Original Scientific Paper

Diagnosing mental illness in general practice

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ABSTRACT

Aim

To understand the process of making a diagnosis of mental illness by general practitioners, the use of classification systems and to explore features of future classification systems that may improve efficacy.

Method

A series of focus groups with 34 general practitioners were held throughout the Midland area of New Zealand. The results were transcribed, coded and a thematic analysis undertaken.

Results

For general practitioners, the process of diagnosis is often subservient to the imperative of devising an appropriate management plan. General practitioners rarely use diagnostic schema such as the DSM 4. A more useful diagnostic classification would have a strong focus on disease management in the general practice setting, be integrated across undergraduate and postgraduate training, integrate with current practice management systems and would be limited to only those conditions commonly seen and managed in general practice.

Conclusion

General practitioners as a group employ a non-linear approach to the diagnosis and management of mental illness. New models of clinical reasoning that reflect the needs of both those seeking general practice services and general practitioners need to be further developed.

Keywords

Mental disorders, diagnosis, general practice

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Introduction

Mental health problems are common amongst general practice attenders in New Zealand. It is estimated that one in three people presenting to a general practitioner have had a diagnosable mental disorder in the previous 12 months.[1] The Christchurch Psychiatric Epidemiology study found a lifetime prevalence of severe mental disorder of 63% for males and 68.5% for females and an overall six-month prevalence for all levels of severity of 28%.[2,3] Surveys in the developed world generally show a six-month period prevalence of diagnosable mental disorder in approximately one quarter of populations.[2] One-third of these people will seek medical help for their disorder.[4] Of those seeking help, three-quarters will see a general practitioner and one-quarter will see a psychiatrist.[5] From the provider perspective, general practitioners identify one in five of patients seen as having psychological symptoms.[6] Thus the burden of psychiatric disease presenting to general practice is considerable and the majority of mental health problems are seen and managed in primary care rather than specialist psychiatric services.

A substantial body of research suggests that general practitioners miss a small but significant number of diagnoses of mental illness.[7–10]

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Studies that determine the prevalence of mental disorder in general practice usually use standard diagnostic criteria such as the DSM 4 and ICD-10. Exhortations for general practitioners to improve performance in diagnosing mental illness commonly encourage the use of diagnostic stratagems such as depression scoring systems and the ICD-10.[9,11] However, research shows little or no effect of educational initiatives on outcomes of general practitioners interventions in mental illness.[12-14] It would appear that general practitioners represent a distinct 'cultural' group and behave clinically in a different way than psychiatrists when making a diagnosis of mental illness. Questions are therefore raised concerning the appropriateness of current diagnostic classification systems in the management of mental illness by general practitioners and, if such systems are not appropriate, what factors would guide the development of systems with better efficacy.

Method

Ethical approval was obtained. An ethnographic approach to both data collection and data analysis was considered appropriate as we sought to understand how general practitioners, as a cultural group, understand the diagnosis and management of mental illness.[15,16] Standard qualitative techniques suitable for ethnographic methodology were employed.[17,18]

A series of nine focus groups was held with general practitioners in the Waikato region of New Zealand. Four groups were with urban practitioners, three with rural practitioners and two with practitioners working in Maori-led medical centres. All rural practitioners worked at least 75kms from a base hospital. A total of 34 general practitioners participated of which eight were female. Focus groups were run according to accepted guidelines.[19,20] The questions used to initiate discussion in the focus groups were:

1. How useful are diagnostic classification systems such as the DSM4 and ICD-10 in general practice when making a diagnosis of mental illness?
2. How widely are they used?
3. When making a diagnosis of mental illness, what factors do you take into consideration?
4. How do cultural influences and inequalities in health outcomes impact on the diagnostic process?
5. What is different in the process of diagnosis of mental illness in general practice in comparison to the process used by psychiatrists?
6. If a new classification of mental illness were to be developed, what would it need to achieve to be useful to general practitioners?

All focus groups were taped. The tapes were digitally transcribed and the transcriptions entered into standard qualitative software (NVIVO) for analysis. The initial transcripts were analysed separately by three general practitioners to individually search for themes that reflected shared concepts amongst the participants regarding mental illness. Subsequent group discussion by the three general practitioners generated was used to generate a coding system. All transcripts were then coded.

Results

Use of diagnostic schema by general practitioners

It was clear that the general practitioners who participated do not use diagnostic schema such as DSM 4, ICD-10 or the primary care version of the DSM 4. Further, the opinion of the respondents was that the wider general practice community hardly ever use such schemas.

Perceived difficulties in using existing schemas

When exploring reasons as to why the existing schemas were not in common use, the respondents focused on the inappropriateness of the schemas to the work of general practitioners:

'I see it as being overly complicated, I see it as being a bit artificial in that if someone doesn't meet the time criteria for a particular illness, I am not going to wait two extra weeks until they meet the criteria before I start them on appropriate medicines, so it is there as a guide; having said that, a guide I don't use very much.'

The range of mental illness treated by general practitioners was considered different from that treated by psychiatrists. Thus, schema appropriate to speciality psychiatric services was considered to have poor generalisability to the work of general practitioners. Examples were given of the prescription of intermediate dose tricyclic antidepressants with apparent therapeutic effectiveness, the inappropriateness of having to meet strict time criteria before making diagnoses, instituting treatment for depression before strict criteria had been met and the language used in diagnostic schemata being foreign to general practitioners. Other adverse comments included the excessive complexity of the schema, poor inter-rater reliability with different psychiatrists making different diagnoses on the same patient, and lack of therapeutic usefulness. Several respondents noted a considerable lack of experience and training with diagnostic schemata and obtaining access to DSM 4 and ICD-10 manuals was problematic. There was a common perception that the schemata were devised by psychiatrists and therefore based on a highly skewed experience of mental illness.

'I suspect the criteria were written by partialists [specialists] who receive a filtered population that already have been worked over by other people from primary care.'

Making a diagnosis of mental illness

The purpose of diagnosis

A strong theme emerged concerning the variable role of diagnosis in formulating a management plan. A diagnosis may assist in the formulation of a management plan, may be peripheral to it or may hinder management.

'I am more focused on how that patient is going to cope, how she or he is going to get along when she gets

home and how things are going to go and what is going to happen in the next week and if they can come back and see me, I am more concerned with that kind've stuff than I am with the label itself.'

'I think we treat the patient as a whole, rather than use the diagnosis to manage.'

'To paraphrase all that we as a group saying, that we're less interested in diagnosis, and more interested in function with most of our chronically mentally ill.'

The implications of applying a particular diagnostic label were sometimes influential on whether the label should be applied or not. An example was given of not discussing a diagnosis of bipolar disease in circumstances of diagnostic uncertainty because of the emotional impact on the patient when the diagnosis may be wrong. Also, the perception of how well a patient will accept a diagnosis may influence what the general practitioner will say concerning the illness. Conversely, it was also felt that a particular diagnostic label may be of benefit in selecting appropriate treatment.

'Well being able to justify to myself that I am treating them correctly. So the purpose is for me to make sure that they are fitting some kind of criteria so that my treatment is acceptable kind of treatment for them.'

The sentiment expressed above concerns the desire for the individual doctor's practice to be consistent with the wider general practice and medical community, and demonstrating logical progression from diagnosis to appropriate treatment is part of that consistency.

The complexity at the interface between society and medicine also influences how diagnostic labels are applied and, indeed, if they will be applied at all. Describing the difficulties of diagnosing depression in those with very difficult social circumstances, one general practitioner commented:

'It's a lifelong saga, isn't it really, of, you know, is it anxiety or is it depression or is it just general life struggles, and it's all sort of interwoven, intermixed, and yes they might have a bit of depression classification in it. You're not going to say, "this is a depression consultation therefore I will treat this person this way".'

The utility of diagnostic schema would seem to be low in circumstances of significant social problems:

'...the DSM criteria come into none of this because immediately they walk in the door, I feel hopelessly overwhelmed and out of my depth by these sorts of families of which there are quite a few. It's dual diagnosis again. Hopelessly overwhelmed by a feeling of helplessness, and for all the diagnostic criteria in the world, I get this feeling of: goodness me, you know, we are on a road to nowhere no matter who is involved here.'

Further limitations on the utility of diagnostic schema occur as a result of the limited range of mental illness treated solely by general practitioners. The respondents felt comfortable diagnosing and managing a significant majority of depression and anxiety cases without the support of a psychiatrist. On the other hand, acute presentations of conditions such as psychosis, bipolar disease and mania were referred on for urgent specialist assessment and diagnosis almost without exception, and therefore had specialist input to the diagnostic process. Thus, the general practitioner was considered to be very rarely in the position of having to make an unsupported diagnosis in such cases.

Cultural influences on diagnosis

The presence of symptoms of psychosis does not automatically lead to diagnosis of psychosis. A general practitioner describing his clinical experiences of hallucinations in Maori commented:

'Well just one thing I have seen several times over the years is that for the Maori to hear voices, or to have visitations, is not deemed abnormal in a cultural sense. Whereas if I was hearing voices telling me something, or having visitations from some past dead family member, I would be a little worried about it, but at the cultural level, that seems to be fine.'

This experience of psychiatric symptoms merging into normal behaviour when viewed through different cultural lenses was not rare. It did, however, cause some concern when first experienced due to a tension between traditional training with its imperative of identifying abnormal behaviour as disease and the cultural context of the phenomenon that normalised the behaviour.

The individuality of patient presentations and the difficulties of fitting such presentations into a rigid framework were also discussed: *'Every person who carries the same disease label has a completely unique illness experience.'* This also highlights the focus of general practice on the individual rather than a population.

Pre-existing diagnoses

In a significant proportion of cases, the respondents indicated that new patients arrive with pre-existing diagnoses or that an acute episode has resulted in a diagnosis with no involvement of the general practitioner in the diagnostic process. Another common presentation is that of informed patients who self diagnose based on information they have researched and who want either confirmation of their diagnosis or access to specific treatment options only available through a general practitioner.

Supporting evidence

Supporting evidence for a diagnosis may come from a past history of psychiatric disease, contact from relatives with concerns, using checklists such as depression scales, social circumstances and, most importantly, the severity of symptoms.

Legal considerations

Attaching a diagnostic label was considered useful for informing future medical practitioners and to satisfy medicolegal requirements. A common difficulty experienced by general practitioners was the reluctance to apply a diagnosis of mild depres-

sion when such a diagnosis would have major implications on the ability of the patient to obtain services such as income protection insurance. Reservations were also expressed concerning the dynamic nature of some mental illness and the difficulties that a static diagnosis may therefore cause and the possible consequence of diagnostic inaccuracy.

Expert thinking

If general practitioners do not use diagnostic schema in the process of making a diagnosis of mental illness, the question remains as to what is the underlying process. Clearly, with florid symptoms diagnosis is a relatively simple process. With symptoms that are obscure or are common to several mental health problems, diagnosis becomes problematic. In particular, there can be difficulty distinguishing between mental illness, life sadness and difficult social conditions.

The focus groups revealed some interesting insights into making diagnoses in such circumstances. The expression 'working on hunches' was used by one general practitioner to explain this form of clinical reasoning. The hunches were further explored and described by others as the presenting symptoms not making sense in any disease structure apart from mental health, looking for things that do not fit a pattern, pattern matching with supportive questioning and the observation that scanning for depression seems to occur automatically for some general practitioners.

Requirements of new schema

In discussions on the requirements of any proposed new schema, the consensus was for a pragmatic approach based on informing management in a general practice setting.

'Well a diagnosis is useless unless it has got implications in terms of prognosis and treatment, as a general principle, so it has got to have those things.'

The issues of management would include the provision of information on patient safety, referral criteria, prognosis, treatment choice and patient education. There is need for a diagnostic category for mild depression that has no implication on insurance risk.

The diagnostic categories would reflect both the range and complexity of mental illness treated in general practice. The range of conditions would be small (probably no more than 10), integrated into the practice management software and quickly accessible.

'Depression, anxiety, the mild dysthymic illnesses, bipolar, that is 90% of our work right there really isn't it, and maybe touching on some of the alcohol, drug and psychotic type of illnesses. There is no need to go into the weird and wonderful stuff, that is just over complicating it.'

Comments made by general practitioners on the meaning of psychotic symptoms and how meaning changes according to which cultural lens is used, would support the notion that general practitioners do not use an objectivist framework

The categories would have high sensitivity and specificity, be stable over time, would provide criteria that would assist in distinguishing between diagnoses, have high inter-rater reliability and would act as a prompt for gathering important ancillary information such as substance abuse.

The new schema would be relevant to, and integrated across, all stages of general practitioner training, from undergraduate to continuing professional development. The diagnostic categories would assist in inter-professional communication but would not necessarily be aligned with diagnostic schema used by specialist psychiatrists.

Discussion

This research reveals a split between specialist psychiatry and general practice when involved in the same activity of diagnosing mental illness. Traditionally, the use of a diagnostic schema has been fundamental to the discipline of psychiatry and is the keystone that links symptoms to management. Knowledge gained primarily by measurement and classification exemplifies the scientific tradition and can be considered objectivist in nature.

This research would suggest that general practice sits uncomfortably with linear scientific principles when faced with problems that are, at times, inherently complex mixtures of social dysfunction, physical ailments, poverty, cultural differences and mental illness. The arguments relevant to this discomfort concern the failure of descriptive systems to account for meaning as well as the assumption of complete impartiality of the observer, an ideal state that is remote from reality.

Comments made by general practitioners on the meaning of psychotic symptoms and how meaning changes according to which cultural lens is used, would support the notion that general practitioners do not use an objectivist framework. The discomfort described in labelling patients with mental illness who meet diagnostic criteria of depression with coexistent difficult life problems further highlights this tension and has been noted elsewhere.[21] The general practitioners also related instances when treatment was needed yet the patient did not fit psychiatric diagnostic criteria.

The premise of impartiality of the observer in an objectivist worldview was questioned by the respondents, who described their concern over poor inter-rater reliability of specialist psychiatric diagnoses. Of further interest is the priority of management over diagnosis that seems to occur in general practice and the observation that the diagnostic process may not always be useful in informing management. This is in direct contrast with the centrality of diagnosis

in a positivistic framework, but is consistent with emerging psychiatric opinion.[22]

A constructivist framework would hold that all knowledge is socially constructed and that each individual creates a unique understanding of everything that is learned and experienced. The comments from general practitioners discussing the purpose of diagnosis would support the concept that a constructivist framework underlies much of general practice work. This instinctive use of a constructivist framework by general practitioners has been explored from a theoretical perspective elsewhere.[23] Because of the complexity of presentation of mental illness where social, environmental, physical and mental processes combine, together with the recognition of unique patient experiences of mental illness, the priority of diagnosis gives way to priority of management.

Conclusion

The research reported here would indicate that the existing schemas, such as the ICD-10 and DSM 4, have little utility in general practice and are seldom used. The underlying reasons reflect the tension between two very different belief systems. The objectivist stance that gave rise to such schemas supports the notion of diagnosis being central to intervention. A constructivist approach would emphasise the uniqueness of each presentation of mental illness and place negotiated management as the fundamental role of the health care provider. The approach taken by general practitioners to the diagnosis and management of mental illness would reflect a complex interplay between the utility of the label in the development of a management plan, the acceptability of the diagnostic label by the patient, medicolegal considerations and avoidance of diagnostic error. Disease diagnosis would seem to take second place to disease management.

The requirements of a new schema would incorporate a strong focus on management in a general practice setting, integration across all stages of general practice training, be reflective only of conditions diagnosed or seen commonly in general practice and be integrated into existing information management systems.

A survey is planned to study the generalisability of these conclusions across a wide section of New Zealand general practitioners.

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Competing interests

None declared.

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