



Title	Cases of anxiety and depressive disorders in general practice
Author(s)	Lam, CLK
Citation	Hong Kong Practitioner, 1995, v. 17 n. 2, p. 77-81
Issued Date	1995
URL	http://hdl.handle.net/10722/45125
Rights	Creative Commons: Attribution 3.0 Hong Kong License

DISCUSSION PAPER

Cases Of Anxiety And Depressive Disorders In General Practice*

Cindy L K Lam**, FRCGP
General Practice Unit
Department of Medicine
The University of Hong Kong

Introduction

I want to share with you my clinical experience with anxiety and depressive disorders in general practice. I found that a lot of times, patients presenting to me don't really fall into the category of either a pure physical or psychological problem but a mixture of both. I shall illustrate with some real patient examples how patients with psychological problems present, some of the difficulties in their diagnoses, the interaction between physical, social and psychological problems and some management issues.

How Do Psychological Problems Present in General Practice?

A Lady Complaining of Runny Nose

Mrs. A, a 40 year old housewife, came to see me complaining of runny nose. After describing her runny nose, she also softly uttered that she had problems sleeping. We can choose to explore the runny nose or the insomnia. The resulting diagnosis will be very different – we can label it as a simple upper respiratory infection or it may be depression.

Patients often somatise their psychological problems in order to legitimise the consultation. On the other hand, most patients are able to tell us and want to tell us about their psychological problems if we are interested. The tendency to somatisation is common in the Chinese culture. According to Goldberg and Bridges: 'somatisation is the most common reason why psychiatric illness goes undetected In ancient Buddhist scripture psychologisation was regarded as the original and most primitive response somatisation was regarded as an adaptive achievement of mankind, lessening the psychic pain and exchanging it for physical pains for which there have always been treatments'¹.

Probably we doctors reinforce this belief in what we do by paying a lot of attention and offering endless treatment to physical symptoms but tending to ignore and do very little other than give blanket reassurance to help patients' psychological problems. The time has come for us to change our attitudes and approach to our patients. We need to show our patients that we are prepared to help their mind as well as body and it is alright for them to present their psychological symptoms directly to us.

Until our patients have learned that it is safe and acceptable to present psychological problems directly, we have to rely on certain cues to help us pick up the psychological problems behind the physical complaint:

* This article was based on a presentation at the Workshop on Depression and Anxiety organized by the HKCGP on January 9, 1994.

** Address for correspondence: Dr. Cindy L K Lam, G.P.U. 3/F, Ap Lei Chau Clinic, 161 Main Street, Ap Lei Chau, Hong Kong.

Anxiety and Depressive Disorders

1. The look of the patient – one looks anxious when one is anxious, depressed when one is depressed.
2. The nature of the complaint – some symptoms are frequently psychosomatic and we have to be more aware of the possible underlying psychological problem in patients presenting with them (Table 1). Increasingly I discover that much chronic pain is psychological in origin. If you have a patient complaining of some intractable pain for which no cause can be found despite complete 'physical' examination, multiple investigations and referrals, and it does not respond to any physical or drug treatment, think about depression and look for psychological symptoms, do a psychological examination!

Table 1: Clues to Diagnosis

Patient's appearance
Psychosomatic symptoms:
* insomnia
* dizziness
* headache
* tiredness & gen. aches
* dyspepsia
* breathlessness
* chronic pain
Psychological symptoms
Frequent consulters / fat folders
Doctor's feelings

3. The mood and feelings of the patient – if you ask the right question, the patient will tell you the right answer. I do not mean asking leading questions but quite the opposite, ask

an open question like: 'What is your mood like? How do you feel?' Try to encourage patients to talk about how they feel and what they think. It is a bit more difficult to express emotions and describe one's mood in Cantonese but most people can tell you how they feel and what they think. On the other hand, most Chinese react very negatively to the question, 'Are you worried?' Being worried is often regarded as a stigma of psychic weakness.

4. The frequent attender – one clue is the "fat" folder. The patient with psychological problems often consults frequently as a cry for help and the record becomes thicker and thicker as more and more investigations, referrals, and treatments are given but without success.
5. The doctor's own emotional reaction – ask yourself and reflect on how you feel after or during the consultation. Very often I find myself feeling depressed after talking to a patient who is depressed. I feel anxious when talking to a patient who is anxious. We get a lot of useful information on the patient's emotional state by reflecting on our own.

How to Share the Diagnosis with the Patient?

A Lady Complaining of Shortness of Breath

Mrs. B aged 32, complained of recurrent episodes of breathlessness for about 2 years. She also had chronic right sided shoulder pain which she attributed to overwork. When I asked her in detail what the breathlessness really was like, she said that she had pins and needles sensations in her fingers and around her mouth, and she felt like dying. Sometimes the discomfort was so great that she thought she was going to die. The breathlessness was relieved by rebreathing into a bag.

This patient was suffering from panic disorder and a lot of her symptoms were caused by hyperventilation. I tried to explain to her that she had a psychological problem but she said that she had no worries (remember Chinese are very defensive about worries). After a period of silence, the patient told me that she thought she had 'neurasthenia'.

What is "neurasthenia"? A lot of literature has been written on neurasthenia in Chinese; the term is used much more loosely than its original meaning. About 80% of the patients with neurasthenia were found to have depressive disorders²⁻⁴. Chinese seem to accept and relate to this term very well. Should we use this term as a convenient label for any anxiety or depressive disorder in our Chinese patients?

The problem is often not so much of making the diagnosis but of sharing it with the patient. What are the Cantonese names for "panic disorder" and "hyperventilation"? I don't think there are any, and even if there are, they probably mean very little to an average Cantonese. While 'depression', 'panic' and 'obsession' are commonly used terms in conversational English, there is not even an easily understood Cantonese translation for depression, let alone the more complicated obsessive compulsive disorders.

In sharing the diagnosis of a psychological problem, it is important to tell the patient that we do not mean that he/she is malingering. Patients may feel upset and rejected when they think the doctor does not believe them. Acceptance of their symptoms is very important. Try to empathize with them by telling them that we understand psychological problems are much more unbearable and could cause more suffering than physical illnesses. We often have to help patients express their symptoms in psychological terms. This may be more difficult in Cantonese than in English but it is not impossible.

We have to gradually educate our patients that it is very acceptable to present psychological problems directly to us. Patients will keep on somatizing their psychological problems if doctors reinforce this behaviour by paying attention to only pain, headache, or shortness of breath, but taking it very lightly when they say that they are unhappy. It is not difficult to identify the clues of psychological problems, but we sometimes, consciously or subconsciously, pretend that we have not seen them because we are not sure how to explain and manage the real problem. So we just go on playing the physical game with the patient over and over again until our hearts sink. I think the time has come for us to break this vicious cycle by facing the challenge.

Is It A Physical, Social or Psychological Problem?

A Man Complaining of Blurring of Vision

Mr. C, aged 50 complained of blurring of vision and dizziness for about a year. One year ago, he had an episode of loss of consciousness due to a minor stroke which caused residual left upper quadrantanopia. He was found to be hypertensive at that time and was given metoprolol (which may cause depression). He used to be a watchman and was quite happy though he was not well-off. Since this episode of illness he was unable to work because of blurring of vision and dizziness. He was afraid to go out because of his dizziness. He lived with his brother on whom he was now dependent, but his sister-in-law did not like him at all. He came to ask me to cure his blurring of vision and dizziness so that he could get back to work. On physical examination, his visual acuity was good but there was left upper quadrantanopia. There was no ataxia or diplopia.

The most striking examination finding was that he looked very very depressed. On further enquiry, he thought he was going to be blind like

Anxiety and Depressive Disorders

his mother. He felt inferior and useless at home, and had lost all interests. He had strong suicidal thoughts, planning to jump from a height. The physical disability was not severe in objective terms but subjectively he felt he could not do anything. I tried to counsel the patient and in view of his suicidal intention, I referred him to a psychiatrist. The psychiatrist admitted him to Kwai Chung Psychiatric Hospital but he discharged himself the next day because he thought he was not mad. He came to see me the next day after his discharge complaining about my referring him to a psychiatric hospital. He felt even worse in Kwai Chung because the environment was very disturbing.

He went to see another doctor because he thought I was not helping him. The doctor advised him to have a CT scan and told him that there was an infarct in his brain which was incurable. He was found unconscious the next morning by his brother who took him to Queen Mary Hospital. The initial diagnosis was another stroke, but his signs were hard to explain. He had taken an overdose of metoprolol and prothiaden. Luckily he survived, but is still incapacitated with his dizziness and blurring of vision.

Was this a physical, psychological, or social problem? The interaction between these three aspects of a person's health is so close that treating one aspect and not the other will probably do more harm than good. Gentle and gradual counselling is required to make the patient accept his/her illness, otherwise he will reject your help and go doctor shopping.

Have We Cured The Problem?

An Old Man with Severe Chest Pain

Mr. D, aged 75, complained of chest pain for 3 months. The pain became progressively more severe to the point that he could not carry out any of his daily activities. It even disturbed his sleep.

He had pain even at rest, and his family took him to the hospital. He was diagnosed to have unstable angina due to ischaemic heart disease. He was discharged one week later with four cardiac drugs and nitroderm.

His wife brought him to see me because his chest pain was not improved despite the drug treatment. I did not find anything on physical examination except an old gentleman in agony and a wife in distress. I told the couple that he was already taking all types of anti-anginal drug, there was really nothing that I could offer except re-admission to the hospital, but the patient refused to go. When the patient was dressing, the wife said to me in tears that something must be done because she could not bear it any longer. The diagnosis became clear when the wife told me that her husband would cry in pain and asked her to put a rope on the ceiling so that he could hang himself. As a matter of fact, this man is afraid that his wife will desert him now he is getting old. I gave him an antidepressant and his chest pain started to improve after two weeks and subsided one month later.

Have I really cured this man? When can we stop the antidepressant? How about the wife? Who was the real patient? Why did he become depressed? The antidepressants might have helped him symptomatically, but counselling is required to solve the problems in this family.

Conclusion

We, as general practitioners, can stop the process of somatic fixation by picking up the cues of psychological problems, being brave in making the diagnosis, sharing our understanding of the problem with the patients in terms that they can understand, adopting a whole person approach in our management, and providing the necessary counselling and support. We need to show our patients that we are ready to help them with their psychological problems and that they do not need

to somatise in order to gain the ticket of admission.

I would like to end this discussion by quoting Professor Richard Grol's saying:

'The general practitioner has important roles in the prevention of somatic fixation but the general practitioner's behaviour can also promote processes of somatic fixation⁵'. ■

References

1. Goldberg DP, Bridges K, Somatic presentations of psychiatric illness in primary care setting. *J Psychosom Res* 1988; 32: 137-144.
2. Kleinman A, Neuraesthesia and depression: a study of somatisation and culture in China. *Culture, Medicine & Psychiatry* 1982; 6: 117-190.
3. Tseng WS, The nature of somatic complaints among psychiatric patients: the Chinese case. *Comprehensive Psychiatry* 1975; 16: 237-245.
4. Cheung FM, The indiginization of neuraesthesia in Hong Kong. *Culture, Medicine & Psychiatry* 1989; 13: 227-241.
5. Grol R. (ed), *To heal or to harm - the prevention of somatic fixation in general practice*. 2nd ed, London: RCGP.

**** **** **** **** **** ****

**Department of Community Medicine
&
Hong Kong College of Community
Medicine**

**Invites your participation in an
intensive preparatory course for
Part I, MFPHM & FHKCCM
Joint Examination**

Mock Examination March 25th and 26th
tutorial
April 8th - 13th (excl 9th)
9 am to 5 p.m.

**Local and overseas tutors, rehearsal of examination
technique, in depth study of examination paper
style and content.**

Course fee \$5000 (*inclusive of tuition and materials*)

**Address inquiries to Mrs. J. Johnston, Department
of Community Medicine, Patrick Manson Building
South Wing, 5 Sassoon Road, Pokfulam. Tel 2819
9199 Fax 2855 9528**