

Essential psychiatry in general practice

**Series Editors:**

Manit Arya  
Iqbal Shergill  
Bob Mortimer

Other titles in the Essential General Practice Series include:

*Essential Urology in General Practice*

**Note**

Health and social care practice and knowledge are constantly changing and developing as new research and treatments, changes in procedures, drugs and equipment become available.

The authors, editor and publishers have, as far as is possible, taken care to confirm that the information complies with the latest standards of practice and legislation.

# **Essential Psychiatry in General Practice**

*Edited by*

*Afia Ali, Ian Hall and Andrew Dicker*



A division of MA Healthcare Ltd

Quay Books Division, MA Healthcare Ltd, St Jude's Church, Dulwich Road, London  
SE24 0PB

British Library Cataloguing-in-Publication Data  
A catalogue record is available for this book

© MA Healthcare Limited 2010

ISBN-10: 1 85642 387 5

ISBN-13: 978 1 85642 387 8

All rights reserved. No part of this publication may be reproduced, stored in a retrieval system  
or transmitted in any form or by any means, electronic, mechanical, photocopying, recording  
or otherwise, without prior permission from the publishers

Printed by CLE, Huntingdon, Cambridgeshire

# Contents

Foreword	viii
Preface	ix
Series editors	xi
The editors	xiii
Contributors	xv
<b>Part I</b>	
<b>Psychiatric disorders</b>	
Chapter 1	
<b>The psychiatric consultation</b>	<b>3</b>
<i>Jonathan Pimm and Golda Mary Ninan</i>	
Chapter 2	
<b>Depression and other common mental disorders</b>	<b>15</b>
<i>Jonathan Pimm and Golda Mary Ninan</i>	
Chapter 3	
<b>Severe mental illness</b>	<b>39</b>
<i>Kazuya Iwata</i>	
Chapter 4	
<b>Alcohol and substance misuse</b>	<b>51</b>
<i>Vanessa Crawford and Lucy Carter</i>	
Chapter 5	
<b>Eating disorders</b>	<b>65</b>
<i>Adrienne Key and Michael Harding</i>	
Chapter 6	
<b>Organic psychiatry</b>	<b>81</b>
<i>Luke Solomons and Joyce Solomons</i>	

Contents

<b>Chapter 7</b> <b>Medically unexplained symptoms and chronic fatigue syndrome</b>	<b>93</b>
<i>Mohamed Abdelghani and Geoff Lawrence-Smith</i>	
<b>Chapter 8</b> <b>Mental health problems in women</b>	<b>103</b>
<i>Catherine Murgatroyd and Ruth Townsend</i>	
<b>Chapter 9</b> <b>Sexual disorders</b>	<b>115</b>
<i>Josephine Woolf and Margaret Denman</i>	
<b>Chapter 10</b> <b>Mental health problems in children</b>	<b>127</b>
<i>Helen Bruce and Benjamin Keene</i>	
<b>Chapter 11</b> <b>Learning disabilities</b>	<b>139</b>
<i>Angela Hassiotis and Martha Buszewicz</i>	
<b>Chapter 12</b> <b>Mental health problems in the elderly</b>	<b>149</b>
<i>Joanne Rodda, Shirlony Morgan, Faye Dannhauser and Thomas Dannhauser</i>	
<b>Chapter 13</b> <b>Community mental health services for adults</b>	<b>167</b>
<i>Karl Marlowe and Gary Marlowe</i>	
<b>Chapter 14</b> <b>Risk assessment and management</b>	<b>177</b>
<i>Anthony Kerman and Andrew Crombie</i>	
<b>Part 2</b> <b>Legislation</b>	
<b>Chapter 15</b> <b>Consent and capacity</b>	<b>189</b>
<i>Diana Andrea Barron and Adrian Raby</i>	

Chapter 16 <b>Using the Mental Health Act</b> <i>Afia Ali, Ian Hall and Andrew Dicker</i>	<b>203</b>
<b>Part 3</b> <b>Treatment</b>	
Chapter 17 <b>Pharmacological treatment of mental disorders</b> <i>Eleni Palazidou</i>	<b>217</b>
Chapter 18 <b>Psychological therapies</b> <i>Helen Caird, Michael Layton, Elza Tijo and Jonathan Bickford</i>	<b>237</b>
Index	<b>249</b>

# Foreword

Although the Quality Outcome Framework (QOF) has biased attention towards physical medicine, much of the core of GP work remains mental and emotional health. At least a third of consultations are primarily for mental illness and this figure rises when the depression that often underlies unexplained physical symptoms and associated comorbidity is included. In almost all consultations, the emotional accompaniment of illness needs to be addressed. Consulting in primary care is a highly pressured and emotionally demanding activity.

As a practising GP, I would have had my copy of *Essential Psychiatry in General Practice* close to hand. Refreshingly, it takes a wide-angled view of psychiatry and includes chapters on medically unexplained symptoms, sexual disorders, women, children, learning disability, risk assessment and legislation – uses of the Mental Health Act as well as the ethics of consent. It is practical – lots of tables and lists of ‘key points’ – relevant, well researched, and written mainly by GPs and practising psychiatrists.

Whether or not to refer a patient to secondary services is a key decision in all primary care consultations, but it has additional complexity in mental health – the doctor’s reaction to disturbed mental states may play a part; evidence of likely benefit may be unclear; subjective factors for the patient are of particular importance, and the question of stigma and the reluctance of the patient to be referred at all often arise. Thus the focus that the editors have chosen on the indications and appropriateness of referral to secondary care is likely to be particularly helpful for busy GPs in what is a highly complex subject.

Mental health services and treatments are proliferating. It is therefore all the more important for GPs and primary care mental health workers to have a reliable road map written by people familiar with the difficulties of the front line.

*Andrew Elder FRCGP  
President of the Balint Society  
Consultant in General Practice and Primary Care  
Marlborough Family Service  
London NW8*



# Preface

A significant proportion of primary care consultations involve assessing and managing the mental health needs of patients. However, many General Practitioners (GPs) feel that they lack the skills and confidence in order to be able to diagnose and manage psychiatric conditions in primary care, particularly because of the lack of time available for consultations and issues related to managing risk.

This book is aimed at busy GPs and trainees and provides up-to-date, concise, practical guidelines on managing common mental health problems. This book will be essential to trainees sitting the MRCGP exams, but will also be useful to medical students, trainee doctors in related specialties and specialist nurses.

Most of the chapters have been written jointly by psychiatrists and GPs. Many of the authors are experts or have a special interest in their subject area, and the content of each chapter has been carefully selected and edited to ensure that it is relevant and accessible to GPs. Each chapter commences with case studies, followed by a discussion of relevant key points from the history, mental state examination and physical examination. The chapter is then followed by a discussion of relevant investigations and management options, including when it is necessary or appropriate to refer to secondary care. Each chapter is summarised by a list of key points at the end of the chapter.

We hope you find *Essential Psychiatry in General Practice* both a useful and enjoyable to read.



# Series editors

**Manit Arya MBChB, FRCS, FRCS(Urol)**

Honorary CCT Fellow in Urology, King's College Hospital, London, UK

**Iqbal S. Shergill BSc(Hons), MRCS(Eng), FRCS(Urol)**

Consultant Urological Surgeon in Wrexham, North Wales, UK

**Bob Mortimer FRCGP**

General Practitioner in Swansea, South Wales, UK



# The editors

**Afia Ali MBBS, MRCPsych, MSc**

Medical Research Council Clinical Research Fellow, Department of Mental Health Sciences, University College London

**Ian Hall MA MB BChir MPhil FRCPsych**

Consultant psychiatrist for people with intellectual disabilities at East London NHS Foundation Trust, Associate Program Director for Specialty Training in Psychiatry of Learning Disability for the London Deanery, and Honorary Clinical Senior Lecturer in Psychiatry of Learning Disability at Queen Mary, University of London

**Andrew Dicker MA MSc MBBS**

General Practitioner in central London, Programme Director for the London Postgraduate Deanery at Royal Free Hospital Vocational Training Scheme for General Practice, and Honorary Senior Clinical Lecturer at Imperial College



# Contributors

**Mohamed Abdelghani MBBS, MRCPsych**

Specialty Registrar, Bexley Recovery Team, Oxleas NHS Foundation Trust

**Afia Ali MBBS, MRCPsych, MSc**

Medical Research Council Clinical Research Fellow, Department of Mental Health Sciences, University College London

**Diana Andrea Barron MBBS MSc CPE MRCPsych**

Clinical Research Fellow, Department of Mental Health Sciences, University College London

**Jonathan Bickford**

General Practitioner and GP Trainer, Oxford

**Helen Bruce MBBS FRCPsych**

Consultant Child and Adolescent Psychiatrist, Emanuel Miller Centre, East London NHS Foundation Trust and Honorary Clinical Senior Lecturer, Barts and the London School of Medicine and Dentistry

**Marta Buszewicz MRCPsych, MRCPsych**

Senior Lecturer in Primary Care, Research Department of Primary Care & Population Health, University College London

**Helen Caird BA, BSc, DClinPsych**

Clinical Psychologist, Ridgeway Partnership NHS Trust

**Lucy Carter MBBS, MRCPsych**

General Practitioner and Shared Care GP, City and Hackney Primary Care Trust

**Vanessa Crawford MBBS, MRCPsych**

Clinical Director, Specialist Addiction Service, East London NHS Foundation Trust

*Contributors*

**Andrew Crombie MRCPsych**

Specialty Registrar, UCL Training Rotation, North London

**Faye Dannhauser MA, MBBS, MRCP, MRCGP, DFFP**

General Practitioner, Chigwell, Essex

**Thomas Dannhauser MRCPsych**

Consultant in Old Age Psychiatry, North Essex Partnership NHS Foundation Trust

**Margaret Denman MB ChB, DFFP, MIPM**

General Practitioner, Institute of Psychosexual Medicine, 12 Chandos Street, Cavendish Square, London

**Andrew Dicker MBBS, MA MSc**

General Practitioner and GP trainer, central London

**Ian Hall MA, MB, BChir, MPhil, FRCPSych**

Consultant Psychiatrist, East London NHS Foundation Trust

**Michael Harding MB ChB Dip Obs (NZ) MRCGP**

General Practitioner, London

**Angela Hassiotis FRCPSych PhD**

Senior Lecturer in the Psychiatry of Learning Disabilities, Department of Mental Health Sciences, University College London Medical School

**Kazuya Iwata BSc, MBBS, MRCPsych, MSc**

Specialty Registrar in General Adult Psychiatry, Camden and Islington NHS Foundation Trust

**Benjamin Keene MBChB MRCPsych**

Specialty Registrar in Liaison Psychiatry, Department of Psychological Medicine, Newham University Hospital, East London NHS Foundation Trust

**Anthony Kerman MRCGP**

General Practitioner, North London

**Adrienne Key MB ChB MRCPsych**

Member of Executive Committee Eating Disorder Section, Royal College of Psychiatrists and Lead Consultant at the Eating Disorder Service, Priory Hospital, Roehampton, South London



**Michael Layton BSc MA MBBS MRCPsych PGDip (Forensic Mental Health)**  
Consultant Psychiatrist in Psychiatry of Learning Disability, Ridgeway Partnerships NHS Trust

**Geoff Lawrence-Smith MBBS, MRCPsych**  
Consultant Psychiatrist, Bexley Recovery Team, Oxleas NHS Foundation Trust

**Karl Marlowe MBChB, MSc, PgC-Ed, PgD-CBT, MRCPsych**  
Consultant Psychiatrist, East London NHS Foundation Trust, Burdett House, Mile End Hospital

**Gary Marlowe**  
General Practitioner, De Beauvoir Surgery, North London

**Shiriony Morgan MSc MRCPsych**  
Specialty Registrar in Old Age Psychiatry, London Deanery

**Catherine Murgatroyd BSc, MbChB, MRCPsych**  
Locum Consultant in Perinatal Psychiatry, East London NHS Foundation Trust

**Golda Mary Ninan MB.BCh., MRCGP, DRCOG, DFFP**  
General Practitioner, Chrisp Street Practice, 100 Chrisp Street, East London

**Eleni Palazidou MD PhD MRCP FRCPsych**  
Consultant Psychiatrist, East London Foundation Trust

**Jonathan Pimm MBBS, MSc, MRCPsych, MPhil, MD**  
Consultant in Primary Care Psychiatry and Honorary Senior Lecturer, East London NHS Foundation Trust and Queen Mary, University of London, Department of Psychiatry, Mile End Hospital

**Adrian M. Raby MA MB BS BSc MRCGP**  
General Practitioner, Department of Primary Care and Social Medicine, Imperial College, London, Charing Cross Campus

**Joanne Rodda MSc MRCPsych**  
Specialty Registrar in Old Age Psychiatry, London Deanery

**Luke Solomons MBBS, MRCPsych, DGM**  
Consultant Psychiatrist in Old Age Psychiatry, Beechcroft CMHT for Older Adults, Hillcroft House, Rooke's Way, Thatcham

*Contributors*

**Joyce Solomons MBBS, MRCP, MS**

Academic Clinical Fellow, Clinical Genetics, Churchill Hospital, Oxford Radcliffe NHS Trust, Oxford

**Elza Tijo**

Foundation Trainee in General Practice, Oxford

**Ruth Townsend MbChB MRCGP DFFP**

Salaried General Practitioner, Stepney Health Centre, Tower Hamlets PCT

**Josephine Woolf MA BM BCh, MRCGP, MIPM**

Institute of Psychosexual Medicine, 12 Chandos Street, Cavendish Square, London

PART I

---

# Psychiatric disorders



# The psychiatric consultation

*Jonathan Pimm and Golda Mary Ninan*

## Case history

A middle-aged woman with a long history of anxiety and depression who complained of low mood and occasional periods of elation was referred by her GP to a primary care psychiatrist. The patient was well presented and denied having any problems in her personal life. She was referred with a concern that she might be suffering from some form of manic depressive illness. A thorough history-taking over an hour revealed no abnormalities apart from three periods of 'elation'. Only when directly questioned about forensic problems did the patient break down in tears, explaining that she was facing a charge of shoplifting. Later, when her lawyer was contacted, it was found that the patient had a string of previous convictions for similar offences. At a subsequent consultation, the patient explained that she had never been 'so excited' as when she had managed to get out of a store without paying for clothes. On closer examination, it was clear that her elation followed her act of theft and that she was probably not suffering from a manic depressive disorder.

## Introduction

Psychological ill health and psychiatric diseases rarely occur in isolation. Aetiological factors operate at all levels and in many cases are immediately obvious to the assessing physician. But in other cases, the causes of both patients' psychological and psychiatric disorders can be complicated and covert.

At the individual level, relationship difficulties, work-related problems or stressful neighbours are important common causal components of both psychological and psychiatric disorders seen in primary care. At the sociological level factors such as economic deprivation, unemployment, lack of education and ethnicity have been shown to be associated with most of the common psychiatric diseases. Both biological and genetic factors play a part in the causation of psychiatric and psychological conditions.

The degree to which different aetiological factors are responsible for causing a particular psychiatric or psychological disorder varies depending upon the individual, their environment and the disease. For example, some people develop depression or anxiety in stressful work environments, whereas others might thrive and indeed perform better in the same situation. With regard to conditions like schizophrenia and manic depression (also known as bipolar affective disorder), hereditary (genetic) factors are thought to be the major aetiological component.

Teasing out the importance of the various factors involved in the causation of both psychiatric and psychological disorders is vital to the understanding, management and treatment of such conditions.

Patients with both psychological and psychiatric problems often present with physical symptoms as indicators of their underlying distress or difficulties. The situation is often made more complicated when the presentation occurs at a time of crisis. Assessment of such individuals is difficult and often anxiety provoking – especially if the patient is unknown or unfamiliar to the attending physician.

In any consultation, the GP should endeavour to consider the presentation and its context. Both are important as they may provide information about the so-called ‘illness narrative’, or the story of the problem. Every patient has a narrative; it may appear superficial, trivial or even absent on first appraisal – but inevitably it is there somewhere. The purpose of the consultation is to try to find it, or at least help the patient to identify it, so that he or she may then begin to understand their difficulties and, if possible, begin to initiate change.

The more entrenched the patient’s psychological problems, i.e. those starting early in the individual’s life and continuing for several years, the less important the narrative. The reason for this is probably that the link between the original distress and the psychological difficulties which the patient continues to suffer has been lost; in essence the trauma and distress continue without a clear indication as to its source. Such patients – often labelled with the unhelpful term ‘heartsink’ – pose particular challenges in primary care.

## **Presentation**

Patients’ presentations of psychological problems are many and varied. However, the old adage that common things are common is as true in psychiatry as

it is in any other specialty. The weird and wonderful diagnoses often named after eminent experts of days gone by are rare and probably best forgotten. Up to 40% of patients presenting to primary care have depression or a mixture of depression and anxiety. Many of these present with physical complaints as a manifestation of the psychological distress. Headaches, fatigue and poor sleep are among the problems most commonly faced by the primary care physician; rarely seen are nihilistic, delusional beliefs of rotting flesh or catatonic symptoms where the patient can be made to adopt various poses in a manner similar to an anglepoise lamp.

Once in the surgery, the ease with which a psychiatric diagnosis emerges is determined not only by the patient but also by the doctor. Research has found that patients often fear revealing feelings of unhappiness; they are sensitive to even the slightest cues from their doctors that might indicate lack of interest or impatience with such complaints.

## **Context**

Knowledge of the context of the patient presenting to general practice with psychological complaints is in many respects more important than for patients seen in secondary care, since it is in hospital medicine that psychiatrists tend to deal with major disorders where the disease process is less influenced by the environment.

The idea that individuals at most times during their lives are asymptomatic is false; general surveys have found there is scarcely anyone who does not possess some psychological symptom or other. Further, the belief that the degree of seriousness of these symptoms is what motivates patients to seek help is also in many cases unfounded. Patients will delay seeking help for many reasons, including feeling guilty, ashamed, fearful, anxious or embarrassed, because of a dislike of their physician or because they have no one to care for their children while they go to the surgery. Even the phase of the Moon has been found to positively affect attendance in the primary care setting!

The patient's 'illness behaviour' – that is, the way a person behaves when they feel a need for better health – depends on many factors. Of particular relevance in psychiatric or psychological problems is their perception of their diseased status, cultural factors and stigma. The degree of fear of being given a psychiatric label will depend upon several factors, including the patient's past experience of services, knowledge of someone else's experience of the system or their treatment by the local community and beliefs about the treatments available (fear of side-effects and the development of dependency on drugs are of particular importance, specifically when considering adherence).

Conversely, many patients attend their GPs with seemingly minor difficulties. Their illness behaviour could be thought of as abnormal in certain circumstances. Sickness affords patients certain privileges, including the right to be exempted from normal activity (e.g. not going to work) and being regarded as in need of care and not being blamed for causing the illness (the sick role). However, the privileges also carry with them certain obligations, firstly in seeking medical advice and secondly not wanting to get well as quickly as possible. The doctor has an obligation to be objective and neutral (e.g. not to judge patients' behaviour on moral grounds) and to use his or her professional skills for the welfare of the patient and the community.

Overall, the severity of the patient's distress and his or her belief about the extent of the disability caused by the disease are the most important determinants of perceiving a need for care.

The impact of the individual doctor upon patients' consulting behaviours should not be underestimated. Some patients wait for several days before they can see a doctor of their choice. In many cases the original problem may have resolved by the time they get to see their physician; yet they may still decide to attend!

The Hungarian-born physician Michael Balint pioneered study of the interactions between doctors and their patients. In his classic text published in 1964, Balint remarked: 'The ability to listen is a new skill, necessitating a considerable though limited change in the doctor's personality' (Balint, 1964). Detailed recommendations as to how GPs should conduct consultations will not be given. For a comprehensive, and extremely readable, review on the general practice consultation the reader is advised to see Jill Thistlethwaite and Penny Morris's book (2006). Many different methods or models describing the process and structure of the consultation have been proposed over the past few decades – see Table 1.1.

The so-called 'patient-centred clinical method' is one that has been found the most suitable in the assessment and treatment of patients in primary care with both psychological and psychiatric complaints and details of this will be given later.

## **Preliminaries**

The vexed problem of consultation length is one which has attracted much debate in primary care. Doctors continue to protest about a lack of time for the increasing number of tasks involved in routine consultations and they report greater satisfaction with surgeries if they only have to deal with simple patient agendas.