Psychiatry and Medicine

mind–body dualism

Patients usually attend their doctors because of symptoms that are causing distress and/or dysfunction; that is, when they have an illness. Medical assessment is directed to making a diagnosis of the illness, and this diagnosis is used to guide the plan of management. The diagnosis is conventionally defined as either medical or psychiatric

Medical diagnosis

Most medical diagnoses are based on symptoms and physical signs and the results of biological investigations that together indicate the presence of bodily pathology (abnormal structure and/or function), which is referred to as disease. Not all medical diagnoses are arrived at in this way (e.g. migraine) and ultimately a medical diagnosis is a label for a condition that is conventionally .treated by medical doctors and listed in classifications of disease such as ICD-10

Psychiatric diagnosis

A psychiatric diagnosis, like a medical one, is essentially a label for a condition that is conventionally treated by doctors, sometimes psychiatrists, but often by other practitioners too. Psychiatric diagnoses are listed in the classifications of diseases, along with medical diagnoses but, although some have associated physical pathology, many do not. Because they generally lack known pathology, they are generally referred to as disorders rather than diseases. In the past, psychiatric diagnoses have been regarded as ‘mental’ in nature, in contrast to the ‘physical’ nature of medical diagnoses. This distinction reflects the absence of gross pathology in most psychiatric disorders, and the fact that these conditions usually present with disturbed mental states or behaviour rather than .physical symptoms

Dualism is at best an oversimplification. It can be convincingly argued that there are no such things as purely physical or psychological conditions, whether in health or illness. The associated assumption that psychological symptoms indicate psychopathology and physical symptoms physical pathology leads to the categories

Psychological symptoms		Physical symptoms
Bodily pathology	Comorbidity	Medical disease
Psychopathology	Psychiatric disorder	Somatization

Somatization: Some patients have somatic symptoms but no evidence of bodily pathology. It is unclear whether their illness should be categorized as medical (with presumed but unidentified somatic pathology) or as psychiatric (with assumed psychopathology). In the past these conditions were generally given the medical diagnosis of functional illness (function is abnormal but there is no .pathology)

In psychiatric practice these conditions would usually be called a somatoform disorder. This latter diagnosis implies that: (i) the somatic symptoms are caused by psychopathology; and (ii) there is a hypothetical process—somatization—by which the psychopathology has caused the bodily symptoms. Such patients can therefore receive both a medical diagnosis (functional disorder) and a psychiatric .diagnosis (somatoform disorder)

Presentation of psychiatric disorder in medical settings

Although psychiatric disorders commonly present in medical settings with psychological symptoms or behavioural disturbance, other less obvious :presentations are common. These are as

.somatic symptoms(a)

a medical management problem and/or difficulties with adherence to (b) .treatment

.an apparent exacerbation of a medical condition (c)

Psychiatric disorder presenting with somatic symptoms

A significant minority of patients seen in general practice and in hospital outpatient clinics have somatic symptoms that cannot be explained by medical .disease, and many of these have a psychiatric disorder

Somatic symptoms due to depressive and anxiety disorders. Depression is associated with somatic symptoms, such as fatigue, weight loss, and pain, which may lead to referral to a medical specialty. Anxiety is associated with symptoms of autonomic arousal, such as palpitations, and with breathlessness and sensory symptoms. A World Health Organization (WHO) collaborative study of patients presenting to primary care in 14 countries found a strong association between somatic symptoms and depressive and anxiety disorders in all centres, despite .different cultures and health services

Somatoform disorders. Medically unexplained somatic symptoms in the absence of a depressive or anxiety disorder are either diagnosed as medically unexplained symptoms or as somatoform disorders. Somatoform disorders are diagnosed when there is a strong suspicion of a psychogenic cause, not just as a diagnosis of .exclusion

Epidemiology

Medically unexplained symptoms are common in the general population and in people attending primary care; and they are more frequent in women than in men. Although most of these symptoms are recognized as not serious and although most are short-lived, a sizeable minority lead to distress, functional disability, and role impairment with more time off work, consulting doctors, and taking medication

Aetiology

Although unexplained by any physical pathology, something is known about the causes of medically unexplained symptoms. Most arise from misinterpretation of the significance of normal bodily sensations: they are interpreted as a sign of disease. Concern leads to the focusing of attention on the sensations and this leads to even greater concern, apprehension, and anxiety, which exacerbate and maintain the symptom. For example, awareness of increased heart rate when excited or anxious may lead to worry about heart disease, restriction of daily .activities, and repeated requests for investigation and reassurance

Assessment

:An adequate medical assessment is essential. At the end of this the physician should explain

The purpose and results of all investigations carried out, and why it has been concluded that ● there is no medical cause for the symptoms. ● That the symptoms are nevertheless accepted as real and that it makes sense to seek other causes. If the patient is then referred to a psychiatrist, the latter should be informed about the results of the investigations and of the way these have been explained to the patient. The psychiatrist explores the nature and significance to the patient of the unexplained symptoms, and completes the usual psychiatric :history and a mental state examination, with particular attention to

.Previous concerns about illness ●

.Current beliefs about illness ●

.Personality ●

.Social and psychological problems ●

Detection of a depressive or anxiety disorder. Information should be sought from other ● .informants as well as from the patient

Management

The basic plan of management is the same for all medically unexplained symptoms, but individual treatment plans should take account of the patient's special concerns, the type of unexplained symptoms, and any associated .psychiatric disorder

.Emphasize that the symptoms are real and familiar to the clinician ●

.Explain the role of psychosocial factors in all medical conditions ●

.Offer and discuss a psychosocial explanation of the symptoms ●

.Allow adequate time for the patient and partner/family to ask questions ●

:Agree a treatment plan to include ●

Treatment of any minor medical problem contributing to the symptoms ●

Treatment of any associated psychiatric disorder (commonly anxiety or ● depression)

If appropriate, improve fitness by graded activity ●

If appropriate, diary keeping to explore the relationship between symptoms ● .and possible psychosocial causes

Further treatment should be based on the formulation of the person's individual problems. The treatment plan might include, for example, antidepressant medication, anxiety management, and cognitive therapy to change the .inaccurate beliefs about the origin and significance of symptoms

Prognosis

The prognosis for less complex cases of fairly recent onset is good, but for chronic, multiple, or recurrent conditions it is much less so. For such cases the realistic goal may be to limit disability and requests for unnecessary medical investigation. Doctors need to recognize that they may also contribute to this process. Bensing and Verhaak (2006) review evidence from studies in primary care, which demonstrate that doctors are as active in proposing biological .explanations and tests as these patients are in asking for them

Chronic fatigue syndrome

- Many terms have been used to describe this syndrome, whose most prominent feature is chronic disabling fatigue: the terms include postviral fatigue syndrome, neurasthenia, and myalgic encephalomyelitis (ME). The descriptive term chronic fatigue syndrome (CFS) is now preferred. The diagnosis requires that the illness must have lasted for least 6 months and .that other causes of fatigue have been excluded
- The central features are fatigue at rest and prolonged exhaustion after minor physical or mental exertion. These features are accompanied by muscular pains, poor concentration, and other symptoms like sore throat, tender lymph nodes ,muscle pain, joint pain, headache, unrefreshing sleep and .post-exertional malaise lasting more than 24 hours

Irritable bowel syndrome

Irritable bowel syndrome is characterized by abdominal pain or discomfort, with or without an alteration of bowel habits, persisting for longer than 3 months in the absence of any demonstrable disease.
Epidemiology :The condition occurs in as many as 10% of the general population, the majority of whom do not consult a doctor.
Aetiology :The cause of the syndrome is uncertain, although there appears to be a disturbance of bowel function and sensation. Depressive and anxiety disorders are common among people who attend gastroenterology clinic with irritable bowel syndrome, especially among those who fail to respond to treatment.
Treatment: People with mild symptoms usually respond to education, reassurance about the absence of serious pathology, change in diet and, when required, antimotility drugs. More severe and chronic symptoms may need additional treatment. Cognitive behavioural therapy has been shown to be of benefit, and so have tricyclic antidepressants, although SSRIs do not seem .effective

Fibromyalgia

The term fibromyalgia refers to a syndrome of generalized muscle aching, tenderness, stiffness, and fatigue, often accompanied by poor sleep. A physical sign of multiple specific tender points has been described, but it is probably non-specific. Women are affected more than men, and the condition is more common in middle age. The aetiology is uncertain, but there is a marked association with depression and anxiety. A network meta-analysis shows limited evidence for the efficacy of either pharmacological or psychological therapy, but a combination of antidepressant, aerobic exercise, and cognitive behavioural therapy shows some promise

Conversion disorder

Conversion disorder was a term introduced in DSM to replace the older term hysteria; in DSM-5 it is now also known as functional neurological symptom disorder. The term refers to a condition in which there are isolated neurological symptoms that cannot be explained in terms of known mechanisms of pathology .and in which there has been a significant psychological stressor

Clinical features

In DSM-IV, conversion disorder was divided into four subtypes (with motor symptoms, with sensory symptoms, with seizures or convulsions, and mixed). In DSM-5 the coding simply indicates the predominant symptom (e.g. speech, swallowing, seizures). Conversion symptoms do not normally reflect the appropriate physiological or pathological mechanisms. They are also highly responsive to suggestion and may vary considerably in response to the comments of other people, especially doctors. Symptoms may be ‘reinforced’ by measures such as providing a wheelchair for the patient who has difficulty walking. Patients with conversion disorders may seem surprisingly unconcerned about the nature and implications of the symptoms (‘belle indifference’). This belle indifference is not .invariable

The original psychoanalytical understanding focused on the concepts of primary and secondary gain. Secondary gain implies a significant external benefit or avoidance of unwanted responsibilities from the symptoms. The primary gain was the relief obtained by the conversion of the mental distress generated by a hypothesized neurotic conflict into physical symptoms, thereby allowing the conflict to remain unconscious. Secondary gains are usually prominent in conversion .disorders, but are also common in other psychiatric—and physical—disorders

Common Symptoms of Conversion Disorder

Motor Symptoms

involuntary movements, tics, blepharospasm , torticollis, opisthotonos, Seizures, abnormal gait, falling, paralysis, weakness

Sensory Deficits

Aphonia , Anesthesia, especially of extremities

Midline anesthesia, blindness, tunnel vision, deafness, visceral symptoms, psychogenic vomiting, Urinary retention, Diarrhea

Epidemiology

The prevalence of conversion disorder in the general population is difficult to determine, and estimates vary widely. A review of five studies indicated an incidence rate of 5–12 per 100,000 per annum, with the lowest rates in a study of psychiatric practice, in keeping with the view that many of these patients are not .referred to psychiatrists

Aetiology

The aetiology is unknown, reflected in the wide range of theories with few research .findings to support them

- Psychodynamic theories use the explanatory concept of conversion of emotional .distress into physical symptoms, which often have a symbolic meaning
- Social factors appear to be major determinants of the onset and development of .conversion symptoms
- Neurophysiological mechanisms: little is known of the neural basis of conversion disorder. Functional neuroimaging shows alterations in brain activation related to how adverse events are processed, and in the links between emotion, memory, and body .schema
- Cognitive explanations: Brown (2002) suggested that the symptoms are caused by the chronic activation of representations of the symptoms stored within memory, the process .being driven by attention directed to these representations

Prognosis

Prognosis for subsequent neurological disorder

Owing to the limited numbers of studies and their high heterogeneity, there is a lack of rigorous empirical evidence to identify relevant prognostic factors in patients presenting with persistent medically unexplained symptoms. However, it seems that a more serious condition at baseline is associated with a worse outcome. Most of the patients seen in general practice or hospital emergency departments with conversion disorders of recent onset recover quickly. Disorders lasting longer than .a year are likely to persist for many years

Prognosis for subsequent psychiatric disorder

Although subsequent neurological disorder is uncommon in these patients, psychiatric morbidity is high. Usually the psychiatric symptoms are present when .the patients were first seen

Predictors of prognosis

Predictors of good outcome are short history and young age; predictors of poor outcome are long history, personality disorder, and receipt of disability benefit or .involvement in litigation

Treatment

For acute conversion disorders seen in primary care or hospital emergency departments, reassurance and suggestion of improvement are often sufficient, together with immediate efforts to resolve any stressful circumstances that provoked the reaction. The doctor should be sympathetic and positive, and provide a socially acceptable opportunity for rapid return to normal physical functioning; for example, by arranging a brief course of physiotherapy. The patient should feel that the problem is accepted as deserving assessment, that it is common, and that a good outcome can be expected. The therapist should discuss any personal difficulties that have been identified, and suggest that they deserve attention in .their own right

Treatment of acute conversion disorder

Obtain medical and psychiatric history from patient and informants ●

Carry out appropriate medical and psychiatric examination and arrange investigations ● for physical causes

Reassure that the condition is temporary, well recognized and, for motor disorders, due ● to a problem of converting intention into action

Avoid reinforcing symptoms or disability ●

Offer continuing help with any related psychiatric or social problems ●

Where symptoms have persisted for more than a few weeks more elaborate treatment is required. The general approach is to focus on removing any factors that are reinforcing .the symptoms and disability and on encouraging normal behaviour

Hypochondriasis

The term hypochondriasis is one of the oldest medical terms, originally used to describe disorders believed to be due to disease of the organs situated in the .hypochondrium

:DSM-IV described the condition as a

preoccupation with a fear or belief of having a serious disease based on the individual's interpretation of physical signs of sensations as evidence of physical illness. Appropriate physical evaluation does not support the diagnosis of any physical disorder that can account for the physical signs or sensations or for the individual's unrealistic interpretation of them. The fear of having, or belief that one has a disease, persists despite medical reassurance. The criteria exclude patients with panic disorder or delusions, and require that symptoms have been present for .at least 6 months

Body dysmorphic disorder

Body dysmorphic disorder is the DSM term for a subgroup of the broader but .ill-defined syndrome of dysmorphophobia

Patients with dysmorphophobia are convinced that some part of their body is too large, too small, or is misshapen. To other people the appearance is normal, or there is a trivial abnormality. In the latter case, it may be difficult to decide whether the preoccupation is disproportionate. The common concerns are about the nose, ears, mouth, breasts, buttocks, or penis, but any part of the body may be involved. Patients may be constantly preoccupied with and tormented by their mistaken .beliefs

It seems to them that other people notice and talk about the supposed deformity. They may blame all their other difficulties on it: if only their nose/breasts were a better shape, they would be more successful in their work, social life, or sexual relationships. Time-consuming behaviours which aim to re-examine, improve, or hide the perceived defect are frequent. Social impairment is considerable. There is .substantial comorbidity, especially with major depression and social phobia

The preoccupation with the imagined defect in appearance is usually an overvalued idea, but individuals ‘can receive an additional diagnosis of delusional disorder, somatic type’ there is also overlap with hypochondriasis and .obsessive–compulsive disorder

Factitious disorder

DSM-5 defines factitious disorder as the ‘Falsification of physical or psychological signs or symptoms, or induction of injury or disease, associated with identified deception’. The category is divided further into that imposed on the self and that .imposed on another

In factitious disorder, symptoms are feigned to enable the person to adopt a sick role and obtain medical care (in malingering, symptoms are feigned to obtain other kinds of advantage). The term Munchausen’s syndrome denotes an extreme form .of this disorder