Identification and Management of the Anxious Patient Within A Model Family Practice Unit

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Because anxiety is the third most common problem encountered in this Model Family Practice Unit, the presentation and management of 36 randomly selected cases were reviewed. The incidence was not greater in one race, but was increased in all married females (age 25 to 35) who, despite wife or husband working, had a very low income. The foremost complaints were insomnia, headaches, and chest pain with 80 percent of the patients maintaining the same symptoms. The resident identified a conflict (the most frequent being marital problems) in 47 percent of the cases. Drug therapy was used in 86.1 percent with ten percent selected for symptom relief. Because there are times when an alternate to drug therapy is needed, an overview teaching series on brief psychotherapy is suggested as an appropriate part of the behavioral science curriculum in a residency program.

Anxiety is a common problem for the family physician. According to some, it is the most prevalent problem seen in the average family physician's office in this country. In the Model Family Practice Unit at Earl K. Long Family Practice Residency Program in Baton Rouge, Louisiana, anxiety is the third most common disorder seen. As part of the ongoing development of the residency program's behavioral science training needs, the incidence and management of patient anxiety in the unit's patient population was studied.

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By retrospective analysis, the presentation, symptom complex, and treatment methods for anxiety were reviewed in the Model Family Practice Unit. An alternative method for the treatment of the condition was explored.

Background

Anxiety was defined as "a disagreeable emotional state in which feelings of impending danger are characterized by uneasiness, tension, or apprehension."[1] In diagnosing patient anxiety, the physician must consider the severity of symptoms and the direction of focus of the anxiety. He/she must also be crucially alert to differentiate normal from pathological anxiety.

Normal anxiety results from the pressures and strains of everyday life. It only becomes patholog-

ical "when a patient complains of anxiety which is more frequent, more severe, or more persistent than he/she is accustomed to and can tolerate."[2] The family physician must not overlook "normal" anxiety and must not fail to treat the patient having this problem.

Because anxiety occurs in various forms and is similar to so many other diseases, its diagnosis must be one of exclusion. Some diseases that must be differentially excluded are the following:[1,3]

1. Agitated depression
2. Early schizophrenia
3. Early chronic brain syndrome
4. Hyperthyroidism
5. Systemic diseases
   a) Peptic ulcer disease
   b) Paroxysmal tachycardia
   c) Angina
   d) Asthma
   e) Addison disease
   f) Hyperinsulinism

The exact cause of anxiety is unknown. In classical psychoanalytical interpretations anxiety begins in infancy. Every infant experiences "traumatic states" or periods during which his instinctual urges and desires cannot be met. With future intellectual growth, the child

> . . . begins to anticipate the development of a traumatic state, to react to what has often preceded it . . . . In other words, certain experiences . . . become situations of *danger* and he reacts to *them* with unpleasure, the same emotion which characterizes a traumatic state . . . . An adult or an older child who is anxious is experiencing *unpleasure which has a particular ideational content:* Something bad is going to happen (Brenner's italics).[4]

Materials and Methods

Patient charts from January 1976 to June 1976 were reviewed which had recorded the diagnosis of hysterical and hypochondriacal neurosis (ICHPPC 3001). The first 36 cases were selected which fit the previously stated definition of anxiety and had no illnesses listed in the differential diagnosis given above. The attending physician actually recorded each diagnosis and clerical personnel transferred the information to an E-book. A work sheet for systematic data retrieval was used for each case. Tables 1 through 8 and Figure 1 summarize the results.

Results

Although the cases studied were few, some specific characteristics of the anxious patient were identified. For example, anxiety was more frequent in the married woman who had a low income despite the fact that either she or her husband worked (Table 1). Indigency in these cases was determined as "being on welfare" or as having income below the following levels: Single—$200/month; Husband and Wife—$225/month; Each child—+$25/month.

The incidence of anxiety apparently was greater among those whose families reside in the inner city, although these figures are not as clear cut. Anxiety was not more prevalent in a selected race or in families with or without children.

In Figure 1, the age distribution confirms that few cases occur in children and the elderly. A substantial number of patients were aged 15 through 54, with a peak in the 25 to 34-year-old group. When compared with the age distribution of the general population, that for the study group showed an increase in incidence in persons ages 25 through 54 years.

Realizing that the recognition of anxiety may increase with the experience of the resident, the number of cases diagnosed at each level of residency training was compared. The recognition of anxiety increased from the first to the second year of training but declined in the third year.

Almost one third of the cases were identified by two residents, one in his first year, the other in his third year. A three-year study of each resident's cases might have shown a gradual increase in his recognition of anxiety, but, this study could not show that increase in learning.

Anxiety is associated with various somatic and autonomic complaints that tend to remain constant for the patient. The findings in Table 2 confirm that observation; more than 80 percent of the patients had only one unchanging set of complaints. Among the common presenting complaints are

Table 1. Statistical Data—Anxiety Patients

	No. Patients Studied	% Patients Studied (N=36)	% General Population MFPU*
Sex			
Male	2	5.6	32
Female	34	94.4	68
Race			
White	12	33.3	39
Black	24	66.7	61
Marital Status			
Married	17	48	25
Divorced	4	11	6
Separated	5	14	5
Single	10	27	60
Children			
With	29	80	79
Without	7	19	21
Income			
Indigent	35	97	87
Not indigent	1	3	13
Occupations			
Spouse works	5		
Self works	7	55	27
Both work	2		
In school	5		
No work	16	45	73
Location of Dwelling			
Rural	8	22	30
Inner City	12	33	22
Suburbs	16	45	48
Type of Dwelling			
House	30	84	91.8
Apartment	6	16	8.2

*Model Family Practice Unit

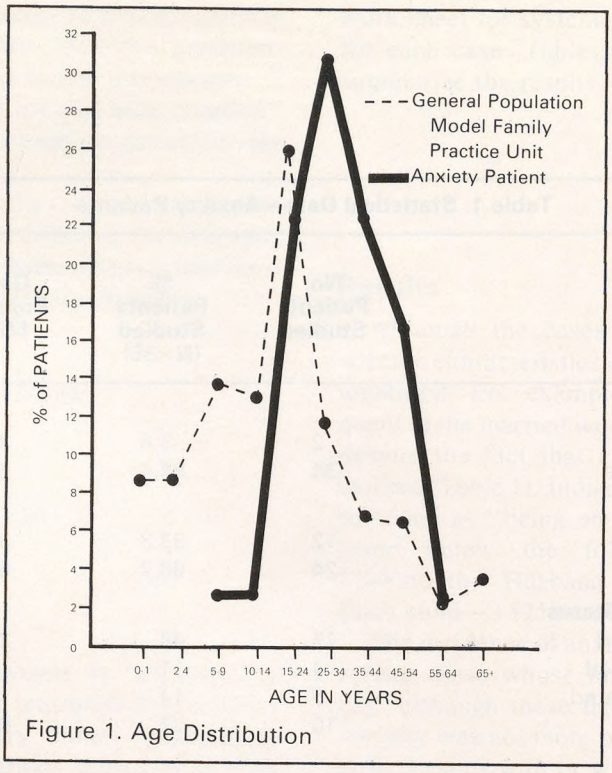

Figure 1. Age Distribution

"general apprehension, fatigue, palpitations, shortness of breath, tachycardia, abdominal pain or discomfort, insomnia, and tremors."[3] In the Model Family Practice Unit, insomnia, headaches, and chest pain were the three most frequent complaints (Table 3). From this table, one can see that many patients had more than one complaint. More than 50 percent of the cases were accounted for in six complaints.

In almost one half of the cases, the physician identified a conflict that might have been the cause of the patient's anxiety (Tables 4 and 5). Marriage, children, and physical problems were the most frequently attributed causes. For this study the physician's additions to the patient's record were relied upon. The data cannot show any information the physician may have decided not to record.

A tendency was noted to prescribe a drug-dominated treatment (Tables 6 and 7), although 13.9 percent of the patients did not receive a prescription. Ten percent of the drugs selected were for relief of anxiety symptoms (Dalmane [flurazepam], Bellergal, Darvon [propoxyphene], Donnatal, Fiorinal [butalbital]). Valium (diazepam) accounted for one fourth of the drugs used.

All of the patients have been seen after the first diagnosis. Thirteen patients (36.1 percent) had only one visit for the problem of anxiety (Table 8). Almost one half of the cases were managed in two visits. These figures suggest that anxiety is a self-limiting process that can be managed in a few office visits.

Discussion

As seen in this study, anxiety presents in a variety of symptom complexes (Table 3). With insomnia, headaches, and chest pain leading the list, the type of complaint varies depending on what the patient believes is acceptable. In another patient population, the leading symptoms might change drastically. For example, studies of Africans showed a low incidence of peptic ulcer disease. The studies were based on information gathered from physician's diagnoses in their pa-

Table 2. Number of Symptom Complexes Per Patient

No. Symptom Complexes	No. Patients Studied	% Patients Studied (N=36)	Cumulative %
1	29	80.6	80.6
2	3	8.3	88.9
3	3	8.3	97.2
4	0	0.0	97.2
5	1	2.8	100.0

Table 3. Symptoms Among Anxiety Patients

Symptoms	No. Patients Studied	% Patients Studied (N=110)	Cumulative %
Insomnia	14	12.6	12.6
Headaches	14	12.6	25.2
Chest pains	12	10.8	36.0
Gastrointestinal complaint	7	6.3	24.3
Dizziness	6	5.4	47.7
Crying	6	5.4	53.1
Palpitations	5	4.5	57.6
Fatigue	5	4.5	62.1
"Nervousness"	4	3.6	65.7
Shortness of breath	3	2.7	68.4
Weight gain	3	2.7	71.1
Anorexia	2	1.8	72.9
Irritability	2	1.8	74.7
Decreased libido	2	1.8	76.5
Nail biting	2	1.8	78.3
Muscle aches	2	1.8	80.1
Genitourinary complaint	2	1.8	81.9
Neurodermatitis	2	1.8	83.7
Agitation	1	0.9	84.6
Itching	1	0.9	85.5
Hot and cold flashes	1	0.9	86.4
Tremors	1	0.9	87.3
Hallucinations	1	0.9	88.2
Other	8	7.2	95.4
None given	4	3.6	99.0
Total	110		

Table 4. Conflict Identification

	No. Patients Studied	% Patients Studied (N=36)
Identified	17	47.2
Not Identified	19	52.8

Table 5. Conflicts Evident for Patients with Anxiety

Conflict	No. Patients Studied	% Patients Studied (N=25)	Cumulative %
Marital problems	7	28.0	28
Children	5	20.0	48
Physical injury/illness	5	20.0	68
Sex	2	8.0	76
School	2	8.0	84
Finances	2	8.0	92
Patient's childhood	1	4.0	96
Death	1	4.0	100
Total	25		

tient encounters. However, when the study included all autopsy results, the increase in cases of peptic ulcer disease was considerable. One would expect that those patients did not find complaining about a stomachache acceptable and, therefore, gastrointestinal complaints were not prevalent. Similar examples can be shown in various ethnic groups.[5] This diversity of presenting symptoms in patients with anxiety makes identifying each case more difficult, necessitating that the physician really know the individual patient.

Treatment or management of anxiety differs greatly, and no particular method is absolute. One method of treatment is proposed that has proven effective in the brief management of normal anxiety encountered by the family physician. Most important is establishing rapport with the patient. Being attentive and sympathetic and allowing the patient to ventilate his/her feelings characterize a successful relationship. To establish rapport and manage anxious patients effectively, the physician should: (1) be direct and sincere; (2) have a nonjudgmental attitude; and (3) act as a catalyst and guide to promote free expression and to help the patient put his troubles into words. The physician must be quick to advise the patient that no magic "cures" can be offered, but that the stresses and conflicts causing the anxiety need to be discovered.

Castelnuovo-Tedesco (1965)[6] discovered that the nonpsychiatric physicians he studied did not use brief psychotherapy. He discussed various factors in that group's decision not to include brief psychotherapy in their medical skills. Here, two of the factors are considered: (1) lack of time and (2) lack of experience (being unfamiliar with short-term psychotherapeutic techniques).

First, the physician asks, "How can I spend an hour doing psychotherapy with a patient?" Castelnuovo-Tedesco points out that nothing is sacred about the 50-minute hour. In fact, his 20-minute concept for the nonpsychiatric physician blends well with the family physician's practice. It represents an interval that the physician can reasonably spend with each patient. Psychotherapy does not need to be a lengthy process. A six to eight-week treatment seems appropriate in the management of normal anxiety.

Table 6. Number of Drugs Prescribed Per Patient

No. Drugs	No. Patients Studied	% Patients Studied (N=36)	Cumulative %
0	5	13.9	13.9
1	13	36.1	50.0
2	10	27.8	77.8
3	4	11.1	88.9
4	3	8.3	97.2
5	1	2.8	100.0

Table 7. Drugs Prescribed to Patients with Anxiety

	No. Patients Studied	% Patients Studied (N=65*)	Cumulative %
Valium	17	26.2	26.2
Elavil	9	13.8	40.0
Triavil	8	12.3	52.3
Librium	5	7.7	60.0
Sinequan	5	7.7	67.7
Tranxene	3	4.6	72.3
Dalmane	2	3.1	75.4
Ballergal	2	3.1	78.5
Darvon	1	1.5	80.0
Donnatal	1	1.5	81.5
Haldol	1	1.5	83.0
Norpramin	1	1.5	84.5
Serax	1	1.5	86.0
Fiorinal	1	1.5	87.5
Butisol	1	1.5	89.0
Vistaril	1	1.5	90.5
Ru Vert	1	1.5	92.0
None	5	7.6	99.6

*Some Patients had more than one drug prescribed

Table 8. Number of Times Patient Seen for Problem			
No. Visits	No. Patients Studied	% Patients Studied (N=36)	Cumulative %
1	13	36.1	36.1
2	4	11.1	47.2
3	5	13.9	61.1
4	5	13.9	75.0
5	2	5.6	80.6
6	2	5.6	86.1
7	1	2.8	89.0
9	1	2.8	91.7
12	2	5.6	97.4
14	1	2.8	100.0

To help the inexperienced physician, the behavioral science faculty must develop appropriate seminars and practicums in the art of short-term treatment, including the development and use of practical psychological skills.

For any treatment method to be effective, its objectives must be measurable. Some of these objectives are:

1. Providing symptomatic relief of patient's presenting complaints.

2. Helping patient deal with what is troubling him now—focusing on current life situation.

3. Expressing an interest in patient's hopes and expectations for the future.

Although an in-depth history of the patient's experiences is important, in the brief-treatment approach that history is left untouched. Realistically, the most pressing problems are the current ones and they should be addressed. Examining the patient's past is time-consuming and beyond the expectation of brief treatment.

During treatment, the patient becomes responsible for his progress. Two important questions are posed for him to deal with: (1) What is it that *I* am troubled about? and (2) What can *I* do to alter this situation to make it more to my liking? Thus, during brief treatment, the focus remains on the patient and his problem.

These are indications for use of the 20-minute hour:

- minor neurotic disorders
- emotional difficulties related to environmental stresses
  - death, divorce, illness
  - mental difficulties
  - parent/child difficulties
  - occupational problems
- anxiety and minor depressive reactions

Conclusion

For the family physician to recognize and treat anxiety properly, the behavioral science component must provide meaningful learning experience during residency training. An overview teaching series on brief psychotherapy is suggested as an appropriate part of the behavioral science curriculum in a residency program. The family practice resident must gain an understanding of the cause, diagnosis, and treatment of anxiety. This study highlights the strengths and weaknesses in the recognition and management of anxiety at the Earl K. Long Family Medicine Clinic and identifies some specific characteristics of the clinic patients who are at risk in developing anxiety.

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