

Are you thinking too much? Recognition of mental disorders in South African general practice.

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Abstract

Research shows that up to 24% of primary care consultations have an underlying mental disorder and the majority of these patients are unrecognised in general practice. A number of factors relating to the doctor, patient, health system and research methodology may help to

explain this finding. Continuing professional development that targets effective interviewing skills, knowledge of diagnostic categories, therapeutic options and creates awareness of beliefs and attitudes within both the GP and the patient, may be helpful in addressing this issue.

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Introduction

This review has arisen from an initiative to adapt the World Health Organisation's educational program "Mental Disorders in Primary Care" ¹ for general practitioners in South Africa, as part of a new distance education

program that will be launched in 2000.

The intention is to review the factors that influence recognition of mental disorders by general practitioners and to consider how recognition can be

improved. Much of the evidence comes from studies performed in developed countries within a very different context. Nevertheless I have attempted to summarise the evidence and to discuss its relevance to South Africa.

Discussion

What are the common conditions?

It is now well established that the majority of mental disorders are managed in primary care and not in specialist psychiatric services.² Primary care providers therefore should be highly skilled in recognising and managing these disorders. Internationally 24% of patients attending primary care facilities were found to have an identifiable disorder using the International Classification of Diseases -Version 10 (ICD-10).² In

South Africa a study in Soweto found a prevalence of mental disorders of 14.4% among adults at a primary care facility³ and a study of children in Khayelitsha found a prevalence of 18.8%.⁴ These studies suggest that in a morning surgery of 24 people between 3 and 6 people on average could be suffering from a diagnosable mental disorder. Is this our experience as general practitioners?

Among these patients with mental disorders the commonest conditions

are depression and anxiety. Community studies in South Africa have found a high prevalence of depression and anxiety disorders with values ranging between 16 and 24%.^{5 6} A large international study by the World Health Organisation identified the six most common conditions at primary care facilities as depression, anxiety, alcohol abuse, sleep disorders, chronic tiredness and unexplained somatic complaints.² A community study in Kwa-Zulu Natal found a prevalence of 7.8%⁵ for alcohol abuse and in Fraserburg, North West

Province an incredible rate of 56% for alcohol dependence.⁷ Violence in South Africa is an important determinate of mental illness. A national survey in general practice found that 21.5% of women in primary care facilities had a history of exposure to physical domestic violence.⁸ Amongst these women 35% were suffering from post-traumatic stress disorder and 48% from depression. Another study of Xhosa children in Khayelitsha found that 95% had witnessed violence and 56% had experienced violence themselves.⁹ Amongst these children 40% were suffering from mental disorders, especially post-traumatic stress disorder. The HIV/AIDS epidemic is likely to have a major impact on the mental health of both sufferers and their families.¹⁰

How well do general practitioners recognise mental disorders?

The overwhelming message from international studies is that primary care providers detect slightly less than half of all patients with mental disorders.^{2,11} All of these studies detected “cases” by the use of standardised tools and questionnaires based on international classifications of disease such as the ICD-10 and compared these “cases” with the diagnosis given by the primary care provider.¹²

An important debate in the South African context is how useful are these standardised categories for defining mental disorders in our communities? The WHO has conducted extensive international research that shows the presence of these categories in all communities studied in both developing and developed countries.¹³ However within this system of classification some of the most common problems in primary care such as acute anxiety and somatization are represented by non-categories such as “anxiety not otherwise specified”.^{14,15} The WHO approach has also been criticised as you will only find

what you look for and may miss or ignore expressions of mental illness that are not included in the definitions but are relatively common in local communities or cultures.¹⁶ This dilemma has been labelled as the “universalistic approach” versus the “relativist” approach.¹⁷ It is a familiar story in family medicine where the need to explore both the “disease” and the “illness” can be seen as a parallel argument. On the one hand the doctor’s training in explanatory models of disease attempts to fit patient’s symptoms with internalised diagnostic categories but on the other hand only 50% of patients in primary care can be allocated within these categories. In order to manage all patients a broader definition of illness using a “systems” model and not a “disease” model is more practically useful and an approach which elicits and accepts the patient’s own explanatory model.¹⁸ In the field of mental health for example there may be a need to recognise and explore local expressions of emotional distress such as “Thinking too much”, “I felt like throwing down the spears” or “I feel things crawling through the body”.¹⁹ In addition it may be necessary to elicit explanatory models held by the patient such as “amafufunyana”.²⁰ “Amafufunyana” may present as an emotional disturbance with agitation, weeping, aggression or delirium. It is believed to be caused by sorcery resulting in spirit possession.²¹

In summary family medicine operates in a relativist worldview where exploration of the patient’s unique explanatory model is important to build understanding and enhance accurate diagnosis, patient satisfaction, compliance, outcome and recall of information.¹⁸ This is in tandem with the use of the doctor’s explanatory model to recognise and treat diseases. The doctor’s explanatory model is based to some extent on universally accepted diagnostic categories.

Does non-recognition matter?

Having outlined the evidence that shows general practitioners do not recognise

cases of mental disorder identified by standardised screening tools; we should now consider what factors are important in understanding this phenomenon.

The implied criticism of general practitioners should be balanced by the understanding that mental disorders may be recognised and treated, but not recorded in the medical record and therefore not counted.²² In addition, studies which only use self-reported questionnaire tools to detect disorders, may over-estimate their prevalence.²² Studies varied in the way recognition was determined and defined.¹¹ Furthermore GPs may be aware of mental disorders but resist diagnosing them due to likely spontaneous improvement, lack of effective treatment or unwillingness of the patient to accept this diagnostic label.¹¹ One study demonstrated that a psychiatrist who became a general practitioner failed to detect one third of patients with mental disorder.²³ This may point towards the difficulties inherent in general practice of sifting through undifferentiated and multiple symptoms within a brief consultation.

It is also noted that the more severe mental disorders are more likely to be recognised and so if the less severe are overlooked does this matter? Evidence is conflicting on this issue.²⁴ One naturalistic study concluded that recognition was positively associated with a better course and outcome of psychological problems in primary care.²⁵ In addition recognition was associated independently from treatment with a better outcome and it was postulated that re-framing of the illness by the patient may allow them to pursue more effective solutions within their own support network. Other naturalistic studies have shown that non-recognition of depression does not adversely affect outcome, but this may be because recognition is not associated with effective treatment.²⁶ Obviously maximum benefit from recognition will be obtained when an effective treatment strategy exists and

is used. It has also been noted that non-recognition is linked to prolonged disability for the patient, an increased consultation rate, unnecessary investigations and a waste of resources.²⁷ In studies looking at the natural history of mental disorders physical illness, social adversity, poor housing and poverty, which are all common problems in South Africa, have been linked to poor outcomes.²⁴

What level of performance is reasonable to expect from general practitioners?

One study performed in an established health system and with well-trained family physicians found that two thirds of patients with major depression were recognised, two thirds of these were treated and two thirds of these were treated adequately. Two thirds of all patients, whether recognised or unrecognised were well 1 year later. The recognised cases however were more symptomatic and not the same as the unrecognised.²² In the best of circumstances only one third of recognised patients with depression took adequate doses of antidepressants and achieved significant improvement.²⁸ In South Africa one could anticipate that with no systematic vocational training in general practice, barriers of language and culture, and many limitations in the health system our less than ideal situation would lead to a lower performance and patients with even severe disorders could go unrecognised.

Therefore despite some evidence in more developed settings, that unrecognised cases may do as well as recognised, these studies may not be generalisable to the South African context. I would argue that in South Africa our present ability to recognise and treat mental disorders in the primary care system might be so poor that the benefits of treatment are denied a substantial proportion of eligible patients. In the Soweto study 93% of patients with mental disorders were unrecognised and in Petrusburg 96% of patients with depression.^{3, 29}

What factors influence the doctor's ability to recognise mental disorders?

It seems therefore that non-recognition is a real issue and can lead to adverse outcomes for both patient, GP and health system. If we accept this then we must consider what factors influence this problem and what can be done to improve the situation. In order to answer this question I will consider the factors relating to the doctor, the patient and the health system separately.³⁰⁻³³

1) Factors relating to the doctor.

· Decision making in general practice often involves hypothesis generation and testing.³⁴ From the moment the patient begins to speak the doctor's internal dialogue is generating and testing hypotheses. Hypotheses may be considered and discarded as the patient tells their story or as a result of inquiry by the doctor. A doctor who fails to generate and test psychological hypotheses alongside physical ones will of course fail to recognise mental disorders. Psychological problems in primary care frequently present with somatic complaints such as headaches, musculoskeletal pain, palpitations and chest pain. An emphasis therefore on always exploring physical hypotheses first will systematically prevent the recognition of mental disorders. An approach of if "there is nothing wrong" it must be "in the head" will be a frustrating one for both patient and doctor. Recognition should be followed by the ability to decide on severity and formulate a specific diagnosis according to accepted criteria.³⁵

· Communication and consultation skills in general practice have also been clearly linked to effective recognition and management of mental disorders.³⁶⁻³⁸ For example skills in attentive listening such as not interrupting the patient's narrative, use of facilitative silence and responding to what the patient has said rather

than asking questions from theory have been linked to better recognition. The ability to ask questions with a psychological and social content has also been identified as important. In short effective communication skills within a patient-centred clinical method are essential. Skills in working with an interpreter, learning the language of your patients as well as local customs and expressions of illness may be needed.²¹ In addition to this a more holistic approach that inquires about the person, their family and context is more likely to elicit mental problems. Continuity of care with the same doctor and repeated consultations favour recognition. Whilst longer consultations favour recognition the use of a patient-centred approach does not necessarily mean longer consultations.¹⁸

· Another important factor is the beliefs and attitudes of the GP. GPs who do not believe mental disorders are "real illness" or who believe that their diagnosis and management is too time consuming are less likely to recognise mental disorders. Similarly GPs who do not see managing mental illness as part of their role, who blame the patient in some way for their illness or who can see "a good reason" for the patient's illness will struggle to recognise mental disorders. Conversely GPs who believe that effective treatment exists, that they have the ability to treat mental illness, that there is enough time to deal with psychological issues and that psychological factors are important in both physical and mental problems are more likely to recognise mental disorders.

· Finally there may be a lack of knowledge about common mental disorders due to a historical emphasis on the more severe and unusual disorders during undergraduate training and a lack of effective and relevant postgraduate vocational training and continuing professional development for general practice.

2) Factors relating to the patient.

· Patient's help-seeking behaviour is important. Not all patients with mental disorders seek help and not all who do seek help look to the primary care services. In South Africa a large number of people will deal with their illness themselves within their own social network or "popular" health sector.³⁹ The opinions and attitudes of key family members towards consultation and treatment will be important. Others will consult within the "folk" sector and attend traditional healers or alternative practitioners. In the WHO study only 50% of people with a mental disorder consulted a primary care provider.² In a Zimbabwean study only 29% of depressed women consulted in the "professional" sector;¹⁹ 82% of them were treated with paracetamol and none with anti-depressants. In addition patients may not share the same concepts as doctors and for example have no word for "depression".⁴⁰ The mental illness itself may cause symptoms that inhibit help-seeking behaviour. For example in depression you may not feel worthy of help, you may not believe that any help is possible or be too lethargic to seek help.

· The presentation of the problem is also important. Mental disorders present frequently with physical symptoms in all countries and as outlined above this makes the differentiation of mental disorders a huge challenge in general practice.^{16,41} However in the Zimbabwe study although 60% of terms used to describe emotional distress were physical; the 40% of psychological and behavioural terms were used more frequently.¹⁹ In addition some expressions that were translated as physical symptoms were in reality metaphors for emotional distress. Skills in language or interpretation may be a particularly relevant issue in South Africa.²¹ In addition although patients present physical symptoms to the primary care provider their own explanation of the problem is often psychosocial. In Kwa-Zulu Natal Petersen reported that body aches and pains were the main reason for encounter, 56% had the problem for one or more years and 62% saw

their problem as psychosocial.⁵ This again demonstrates that a question such as "What do you think is the problem?" may be an efficient short cut to the real issues.

· Co-morbidity with physical illness reduces the chance of recognition by a factor of five ⁴²whereas co-morbidity with other mental disorders increases the chance. More severe disorders are, not surprisingly, more likely to be recognised whereas disorders that are not of recent onset, have less overt or less typical symptoms are less likely to be recognised. A past history of mental illness will also increase the chances of recognition.

3) Factors related to the health system.

· One of the most important issues is the accessibility of primary care providers. In many parts of the country access is still limited by geographical distance in rural areas or by sheer numbers of patients in peri-urban areas.

· The organisational culture may value physical problems above mental and channel patients into having somatic complaints as "tickets of admission". The perception of psychiatry as being a separate program from primary care and having its own psychiatric sisters and doctors may support the notion that mental health is not part of the general practitioner's role. In private practice the unwillingness of medical aid organisations to pay GPs for psychological therapies may also be important.

· In the public sector the lack of a range of effective drugs with a low side effect profile may be important, as GPs will not recognise what they feel unable to adequately treat.

· The secondary and tertiary level support for the primary care provider is also a factor. If the general practitioner feels unsupported and without access to specialist advice and support she may resist diagnosing disorders which might require referral and for which she feels "out of her depth."

How can recognition of mental disorders be improved?

The previous discussion, of factors related to the GP's ability to recognise mental disorders, naturally leads on to a consideration of what can be done to improve recognition and what evidence exists for facilitating effective change.

Traditional "Continuing Professional Development" with talks and lectures by psychiatrists has not been shown to improve recognition.⁴³ There is a strong body of evidence that interview skills training using experiential learning techniques, in particular video feedback, can improve not only detection of psychological problems, but also their management.⁴⁴ The use of screening tools and questionnaires in general practice has been recommended by several studies^{23 45} although I think there may be an underlying assumption that tools developed as research instruments will be practically useful in every day practice. The use of self-rating scales outside of the consultation time may be limited in South Africa by barriers of language and literacy. Widespread screening of patients without improving the skills of the general practitioner is also unlikely to be helpful. A number of clinical guidelines and algorithms have been produced and may be useful,^{46,47} although research indicates that producing and disseminating a guideline does not in itself lead to effective change. Multifaceted interventions, that target both patient, doctor and health system, are more likely to be effective in improving recognition and management of disorders.³⁵ In terms of curricular content the following areas have been highlighted; patient-centred interviewing and treatment, the therapeutic effect of the doctor-patient relationship, a bio-psychosocial approach to clinical reasoning and care, synergistic attitudes and values, and the ability to diagnose and manage common mental disorders.⁴⁴

Conclusion

In South Africa the majority of patients with mental disorders may go unrecognised in general practice. It is hoped that this problem can be improved by continuing

professional development that targets effective patient-centred interviewing skills, knowledge of diagnostic categories and therapeutic options and creates awareness

of beliefs and attitudes within both the GP and the patient. A distance education program based on WHO materials will be launched in 2000.

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