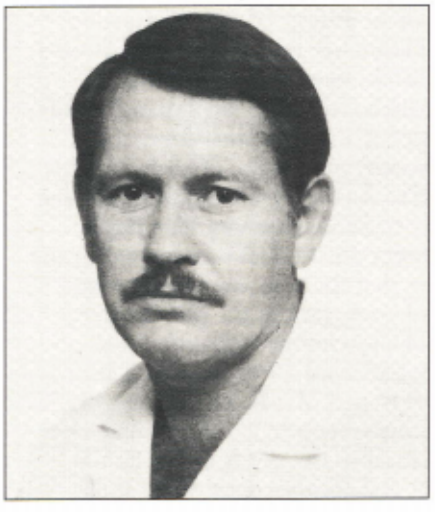
General Practitioner-Clinical Psychologist Symbiosis – Dr RJE Erasmus



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Curriculum vitae

Dr Bobby Erasmus qualified with an MBChB from the University of Pretoria in 1974. He went into private general practice in Springs, 1976-81, then worked in Durnacol and thereafter in Randburg, 1983-89. During this time he completed the M Prax Med at U.P. and is currently busy with his doctoral thesis in Family Medicine: "Rolverwagting en rolvervulling in Huisartspraktyk in Suid Afrika". He is a member of the Academy of Family Practice/Primary Care and has served as vice-chairman of the executive of the National General Practitioners Group. His interests lie in academic medicine, the role of the GP and the improvement of the image of the GP. At present he is Senior lecturer in the Department of Family Medicine, MEDUNSA and head of its section in KwaNdebele. He lives in Groblersdal.

Summary

I describe the cooperation between a general practitioner and a clinical psychologist in private practice through the presentation of three patient encounters. An effort is made to stimulate general practitioners in private practice to evaluate their knowledge about psychological problems, and to improve their team building efforts with clinical psychologists. Practical hints on how to implement this are proposed.

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KEYWORDS:
Physicians, Family; Psychology, Clinical; Interdisciplinary Health Team; Case Reports.

Introduction

In medical practice some patient presentations are not adequately explained by the usual textbook descriptions of pathophysiology, and many newly qualified general practitioners comment on the inappropriateness of their hospital based psychiatric training to prepare them for the psychological problems they encounter in general practice.[1]

Lesser[2] commented that if a successful partnership between the general practitioner and psychiatrist is to occur, not only must the psychiatrist come equipped with the knowledge-base and eclectic experience suitable for general practice and its patients, but the general practitioner must be prepared to identify and treat the problems of his patients who are emotionally disturbed. Similar considerations apply to the integration of clinical psychologists into the primary care team. Both members of the team must acknowledge the importance of each other's role and respect the other member as an equal partner in the management of psychologically disturbed patients.

McWhinney[3] described nine principles of family medicine, and the first principle is that the family physician is committed to the person rather than to a particular body of knowledge, group of diseases, or special technique, and that this commitment is open-ended. The second principle is that the family physician seeks to understand the context of the illness, because many of the illnesses seen in family practice cannot be fully understood unless they are seen in their personal, family and social context.

Goldberg and Blackwell[4] found that ninety percent (90%) of the psychiatric problems in the population are minor mental disorders which are usually cared for by family physicians. Several studies[5,6,7] have revealed that a high incidence of stressful life events is associated with minor mental disorders. In a recent study Chen, Liang and Hsieh[8] showed that about a half of all patients had a psychological component to their health problems. In addition, stressful life events had occurred in most patients who had a problem with a diagnosis of psychological illness.

Patient presentation

Three patients are presented and discussed to illustrate the tremendous value of the harmonious cooperation between a clinical psychologist and general practitioner in private

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practice in assessing and managing mental disorders presenting as physical symptoms after stressful life events.

Patient 1

Mrs R was 40 years old when she first consulted me for an upper respiratory tract infection. She is married with two children, a son and daughter, and is employed in a State Department. Her previous medical history included idiopathic hypothyroidism and bilateral fibroadenosis of the breast for which biopsies were done on two occasions. At that stage her appearance was unimpeachable and she was very slim, most probably due to her smoking and a degree of anorexia. About a month after the first consultation she came to see me in a state of anxiety for which I was unable to establish a cause, in spite of what I thought was a very thorough consultation, with all the necessary leading questions according to the clinical method taught at medical school. She was referred to a psychiatrist who

The GP is committed to the full person

admitted her to a private hospital and sedated her for three weeks. After more than a year, during which she was treated by the psychiatrist, she presented again to me with the clinical picture of hypothyroidism, but all the thyroid function tests proved to be within normal limits. By that time she was obese, always tired and untidy in her appearance. A full blood count was done which showed macrocytic erythrocytes, and that alerted me to be suspicious of ethanol abuse.

When I discussed these findings and my suspicion with Mrs R, she admitted to indulgence in alcohol, because, she said, it relieved her anxiety caused by marital disharmony.

Do not hesitate to get to know the clinical psychologist in your area

She accused her husband of having an affair, which he denied emphatically. During the next two years she was treated on three occasions for three weeks at a time, by the psychiatrist in hospital. She refused to return to work or to resign from her employment, because then she would have forfeited her medical aid and pension fund. Eventually she returned to me more frequently because the psychiatrist decided that he was not going to continue treating her, due to the alcohol abuse. It became obvious to me that she was using me only to get repeat prescriptions of antidepressant and anxiolytic drugs the psychiatrist had prescribed previously.

I realised that there was no progress towards a solution of this difficult problem and that the relationship between me and the patient was deteriorating swiftly, so I referred her to a clinical psychologist colleague. His assessment was that Mrs R was suffering from unipolar depression with a paranoid personality disorder, which led to the development of marital paranoia. Her paranoia reaction also effected the whole family system to the extent that she became jealous of the relationship between her husband and her twenty year old daughter. Mrs R was so intoxicated by the alcohol and drugs that her daughter took over the management of the household. This led to further confrontation between mother and daughter. The family system was further pressurised by the fact that the son, aged twenty four and a sergeant in the police force, had a love affair with a divorced woman aged 29 years, which also threatened Mrs R. In fact, the whole family system rejected her. She never reacted to the needs of her family, but was continually seeking their attention. This was complicated by the fact that she combined alcohol with psychotropic drugs which obviously worsened the prognosis.

The clinical psychologist embarked on a course of psychotherapy in an attempt to teach her to control her love and hate feelings through the establishment of a therapeutic

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relationship, which I was unable to do. He reported later that the therapeutic relationship was sabotaged by her "YES, BUT!" attitude towards his therapeutic interventions.

Unfortunately my colleague was also unsuccessful in solving Mrs R's problem; and after three sessions the patient decided to abort the counselling sessions. During subsequent discussions with members

of her family we learnt that the patient had not changed her attitude and destructive behaviour towards them. She seems to be a typical POLTIMI SYNDROME PATIENT, as described by Kirkby[9], because she presented with so many symptoms and complaints, she felt unwell

Stressful life events occurred in most patients who had a diagnosis of a psychological illness

because her life was unwell and there was no diagnosis with which she could be labelled.

Although both the psychologist and I were very disappointed by the unsatisfactory outcome of our management of this patient, we felt that we had learnt a lot about the ways in which difficult patients present and behave. This experience served as a stimulus to strengthen our professional cooperation and relationship.

Patient 2

When Mrs P consulted me initially for dermatitis of her face and allergic rhinitis, she was 38 years old. She was married to a wealthy businessman, had four children and lived in an upperclass suburb. Three of her children had severe atopic problems with asthma and eczema, which caused much anxiety in the family. The father was a hardworking man with little time to spend with his family, with the result that Mrs P had to carry the responsibility of the children.

Mrs P led a very active life, playing tennis regularly and responding briskly to the demands of her children. She consulted me regularly for routine examinations and treatment for the allergic rhinitis and secondary sinusitis, but suddenly developed severe headaches with spasm of the neck and back muscles. She attended a physiotherapist regularly and I administered local infiltrations with cortisone on a few occasions, without any significant improvement. After treatment for about a year, I was convinced that the cause of her headaches and muscle tension had to be the result of an underlying psychological disharmony, but I was unable to confirm my suspicion.

During one of the consultations with Mrs P, I conveyed my suspicion to her, but she denied any anxiety provoking factors. When I suggested referring her to a clinical psychologist, she initially refused, but after I had explained my reason for doing so and what she could expect from him she agreed to go; but only once! After the first consultation with her the clinical psychologist reported that her anxiety was due to certain personality disturbances, that she had a phobia for being rejected by others, and that her low self-esteem and social non-identity led to destructive social interactions. She was very reluctant to attend another session with him, but returned spontaneously much sooner than we had anticipated, and then the story of her life unfolded.

The psychologist used a paradoxal intervention method by indicating to her that he was not interested in her past history, and that he was only interested in the present problem. This made Mrs P very angry, and because she wanted to share her history with someone, she told him that she grew up on a Karoo farm, the only child of a wealthy farmer. While at high school she became pregnant and was sent to London by her parents to have an abortion done. Only her parents knew about this unfortunate incident and she never told her husband about it. During the subsequent counselling sessions she gained insight into how her past has led to the development of a corrective emotional experience which influenced her perception of her own sexuality. This has influenced her subconscious psyche and she was able to handle her anxiety in a more efficient manner. She even had the courage to tell her husband about her past and he understood and accepted it. He realised later that after he had been told, he had a better understanding of his wife's actions.

Mrs P continued with the counselling sessions and her self-confidence improved to the extent that she even embarked on a new career and enrolled for a training course in

This team approach resulted in a very satisfying service to our patients

travel management. She became so involved in her career that she even delegated responsibilities at home to her children and servant. Her symptoms disappeared and although she remained anxious at times, she was able to control it.

Patient 3

Miss L was 15 years old when she came to see me for the first time in

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1984 with symptoms suggestive of gastritis, which I treated conservatively with antacids. Nine months later she presented with a similar problem and a barium meal was done which showed an active duodenal ulcer. Treatment with a modified diet and sucralfate resulted in dramatic improvement and after four weeks she was free of any symptoms. Four years later she presented again with an acute anxiety condition which I ascribed to exam stress, but because I was also aware of stress factors in her family that might have contributed to the development of her anxiety, I referred her to my clinical psychologist colleague for psychological assessment and the necessary therapy.

This young and beautiful ballet dancer presented herself to him with an attitude of being perfect and too good to be true, but in fact she felt that her life was meaningless. He established that although she was self-assured and very sensitive, she was emotionally very vulnerable. I was surprised when he reported back to me that she was sexually harrassed a few days prior to seeing me for the first time in 1984. During the third session with the psychologist, he performed a role play with her in which he played the role of her father. She responded that she longed to touch her father, but her guilt prevented her, and when the psychologist explored this further, she said that she was the victim of attempted rape. She never told anybody about it because she tried to manage the incident by denial. Unfortunately this created an immense guilt feeling. The psychologist helped her through psychotherapy to work through that incident and to gain insight in her own life.

Discussion

The patients presented here illustrate how difficult, if not impossible, it is for a general practitioner to manage patients presenting with physical symptoms for which no organic cause can be found if the traditional biomedical clinical model is used. By using this model whereby the patient is interrogated according to a set of questions the patient does not have the opportunity to tell the doctor what he really wants to tell the doctor. The traditional clinical method will not encourage a patient to elaborate on stressful life events, because the questions usually asked by the doctor are intended to obtain information on the physical signs and symptoms only. General practitioners should be aware of the limitations their basic training has caused with regard to the management of psychological problems, and must be willing to cooperate with counsellors like clinical psychologists in the management of problems caused by stressful life events which patients tend to avoid by denial.

I built up a strong relationship with the clinical psychologist, and this resulted in a team, rendering a much more satisfying service to our patients and a better understanding of the contextual foundation of family practice. In the examples cited above, we were able to solve two out of three very difficult problems.

Practical Suggestions

1. Do not hesitate to refer patients to a clinical psychologist, unless you suspect a psychosis.
2. Find out whether there is a clinical psychologist available in your practice area and make an effort to meet him or her.
3. To find out whether a clinical psychologist is available in your area, you may contact The Chairman, The Psychology Association, PO Box 2729, Pretoria 0001. Tel (012) 326-1981.
4. Consider the clinical psychologist as a member of the primary health care team. Your practice will be enriched by a professional relationship with a clinical psychologist. A general practitioner also often needs someone to talk to, psychologically!

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