

# Primary Care Reports



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**Editor's Note**—The term, “psychological distress,” refers to a range of psychological phenomena from subclinical symptoms to major psychiatric disorders. The relationship between psychological distress and medical illness is a complex one, and their mutual intersection is unfortunately frequent. Up to 10-15% of patients with acute medical illness experience depression, as well as 25-50% of those with chronic illness.<sup>1</sup> The presence of psychological distress may deter both effective medical intervention as well as the outcome of medical illness. In this regard, studies indicate that psychological distress among medically ill patients may increase the length of hospitalization,<sup>2</sup> result in decreased patient compliance,<sup>3</sup> contribute to possible secondary medical complications,<sup>3</sup> and increase patient rehospitalization rates.<sup>4</sup>

Due to the frequency of psychological distress in the medically ill and its potential effects on medical care, recognition and treatment of symptoms among the medically ill is clinically important. In this article, we review the various contributory factors to psychological distress in medically ill patients, and we offer suggestions for assessment and treatment.

## Contributory Factors To Psychological Distress

### Factors that Precede Medical Illness

Prior to the onset of medical illness, an individual may have pre-existing psychological factors that manifest or under-

go exacerbation during illness. These factors may include early life experiences around illness (including cultural influences) as well as pre-existing major psychiatric or personality disorders.

### Early Life Experiences

Childhood experiences tend to shape how individuals react to situations in adulthood. With regard to medical illness, negative early life experiences may affect a patient's reaction to and ability to cope with illness in adulthood (*see Figure 1*). For example, family mem-

bers may have used illness to manipulate relationships—ie, members may have used illness as a vehicle to communicate emotional and/or physical needs, or to emotionally control or take advantage of the ill member. Illness may not have been acceptable in the family-of-origin, resulting in the ill individual being stigmatized and shunned. In addition, family members may have perceived illness as a consuming and unnecessary family burden, both emotionally and financially, resulting in the blaming of the victim and/or the patient when a child.

These ancient childhood legacies tend to re-emerge under the stress of illness and may affect the adult individual's ability to manage dependency, trust others (ie, the ability to rely on the medical team), and resolve ambiguity (ie, teasing out treatment options, selecting medication regimens, sorting out survival rates).

Cultural influences (ie, ethnicity, religion, nationality) may also affect a patient's experience of illness. Cultural attitudes

## Psychological Distress in the Medically Ill

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shape one's beliefs and feelings about aging, infirmity, and debilitation. They may affect the individual's reactions to proposed interventions, including the right to suicide. Even the manifestations of illness are open to cultural interpretation (eg, a delirium that is culturally interpreted as a communication from long-dead ancestors).

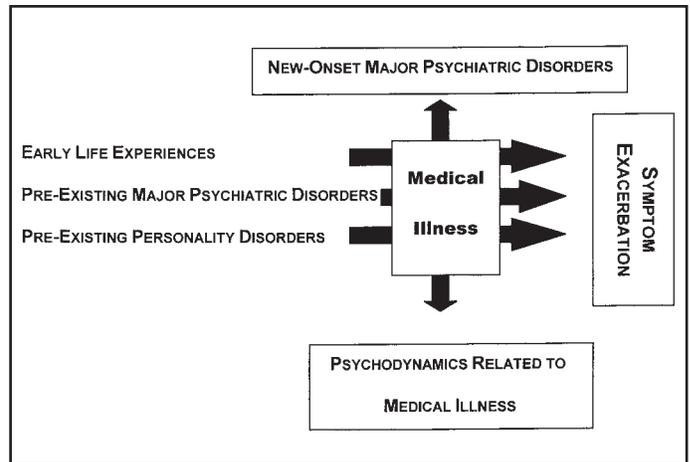
### Pre-Existing Major Psychiatric Disorders

Given their lifetime prevalence, it is expected that major psychiatric disorders will precede medical illness in some patients (see Table 1).

The relationship between pre-existing psychiatric illness and current medical illness is an illusive one. In some cases, the presence of acute medical illness may cause an exacerbation of a pre-existing psychiatric condition (eg, the worsening of panic disorder symptoms with viral illness, the deepening of depression with thyroid or other hormonal diseases).

However, recent research is clarifying that psychiatric illness may function as a contributory factor to evolving medical illness. For example, in a review of 15 epidemiological studies, Roose and colleagues<sup>5</sup> concluded that pre-existing depressive symptoms increased the risk of developing ischemic heart disease. This unexpected relationship may be mediated by several variables including hypothalamic-pituitary-adrenocortical axis hyperactivity (eg, elevated cortisol levels) as well as elevated levels of plasma catecholamines (eg, norepinephrine), resulting in platelet aggregation.<sup>5</sup> In addition to ischemic heart disease, depressive symptoms may predispose individuals to congestive heart failure,<sup>6</sup> risk of death from myocardial infarction,<sup>7</sup> and cerebral vascular

**Figure. Relationships Between Psychological Distress and Medical Illness**



accidents.<sup>5</sup> Therefore, rather than conceptualizing mood and anxiety disorders as outgrowths of medical illness, these disorders may actually contribute to medical illness in some individuals.

### Personality Disorders

Some manifestations of psychological distress in medically ill patients may be due, in part, to an underlying personality disorder. With their onset in childhood, personality-disordered behaviors may be intensified by medical illness. For example, the narcissistic individual may experience a heightening of control needs, resulting in highly demanding behavior. The histrionic individual may become more dramatic and flamboyant, if not more emotionally labile. The dependent individual may funnel their dependency needs into medical disability. On the contrary, some patients with personality disorders, such as borderline personality, may temporarily stabilize during a medical crisis, followed by a postcrisis worsening of personality-disorder symptoms. The prevalence rates of these disorders in the general population are shown in Table 1.

### Concurrent Psychiatric Factors

#### New-Onset Psychiatric Disorders

After the onset of medical illness, many patients experience new-onset major psychiatric disorders. These secondary disorders are most frequently characterized by either depressive and/or anxiety symptoms. For example, depression is particularly frequent among sufferers of neurological or cardiovascular disease<sup>8</sup> and up to 50% of patients with cancer experience depression or anxiety.<sup>9</sup> The majority of these new-onset syndromes are manifestations of, or reactions to, illness<sup>9</sup> or its treatment (eg, medications<sup>10</sup>). Once established, it is possible that psychiatric illness and medical illness function in a reciprocal fashion, with each reinforcing the other. As with pre-existing major psychiatric disorders, these secondary mood and anxiety disorders have the same potential to interfere with treatment by reducing compliance, optimism, and cooperation.

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**Table 1. Prevalence of Several Major Psychiatric\* and Personality\*\* Disorders**

Major Psychiatric Disorder	Lifetime Prevalence (%)	Personality Disorder	Prevalence (%)
Major depression	17.1	Paranoid personality	0.5-2.5
Dysthymic disorder	6.4	Schizoid personality	?
Panic disorder	3.5	Schizotypal personality	3
Social phobia	13.3	Antisocial personality	4
Generalized anxiety disorder	5.1	Borderline personality	2
Alcohol dependence	14.1	Histrionic personality	2-3
Any substance abuse	26.6	Narcissistic personality	< 1
		Avoidant personality	0.5-1.0
		Dependent personality	?
		Obsessive-compulsive personality	1

\* National Comorbidity Survey<sup>68</sup>

\*\* Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)<sup>69</sup>

### Psychodynamics Related to Medical Illness

A variety of psychodynamics may be associated with medical illness (*see Table 2*). Invariably, the onset of medical illness is accompanied by loss, whether functional (eg, use of one's legs), economic (ie, inability to work), relational (eg, loss of significant other, exhausted social support), and/or self-esteem (ie, loss of productivity, less value to self). The complex dynamics around loss may function as contributory factors to incipient mood disorders.

In addition to facing the challenges around loss, reaction to the disease process, itself, may be maladaptive. As examples, some cancer patients attempt to overly control their feelings in an effort to literally control the cancer. As an approach to curing cancer, patients may rigidly adhere to a positive attitude, even at the expense of dealing with by-product emotional issues.<sup>9</sup>

### Assessment of Psychological Distress in the Medically Ill Patient

#### Clinical Assessment

The primary care clinician should retain a high level of suspicion and carefully scrutinize medically ill patients for mood and anxiety disorders due to their anticipated prevalence in this population. The unique advantage of longitudinal experience with the patient and ongoing contact with the family may enable greater awareness of changes in the patient's behavior and emotions.

While several psychological measures that assess mood and anxiety are available, the direct verbal approach may be the most efficient. Among a group of terminally ill patients, investigators found that asking the direct question, "Are you depressed?," was more valid than 3 sophisticated psychological assessments for depression.<sup>11</sup>

### Psychological Measures for Depression and Anxiety

Clinically established<sup>12</sup> psychological tools for the assessment of depression and anxiety include the Beck Depression Inventory<sup>13</sup> and Zung Self-Rating Depression Scale.<sup>14</sup> While potentially helpful, assessment with these measures may be complicated by symptoms that are due to medical illness and not to mood or anxiety disorders (eg, sleep disturbance, appetite, weight, or psychomotor changes),<sup>8</sup> resulting in false positives.

### Psychological Measures of the Illness Experience

Used primarily for research purposes, psychological measures for assessing the illness experience include the Millon Behavioral Health Inventory,<sup>15</sup> the Psychological Adjustment to Illness Scale,<sup>16</sup> and the Illness Behavior Questionnaire.<sup>17</sup> Some scales are highly specific to the type of medical illness, such as the Mental Adjustment to Cancer Scale.<sup>18</sup>

### Assessment of Suicidal Ideation

The patient's desire to end pain, suffering, family stress, and financial exhaustion may precipitate the contemplation of suicide. The issue of suicide should be explored directly with high-risk patients (eg, those with impending grueling death; comorbid severe mood disorders; and/or histories of suicide attempts, psychiatric difficulties, and substance abuse). When patients actively disclose their contemplation of suicide, the immediate clinical issue is the risk of intent.

In assessment, it is important to differentiate suicidal thoughts from imminent behavior, as many individuals contemplate thoughts of "not going on" but readily acknowledge that they would never attempt suicide. The clinician might ask, "Have you had any thoughts of harm-

## Table 2. Examples of Psychological Dynamics Related to Medical Illness

- Increased dependency on others
- Greater needs for social support
- Mourning of losses (eg, economic, ability to work, sense of future)
- Potentially dramatic changes in daily life patterns
- Needs to re-assess priorities in life with greater attention to future
- Social alienation from others (eg, social stigmatization with HIV)
- Threat of premature death
- Need to deal with ambiguity (eg, treatment response, prognosis)
- Secondary gain (eg, nurturing, controlling other, sustaining dependency)

ing yourself? Do you think that you might genuinely act upon these thoughts?" If imminent risk is present, the patient requires prompt psychiatric evaluation and possible psychiatric hospitalization, whether voluntary or not, for further assessment.

### Treatment Approach

#### Pre-Existing and Concurrent Major Psychiatric Disorders

Mood and anxiety disorders are statistically the most likely psychiatric disorders to be present. Their treatment is approached in a traditional fashion—with antidepressant medications as well as consideration of psychotherapy.

#### Antidepressant Medications

In the medically ill patient, the selective serotonin reuptake inhibitors (SSRIs) are typically favored over other types of antidepressants because of their: 1) proven ability to treat numerous psychiatric symptoms (eg, depression, anxiety, social phobia, panic attacks, impulsivity, worry and rumination, post-traumatic stress disorder, obsessive-compulsive disorder);<sup>19</sup> and 2) mild side effects. The latter is an advantage in medically ill patients who are physically compromised and on other medications.<sup>20</sup>

The side effects of SSRIs tend to be minimal and may include headaches, nausea, sexual dysfunction, gastrointestinal symptoms, and varying potentials for P-450 drug interactions.<sup>21</sup> SSRIs have no known cognitive effects,<sup>22</sup> which support their use in neurological disorders. SSRIs have few cardiovascular effects,<sup>23</sup> although one group of investigators described infrequent abnormalities (ie, first-degree atrioventricular block, QTc prolongation, orthostatic hypotension).<sup>24</sup> Among diabetics, SSRIs tend to reduce glucose levels whereas tricyclic antidepressants have the opposite effect.<sup>25</sup>

As a class, SSRIs can cause some unexpected but infrequent side effects. For example, when combined with other

serotonergic compounds (eg, buspirone), additive effects may precipitate serotonin syndrome, which is characterized by mental confusion, and autonomic and neuromuscular (eg, myoclonus, agitation, hyperreflexia) symptoms.<sup>26</sup> On rare occasions, SSRIs have precipitated pancreatitis,<sup>27</sup> bleeding events,<sup>28</sup> hyponatremia,<sup>29</sup> falls,<sup>30</sup> weight loss in the elderly,<sup>31</sup> and extrapyramidal side effects (most commonly akathisia<sup>32</sup>). The latter finding does not preclude their use in Parkinson's disease.<sup>33</sup>

SSRIs may also cause discontinuation syndrome, a collection of symptoms that robustly and transiently emerge following abrupt discontinuation of the medication, usually after several months of continuous exposure. Symptoms may include, but are not limited to, nausea, headaches, gait disturbances, mood lability, irritability, and insomnia. Compared with other SSRIs, paroxetine appears to have a higher frequency of discontinuation syndrome.<sup>34</sup> Treatment of discontinuation syndrome entails resumption of the causative SSRI and gradual tapering of the drug.

There are clinical differences among SSRIs. For example, citalopram may be safely taken by patients prescribed coumadin<sup>35</sup> but is potentially lethal in overdose due to cardiac arrhythmias.<sup>36</sup> Fluoxetine may cause over-activation, insomnia, and akathisia. Sertraline may cause loose stools. Paroxetine has some anticholinergic activity and may cause dry mouth and constipation.<sup>37</sup> Finally, fluvoxamine has extensive potential drug interactions.<sup>38</sup>

Other antidepressant types may also be considered in medically ill patients and most, if not all, have both antidepressant and anxiolytic effects.<sup>39</sup> Amitriptyline, a tricyclic antidepressant (TCA), may be effective in pain management<sup>40</sup> as well as insomnia. However, TCAs have anticholinergic effects that may exacerbate confusional states and cause cardiovascular symptoms (eg, tachycardia, lightheadedness). TCAs are also extremely dangerous in overdose because of their effects on cardiac conduction.<sup>41</sup>

Venlafaxine has diverse neurotransmitter effects,<sup>42</sup> making it an option for nonresponders to SSRIs. Like SSRIs, venlafaxine is effective for the treatment of both depression and anxiety.<sup>43</sup> Potential limitations of venlafaxine include diastolic blood pressure elevation and discontinuation syndrome with abrupt cessation.<sup>44</sup>

Trazodone may be prescribed as a long-term, nonaddicting hypnotic. With few drug interactions, side effects include light-headedness, nausea, and the very rare occurrence of priapism (prolonged, painful erection which may require medical management).<sup>45</sup> Another hypnotic option is mirtazapine, which may precipitate weight gain as well as somnolence, making it a practical choice for the low-weight insomniac.

Several antidepressants pose specific risks. For example, bupropion may lower the seizure threshold, is contraindicated in patients with a history of seizures or eating disorders, and should be used with caution in patients with neurological compromise or head injury. Nefazodone undergoes a relatively complex metabolism in the liver (ie, to be avoided in those with liver disease) and, in a small number of patients, has precipitated fulminant hepatic failure requiring liver transplantation.<sup>46</sup>

## Augmentation Strategies

An augmentation strategy entails the addition of a second psychotropic drug to the first, for patients with partial treatment responses. This approach may be specifically useful for partial responders who are unable to tolerate higher doses of the primary antidepressant.

Practical augmentors in the primary care setting include buspirone<sup>47</sup> or gabapentin,<sup>48</sup> at dosages that are usually lower than typically prescribed. Buspirone may be started at 5 mg per day and gradually increased to 10 mg twice per day. Side effects may include headaches, nausea, and/or sedation. Buspirone, in combination with an SSRI, has on occasion precipitated serotonin syndrome.

Gabapentin may be started at 100 mg at bedtime and gradually increased to 600 mg per day in divided doses (ie, twice daily). Side effects may include light-headedness and sedation. Gabapentin has few drug interactions due to renal excretion and is safe in overdose but is potentially teratogenic.

Augmentation trials with either drug should be 14-21 days in duration. Dosages of the augmenting drug should be increased gradually, as tolerated. If the patient does not respond to either strategy, consultation with a psychiatrist is warranted. The psychiatrist may attempt other augmentation strategies including the addition of low-dose atypical antipsychotics (eg, risperidone, olanzapine)<sup>49</sup> or methylphenidate (primarily used on a temporary basis in the elderly to initiate a clinical response).<sup>50</sup>

## Supportive Psychotherapy Intervention in the Primary Care Setting

At the outset, education on the natural course and treatment of the psychiatric and/or medical illness is essential, if such information is available. Supportive psychotherapy may be helpful for sorting out acute psychosocial and relationship stressors. Acute problem-solving may be indicated for resolving practical life issues such as inexpensive resources for medical supplies, financial aid, child-care needs, transportation difficulties, concerns about sexual functioning, and cosmetic concerns (eg, hair loss with chemotherapy). One invaluable role of the primary care clinician is the triaging of specific problems to appropriate adjunctive health care personnel (eg, social worker, psychiatric referral) and community resources (eg, wig salons).

## Referral for Mental Health Intervention

When the patient's mental health needs exceed treatment resources in the primary care setting, the clinician should consider a referral for psychological intervention. Referral may precipitate various patient concerns including social stigmatization, confusion about the relationship between emotions and medical illness, and misinterpretation of the referral to a mental health professional as abandonment by the physician.<sup>51</sup> We advise being alert to these issues and explicitly exploring the patient's reaction to the referral ("How do you feel about my referring you to a mental health professional?")

An important consideration is the timing of the psychotherapy referral. Coping strategies are ideally taught to the patient and family when motivation and physical stamina are relatively

high (ie, the early phases of illness).<sup>52</sup> Referral during the late phases of illness may preempt some types of interventions.

## Mental Health Treatment Options

Various psychotherapy approaches are potentially effective in medically ill patients,<sup>53-62</sup> which underscores the importance of individualizing treatment. Therapy options include: 1) acute problem-solving in a brief treatment model;<sup>63</sup> 2) cognitive-behavioral techniques, which systematically elicit cognitive distortions, modify them, and improve emotional responses;<sup>64,65</sup> 3) psychodynamic psychotherapy, which explores the effect of early life experiences on current behavior and relationships;<sup>66</sup> 4) family intervention to obtain background information, provide education, liaison between the patient and/or hospital personnel, and explore needs for professional support (eg, the spouse who is depressed and needs antidepressant medication); and 5) group therapy.

Each of the first 4 treatment components may be undertaken through group intervention. Potential advantages of group treatment include emphasizing the universality of experiences, dealing with medical disability on a broader level, emotional sharing, sorting out relationships, and acknowledging and attempting to resolve grief and loss. Patients also have the opportunity to build social bonds, use the group experience as a working lab to practice and express emotions, process feelings about death and dying, and redefine life goals.<sup>9</sup>

Group referral may be complicated by the patient's individual needs (eg, social comfortability with groups, level of debilitation, type of medical illness), the availability of such groups or sufficient fellow patients who meet criteria for entry (eg, HIV infection), confidentiality concerns, and the fact that members may have to be prepared for the inevitable death of some participants. Groups may be time-limited or ongoing,<sup>61</sup> open or closed to new members, and/or designed specifically for family members.<sup>67</sup>

## Personality Disorder

The preceding treatment options effectively address many of the substrates for psychological distress among the medically ill. However, the presence of personality disorder may be a challenging treatment issue. Because of their longstanding nature, personality disorders tend to be tenacious and difficult to change. Most theorists believe that long-term treatment is required and the prognosis is oftentimes guarded (eg, schizoid personality disorder). Few studies confirm the efficacy of treatment for personality disorders, and some disorders, such as antisocial personality disorder, have questionable responses to treatment.

While the intersection of medical illness and personality disorder can be exasperating for the clinician as well as the family and health care team, it is important to emphasize that it is not always a meaningful issue in treatment. For example, in cancer victims with poor prognoses, personality disorder treatment is neither realistic nor appropriate. Intervention may function to contain the patient's behavior to enable the health care team and/or family to function more effectively.

## Conclusions

Medical illness is frequently accompanied by psychological distress. Psychological distress may result from an exacerbation of pre-existing psychological factors and/or concurrent or secondary factors. Following assessment, management in the primary care setting may include psychotropic medication, supportive intervention, and/or referral for mental health intervention. Treatment may not only improve the patient's overall sense of well being, but health care use, as well.

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- ### Physician CME Questions
22. New-onset psychiatric disorders in the medically ill are most frequently:
    - a. eating disorders.
    - b. depressive and anxiety disorders.
    - c. schizophrenia.
    - d. obsessive-compulsive disorders.
    - e. impulse disorders, not otherwise specified.
  23. In the medically ill, pre-existing Axis I psychiatric disorders:
    - a. may undergo exacerbation with medical illness.
    - b. may have contributed to the evolution of medical illness.
    - c. may have a reinforcing role with medical illness.
    - d. All of the above
    - e. None of the above
  24. SSRIs:
    - a. have panoramic clinical efficacy (ie, treat various types of psychiatric symptoms).
    - b. lower the seizure threshold.
    - c. are known to cause priapism.
    - d. are known to cause hepatic failure.
    - e. are known to cause an elevation in the diastolic blood pressure.
  25. Discontinuation syndrome:
    - a. is a medical emergency.
    - b. only occurs with SSRIs.

- c. has no known treatment.
- d. varies in frequency among the SSRIs.
- e. None of the above

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