Psychological triage in general practice

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Background

Triage involves matching resources to the patient – based on limited information – as quickly as possible. Principles from triage can be applied to the assessment and management of patients with psychological distress.

Objective

This article describes four steps in triage – once significant distress is identified: assessing the severity, looking for indicators that point to a diagnosis, formulating a working diagnosis, and treating the distress.

Discussion

When the presenting symptoms are nonspecific, or the nature of the distress remains unclear, an approach to gathering more information over three visits is described. After this further assessment is completed, options to tailor treatment to the patient are suggested.

Keywords

stress, psychological; triage; mental health; general practice

The concept of triage was developed to enable healthcare workers to do the most good for the most people with the resources available. It means more than identifying which patient the doctor will see next. It involves matching resources to the patient – based on limited information – as quickly as possible.[1] This information includes the nature and severity of the patient's problem, knowledge of the available resources, self-knowledge of our own abilities and an assessment of the time available. The process recognises that other patients require attention also. These principles can be usefully applied in family medicine when helping adult patients suffering psychological distress.

General practitioners frequently see patients who exhibit distress, or whose suffering is magnified by psychological factors such as worry, grief, resentment, anger or sadness. Patients expect their physician to discuss the psychological and social aspects of their health if relevant to managing their problem.

This article describes a four-step approach to help triage the distressed patient in the general practice setting. Once psychological distress is recognised:

- assess the severity of the distress
- identify indicators suggestive of a diagnosis
- formulate a working diagnosis
- treat the distress by linking the right resources to the right patient.

When the presenting symptoms are nonspecific, or the nature of the distress remains unclear, follow up to gather more information can be arranged.

First, recognise the distress

To effectively treat the distressed patient, the GP must be alert to, and recognise the possibility of, emotional and psychological distress, even when it is not immediately obvious (*Table 1*). Mental health problems are underdiagnosed, primarily because they are often somatised and reported as physical symptoms.[2] 'Somatisers' represented 18.5% of an Australian general practice population in a recent sample.[3] In this audit, most somatisers did not have significant anxiety or depression, but most patients with depression and anxiety had a significant degree of somatisation.

Step one: assess problem severity

In some consultations both the severity and nature of the problem are obvious and treatment can be immediately arranged. When the nature of the problem is not clear, the severity of the problem will guide the management response. Problems can present as:

- emergencies: Is the patient acutely at risk of harm to themselves or others (eg. acute psychosis, major depression with suicide intent, life threatening concomitant illness)? This situation is treated as any other emergency and might involve inpatient

admission, liaison with an acute care facility, and sometimes certification of an involuntary patient

- urgencies: this does not involve an immediate threat to life, but needs active intervention to prevent significant suffering or deterioration in functioning. This might involve contact with a local mental health service, crisis assessment team or equivalent, and follow up of the patient within hours/days
- stable: this patient is suffering, but able to function, despite their distress. The patient's distress should be recognised, acknowledged and possible treatment options discussed. This could involve referral to a psychiatrist, psychologist, counsellor, social worker or local mental health service. Alternatively, the patient could be offered a limited number of further visits to the practice to further define the problem (see below).

This triage based on severity of symptoms should occur rapidly, and might require further data, such as an abbreviated Mini-Mental State Examination; specific inquiry of risk of harm to self or others and details of substance use.

Step two: identify indicators suggestive of a diagnosis

In cases of relative stability, the patient can be offered outside referral, or invited to return for further assessment over three sessions (*Table 2*). In this approach, two questions are asked during each visit, with each visit lasting about 20 minutes. A preamble to each question is included, which may assist future discussions. Further prompts are included and may be helpful if the patient is having difficulty answering questions. After the three sessions, the patient is invited back to organise definitive treatment. The visits are for information gathering, so no interpretation of the data is given until after the three visits are completed.

These sessions of further assessment require a person motivated to attend and a therapeutic patient-doctor relationship. This is not possible if drug seeking or threatening behaviour is present. Similarly, florid psychosis, or risk of harm to self or others requires emergency treatment, not further evaluation. During these sessions, the doctor is trying to further understand the nature and severity of the problem. Assessment of this allows recognition of depression (eg. major, unipolar, bipolar), anxiety (eg. adjustment disorder, post-traumatic stress disorder, generalised anxiety disorder, social phobia, panic disorder, agoraphobia, obsessive compulsive disorder), somatisation, grief, situational crisis and interpersonal difficulties. Certain features may suggest a specific diagnosis (*Table 3*).

Discussing a patient's ideas, concerns and feelings has the potential to revive painful experiences, however, deciding not to assess persistent psychosocial distress has a greater risk of perpetuating suffering and exposing the patient to the risks of overinvestigation, overmedication and overtreatment.

Table 1. Features suggestive of significant psychological distress

- Distress is displayed or articulated by the patient (eg. prominent anxious or depressed affect)
- Symptoms are repeatedly described by the patient
- Persisting symptoms of unexplained dizziness, fatigue, headache or sleep disturbance[14]
- Multiple unexplained somatic features are present*
- The doctor has cognitive or emotional dissonance in relating to the patient
- Out-of-proportion reaction by the patient to their symptoms (over- or under-reaction)
- Out-of-proportion use of the health system for the stated symptoms (over- or under-use, more than five times per year)[15]

* Severe forms (somatisation disorder) can be screened using the mnemonic: Somatisation Disorder Besets Ladies And Vexes Physicians (Shortness of breath, Dysmenorrhea, Burning in the sex organs/mouth/rectum, Lump in the throat of more than 1 hour, Amnesia for hours or days, Vomiting, Painful fingers or toes). Three of seven medically unexplained persisting symptoms screen positive, if onset is before 30 years of age[16,17]

Table 2. Six questions to aid the assessment of psychological distress

Session one

- Who is in your immediate circle of friends or family?
- What is happening in your life right now?

Session two

- How would you describe yourself?
- Who or what tells you how you should act, and when you are doing well?

Session three

- How do you solve problems?
- Is there anything that we've missed?

Three visits toward further understanding

At the initial visit, the patient is welcomed and the purpose of the appointment restated: 'These sessions will help find the best way forward'. The following questions are asked and the answers written on a piece of paper, given to the patient at the end of each appointment.

Visit one

Question 1: We are helped by some people and hindered by others. Similarly, we can help and hinder those around us. Who is in your immediate circle of friends or family? A brief genogram or equivalent is drawn. A genogram captures family relationships over decades, identifies close and ambivalent relationships[4] and identifies the degree of support the patient has. After spending 10 minutes listening to the patient's response to the question, the next question is asked.

Question 2: Sometimes it's hard to figure out what is causing the most distress. What is happening in your life right now?

Table 3. Features suggestive of a diagnosis

Condition	Indicators[18,19]	Treatment[4,18]
Somatisation	• Persisting unexplained symptoms	• CBT, IPT
Adjustment disorder with anxious mood	• Onset within 3 months of an identifiable stressor • Persists less than 6 months, impairs functioning	• CBT, BT (relaxation), SPS
Generalised anxiety disorder	• Excessive worry about multiple things • >6 months duration, impairs functioning • Muscle tension, hyperarousal	• CBT, pharmacotherapy if severe symptoms, or CBT not effective • SPS • Onset in a person aged 40+ years: exclude medical causes, depression and dementia
Panic attack	• Brief period of intense fear • Symptoms peak within 10 minutes	• Explanation, BT (slow breathing) • First presentation: exclude a medical condition (eg. acute coronary syndrome, acute asthma, or thyrotoxicosis)
Panic disorder	• Recurrent attacks, without a situational trigger • Avoidance of situations due to concern over a future attack • Fear of collapse, insanity or death during the attacks	• CBT, BT (slow breathing, graded exposure), pharmacotherapy if these treatments are not effective
Social phobia • Generalised: numerous fears of both performance and interactional situations • Nongeneralised: fear of one or a few performance situations	• Fear that others will think badly of them • Fear of humiliation, embarrassment, scrutiny • Avoidance of social interactions	• Generalised: CBT, BT (exposure based), social skills training • Nongeneralised: episodic pharmacotherapy
Obsessive-compulsive disorder	• Fear of contamination or harm • Repeated, intrusive, distressing thoughts	• CBT, BT (exposure and response-prevention), pharmacotherapy
Agoraphobia	• Fear/avoidance of places or situations where escape would be difficult, or help would not be available	• If associated with panic disorder, treat panic disorder • If not associated with panic attacks, CBT
Acute stress disorder	• Symptoms linked to a traumatic situation • Lasts <4–8 weeks	• Usually remits NB: Debriefing is sometimes harmful
Post-traumatic stress disorder	• Persisting >1 month after exposure • Nightmares, flashbacks and emotional numbing • Hyperarousal • Avoidance of reminders	• Specialist referral important • Treatment of comorbid conditions (eg. substance use, depression) • Pharmacotherapy under specialist guidance • CBT, BT (stress management, sleep hygiene)
Specific phobias	• Intense fear, leading to avoidance of object or situation	CBT, BT (graded exposure)
Grief	• Sadness not accompanied by feelings of worthlessness • Absence of strong suicidal thoughts • Feelings improve with time over months/years (duration proportional to attachment) • Usually lasts 6–24 months[11]	• Support • Individual counselling • Group and family therapy[11]
Adjustment disorder with depressed mood	• Significant stressful event • Does not meet the criteria for another depressive disorder	• Support • Brief counselling

Dysthymic disorder	• Persisting, often fluctuating low mood for 2 or more years • Not meeting major depression criteria	• Pharmacotherapy effectiveness less predictable • CBT
Depression • Unipolar • Bipolar (depression with periods of mania or hypomania) • Psychotic (mood – congruent psychotic features)	• Depressed mood and loss of interest or pleasure • Major depression at least three other features of: appetite or weight change, sleep disturbance, agitation or retardation, fatigue, feelings of worthlessness or excessive guilt, impaired thinking, thoughts of death	• CBT, IPT, pharmacotherapy for moderate to severe major depression • Assess for suicide risk; refer for hospitalisation if significant • Consider referral for bipolar disorder, psychotic depression, active suicidal thoughts,[19] or for failure to respond to treatment
Personality disorders[4] • Cluster A: odd or eccentric behaviours (paranoid, schizoid, schizotypal) • Cluster B: dramatic, emotional or erratic behaviours (antisocial, borderline, histrionic, narcissistic) • Cluster C: Anxious or fearful behaviours (avoidant, dependent, obsessive-compulsive)	• Severe disturbance in interpersonal functioning • Developmental immaturity, mood instability, recurrent impulsive and maladaptive behaviours (eg. binge eating, stealing, substance abuse, and deliberate self harm), an unstable sense of self and identity, and recurrent feelings of 'emptiness or boredom'	• Refer for specialised treatment, possible psychodynamic treatments, often long term • Treat comorbid conditions (eg. substance use disorder)
Eating disorders	• Anorexia nervosa (relentless pursuit of thinness) • Bulimia nervosa (regular episodes uncontrolled over-eating, weight in normal/overweight range) • Binge eating disorder (absence of extreme weight control behaviours)	• Anorexia: manage physical complications (eg. hypokalemia, dehydration), multidisciplinary team, consider specialised service, individual therapy, FT • Bulimia, binge eating disorder: CBT, IPT, treat comorbid conditions

CBT = cognitive behavioural therapy; IPT = interpersonal psychotherapy including IPC (interpersonal counselling); SPS = structured problem solving; BT = behaviour therapy; FT = family therapy

Prompts: What do you think is the main problem? What is taking up your thinking time? If a miracle happened tonight, and everything was suddenly better, what would you notice tomorrow that would be different?[5]

At the end of the consultation, the patient is thanked for answering the questions. The next session's questions can be given in advance as homework (if desired), and the next appointment booked. After this first session, the doctor notices the patient's affect, their ability to articulate their thoughts and identify their emotions, and the answers given so far. A template can be created to document the visit, and sensitive issues might be documented in general terms. This reinforces that the patient is giving their current opinion, which can change in the future.

Visit two

Question 3: We have an opinion about many things, including about other people and ourselves. How would you describe yourself?

Prompt: How would other people describe you? The genogram can be used to explore this further.

Question 4: We all have ideas about how we and other people should act. Who or what tells you how you should act, and when you are doing well?

Prompt: What sources of opinion do you listen to? Again, the patient is thanked for their effort, and the last assessment visit is scheduled.

Visit three

Question 5: We learn to solve problems by copying other people and by learning from the mistakes of ourselves and others. How do you solve problems?

Prompt: Who or what has influenced this?

Question 6: This is a question the doctor asks themselves and the patient. Is there anything that we've missed: Any relevant examination or investigations (eg. thyroid stimulating hormone, haemoglobin, erythrocyte sedimentation rate); any substance use (eg. alcohol, licit or illicit medications)?

A brief Mini-Mental State Examination[6] might also be performed to exclude other significant factors such as memory impairment, that may be behind the distress. The patient is thanked for completing the assessment. The patient is asked to book another visit to discuss treatment options, and the doctor explains that they will use the interval time to consider how the problem might best be helped.

Step three: follow up visit and formulation of a diagnosis

After the three sessions there should be sufficient data to reach a working diagnosis. Tait[7] structured the formulation as a question: 'What kind of person – with what strengths and weaknesses, confronts what kind of situation – with what

stressors and supports, making what type of adaptive response – appropriate or inappropriate, calling for what kind of professional intervention – by self or others?'

After the three assessment visits, the physician should be able to answer the first three parts of this question.

Step four: treat the distress

For many people, the opportunity to discuss their situation, concerns and feelings is sufficient for them to begin making the changes they have identified as necessary. Others might request further specialised help. This can be arranged through referral, or to within the practice, depending on local resources and expertise.

Figure 1 illustrates the differing levels of assistance we can give patients, from empathy and supportive listening, to structured interventions to more intensive treatments.

Resources are available for physicians wanting to develop further skills in approaches such as interpersonal psychotherapy and its briefer version, interpersonal counselling,[8] as well as cognitive behavioural therapy,[9] structured problem solving,[10] grief counselling[11] and family therapy.[12]

Summary

Principles from triage can be applied to the assessment and management of patients with psychological distress. The four steps in triage are: assess the severity, look for indicators that point to a diagnosis, formulate a working diagnosis, and treat the distress.

When the presenting symptoms are nonspecific, or the nature of the distress remains unclear, a three-session approach to gather more information is recommended.

'The only doctor who can continue his work without using some form of psychotherapy is the one who confines himself to the study of the dead'. Dr P Hopkins. *The Lancet*, 1956.[13]

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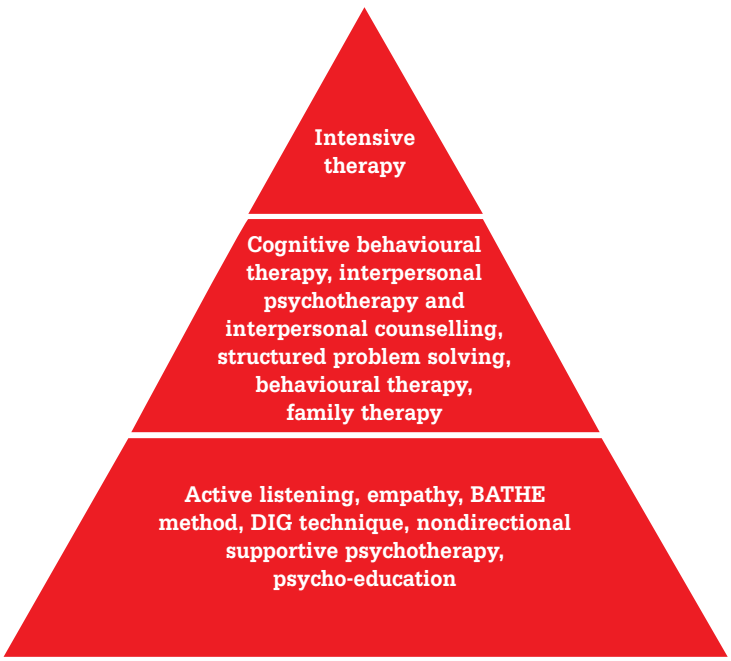

Figure 1. Differing levels of intervention
BATHE method: Background, Affect, Trouble, Handling, Empathy[5,20]
DIG technique: Dream the miracle, Initiate the first small step, Get going and implement the first move[5]
Active listening: refer to reference 21

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