Identifying psychological distress

In the interests of scientific study, please beware of research papers that merely state the obvious. The paper on *'Identifying psychological distress in NZ primary care'*[1] merely demonstrates that if you administer a questionnaire you will get answers to it.

The research says nothing about the actual value of knowing the answers to the questionnaire, and begs the question of whether it is worthwhile for the GP to be aware of the patient's other problems – the ones they are not asking for help with. There is an underlying, but questionable, assumption that learning more about the patient's psychological distress will be of value to the doctor, the patient or both. Sometimes though, it could well be irrelevant or even a distraction.

Let us say you administer a questionnaire about urinary incontinence. Lo, you will uncover a number of patients with urinary problems who are not seeking treatment from the doctor (or at least not on this occasion). Similarly, if you administer a questionnaire about warts, you will find a lot of patients living with untreated warts.

The GP does not have the answer to treating all illnesses, distress and life problems, and it would be perfectly appropriate for a patient not to wish to use the limited time of their consultation with the doctor for discussing their psychological distress, particularly if they have made the appointment in order to deal with their physical illness. They may even prefer other sources of help.

A little reality would be useful here. All sorts of questionnaires could be administered in the waiting room. One might also ask about problem drugs or alcohol consumption, violence, gambling, symptoms suggestive of cancer, untreated musculoskeletal pain, healthy eating, family history etc. Which are the most important ones?

Suppose the GP administers the GHQ-12 and finds additional background psychological problems which the patient did not intend to raise. Then we need to ask the value of this. Are we medicalising normal life experiences? Are we devaluing the interaction in the consultation by replacing it with a form-filling exercise? Or is it useful for some patients to communicate in this way? If so, which of our patients and for what issues?

These are the questions I would really like an answer to.

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References

1. Davis J, Galyer K, Halliday T, Fitzgerald J, Ryan JM. Identifying psychological distress in New Zealand primary care: The General Health Questionnaire-12 (GHQ-12) as a screening instrument. NZ Fam Physician 2008; 35(2): 86-90.

Growing old

'With age, the quality of emotions may shift from negative in tone to positive, but also from active to passive. The shift from negative to positive is consistent with the age as maturity perspective. The shift from active to passive supports the age as decline perspective. If these generalities are correct, then they should apply to positive emotions as well as negative emotions. We should see a shift in positive emotions from active (excitement) to passive (serenity), as well as in the negative emotions (from the agitation of anxiety and anger to the lethargy of depression). In order to accurately portray the shifts in emotional tone, age may best be considered as simultaneously indicating maturity and decline.'

Ross CE. Mirowsky J. Age and the balance of emotions. Soc Sci Med 2008; 66(12): 2391–2400.