Management of the Psychotic Patient by the Family Physician

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The management of psychotic illness has taken some new directions since 1950. One of the effects of these changes is increased responsibility for care of psychotic patients within their own community. Family physicians are expected to play a significant part in the pre-hospitalization and after-care for these patients and their families.

A training program to equip the family physician to give such care should provide the physician with: (1) skills to detect incipient psychotic illness and the ability to intervene at this stage; (2) a working knowledge of the psychoactive drugs; (3) awareness of the available community resources and the ability to mobilize them to provide a network of support for the psychotic patient and his family; and (4) an understanding of family dynamics and behavior. A training program which encompasses these essential elements will allow the family physician to provide the type of care that his patients/families and his community expect of him.

In recent years, several changes have coalesced to improve the care of the psychotic patient. These changes have caused the new specialist, the family physician, and those responsible for his psychiatric education to reassess their roles and functions in the management of the psychoses.

This paper will explore the impact of these new directions since 1950 and will offer some suggestions for a training program which will equip the family physician to provide competent and compassionate care for his psychotic patients and their families.

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Historical Perspective

The discovery of the anti-psychotic phenothiazine group of drugs in the early 1950s was a major breakthrough which had nationwide impact. Psychiatric patients were discharged from state mental institutions and sent back to their home communities. Here they could be managed by the monitored use of the major tranquilizers.

A second change occurred in 1962 when President Kennedy, in his message to Congress, wrote: "Central to a new mental health program is comprehensive community care. Merely pouring federal funds into a continuation of an outmoded type of institutional care which now prevails would make little difference. We need a new type of health facility, one which will return mental health care to the mainstream of American medicine and at the same time upgrade mental health services."[1]

In 1963, the United States Congress passed the Community Mental Health Act. In the years 1963 to 1965, $8,400,000 in federal funds were allocated to states to finance the planning of future community mental health centers.[2]

This legislation called for an all-out effort of all forces in a comprehensive attack on the problems of mental illness. The divisiveness between the federal government and the states would have to be bridged. The state mental institutions were envisioned as but one part, albeit an important link, in the comprehensive care of the mentally ill. The community responsibility was defined through the creation of community mental health boards.

This new and broader concept of community involvement in provision of care for psychotic citizens coincided with, and may even have been generated by, the effective employment of the major tranquilizers. The transition of the psychotic patient from the state mental institution back to his community of origin would not have been possible without the dramatic behavioral changes which were due to the use of the major tranquilizers.

Communities became aware of this new dimension in their responsibility for the mentally ill and began to accelerate their efforts to meet this new obligation. Community Mental Health Boards were formed which were representative of the interests and needs of the communities and their expectations for local commitment. Family physicians were appointed to serve on some of these boards. The author was appointed in 1963 by the Washtenaw County (Ann Arbor) Michigan Board of Supervisors to the original planning committee and then to the Mental Health Board, and continued to serve until 1972 when he moved from the community.

This service on the Community Mental Health Board provided the author with a practical learning experience. Briefly, a new understanding was gained of: (1) the magnitude, complexity and cost of mental illness and mental retardation; (2) the roles and functions of people in other disciplines (ie, social workers, psychologists, administrators, psychiatric social workers), and how to collaborate with these professionals; (3) the scope of a comprehensive mental health program for the community; and (4) the role of

Table 1. Types of Emotional Illness Seen in Practice		
	Number	Percent
Psychosis (Mania/Depression)		
Often (more than once/month)	83	21.8
Occasionally (1-6 months)	154	40.5
Rarely (less than once every 6 months)	129	34.0
Never	13	3.7
Total Responding	379	100.0
Psychosis (Schizophrenia)		
Often	50	13.5
Occasionally	135	36.5
Rarely	165	44.6
Never	20	5.4
Total Responding	370	100.0
Most Frequently Encountered Emotional Illnesses		
The neuroses (anxiety, depressive, hysterical, phobic), psychosocial conditions (marital, family, adolescent, sexual, aging), and psychophysiologic stress reactions are encountered by approximately 85 percent of the respondents more than once a month.		

the family physician both in direct service to his patients and, if called upon, in service on a community mental health board.

The realities of this comprehension coincided with a new understanding locally and nationally of the responsibilities of the general practitioner and the emergence of a new model, the family physician, who would provide comprehensive and continuing care for the entire family.

The American Academy of Family Physicians, almost since its inception, has recognized that "approximately 80 to 90 percent of patients with emotional problems are first seen by a non-psychiatrist," and a majority of such patients first consult their family doctor.[3] Acceptance of this fact has helped to shape and direct psychiatric continuing education for family physicians and led in the 1950s to a formal liaison between the American Psychiatric Association and the then American Academy of General Practice. Collaborative planning produced, with National Institute of Mental Health funding, postgraduate psychiatric training which better qualified the family doctor to deal with the less severe emotional disorders and to provide after-care for psychotic patients discharged from the state mental hospital.

In 1969, the American Board of Family Practice was recognized and family practice became the twentieth specialty. In its application for approval to the American Medical Association, several cardinal principles about the new discipline were enunciated: "specialty in breadth," "patient-family oriented," and "provision of continuing comprehensive care rather than episodic."[4]

Family practice differs from its predecessor, general practice, in several respects. Continuity of care has taken the place of episodic or crisis-oriented medical care. This permits a longitudinal, ongoing relationship not only with the patient but also with the entire family. Today's well-trained family physician delivers comprehensive care. This implies that he has a working knowledge and relationship with the many community resources and personnel which can extend his caring arm to his families. He knows how to relate in a timely and appropriate fashion to these agencies and people without fear of loss of his autonomy. In the past, the general practitioner was often an empathetic and compassionate physician. Now the family physician possesses this same sensitivity buttressed by a knowledge of psychiatry and the behavioral sciences.

At this juncture, several questions should be raised regarding implications for the family physician's care of the psychotic patient. First, how frequently do family doctors encounter psychosis in their practice? Second, is there a potential new role for the family physician in the care of his psychotic patient? If so, what does it encompass, and what kind of psychiatric training program will enable him to meet these new and more inclusive expectations?

Incidence of Psychosis Seen by Family Physicians

It is difficult to estimate the incidence of psychoses seen by the family physician. Pasamanick, in a 1961 study in Baltimore, found that at any one time one person in eight was psychiatrically ill and of these about seven to eight percent were psychotic.[5]

The morbid risk, which is defined as those at risk of becoming manifestly ill with schizophrenia for all persons between 15 and 45 years of age, is commonly recognized as one percent.[6] However, Wiedehorn believes that many schizophrenic patients escape detection because they present themselves to the doctor in many guises other than readily detectable schizophrenia.[7]

In Michigan recently, an effort was made to assess family physicians' attitudes and practices in caring for their patients with emotional and psychiatric disease. A survey was conducted among the 860 members of the Michigan Chapter of the American Academy of Family Physicians. This survey was composed of 110 questions and among these were inquiries concerning the incidence and type of emotional and mental disease encountered by the family physicians. A breakdown of part of the response to the request, "Please list in order of frequency the type of mental and emotional illness you encounter in your practice" is recorded in Table 1.[8]

As might be anticipated, these data indicate that a representative sampling of over 370 active family physicians most commonly encounter the milder types of emotional disorders. However, they are not strangers to psychotic behavior. This circumstance, plus the fact that the family physician will be

called upon to provide or collaborate in the after-care of an increasing number of psychotic patients returned to their home communities, mandates a new and more comprehensive role for the family physician.

A New Role for the Family Physician

If one of the basic goals of family practice is the delivery of comprehensive, ongoing care to the entire family, how will such care be delivered to a psychotic patient and his family? It will imply commitment to a contract between the parties involved. This covenant, as expressed by the family physician, might read as follows:

1. I am competent to care for you. I understand and can accept your behavior and you as a person.
2. I will not abandon or reject you because of your actions.
3. Institutional care may become necessary if you, your family, your doctor or your community finds your behavior so disruptive as to require a more sheltered environment.
4. If you are hospitalized, I will remain in contact with you and communicate with your attending physician, consult with him at the time of your discharge, and resume your care when you return home.
5. I will work with your family and the supporting people and resources in our community to develop a better understanding of your illness and an interpretation of your behavior.

The foregoing covenant has several implications for the provision of comprehensive care of the psychotic patient by the family physician. First, it indicates that the family physician possesses the clinical acumen to detect incipient psychotic behavior among the patients under his care. In fact, the family physician has a special advantage because of his longitudinal relationship with the family and acquaintance with its particular vulnerability to certain disease states. He is knowledgeable about his community and relevant demographic data, census tracts and high-risk areas.

Second, this contract binds the family physician to mobilize his own, the family's, and the community resources to intervene in the early stage of psychosis and hopefully to obviate the need for institutional care, an expensive and often regressive method of treatment. The knowledgeable and well-trained family physician is aware of all the resources the community offers to assist him in caring for his patient. He can coordinate the timely utilization of this network of support. He also has insight into the strengths and weaknesses of the patient's family which permits him to mobilize the former and minimize the latter.

The verbal contract implies that the family physician has an acquaintance with, and a working knowledge of, psychopharmacological agents. Also, it leaves the way open, should the need arise, for removal of the patient from the community to a place of temporary refuge. It provides for a collaborative approach between the family physician and those in the mental institution, which encourages an informed and continuing relationship with the patient and his family.

Finally, it places the family physician in the role of a community educator able to furnish insight into the behavior of psychotic people, which may foster an increased tolerance of these citizens by the public. The family physician assumes the role of advocate for psychotic patients and acts as the catalyst to mobilize community resources to help these disturbed people.

Table 2. Topics for Postgraduate Psychiatric Training

	Number	Percent
Managing Psychotic Patients		
Very useful	37	10.8
Useful	117	34.2
Of little use	138	40.4
Of no use	50	14.6
Total Responding	342	100.0
Need Psychotropic Drug Training		
Very useful	126	37.4
Useful	166	49.3
Of little use	34	10.1
Of no use	11	3.2
Total Responding	337	100.0
Using Community Resources		
Very useful	80	23.6
Useful	182	53.7
Of little use	60	17.7
Of no use	17	5.0
Total Responding	339	100.0
Working with Families		
Very useful	87	24.9
Useful	200	57.3
Of little use	49	14.1
Of no use	13	3.7
Total Responding	349	100.0

Proposal for an Educational Program

The foregoing commitment to a program of comprehensive care for the psychotic patient and his family represents an ambitious undertaking and perhaps even an idealized version of the family physician's responsibility. But this covenant points the direction for psychiatric education at all levels – undergraduate, graduate, postgraduate – if family physicians are to be qualified to meet patient/family and community expectations in the care of psychotic patients.

Data from the Michigan Psychiatric Survey delineates some areas of expressed needs in the care and management of emotional disorders through psychiatric education.

Four of the replies to the several options offered in connection with the

question, "Which of the topics listed below would most interest you as to obtaining further competence in psychiatry through postgraduate training?" are germane to the development of an educational program on managing the psychotic patient. The responses are shown in Table 2.[8]

These data indicate that continuing education in managing the psychotic patient would be "very useful" or "useful" to 44 percent of 342 respondents. This expressed interest, combined with the 75 percent of 350 physicians who replied that they would like to know more about utilization of community resources, and the 86 percent of 337 who indicated a need for psychotropic drug training, and the 78 percent of 349 who replied they would be interested in working with families, could lead to a training program designed to cover these areas.

Discussion

Admittedly, not all family physicians will be motivated to become involved in the management of the psychotic patients. However, Fisher et al have shown that family physicians who graduated after 1950 and also those who graduated before that year but who took postgraduate training recognized the psychoses more often and were more knowledgeable about the use of psychotropic drugs than their older and less educated colleagues.[9]

Psychiatrists who have collaborated with general practitioners and later with family physicians for over 15 years in the development of continuing education training programs have helped to conceptualize the new role for the family physician in the care of his psychotic patients.[10,11] These teachers have found that, while didactic lectures were of some value, the best results occurred when the family physician trainee became involved in an experiential manner.[12]

A program which would involve family physicians experientially might well encompass these three "Rs":

1. *Recognition:* (a) the ability to detect psychotic behavior, especially in its incipient phase when intervention might obviate the need for hospitalization; (b) knowledge of family dynamics and behavior and the ability to recognize the matrix of "psychogenetic" families (ie, families whose nurturing process may engender psychosis).

2. *Resources:* (a) knowledge about available resources, and the skill to employ them for the benefit of the psychotic patient and his family; (b) a thorough understanding of the psychotropic drugs and their appropriate use.

3. *Referral:* (a) the why, where, and how of referral to a psychiatric consultant or mental institution, if necessary, for continuing patient care; (b) communication and collaboration with the personnel in mental institutions both during the period of the patient's hospitalization and following his discharge.

One such program with experiential training was established at the Boston State Hospital in 1965. The program included around-the-clock availability of psychiatric consultation, case-centered seminars, and an opportunity for the participating physicians to engage in hospital patient care. The seminars avoided psychiatric jargon, encouraged the physicians to air their own anxieties, and focused on three major areas: (1) early detection of psychotic illness, (2) collaborative treatment, and (3) after-care management.

The results of this program were highly satisfactory and could well serve as a model of how to provide a both cognitive and affective learning experience. Some changes that were observed were: (1) an increased awareness of and competency in detection of incipient psychoses; (2) more expeditious and collaborative referral patterns to the Butler-Stedman Pavilion of the Boston State Hospital; (3) a change to a more positive attitude about psychiatric hospitals because of participation in the team approach to in-patient care; and (4) an increased ability to function as coordinator and even director of patient care. There were reliable indications that the trained family physician can give appropriate psychiatric support and can provide ongoing after-care. "Because of his position in the community and his intrinsic sensitivity to the patient-family unit, the physician has the opportunity to observe the development of new crises and either handle them directly or present the situation in depth to the psychiatric team for advice."[13]

To provide for improved pre-hospitalization and after-care for the psychotic patient and his family by the family physician, those who plan training at the graduate and postgraduate levels need to communicate and collaborate. Family physicians in active practice, speaking via their local and state chapters of the American Academy of Family Physicians, must articulate their needs for continuing education in psychiatry and the behavioral sciences.

The logical resources to provide these training programs are the Departments of Psychiatry and Behavioral Science and the Department of Family Practice of the medical schools. It can be anticipated that as the academic programs in family practice grow in strength and wisdom they will assume an increasing responsibility for developing sound programs in both graduate and postgraduate education. Recognition of and response to this new obligation can result in, among other benefits, an enlightened and compassionate delivery of care to psychotic patients at a reduced cost, both emotionally and economically.

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