Practical Psychiatry in Medicine

Part 3. Perception and Meanings of Physical Illness

In the preceding chapter, we discussed some of the ways in which people respond to the stresses of life in general. This chapter deals with psychologic responses to a particular group of stresses in which the physician has a special interest, namely, those associated with physical illness.

Perception of Initial Symptoms

Usually an individual whose illness begins by producing serious discomfort, functional impairment, or an observable change in his body perceives these changes promptly and begins to weigh their significance, preparatory to doing something about them. However, this is not always the case, especially when the disease process affects higher cerebral function. Some patients with organic brain syndromes seem not to have observed their deteriorating memory, impaired concentration, tendency to get confused, and other signs of declining cognitive functions. It is particularly common for such a patient to be quite unaware of affective blunting and of changes in his customary way of behaving. In the following clinical anecdote, the patient's unawareness of grave functional impairment posed potential hazards for himself and others.

A 60-year-old practicing physician was seen in psychiatric consultation at the requests of his internist and his family. He vaguely complained of "occasional" trouble in finding the word he wanted to say and in understanding other people. In spite of this complaint he nonetheless stated that he had "very little" difficulty in communicating with people and he denied any other serious problem in functioning. On examination, however, the patient exhibited extreme difficulty in expressing himself, being frequently unable to find the right word and tending to misuse words. He was grossly disoriented in time, memory for recent events was very poor, and he became confused when attempting to subtract 7 from 100 serially. The patient was not only unaware of his obviously grave impairment of intellectual functions but also of his striking tendency in recent months to be distant and unresponsive to others, including his immediate family.

It is noteworthy that, in addition to apparent failure to observe the intellectual, affective, and behavioral changes attributable to cerebral damage, the patient with organic brain syndrome may be relatively insensitive to body sensations. For example, moderately obtunded persons are sometimes unaware of the sensation of thirst and thus may tend to become dehydrated unless fluid intake is monitored.

Slowly progressive disease affecting organs of perception may also go unnoticed until the functional deficit is relatively severe: the patient with gradually advancing deafness may go through a period of being annoyed with others for mumbling while remaining unaware of his own difficulty in hearing; bitemporal hemianopsia and other alterations in the visual field including unilateral blindness may go unobserved by the patient for some time and may first come to his attention through the observations of others or when the patient is given a medical examination.

It is possible that the occasional failure of brain-damaged patients to report symptoms of their illness results not from lack of perception of these symptoms but from unconscious denial of them. If that is the case, the denial of illness is a defense against anxiety generated by the perception of symptoms. This sequence of perception-anxiety-denial is also seen in a variety of disorders not involving cerebral impairment. Denial of illness, conscious or unconscious, is always related to what the illness means to the patient.

Meanings of Illness

To understand fully the meanings of illness for any individual patient is a potentially complicated undertaking, for it would entail knowledge of a number of interacting factors: the nature of the illness, the patient's past experience with illnesses in himself and others, the life-setting in which the illness occurs, and the patient's personality which is in part the product of the sum of all his past experiences. In spite of this complexity it is feasible to gain an approximate notion of the patient's feelings and ideas about his illness by listening to his spontaneous comments, his response to questions, and by observing his behavior.[5]

In some respects, the patient's approach to his illness is not unlike that of the physician, differing from the latter's primarily by virtue of the patient's lack of technical knowledge and by the relatively greater influence of his emotional reaction to what is happening to him. The patient's first response to the initial symptom of illness is to decide whether the symptom is important (deserves further consideration) or trivial (can be dismissed).

The hypochondriac patient, being exquisitely attuned to even minor variations in physical feelings and invariably inclined to place ominous interpretations on them, errs in the direction of considering every symptom important. Through his consistent overreaction to minor complaints, he runs the risk of lulling his family and the physician into being insensitive to symptoms which are indicative of organic disease. Less common is the patient who inappropriately interprets physical symptoms as "just psychologic" as was exemplified by the intern described in the first chapter. Often, the patient's apparent dis-

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missal of initial symptoms as insignificant masks an underlying anxiety about them.

Having made the decision that their symptoms are not trivial, most patients (perhaps all) engage in some sort of speculation about the diagnosis and prognosis although usually the patient does not choose to reveal his speculations to the physician. When asked to do so, he may give the famous reply: "You're the doctor – you tell me!" This response often stems in part from a fear of looking foolish if he reveals his own tentative "diagnosis" and in part from deeper anxiety about his condition. This kind of resistance can be lessened by assuring the patient that the physician respects his views and wants to be sure that the patient's questions and concerns are dealt with as the examination proceeds.

If the patient has interpreted his initial symptoms as being indicative of some disease of which he is frightened or about which he feels hopeless, or otherwise severely threatened, he may temporarily deny their significance or even their existence. This reaction was shown by the patient described in the preceding chapter who tried to ignore the nodule in her breast and did not seek medical attention until her husband insisted upon it. The ways in which an illness can be perceived as threatening to the patient are numerous; for descriptive purposes it is convenient to place them in three categories: physical, psychologic, and socioeconomic. In real life these three categories are closely interrelated and in all of them illness can be perceived as threatening the patient with loss of one kind or another.

Physical Implications of Illness

The patient's interpretation of the physical meaning of his symptoms is basically determined in the same way in which he interprets any other event in his life: presently perceived data are interpreted in the light of related past experiences and this interpretation is influenced by conscious and unconscious fantasies and emotions. For example, the patient with severe headache is especially apt to think of brain tumor if he had a relative who died of a brain tumor; this will be a particularly frightening thought if the patient had a guilt-ridden, ambivalent relationship with the deceased relative.

Undoubtedly, the most basic fear associated with any serious illness, especially one which requires hospitalization and/or surgery under general anesthesia, is that of death. Also common are fears of other kinds of loss: loss of a limb or other body part, loss of an important function, loss of body image through disfigurement, and loss of a sense of well-being.[1,3] The patient's apprehensions may or may not be realistic: for example, the person facing transurethral prostatectomy may incorrectly assume that the operation will inevitably render him sexually impotent unless this is specifically discussed with him.

Psychologic Meanings[4,6]

Any serious illness can be perceived by the patient as threatening him with an undesirable or even unbearable change in his image of himself as a person, ie, his self-image. For example, the alteration of the physical image of the self (body image) following myocardial infarction is often followed by feelings of apprehension and sadness which are eventually overcome as the patient learns to live within the limitations imposed by his illness; that is, the alteration in body image occasioned by the illness leads to changes in self-image to which the patient must adapt. For some patients the threat of physical illness to feelings of self-worth is extreme. This is, of course, apt to be the case if the illness (or its treatment) is perceived by the patient as gravely interfering with patterns of behavior essential to the maintenance of self-esteem or to the avoidance of anxiety. Thus the individual who cannot stand the thought of being passive, dependent, and nonproductive and who therefore has always been very active, competitive, independent, and successful, may conceive of an illness such as myocardial infarction as being nothing short of catastrophic. This is illustrated by the following case report.[2]

Mr. A. was a 45-year-old married man and father of several children. Until the onset of the present illness, he has been in good physical health. His illness began with an episode of chest pain accompanied by weakness, restlessness, and sweating. Upon the urging of his associates, he reluctantly consulted the family physician. Following the examination the physician informed him that he was having a "heart attack," and advised him to enter the hospital and that complete bed rest for a period of time would be necessary. The patient rejected the diagnosis, stated that the chest pain was already much better, and refused any further examination or treatment. The next day, at work, the pain returned and the patient called his physician again. The latter, upon repeating his advice to the patient and again encountering sharp resistance, suggested that a consultant be called. When the consulting internist confirmed the diagnosis of myocardial infarction, the patient angrily denounced him too as incompetent and again returned to work. He got along fairly well for three or four days until he experienced another attack of severe chest pain, went into shock, and was taken by ambulance to the nearest hospital.

At the hospital, the patient continued to deny that there was anything wrong with his heart. When another cardiologist unequivocally confirmed the previous diagnosis, the patient intellectually accepted it and agreed to remain in the hospital. However, he ignored the modified coronary regimen that was carefully explained to him, got up at will from his bed, puttered around his room at various small tasks, and via the telephone, kept in close touch with the small factory of which he was president. In brief, although he now verbally accepted the fact of his illness, his nonverbal behavior reflected continuing denial of it as well as stubborn defiance of the medical team.

The patient talked surprisingly freely to the psychiatric consultant. From early in life, he had striven to be the best at everything he had undertaken. For him, sports and games had never been opportunities for relaxation and fun ; rather, they represented competitive challenges and his participation in them was loaded with tension. He had approached his business in the same way and, for many years, it had been a consuming grind. He had little ability to delegate responsibility to others and had attempted to run the factory singlehandedly. He was determined to be extremely successful with no help from anyone.

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One could speculate about the "underlying problems" reflected in this man's character structure and overt behavior. It is reasonable to hypothesize that he had a great deal of anxiety about persisting infantile, passive-dependent longings. One might wonder if he had an unconscious image of himself as being small and weak, like a child posing as an adult. In any event, it was apparent that he had never truly resolved his inner problems, but had dealt with them through a combination of repression, denial, and reaction formations. The latter were crucial in warding off intense anxiety and feelings of helplessness and worthlessness, ie, he had to be constantly active, self-assertive, and extremely independent, striving for and achieving success whether in business or on the golf course. Therefore, when he was afflicted with an illness that threatened to deprive him of crucial character defenses, he responsed by massive resistance.

About two weeks after admission the patient developed unremitting chest pain, made worse by physical activity. He appeared ashen and weak. At this time he no longer actively opposed the therapeutic regimen and remained at bed rest. With acceptance of the inescapable fact that he was gravely ill, he became despondent and stated that he could not accept the possibility of partial recovery. He made it clear that if he could not get "completely well" and return to his life-long pattern of hyperactivity, unfettered by a heart condition, then he hoped that he would die. A few days later he did.

In the above patient the intense conflict between the illness (or, more accurately, the patient's conception of the illness) and crucial character defenses evoked the following sequence: stubborn denial, defiant behavior, worsening of the illness, breakdown of denial, submission to the illness, followed by despondency and a wish to die. We may note that this patient exhibited, in extreme form, personality features that have been described as frequently present in coronary-prone individuals. Conflict between illness or treatment and psychologically important defenses is not uncommonly seen in one form or another.

Even in the absence of severe conflict, patients may grieve because of actual losses necessitated by illness such as separation from family and friends, relinquishment of cherished plans or goals, loss of a favorite activity or type of recreation, loss of ability to sire or bear children, and so on.

The patient may consciously interpret illness as a punishment for past sins or there may be more vague feelings of guilt, stemming from largely unconscious sources. In either event, the patient may derive a certain amount of satisfaction if he feels that his suffering has expiated him from guilt. Often, however, the guilt-ridden patient who sees his illness as punishment fears that the fates have even more suffering in store for him. Such a person may have a prior history of constantly fearing that something bad is going to happen to him and reacts to physical illness as if the long-dreaded doomsday had arrived.

Not everyone, of course, sees illness as pure adversity. Mention has already been made of the guilt-ridden person whose illness is expiatory. Illness can also be welcomed if it enables an individual to escape from a difficult life situation or if it offers him a "respectable" way of satisfying his needs to rest and be cared for. The longer an illness lasts the more it is apt to become incorporated in the patient's defenses and psychologic needs. The person who welcomes illness and finds it gratifying has no difficulty in shifting into the "sick role" but is apt to have trouble in giving it up during convalescence.

Socioeconomic Meanings

The possible social and economic effects of incapacitating illness are innumerable and, in some instances, may confront the patient with distressingly conflictful choices. The mother of small children, for example, may feel apprehensive and guilty about leaving them to enter the hospital, especially if her husband cannot afford to take time off from work to be with them or if he seems indifferent. Tactful inquiry into the patient's life situation and the consequences of illness and treatment, especially hospitalization, should always be made. The medical social worker can be helpful in assessing the social and economic impact of the illness and in assisting the physician to manage this aspect of the patient's care. The well-trained social worker is aware of resources in the community, such as the availability and costs of homemaking services, with which many physicians are relatively unfamiliar.

Direct discussion with key members of the family is essential in the discernment and management of practical problems raised by the patient's illness. The fact that the physician shows an interest in the patient's life situation, especially in relation to the complications introduced by illness, while at the same time being respectful of the patient's and family's sensitivity and need for privacy, is in itself reassuring to the patient. Many patients hesitate to tell their physician of their worries concerning the family or work because they feel the physician may regard this as not part of his job.

Occasionally, of course, illness is seen by the patient as an economic opportunity, leading to the procurement of disability income or litigation for damages, real or imagined, which are thought to have produced the illness. In the latter instance, if it is likely that a substantial part of the patient's illness or disability has a nonorganic basis, a lump-sum settlement for damages would seem preferable to periodic payments that are contingent upon continuing disability.

The patient's perception of symptoms and the meanings of illness are important determinants of his attitudes toward the therapeutic regimen and of his feelings and behavior if hospitalization is required. These aspects of illness behavior are discussed in the following two chapters.

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