Practical Psychiatry in Medicine

Part 1. Psychiatry as an Integral Part of Medical Practice

Psychiatry is a specialty whose principles find application in all of the disciplines of clinical medicine. Indeed, psychiatry has such an integral relationship with general medicine that it is accurate to say that the question which confronts the practicing physician is not *whether* he incorporates psychiatry in his clinical work but *how deliberately* and *how well* he does so.

Over 35 years ago, a distinguished internist, Louis Hamman, expressed his concept of psychiatry and of how it relates to medicine in these words:

> The physician studies and practices psychiatry continuously, even when he protests that he has not the least knowledge of formal psychiatry. It is the chief instrument of his success, even though he may practice it unconsciously. Psychiatry is a discipline whose purpose it is to study and understand the function and influence of mental processes and emotional states in health and disease. These dominate our life and influence every other function of the body, as in turn they are influenced by every other function.[1]

These assertions are more than exhortations to the clinician to be mindful "that his patient is a person." Hamman's comments remind us, rather, that an appropriate application of the principles of psychiatry to the practice of medicine extends the diagnostic and therapeutic skills of the practicing physician.

In this chapter we will describe in broad terms some of the major areas in which psychiatry is of particular relevance to medical practice.

Psychologic Reactions to Illness

It is a general principle in medicine that many of the signs and symptoms of disease are manifestations of physiologic responses which represent attempts to cope with noxious agents or with alterations in the organism which may themselves be consequences of adaptive processes. The tachypnea, leukocytosis, and fever of pneumonia, the ventricular hypertrophy of long-standing hypertension, and the general malaise and weakness which lead to energy-conserving rest are commonplace examples of physiologic coping responses that comprise an important part of many clinical syndromes. Equally important, though often receiving only token recognition, are the psychologic adaptations to serious illness and concurrent life stresses; these coping reactions also constitute an important part of the whole clinical picture.

The critical nature of psychologic coping responses to physical illness is apparent when one reflects upon (1) the importance of the patient's initial registration of discomfort; (2) his ability to make a judgment that help is needed; (3) his efforts to reduce in-

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The following chapters have been selected by the Publisher from its forthcoming book, *Practical Psychiatry in Medicine*, by John B. Imboden, MD and John Chapman Urbaitis, MD, in the hope that they will have immediate usefulness to our readers.

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tolerable uncertainty by developing his own theories about what is wrong with himself; (4) his feelings about those persons to whom he has entrusted his care; (5) his reaction to the separations, losses, and other hardships occasioned by illness and treatment; (6) his reaction to the extreme passivity and dependence which may be an unavoidable part of the illness experience; and (7) his ability, during convalescence, to relinquish the sick role and to resume his customary functions at home and work.

In the following example, the patient had no difficulty with the first step, the registration of discomfort, but found himself temporarily in a quandary about the second step, that of judging the significance of his symptoms and of his need for medical attention.

The patient was a 26-year-old intern in a large teaching hospital. During his third month on the surgical service he noted the onset of persistent, severe fatigue which was present upon arising in the morning and became worse as the day went on. Within a day or two following the onset of the fatigue, he developed a more or less constant, generalized, moderately severe headache. The young physician attributed these symptoms to his arduous work schedule, sleep deficit, and the frequently stressful atmosphere in which he worked. Noting that his follow interns also were "always tired" and that he himself had long tended to have tension headaches, he tried to disregard his symptoms. After two or three days of private misery the patient developed a cough productive of a small amount of rusty sputum. He noted the latter symptom with a feeling of relief for until then he had interpreted his symptoms as "just neurotic," ie, as meaning that he was not able to bear up under the work load as well as his colleagues. Armed with an acceptable (to him) somatic symptom, the patient sought medical attention and was all but delighted when informed that the x-ray supported the diagnosis of viral pneumonia and that bed rest was prescribed. The patient convalesced rapidly from what was a relatively mild illness and returned to work after a few days with both his lungs and his self-esteem fully restored.

It is not rare for patients to develop feelings and fantasies which interfere with the decision to seek medical help or to comply with the therapeutic regimen, or which result in other behavioral responses that seriously complicate the illness course and convalescence. On occasion, the patient's emotions and behavior arising from psychologic coping processes may even dominate the clinical situation and require just as careful diagnostic evaluation and management as do other aspects of the illness.

Incidence of Primary Emotional Disorders in General Medical Practice

Family physicians probably see far more patients with primarily psychiatric disorders than do psychiatrists. In 1939 Hamman reported the results of his review of 500 consecutive patients who consulted him. Two hundred and seventy-two were males, 228 females, and 68 percent were in the age span from 30 to 60 years. He found that 33 percent of these patients "suffered solely or predominantly from functional disorders." By the latter, the author makes it clear that he is referring to conditions in which no "organic cause" at all was found or in which there were "minor organic lesions" which could not possibly explain the symptoms.[1]

Estimates of the incidence of psychologic difficulties as the primary basis of complaints in various medical outpatient clinics have varied considerably, depending in part upon the strictness of definition. In a review of the records of 1000 consecutive referrals to a diagnostic clinic, Kaufman and Bernstein found that in 69 percent of the patients, there was no evidence of organic disease and in 81.4 percent psychologic factors were at the basis of their complaints.[2] Lipowski, in reviewing various reports on the frequency of psychiatric morbidity in nonpsychiatric divisions of general hospitals, concluded that there is evidence that from 30 to 60 percent of inpatients and from 50 to 80 percent of outpatients suffer from a significant degree of "psychic distress or psychiatric illness."[3]

These are very sobering figures even if one accepts only the lower end of the range of estimates as valid. One cannot conclude from these data that every practicing physician must have the capability of engaging his patients in intensive psychotherapy, but one can conclude that the development of diagnostic acumen and management skill in relation to emotional disorders is at least as important as it is in relation to other kinds of illness. The primary physician has the task of identifying an existing psychiatric disorder and of determining whether he himself will undertake management or refer the patient to a psychiatrist.

Influence of Psychologic Factors on Physiologic Processes

The emotional state of the human being may influence bodily function in health and disease in a number of ways. Perhaps the most obvious of these is that attitudes and emotions may lead to behavior which has a direct impact, favorable or unfavorable, upon the individual's physical well-being, eg, seeking or avoiding needed help, complying or not complying with the therapeutic regimen, exercising moderation or being excessive in eating and drinking, and attempting to salvage one's life versus attempting to end it.

Further, emotional arousal itself is a physiologic process involving central neural pathways which influence peripheral processes and are influenced by

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them. The most classic example of this is the peripheral effects of sympathetic-adrenal discharge that accompanies fear or severe anxiety. There are a number of functional disorders in which somatic symptoms are the immediate consequence of physiologic changes accompanying emotional states, some but not all of which are mediated by the autonomic nervous system.

An intriguing and controversial series of investigations has led to the development of the theory that, in ways not yet understood, psychic stress may contribute importantly to the etiology of certain diseases in which there is structural change or tissue damage, ie, the psychosomatic diseases. Historically prominent among these disorders are duodenal ulcer and ulcerative colitis. Methodologic difficulties in proving the role of psychologic factors in the causation and alleviation of these and other diseases postulated to be psychosomatic are enormous and have led to hotly debated, conflicting points of view. It is obviously important for the practicing physician to be aware of psychosomatic concepts regarding disease etiology and to form his own judgment about the utilization of these concepts in planning treatment and management.

Application of Psychiatric Principles in Treatment and Management

The psychiatric aspects of treatment and management of medical patients in whom emotional or behavioral problems constitute a significant component of the clinical picture are manifold. Here we will only briefly mention the potential therapeutic power of the physician-patient relationship and the significance to general medicine of recent advances in psychopharmacology.

Physician-Patient Relationship

It behooves the physician to be aware that he himself, apart from any drugs or procedures which he may administer, is potentially a therapeutic agent, an agent that is not without the possibility of adverse side effects. In fact, the physician to whom the seriously ill or worried patient comes for help is in a unique position to form a remarkably influential relationship with the patient. For example, experienced clinicians have repeatedly observed that frequently the patient seems convinced that his physician is extraordinarily kind, compassionate, understanding, and competent even though he may have had scarcely more than an hour or two in the physician's company! This interesting phenomenon, which in a general sense may be called "transference," merits our thoughtful consideration. Other manifestations of transference, some of not so positive a quality, are also seen. In any event, there are occasions when the physician may utilize his relationship with the patient quite deliberately in order to attain specific objectives or to help the patient to do so. In doing this it is helpful to have some understanding of the principles of human behavior and of their application in forging diagnostic and therapeutic approaches to specific emotional or behavioral components of the clinical problem.

Chemotherapy

The last 25 years have witnessed a remarkable proliferation of chemotherapeutic agents for the treatment of a wide variety of psychiatric disorders. There has also been a heartening tendency to assess the effectiveness of these agents through carefully designed, controlled clinical trials. The proper use of psychotherapeutic drugs requires an accurate grasp of the conditions for which they are indicated and, as with any class of potent agents, the physician must be well grounded in their basic pharmacologic properties.

In addition to its present clinical applications, psychopharmacology has stimulated intensive research into basic aspects of neurochemistry and neurophysiology which may eventually shed light not only upon the mechanism of action of drugs but also upon the pathogenesis of certain psychiatric disorders.

With the foregoing considerations in mind, the remainder of this book will deal with the basic features of human behavior and personality development, the psychiatric evaluation of the patient, psychologic reactions to physical illness and treatment, psychophysiologic disorders, some common emotional or behavioral problems encountered in medical practice, the major psychiatric disorders, and, finally, psychologic and psychopharmacologic aspects of treatment and management.

References

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