting example of the way in which inability to do simple sums could be a guide. Dr Spillane suggested that we had to turn to a relative in order to get an accurate history and he sometimes found that he could only obtain this from the patient's general practitioner. He thought that the local authority could assist if they recognized that when one of an elderly couple die there was an initial risk to the other of developing a state of confusion. If this was observed early there was less danger of nutritional factors supervening with the inconvenience of so much more work.

MR IWEN MORRIS asked whether it was possible to date the onset of mental illness from the earlier onset of a physical illness such as myasthenia gravis. Dr Petty said it was extremely difficult to subdivide physical and mental conditions and to sort out which factor came first. Dr Spillane confirmed that the aetiology was very often complicated and it was possible for depression and bone marrow change to coincide.

DR J. N. M. PARRY described the difficulty of knowing the stage of the illness at which the patient should be sent into hospital. Dr Parry thought that as little change as possible should be made in the patient's environment since movement often lead to deterioration. If the patient could be managed where he was he should stay there. Dr Spillane thanked Dr Petty and the others who had contributed to this useful discussion.

The neuroses

DR J. P. HORDER, M.A., B.M., B.CH., M.R.C.P. (London), told of a patient who said to him: 'Doctor, there's nothing much wrong with me piece by piece; it's what holds me together that's wrong'. This summarized

the central nature of the neurotic disorder which lay in the patient's feelings and thoughts, even if it sometimes appeared to be in a particular organ. Neurosis might last a week or two or, in varying degrees, for a lifetime. It affected the people round the patient as well as himself, including the doctor. It had to be distinguished on the one hand from normal anxiety, on the other from psychosis. No distinction from psychosomatic disorders was possible but between neuroses and primary physical disorders a very clear line had to be drawn. The management of the two was entirely different, and every doctor needed to become expert in distinguishing the one from the other, no one more than the general practitioner. Taking the strictest definition, one in 15 of the general practitioner's patients suffered from neurosis. If, however, to these were added patients with vague symptoms like headache, and others with disorders like duodenal ulcer where a large psychological factor might be present, the figure rose to one in three patients. Even if there were enough psychiatrists, general practitioners would still have to make a diagnosis for these patients, because so many of them presented in the first place with physical symptoms. Many of them were too slight to deserve referral and, in any case, not all patients wanted to be referred to the psychiatrist; thus general practitioners would have to treat them. In fact, however, there were so few psychiatrists compared to the size of the problem that three-quarters of neurotic patients had to be treated by non-psychiatrists. The difficult neurotics to recognize were those who presented with physical symptoms. Diagnosis was made partly through excluding organic patterns, partly through noticing the positive features of neurosis. There were typical symptoms, like a need to get a deep breath, or a heavy vertical headache. The symptoms might be diffused through several systems of the body. The patient tried to impress the doctor with the badness of his situation. There were also positive physical signs. It was possible to subdivide neurosis into types but the really important thing was to realize that every case was one on its own, unlike the last and unlike the next.

The general practitioner could treat some cases himself, but had to refer others. He could best hope to help early cases and those where the disorder was most obviously related to current events. The first step in management of a neurotic patient was to tell him that the trouble lay in his thoughts and feelings and not in his body. The only bad mistake was to say—'There is nothing wrong with you'. The second step was to complete the diagnosis by finding the problems which lay behind the symptoms. Sometimes this was easy, sometimes impossible. It was necessary to listen to the patient, but the doctor needed to know what to listen for, and this required experience or training. The solution of problems was best left to the patient himself, if possible. Psychotherapy was the main tool for treating neurotic patients and, in general practice, this meant the exploration of the patient's problem in the setting of a trusted relationship. The other tools were sedatives—which should certainly be used, but never as the only treatment—and efforts to change something in the patient's environment, for instance, a change of occupation, or influencing the attitude of his close relatives.

In dealing with neurotics, the general practitioner had many problems—

the first was in accepting their symptoms as real. If he did this, he would find himself in unfamiliar territory and would be painfully aware of his need for more skill. He especially needed skill in dealing with the emotional effects which the patient had on himself, the doctor. Neurotics were particularly liable to make a doctor feel impotent, unable to think of any way to help. The final difficulty was that many of them needed extra time and general practitioners could not always give them all they needed.

As for results, there was no doubt that symptoms could be relieved and their recurrence sometimes prevented. Thus the quality of life could be improved, but general practitioners should not aim to alter personalities. The management of neurosis presented a bigger challenge than that of many organic diseases, so success, though rarer, could bring greater satisfaction. It took the doctor further into the lives of his patients; a doctor could be happy in general practice only if he was at least as much interested in people as in diseases.

PROFESSOR RAWNSLEY commented that if only we had enough time we could effectively treat all neuroses. The general practitioner and the psychiatrist must each accept the limitations of their role. With experience we can learn the results that we should expect.

DR WILFRED HOWELLS the provost of the Welsh Faculty of the College of General Practitioners expressed grateful thanks to the chairman, speakers, the staff of the Medical School, to the audience for their attention and to Dr Sydney Copp for his arduous work in arranging the event. He was supported by the secretary of the Cardiff Medical Students Club who hoped that it would not be two years before the College arranged another symposium which had so enlightened the students about a field of medicine of which they knew almost nothing.

The Welsh Faculty acknowledge with gratitude the assistance given by Messrs. May and Baker in the arrangements for the symposium.

GENEROUS CIDER

I cannot but recommend a generous *red wine* as a most noble, natural subastringent cordial, and perhaps Art can scarce supply a better. . . *Rhenish* and *French* white Wines, diluted, make a most salutary Drink in several Kinds of Fevers, and generous *cyder* is little inferior to either.

JOHN HUXHAM, *On Fevers.*
Second Edition. (1750).