Understanding psychological reactions to physical illness

Geoffrey Lloyd

People react to illness in a manner that reflects a complex and evolving interaction of several factors. These include their premorbid personality, previous experience of ill health, interpersonal relationships, perceived threat of the illness, the physical treatment required and their interaction with medical and nursing staff to whom they turn for treatment. Most illnesses, except the very trivial, require a period of adjustment and a reappraisal of lifestyle, ability to work and engagement in leisure activities.

Coping strategies

The great majority of people cope constructively with illness in the sense that they seek medical advice appropriately and co-operate with treatment in a manner which maximizes their chances of recovery. If an illness is chronic and associated with permanent disability, lifestyle changes are made which enable a realistic adjustment to take place. Coping is a dynamic process. Most people have a range of coping strategies which they can use flexibly, according to the particular problems that their illness creates at the time. Some cope by involving themselves closely with the treatment plan, seeking out information about their illness not only from their doctor but also from medical textbooks and websites. They may become involved in medical charities devoted to their illness and in the case of rare conditions some become so well informed that they know more about the illness than their doctor.

In sharp contrast to this strategy some people cope by distancing themselves from the emotional implications of their illness. They develop other interests and attempt to minimize any disability, ignoring, rejecting or making light of any

Factors which influence psychological response

Personal factors

Individual characteristics play an important role in shaping the response to illness. They influence how an illness is perceived and how the patient copes with the adversity. An assessment of a patient’s usual defence mechanisms and coping style is therefore essential if the psychological response is to be understood. It is also important to know whether there has been a history of serious illness in childhood or affecting close family members and, if so, how the individual coped with this.

People who are habitually anxious tend to worry more about their health and some of these people develop symptoms of anxiety to such a degree that the psychological response becomes a problem in its own right. The anxiety is focused on their health and on bodily sensations which are often interpreted in a morbid manner. A hypochondriacal pattern is established and this leads to excessive invalidism. Obsessional people react similarly. They have a desire to find out as much information about their illness as possible and become preoccupied with new and existing symptoms. The easy availability of medical information on the Internet will inevitably result in more people becoming better
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informed about their illnesses and doctors need to be prepared to enter into a more detailed discussion of symptoms, differential diagnosis and treatment options than was previously required of them. The concept of 'the expert patient' has evolved in recent years, particularly with regard to those coping with a long-term illness. Acquiring expertise gives people a greater sense of control over their illness and enables them to communicate more effectively with professionals. The combination of personal experience of an illness together with detailed information can also provide an invaluable source of advice and support to other patients.

People who deny or minimize the significance of their illness often have a life-long tendency to play down the importance of any adversity. This can be an adaptive mechanism in that it protects against anxiety and depression. However if carried to extreme lengths it prevents people seeking appropriate medical care or, if they have sought care, it often results in advice on treatment and lifestyle changes being ignored. This can have a major negative influence on prognosis.

People with paranoid traits are likely to blame their illness on others. The targets include close relatives, employers, doctors and other healthcare professionals. It is from this group of patients that complaints and litigation are most likely to arise. Not surprisingly doctors find it difficult to deal with. Consistency and openness of communication are vitally important to avoid breakdown of therapeutic relationships. In a few people of paranoid disposition an acute paranoid reaction develops following admission to hospital. Others develop a chronic delusional system which involves the belief that a particular doctor has permanently harmed them, deliberately or otherwise, as a result of a medical procedure. This is classified as delusional disorder (F22.0) by the International Classification of Disease.

The effects of ageing should also be considered. There is no clear distinction between elderly and younger adults with regard to their coping strategies. Ageing is a gradual process and any age criterion used to distinguish older and younger adults is essentially an arbitrary one, often based on the age at which people are entitled to receive state pensions. Nevertheless older people are more likely to develop multiple physical pathology; they are more vulnerable to bereavement, sensory loss due to hearing and visual impairment, financial hardship and loss of independence. They also have to cope with the decline in cognitive function which is characteristic of the ageing process. Comorbid physical and psychiatric disorders are therefore common in the elderly who are comprising an increasing proportion of patients in general hospitals. There is evidence that their psychiatric needs have been under-recognized, perhaps because of therapeutic nihilism and a failure to distinguish symptoms of psychiatric disorders from those of normal ageing. Comparative studies have shown that, when referred to a psychiatric service, elderly patients are more likely than younger patients to receive a diagnosis of cognitive impairment and less likely to be diagnosed as having a personality disorder (Unutzer et al. 2002). The number of elderly patients admitted to general hospitals is going to increase rapidly. It is important that their psychological needs are recognized and met. There should be easy pathways of referral to a liaison psychiatry service. This might be facilitated if there is a specific liaison psychiatry service for the elderly.

Understanding psychological reactions to physical illness

Nature of the illness

Potentially fatal and rapidly progressive disease might be expected to result in more severe psychological reactions but the evidence indicates that there is surprisingly little correlation between psychiatric morbidity and disease severity when this has been measured in a standardized manner. Some of the older studies suggested that certain categories of illness are more likely to be followed by distressing psychological symptoms. Cavanaugh (1983) found that highest scores for psychological symptoms were obtained by patients with cancer and autoimmune disorders together with diseases of the renal, haematological, genitourinary and gastrointestinal systems. Feldman et al. (1987) found that the highest rates of affective disorder were associated with haematological malignancy, ischaemic heart disease and chest disease. Malignant disease is still stigmatized by the general public, as are conditions such as tuberculosis, sexually transmitted disease and acquired immunodeficiency syndrome (AIDS).

The nature of the illness is perhaps best understood by considering its subjective significance, that is, the patient’s perception of the condition. Lipowski (1969) was one of the first to emphasize the subjective importance of the part of the body affected by illness in determining the emotional response. The more highly valued the bodily part, the more intense will be the psychological reaction.

It can be very difficult for patients to adjust to terminal illness. Medical practice in this area has changed considerably during the last two or three decades in recognition of the fact that most patients wish to be informed that they have a terminal condition. Communication between professional staff and their patients has become more open. Terminally ill patients wish to know if death is coming and they need to be supported during the terminal phase. Emotional suffering can be reduced if patients are afforded dignity and privacy and if they are enabled to retain control over as many aspects of their lives as possible. These include choosing the location of treatment, having adequate control over pain and other symptoms and being able to make advance directives which ensure their wishes are respected. Terminally ill patients should have access to emotional and spiritual support and to hospice care if requested.
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Treatment environment

The hospital environment is stressful for most patients. Its unfamiliarity and the presence of complex technology are frightening and bewildering. When inpatient treatment is necessary the patient has to cope with loss of privacy and independence as well as loss of usual sources of comfort such as cigarettes and alcohol. The most distressing areas of a hospital are those which involve complex machinery as found in intensive care and coronary care units. An environment of this type can easily be seen as threatening and some patients develop paranoid ideas about the unit and the staff treating them.

Isolation is another potent source of stress. Patients undergoing bone marrow transplantation and those infected with methicillin resistant *Staphylococcus aureus* (MRSA) may have to spend several weeks in an isolated room, with all staff and visitors having to wear protective clothing and facial masks. Tarzi *et al.* (2001) have shown that, among older adults, isolation for MRSA has a negative effect on mood in addition to that resulting from hospitalization.

Special procedures

Investigations such as colonoscopy, cardiac catheterization and imaging are potentially stressful and can lead to anxiety not only because they are intrinsically unpleasant but because their findings have crucial diagnostic implications which will determine the need for further treatment. Similar considerations apply to blood tests, for example for: HIV infection, and tissue biopsies for suspected cancer, which the patient knows might convey bad news. Patients need to be specially prepared and counselled before investigations of this nature are undertaken and the significance of the results should be discussed with them as soon as possible.

Similarly, genetic screening can be stressful, particularly during the interval between the test being carried out and the result being available. Pretest screening and support following disclosure of the result do much to alleviate anxiety. Michie *et al.* (2001) observed that adults receiving a positive result following genetic testing for familial polyposis coli were more likely to become anxious if they were low on optimism or self-esteem and suggested that counselling should be targeted at those with poor psychological resources.

Drug treatment

Many drugs used in medical practice are known to have significant neuropsychiatric side-effects and therefore affect the patient’s psychological response to becoming ill. The relationship between a drug and an adverse reaction can be established with varying degrees of confidence as recommended by Karch and Lasagna (1975). See Table 4.1.

### Understanding psychological reactions to physical illness

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Depression, mania, anxiety, agitation, sedation, delirium and isolated psychotic symptoms have all been linked with various drugs. Corticosteroids, adrenergic antagonists, anticonvulsants and antiparkinsonian drugs are well established as potential precipitants of psychiatric symptoms. The antiretroviral drugs are also known to affect mental state. Efavirenz, a non-nucleoside reverse transcriptase inhibitor, is particularly associated with the onset of depression and with suicidal thoughts which may be disproportionately intense in relation to the severity of other symptoms of depression. (See Turjanski and Lloyd 2005 for a review of this topic.)

Other physical factors

Metabolic changes accentuate the emotional response to illness. Hypoxia, dehydration, electrolyte imbalance, endocrine changes and infections can all produce affective symptoms in their own right and make it more difficult for patients to adjust effectively.
Treatment environment

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Other physical factors

Metabolic changes accentuate the emotional response to illness. Hypoxia, dehydration, electrolyte imbalance, endocrine changes and infections can all produce affective symptoms in their own right and make it more difficult for patients to adjust effectively.
Communication

Effective communication is an essential element of good clinical practice. Conversely, poor communication is a source of frustration for patients, leading to uncertainty, resentment, anxiety and depression. It increases the likelihood of a psychiatric disorder and is often the reason why patients make a written complaint or take legal action for compensation regarding their medical care. All healthcare professionals who interact with patients need to have communication skills commensurate with their clinical role, whether this be in a hospital, primary care or the community.

Dissatisfaction with communication relates to three separate areas:

• insufficient information
• lack of interest
• lack of involvement in decision making.

Most patients want more information about their illness than they are given. However there is much individual variation on this matter and doctors need to explore how much a particular patient wishes to know about the illness and its treatment. This takes time. Many consultations are hurried and conducted in situations which lack privacy, so patients often feel they have not had the opportunity to ask questions. Likewise doctors do not have time to evaluate the patient’s level of understanding and need for information.

However, it is important to avoid information overload. If too much information is provided at once the patient is likely to feel perplexed, particularly if the information is expressed in technical terms or in medical jargon. Studies of clinical consultations have shown that no more than half the information provided is recalled subsequently. Even less may be recalled if the patient is anxious or depressed at the time of the interview. It is best to give information early during a consultation and to repeat this at the end. Written material, in the form of specially prepared leaflets, is a valuable aid which facilitates recall once the consultation has finished. In the UK the Department of Health has advised that patients should, as a matter of right, be sent copies of all correspondence between doctors concerning their illness. This is another useful source of information, one which has generally been well received by patients.

The essentials of good communication have been summarized as follows (Royal College of Physicians and Royal College of Psychiatrists 2003):

• expressing interest in the patient
• eliciting the patient’s beliefs and concerns
• acknowledging and responding to the patient’s distress
• avoiding jargon and overly complex information
• establishing a collaborative and empowering approach
• maintaining privacy and confidentiality.
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Special issues arise when treating patients from a different cultural background. This is a common occurrence in a multicultural society and all clinicians need to have an understanding of the patient's beliefs about illness, medical and other treatments and the healthcare system. This can be achieved by asking patients to explain their understanding of how their symptoms developed, what has caused them and what treatment they think is appropriate. It is also important to be aware how cultural background influences the way people express emotional distress, often using somatic complaints rather than the psychological complaints expressed by people from Western cultures. If the patient's language ability does not permit adequate description of complaints an interpreter should be engaged to facilitate communication. It is preferable to involve a professional interpreter rather than a close relative.

Communication problems also arise with patients who have disabilities such as visual or hearing impairment, dysarthria, dysphasia or global cognitive difficulties, either congenital or acquired. Special provision needs to be made to help overcome these problems (Royal College of Physicians and Royal College of Psychiatrists 2003).

Involving patients in decisions concerning their illness is an element of practice which has only recently been given importance in medical training. Patients vary in the degree to which they wish to be involved in decision making. Some wish the doctor to take a paternalistic approach and prefer to leave all decisions about management to the professionals. On the other hand a growing number wish to be involved in deciding what investigations are required and what course of treatment should be adopted. It is important that the doctor establishes what the patient's attitudes are on this issue. Those who wish to be involved in decision making need accurate information. Many people now obtain knowledge about medical matters from various sources on the Internet and they may wish to discuss this with their doctor. The doctor needs to establish the patient's current level of understanding about the illness. Misunderstandings need to be corrected and gaps in knowledge filled in.

Stress and previous psychiatric illness

Stressful life events are known to increase the risk of developing a depressive illness. Adverse events affecting a person shortly before or after the onset of illness therefore make it more likely that a depressive illness will develop. Patients are also more likely to become depressed if they have had a previous psychiatric illness (Dickens et al. 2004; Feldman et al. 1987). Those who have been psychiatrically ill are also more likely to become physically ill. Harris and Barraclough (1998) have reviewed mortality studies of a wide range of psychiatric disorders. In the case of affective disorders they found that the mortality was increased from infections and
from nervous, circulatory and respiratory disorders. It is not clear what the causal
links might be but it is apparent that those who develop an affective disorder are
more prone to become physically ill. Their affective illness is likely to recur or to be
exacerbated following the onset of physical illness.

**Psychiatric disorders following physical illness**

**Adjustment disorder**

This is probably the most common emotional reaction to illness that satisfies the
criteria for a psychiatric diagnosis. The symptoms involve a disturbance of mood,
either depression or anxiety or a mixture of both. In severity they form a
continuum, with no clear cut-off between a normal and a pathological reaction.
Psychological symptoms should be regarded as pathological when they themselves
are a source of distress or when they interfere with adjustment to the illness and the
requirements of treatment.

By definition the symptoms of an adjustment disorder are transient, usually
resolving within a few weeks, but they can be very distressing to the patient while
they last. After the development of an acute physical illness the symptoms of an
adjustment disorder become apparent within a few days and tend to remit with
physical recovery or when the patient comes to terms with the implications of the
illness and the limitations it involves. It is often difficult for the clinician to decide
whether the symptoms of anxiety and depression represent an adjustment
disorder, which can be expected to be self-limiting, or a more prolonged
specific mood disorder. There is no clear distinction between the diagnostic
categories. They merge imperceptibly with one another and adjustment disorders
are often regarded as partial syndromes of a mood disorder. The passage of time
usually clarifies the picture and indicates whether specific treatment is required.
Anxiety tends to be the early response to illness, developing within a few days of
the onset, while depression tends to be a later and more persistent reaction. The
content of the psychological symptoms is characteristically centred on the
implications of the illness and on the treatment that will be needed. Similar
patterns of adjustment disorder are seen in a wide variety of illnesses and have been
particularly described in relation to myocardial infarction, cancer and AIDS.

**Anxiety disorders**

Anxiety takes a number of different forms which have led to various diagnostic
categories:

- generalized anxiety disorder
- panic disorder
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- phobic anxiety disorder
- post-traumatic stress disorder.

All can be seen in patients following physical illness. Anxiety is a normal response to threat and uncertainty. In the context of new and unfamiliar medical symptoms anxiety can have a constructive function in that it motivates people to seek advice and commence whatever course of treatment is considered necessary. Excessive anxiety is distressing and counterproductive and can result in dysfunctional behaviour. Generalized anxiety is pervasive. It is not linked to specific objects or situations. In many cases it represents an exacerbation of a previous anxiety trait, amplified by the onset of illness.

Panic disorder, which is characterized by sudden episodic bouts of anxiety with very prominent somatic symptoms, gives rise to diagnostic difficulties when it accompanies physical illness. Episodes of panic may develop after a myocardial infarction if the patient is excessively worried about a recurrent heart attack. The somatic symptoms of sweating, palpitations and chest pain may convince the patient that another heart attack is imminent and medical help is sought urgently, often at an accident and emergency centre. Any diagnostic doubt on the part of the doctor serves to convince the patient that there is some serious cardiac pathology and a pattern of recurrent panics and medical presentations is established. Panic attacks may also cause diagnostic uncertainty in patients with neurological disease if the somatic symptoms are centred on the head. Dizziness, tension headaches and a sensation of faintness often lead to fears of a cerebral tumour or other sinister cerebral pathology.

Phobic anxiety disorders develop in response to some medical procedure which for some people may rekindle traumatic memories from childhood. Undergoing venepuncture, having a subcutaneous or intramuscular injection, receiving chemotherapy or being treated with large, modern equipment such as a linear accelerator can all induce a phobic anxiety response which may lead to complete avoidance of the procedure. Patients with insulin dependent diabetes avoid injecting themselves with insulin, thus resulting in poor glycaemic control and the early development of a range of diabetic complications. Patients with cancer may terminate chemotherapy or radiotherapy and worsen their prognosis unless their phobic condition is treated adequately.

Post-traumatic stress disorder (PTSD) is conventionally defined in ICD-10 as a delayed and/or protracted response to a stressful event or situation of an exceptionally threatening or catastrophic nature. The event or situation is likely to cause distress to almost anyone and they include serious accidents, natural or man-made disasters, and assaults. Witnessing a disaster or violent death also predisposes to PTSD. In general hospital practice most cases are seen following assaults or road traffic accidents. Given that the emergence of
symptoms may be delayed for up to six months after the triggering event. Many who develop PTSD do so long after they have been discharged from hospital. Indeed, their physical injuries may have been relatively minor but at the time of the incident victims often perceive that their injuries are going to be fatal. Mayou and his colleagues have conducted several studies of victims of road traffic accidents and have found that 12 months after an accident 32% had at least one of four psychiatric conditions, namely PTSD, phobic travel anxiety, generalized anxiety or depression. There was considerable overlap between these conditions with many accident victims having more than one disorder (Mayou & Bryant 2001). There was a significant reduction in the number of cases of PTSD three years after the accident, although there were some cases of late-onset PTSD.

Post-traumatic stress disorder has also been described as a reaction to medical illness and treatment. It appears to develop when the illness is life-threatening or when the treatment is intensely frightening (Mayou and Smith 1997) and has been most commonly observed in patients treated in intensive care units and those with HIV infection (Tedstone and Tarrier 2003). Childbirth, when traumatic for the mother, can also be followed by PTSD (Ballard et al. 1995). Partial syndromes of PTSD are probably more common than the full-blown syndrome.

**Depressive disorders**

Depressive disorders are common following physical illness. Numerous studies have shown that the prevalence is significantly elevated, probably twice that of the general population.

Depression resulting from the emotional impact of an illness follows an appraisal of the implications that the illness has on relationships, lifestyle, work prospects, long-term disability and mortality. It represents a psychological reaction to the illness and reflects a sense of loss for those activities and ambitions that the illness has precluded, either temporarily or permanently. Depression can also result from the physical effects of the illness on cerebral anatomical pathways or physiological systems. This type of depression is classified as an organic mood disorder, defined by ICD-10 as being caused by a physical disorder which must be demonstrated independently. The mood disorder must follow the presumed organic factor and be judged not to represent an emotional response. Although the mood disorder follows the physical illness it may become manifest before the physical condition is diagnosed. Depression may, therefore, be the presenting symptom of an underlying condition which has yet to become clinically apparent. It is often associated with symptoms of anxiety which in some illnesses, for example hyperthyroidism, dominate the clinical picture. Suspcion of an
Understanding psychological reactions to physical illness

Table 4.2. Causes of organic depressive disorders.

<table>
<thead>
<tr>
<th>Neurological</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke, multiple sclerosis, Parkinson’s disease, head injury, tumours, degenerative disorders.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Endocrine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cushing’s disease, Addison’s disease, hypothyroidism, hyperthyroidism, hypoparathyroidism, hyperparathyroidism.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Collagen diseases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systemic lupus erythematosus, rheumatoid arthritis, polyarteritis nodosa.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Infections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encephalitis, cerebral syphilis, extracerebral infections, e.g. pneumonia or urinary infection.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Malignant disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary or secondary cerebral tumour, non-metastatic effects of distant tumours.</td>
</tr>
</tbody>
</table>

underlying physical condition should be considered particularly in the following circumstances:

- depression presents in middle or old age
- there is no previous history of mood disorder
- there is no family history of mood disorder
- the patient has a stable premorbid personality
- there is no apparent psychosocial precipitant.

Organic depressive disorders can result from many different conditions, the commonest of which are listed in Table 4.2.

Not all episodes of depression represent an emotional reaction to illness or a consequence of organic changes. Depression may also be a precursor of illness. There is strong evidence that depression is an independent risk factor for the development of ischaemic heart disease and cerebrovascular disease (Roose et al. 2001).

Depression in physically ill patients is often undiagnosed because symptoms are not volunteered or are not elicited by professional staff. Even when staff are aware of a patient’s depressed mood the depression may be regarded as an inevitable and understandable consequence of being ill and therefore not amenable to treatment. The biological symptoms of depression cannot be given their usual significance when trying to establish a diagnosis of a depressive illness. Anorexia, weight loss, fatigue, reduced libido and sleep disturbance can all be directly caused by physical pathology so attention has to be focused on the psychological symptoms listed in Table 4.3.

These are similar to the core symptoms identified by Cavanaugh et al. (1983) who found that high and low ratings of depression were distinguished by feelings of failure, loss of interest in people, feeling punished, suicidal ideas, dissatisfaction,
Table 4.3. Key psychological symptoms of depression.

(Symptoms must be persistent and present for at least two weeks)

- Persistent lowering of mood.
- Diminished interest or pleasure in most activities.
- Reduced motivation.
- Guilt, worthlessness or self-blame.
- Hopelessness.
- Suicidal thoughts.

difficulty with decisions and crying. They may have to be elicited by direct questions if there is reason to suspect depression from the patient’s appearance or behaviour.

Physically ill patients who are depressed are likely to be more functionally incapacitated (Pohjarsvaara et al. 2001) and to consume more medical resources, including spending more time in hospital and having more outpatient visits (Koenig & Kuchibhatla 1998). Depression also worsens the outcome of some conditions. Frasure-Smith et al. (1993) have shown that following a myocardial infarction cardiac mortality in the first six months is increased in patients who are depressed. In a subsequent, longer-term study the significance of other emotional factors such as anxiety, anger and social support was also investigated, but only depression predicted mortality when adjustment was made for severity of cardiac disease (Frasure-Smith & Lesperance 2003a).

These observations led to a multicentre trial to establish whether psychological intervention, specifically cognitive behaviour therapy, and antidepressants where appropriate, could reduce cardiac mortality and recurrent myocardial infarction. The results were disappointing. Although there were small improvements in depression and social support in the intervention group there was no effect on mortality or recurrent infarction (ENRICHD Investigators 2003). Frasure-Smith and Lesperance (2003b) have concluded that depression remains an ischaemic heart disease risk factor in search of a treatment.

In view of the high levels of depression accompanying illness it is inevitable that the risk of suicide is increased. A literature review by Harris and Barracough (1994) found that the suicide rate was increased for a wide range of illnesses including HIV/AIDS, malignant diseases, Huntington’s disease, multiple sclerosis, peptic ulcer, renal disease, spinal cord injury and systemic lupus erythematosus. It is likely that depression, either untreated or unresponsive to treatment, is the connecting factor between illness and suicide but in a small number of cases suicide may occur in the absence of depression or any other psychiatric disorder.

Understanding psychological reactions to physical illness

In these cases suicide is considered a rational decision, occurring in the face of terminal illness and unbearable suffering.

In a few countries, notably the Netherlands, Belgium, Switzerland and the American state of Oregon, it is now legal for doctors to provide the means to facilitate suicide if these patients have expressed a consistent and competent wish to die when they are no longer prepared to suffer the untreatable symptoms of terminal illness. If the patient does not have the physical ability to commit suicide doctors may take an active role in ending the patient’s life.

Psychotic reactions

An acute psychotic reaction may develop in some patients following admission to hospital, particularly when the admission involves an intensive care or coronary care unit or some other unfamiliar and frightening environment. The reaction takes the form of an acute delusional system, the delusions often having a paranoid content and involving the nursing and medical staff who the patient believes are deliberately trying to harm or even kill him. There are usually no hallucinations nor any thought disorder. The reaction is sometimes mistaken for an acute delirium but careful mental state examination reveals that there are no features of organic impairment. The patient is alert, correctly orientated and has no memory impairment. Antipsychotic medication alleviates the psychotic symptoms but complete resolution may not occur until the patient can be moved to an environment which is perceived as less threatening. Every effort should therefore be made to transfer the patient from an intensive care unit to a general ward or from a general ward to the home if adequate care can be provided there.

A chronic delusional system can also occur following medical or surgical treatment. These delusions are predominantly paranoid or hypochondriacal in nature and consist of a fixed belief that some damage has been deliberately inflicted by a particular member of the medical or nursing team. This type of disorder is classified as a persistent delusional disorder (F 22.0) by ICD-10.

Sexual dysfunction

Sexual dysfunction is greatly increased in prevalence in medical and surgical patients compared with the rest of the population. It can be caused by:

- the direct effects of the illness
- the psychological effect of the illness
- side-effects of prescribed medication
- a coexisting psychiatric disorder such as depression.

Loss of libido follows most physical illnesses. It is usually transient, resolving in tandem with recovery from the physical condition and most patients are reassured if this explanation is given. They should also be advised of the sexual side-effects.
Table 4.3. Key psychological symptoms of depression.

(Symptoms must be persistent and present for at least two weeks)
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of prescribed medications. Anticholinergic and ganglion-blocking drugs are particularly likely to cause impotence or ejaculatory failure while sedative drugs often lead to a loss of desire. Sexual problems may be increased if antidepressant drugs are used to treat a depressive reaction. The selective serotonin reuptake inhibitors are all associated with sexual problems. They can cause decreased sexual interest, diminished genital sensation, erectile dysfunction and delayed ejaculation and orgasm. Venlafaxine causes similar problems. These side-effects resolve once the medication can be withdrawn and many patients are content to wait until this can be achieved. However for some the sexual side-effects are so problematic that a change of antidepressant needs to be made. Mirtazapine is a useful alternative in that it has no appreciable sexual side-effects.

Sexual dysfunction is likely to be persistent if it follows chronic illness with structural changes in the vascular or neurological systems. Chronic renal failure and diabetes mellitus are often accompanied by microvascular changes and peripheral neuropathy which result in impotence or reduced arousal. Other neurological disorders such as multiple sclerosis, stroke and spinal cord trauma are also accompanied by a high prevalence of sexual difficulties. Prostatic surgery, especially for malignant disease, carries a high risk of permanent impotence.

Advice about overcoming sexual problems and adjusting to permanent disability can be given in the context of an outpatient appointment once the doctor has established a trusting relationship with the patient and partner (Royal College of Physicians and Royal College of Psychiatrists 2003). In addition to counselling the use of sildenafil or a similar drug should be considered for patients with decreased arousal, including impotence, due to chronic disease or to the side-effects of medication. For more complicated problems referral to a special sexual dysfunction clinic should be made if the patient wishes to have expert treatment. This topic is discussed in greater detail in Chapter 10.

**Eating disorders**

The commonest eating disorder encountered in medical practice is overeating but it receives less attention in the medical literature than anorexia or bulimia nervosa. The prevalence of obesity is rising in most Western countries and results from an excessive calorie intake in relation to energy expenditure. This often occurs in response to illnesses that result in reduced mobility. Physical exercise is greatly reduced but food intake remains unchanged or even increases as a way of coping with boredom. Weight gain is therefore inevitable. This greatly adds to the disability of most chronic diseases. Dietary advice, if followed, and an appropriate exercise regime should ensure that eating habits are modified and weight reduced.

There have been several reports that anorexia nervosa and bulimia nervosa can be triggered by the onset of a medical condition. Diabetes mellitus has been particularly implicated in this respect and eating disorders have been described in young, female, insulin-dependent diabetes patients, occurring soon after treatment for diabetes has been established (Steel et al. 1987). It has been proposed that the rapid weight gain which can follow insulin treatment causes a body image disturbance which then leads to a desire to lose weight. However the association has not been firmly established. This may be due to the fact that eating disorders in diabetics have an atypical presentation. Food intake may be relatively normal but weight loss is achieved by omission of insulin. Glycaemic control becomes erratic and complications of diabetes such as retinopathy and peripheral neuropathy may develop at an early age.

The physical changes associated with anorexia are essentially those of starvation and profound weight loss (Fairburn and Harrison 2003). They include dehydration, bradycardia, syncope, electrolyte disturbances, osteoporosis, osteopenia, anaemia and thrombocytopenia. In patients with electrolyte disturbances, particularly hypokalaemia, potentially fatal cardiac arrhythmias may develop. Most of these changes revert to normal with gradual restoration of weight.

**Abnormal illness behaviour**

When people become ill they expect to receive treatment appropriate to their condition and advice about changes in levels of activity, work, diet and personal habits such as smoking and alcohol consumption so that they can maximize their prospects of recovery and reduce the risks of complications. This is one of the main reasons why they consult their doctor. Broadly speaking medical advice is usually followed but some people find it impossible to adjust their lifestyles in keeping with conventional practice. They may ignore medical advice on the one hand or adopt an exaggerated level of disability which is out of keeping with the severity of the objective pathology. Both these patterns are sometimes referred to as abnormal illness behaviour.

Some rebel against the limitations imposed by their illness. Patients with ischaemic heart disease may not follow advice to reduce levels of stress in their lives; they may over-exert themselves physically or they may persist with smoking or overeating, all of which increase the likelihood of recurrent illness. Similar patterns of behaviour can be observed in some patients on haemodialysis for chronic renal failure and in diabetics who cannot come to terms with the demands of dietary control and regular insulin injections. Adjustment is most difficult for those who develop diabetes during adolescence. They resent having to behave differently to their peer group and prefer to follow the trend towards consuming chocolate, sweets and quickly prepared foods with a high calorie content. Glycaemic control is unstable. Episodes of hypoglycaemia and ketoacidosis are relatively common and vascular and neurological complications develop early.
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realized by medical staff the patient usually discharges himself from hospital, angrily protesting the validity of his symptoms. Attempts at psychiatric treatment are usually unrewarding. Munchausen’s syndrome by proxy is seen in paediatric practice. Mothers repeatedly bring their children to medical attention, giving fraudulent histories or fabricating signs of disease in their children. Some of these mothers themselves have a history of fabricating their own symptoms. Further information on this condition should be sought in paediatric textbooks.

Implications for management

Understanding how people cope with becoming ill is a necessary step towards providing better management through improved communication, emotional support, recognition of emerging psychiatric symptoms and treating those who require specific psychological or pharmacological intervention. The treatments available are discussed in Part IV.

REFERENCES


The reverse pattern involves exaggerating the extent of functional disability or prolonging its duration beyond the time when recovery would be expected to have occurred. This has been referred to as illness deception. Halligan et al. (2003) have written a useful review of this topic, pointing out that any physical illness can be exaggerated or faked. Exaggeration of symptoms sometimes occurs when a patient wishes to impress a doctor concerning the validity and severity of his condition. Much of this amplification occurs without full insight on the patient’s part. Illness deception is defined as a conscious voluntary act which is intended to obtain personal advantage by securing the social, financial or legal benefits which society confers on the sick role. This may occur in the complete absence of physical pathology, but it can also be a reaction to illness when the patient is seeking to exaggerate symptoms and signs to obtain disability benefits, sickness absence from work, compensation for personal injury or medical negligence or early retirement on grounds of ill-health. Great care needs to be taken to distinguish those symptoms that can be confidently attributed to a disease process from those which are being consciously exaggerated. This is not an easy task nor is it always possible to determine whether the patient is deliberately or unconsciously exaggerating. In medicolegal cases covert videotaped evidence may be produced to help clarify this dilemma.

The most extreme example of abnormal illness behaviour is seen in patients with factitious disorders in which symptoms and signs of disease are deliberately fabricated. Motivation for this type of behaviour is difficult to establish. It often appears that the only gain the patient achieves is to receive medical attention and to create diagnostic confusion. Dermatitis artefacta is the best recognized of these disorders. Ulcerating skin lesions are produced surreptitiously and fail to heal even after treatment with occlusive dressings because of deliberate excoriation. Other examples include iron deficiency anaemia due to repeated self-induced bleeding, hyperthyroidism resulting from ingestion of thyroxine and hypoglycaemic episodes due to self-administered insulin. Any of these conditions may coexist with, and complicate, genuine physical pathology. This pattern of behaviour is seen most often in young women, many of whom are employed in nursing or other paramedical professions. They have been described as having unresolved dependency needs which are partially met by gaining unwarranted access to the sick role.

Munchausen’s syndrome is a variant form of factitious disorder. Its clinical features include simulated disease with a dramatic presentation, pathological lying and a tendency to move from one hospital to another, often presenting with a different name and identity. The clinical presentations simulate clinical emergencies such as myocardial infarction, pulmonary embolism or acute intestinal problems. This behaviour is more likely to be seen in men from lower socioeconomic groups with a chronic pattern of social maladjustment. Once the nature of the condition is realized by medical staff the patient usually discharges himself from hospital, angrily protesting the validity of his symptoms. Attempts at psychiatric treatment are usually unrewarding. Munchausen’s syndrome by proxy is seen in paediatric practice. Mothers repeatedly bring their children to medical attention, giving fraudulent histories or fabricating signs of disease in their children. Some of these mothers themselves have a history of fabricating their own symptoms. Further information on this condition should be sought in paediatric textbooks.

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Detection of psychiatric disorders in the general hospital: a practical guide

Damien Longson

Introduction

Trainees in liaison psychiatry are frequently surprised to find that the detection and management of psychiatric disorders in the general hospital is a complex and time-consuming process. Liaison psychiatrists need to integrate a broad range of skills — communication, clinical, diagnostic, medical, legal and pharmacological. Interviewing patients in challenging situations, for example on intensive care units or following maxillo-facial surgery, requires the development of unique clinical skills and a certain amount of improvisation. This chapter considers those aspects of psychiatric assessment that are unique to the general hospital, and offers guidance on the assessment of the most prevalent psychiatric symptoms. The supportive use of objective questionnaires is also considered.

Clinical skills

Information gathering

The assessment process starts as soon as the referral is received. Ideally, the referral should ask a specific question about a patient’s psychological health, or ask for guidance on the psychological components of a more complex management problem (for example in situations where capacity to consent is a problem). Often, a telephone call to the referrer clarifies the nature of the clinical conundrum, and it helps establish whether the referral has been made with the agreement of both the patient and the patient’s senior physician. Previous psychiatric notes should be obtained at this stage.

It is essential to telephone the ward prior to the consultation to establish a mutually convenient time for both the patient and the ward staff. Patients in the...