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Issues in Ethical Practise: Psychological Presentations of Medical Conditions

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"First, do no harm"

Indulge me with your imagination to the following fictitious though plausible scenario:

A 20-something client is referred to you by her GP with complaints of mild depression, anxiety, restlessness, poor concentration and a chronic sense of lethargy and malaise for which no apparent cause has been found. Visits to the doctor had not revealed anything out of the ordinary. She reports having had a history of taking the latest anti-anxiety and anti-depressant medications, with little or inconsistent effect. She reports days and parts of the day when she experiences exacerbations and ameliorations, and though lacking in energy and motivation much of the time, she occasionally feels fine and she does not report feelings of apathy, depressed intent or volition; to the contrary, she has an eager intent and despite her reported disposition, she assures you that she maintains an inner enthusiasm for life, her friends and her studies. Her difficulties, she reports, are in her attention, energy, moodiness, languor and anxiety, which has, on a number of occasions, already discouraged her to the point of tears, despondency and social withdrawal. She also reveals having had a history of counselling and psychotherapy, out of which she reports having achieved greater self understanding, self-validation, feeling generally accepting and congruent about her identity and having made significant strides in coping with the conflicting demands and stresses of her family, her partner and her own pursuits, career, social, artistic, expressive and academic. Nevertheless, she reports continuing struggles in managing her stress, relationships and interests, but insists that the difficulty has nothing to do with these in and of themselves or her attitude toward them, but rather come about through her unbidden states of mood, energy and attention. She feels at the end of her tether and wants desperately to get to the bottom of it. Since her trusted doctor found nothing medically wrong with her, and since the prescribed medication had been largely ineffective, she comes to you for assistance with the challenges of sorting out the "psychological roots" of her dilemma.

Now, the sixty-four-thousand dollar question is, given this nebulous and contradictory presentation, what do you do? What are the first thoughts and questions running through your mind? You may wish to jot these down, because they may reveal a great deal about your own diagnostic, ethical, theoretical and professional proclivities, blind spots and biases.

Consider the following questions: What do you know? How do you know what you know and how certain are you? What don't you know? What do you feel you really need to know? How

will you find out? What determines whether or not you decide to work with her or refer? If you decide to refer, whom to and for what? What are your main concern(s) and central responsibilities? Suppose you consider her condition in psychosomatic/psycho physiological terms. How is this likely to influence or guide the nature of the psychotherapeutic relationship (roles) and possible interventions? Suppose you consider the doctor may have missed something. Yet she's convinced, along with her doctor, that it's "all psychological" and requests you not to bother with anything but psychotherapeutic care. Do you comply?

Her doctor visits likely took less than 15 minutes to run through the protocol on deciding how to treat her. You have an hour with her. As a psychotherapist, like her doctor, your first concern is the welfare of the client and above all, "first, do no harm". You, like the doctor, are also called upon in your professional ethics to recognise the limits of your competence and to recognise the gaps in your skills and training. Optimally meeting the ethic and responsibility of doing no harm and practising competently require a certain experiential and knowledge base. Though most of us are familiar with the psychological influences on physical conditions, even recognising in a holistic sense that it is difficult to characterise any condition which is not "psychosomatically" influenced to some degree, we nonetheless tend to have little background in those conditions that could primarily be qualified as "somatopsychic", or rather, medical conditions with a psychological presentation primarily, symptomatically, or secondarily in adaptation.

Somatopsychic vs. Psychosomatic Presentations

We know from research in psychoneuroimmunology that there really is no clear demarcation between mind (psyche) and body (soma) and that the distinction between psychological and somatic is in many ways purely academic. The molecules of thought and emotion that concentrate in and course throughout the brain are not only everywhere else in our bodies, effecting every cell, but they are also the very same informational molecules of the soma that direct the flow of communication and information for all activity in the human anatomy and physiology (Pert, 2000). The distinction between mind and body is in this sense purely academic, depending upon the context and area in which we find these information molecules. That said, we nevertheless have to direct our focus on not only their primary places of origin or activity, but also to the results and symptomatic manifestations of their feedback loops. Though one might philosophically argue for a treatment focus on either the mind or the body as a point of *possible* primary intervention, the academic distinctions and representations of psyche and soma as psychosomatic and somatopsychic serve us by providing guiding roadmaps as to the primary point of intervention and leverage. Therefor, psychological presentations of somatic conditions need to be heeded in our concern for the welfare of our client, certainly as much as psychosomatic conditions.

Undiagnosed physical conditions that contribute to or cause psychological symptoms are not as rare as they may seem. In a number of large studies of psychiatric patients, between 9-18% were found to have a medical disorder causing their psychiatric symptoms (Flaherty, et. al., 1989). Numerous studies have shown that previous screening tests and medical examinations offer no absolute guarantee that the client (patient) is without physical illness, either independent of the psychological symptoms or directly related to them (Schenkenberg, 1999). In a study of 2090 psychiatric patients, for example, Koranyi (1979) found that 43% were actually suffering from one or more physical illnesses, out of which 46% of these *remained undiagnosed* by the referring

source. Similarly, a study (Anderson, et. al. 1989) encompassing some 50,000 autopsied cases over five decades, described the great and worrisome variations in accuracy of clinical diagnosis depending on disease condition. The authors concluded with commentary on "necessary fallibility" as a fact of clinical life. In fact, this is not too shocking for the medical community, because in the early stages, many illnesses are very difficult to detect, sharing symptom overlap with a greater variety of other conditions. This results in failure to order investigative screening and examinations that might accurately pinpoint the problem.

Furthermore, when confronted with confusing, contradictory and unclear client presentations as in the example given, many doctors have been too eager to reach for the latest vigorously promoted psychiatric medications, such as the latest Selective Seratonin Re-uptake Inhibitors (SSRIs, like Prozac or Zoloft). In fact, the majority of "drugs for mental health" are prescribed not by psychiatrists, who are more familiar with the complexities of psychological symptom presentation, but by GPs whose expertise in the area is comparatively limited, despite any posturing to the contrary. Side effects or treatment failures often complicate the symptom picture even further, and the changed profile may last for some time after the withdrawal of any medication or other treatment.

When a client presents with what may appear to be clinical or sub-clinical depression, the first diagnostic question that runs through the doctor's (or psychotherapist's) mind might be, "is this person depressed?", as opposed to, "what, if anything, is wrong with this person at this time?". The former question may bias the focus to the criteria for depression or another functional mood disorder, whereas the latter avoids this bias in order to consider discovery of conditions falling outside the mental health arena as well. It is widely known that many general medical conditions produce symptom patterns meeting the criteria for clinical or sub-clinical depression.

By being alert to conditions that masquerade with a psychological presentation, the psychotherapist is better equipped to ethically and competently serve the welfare of the client. This addition to the knowledge base puts the psychotherapist in a better position to refer judiciously and, as and where appropriate, to actively collaborate with the physician in arriving at an as accurate an answer to the latter question as possible. For the welfare of the client, your professional and aspirational ethics should warrant no less.

Somatopsychic Conditions: Medical Conditions in Psychological Masquerade

Unfortunately, there are relatively few workshops or courses dealing with the psychological manifestations of physical illness. These would be ideal in the training and continuing education of all psychotherapists. Not finding formal training, however, does not excuse the psychotherapist from not picking up a copy of a psychiatric manual on their own and becoming familiar with the section on 'Medical Conditions with Psychiatric Symptoms'.

The LANGE Clinical Manual of Psychiatry (Flaherty, et. al. 1989) lists 11 different categories of medical conditions that may present with psychological symptoms. A brief list and summary of just a few of these are provided below. The reader is encouraged to follow up to learn more.

I. Neurological Disorders

A. Epilepsy It is estimated that 30-50% of epileptics have co-occuring psychiatric problems, with personality disorders being the most frequent, followed by psychosis. In addition to possible hallucinations, illusions and dream like states, interictal psychiatric symptoms can include personality problems, anxiety, depression, withdrawal, destructive assaultive behaviour, obsessive-compulsive symptoms, deviant sexual behaviour and euphoria.

B. Focal Brain Lesions Patients with supratentorial neoplasms may present with depression, anxiety and confusion. Those with frontal lobe disease may present with euphoria, labile affect, disinhibition, childish behaviour and distractibility. In its milder forms, basilar artery infarction may present with decreases in spontaneous activity, delayed response or sleepiness.

C. Cerebrovascular Insufficiency In subclavian steal syndrome, the client may present with episodes of anxiety associated with dizziness and intermittent confusion.

D. Encephalitis Creutzfeld-Jacob Disease (CJD, as in the headlines recently), for example, may present with depression and psychosis associated with dementia.

E. Multiple Sclerosis

F. Huntington's Disease

G. Post-concussional Syndrome Associated with anxiety and personality changes that can last for months.

H. Normal-Pressure Hydrochephalus

I. Narcolepsy

J. Alzheimer's Disease

K. Wilson's Disease

L. Sleep Apnea Syndrome

II. **Endocrine Disorders** Many of these disorders will present with anxieties and depressions, dysphoria, changes in eating behaviour and fatigue. Hyperparathyroidism, for example, includes symptoms of dysphoria, loss of initiative, anorexia and fatigue, in which a normalisation of calcium levels resolves the symptoms. In Pheochromocytoma, the initial presentation can be with sudden onset of severe anxiety, which may progress to acute, but transient psychosis.

A. Hyperthyroidism
B. Hypothyroidism
C. Hyperparathyroidism
D. Hypoparathyroidism
E. Hypercortisolism (Cushing's Disease)
F. Hypocortisolism (Addison's Disease)
G. Pheochromocytoma
H. Sex Hormonal Disorders

III. Cardiovascular Disorders

IV. Pulmonary Disorders

A. Hyperventilation Syndrome—Is associated with anxiety
B. Pulmonary Embolism

C. Chronic Obstructive Pulmonary Disease—Is associated with depression, apathy, withdrawal and helplessness.
D. Sleep Apnea Syndrome—Is associated with fatigue and excessive somnolence, especially during the daytime, and depression.

V. Gastrointestinal Disorders

It may be wise to pay particular attention to this category. In pancreatic carcinoma, for example, the initial presentation may revolve around symptoms of depression, loss of motivation, and a sense of doom. These symptoms can predate the discovery of the tumour by years.

A. Pancreatitis
B. Hepatic Encephalopathy

VI. Renal Disorders

VII. Hematologic Disorders

These include anemias which pay present as depression and can include symptoms of anorexia, decreased libido, weakness and fatigue.

VIII. Infectious Diseases

These include Hepatitis that typically features severe depression in the recovery phase.

IX. Metabolic and Toxic Disorders

Much of this is, especially the effects of endocrine disrupters/mimicers, still being researched. These may be encountered more than the others and are worth paying particular attention to. They include hypo and hyperglycemia, which frequently presents with a combination of anxiety and depression related symptoms that include mood changes, weakness, fatigue and inability to concentrate. These also include vitamin deficiencies, such as lack of vitamin B12—which can produce symptoms of apathy and severe depression; lack of vitamin B6—often manifested as depression, typically associated with oral contraceptive use or alcoholism; Folic acid deficiency—can manifest as fatigue, insomnia, memory impairment, restless legs and depression.

X. Collagen Vascular Diseases

These are also essential to learn about, as they can account for roughly 12% of the medical causes of anxiety.

A. Systemic Lupus Erythematosus
Can present with depression and sometimes schizophreniform disorder.
B. Temporal Arteritis
Often occurring in the elder population and manifested as fatigue and depression, concomitant with pain and headache.
C. Mixed Connective Tissue Disease
Mostly affecting women and can present as depression and anxiety.
D. Polymyalgia Rheumatica—Typically presents with fatigue and depression.

XI. Neoplasms

Psychiatric symptoms will vary depending on location

A. Paraneoplastic syndromes—may include psychological presentations of lethargy, anorexia, memory impairment and confusion.
B. Carcinoid syndrome—will often involve serotonin-secreting tumours and may manifest as severe depression, anxiety, confusion or hypomania.

Conclusion

Prior to my studies into the worlds of natural, homeopathic and behavioural medicine, I have actually encountered clients presenting with profiles not dissimilar to the one conjured up for you in this presentation. Their frustration was often enormous. Was it all in their head, in their body, or some mystical combination of things? To ferret it out was no easy task and I we were not always completely successful. The most common somatopsychic presentations I have encountered in my own practises were of the Metabolic and Toxic variety, which, after confirmatory tests as simple sometimes as a Glucose Tolerance Test, resolved rather quickly with non-invasive ensuing treatments such as dietary, lifestyle, hygienic, movement or environmental adjustments. Sometimes restricting sugar, caffeine and a spinal adjustment here and there will indeed get to the bottom of what seems to be an intractable psychological presentation, and with a lot less time, expense and grief. Other times, more sophisticated treatment may be called for that might just save the clients life!

Ethical practise in psychotherapy demands that therapists do no harm, make the welfare of their clients the priority and recognise the gaps in their competence and training. The training of psychotherapists typically does not offer much in the way of formal study that explores the psychological presentations of medical conditions, psychosomatic and somatopsychic feedback loops, nor the intricacies of therapeutic leverage in the treatment of conditions with unclear psyche-soma presentation. In order to do the utmost to insure the optimal care and welfare of the client, the psychotherapist needs to be aware of somatopsychic conditions, learn when to refer in these cases and collaborate with the medical community when there is an index of suspicion.

In clients resisting such referral or treatment, appropriate ethical safeguards of disclosure and consent must be included in considering further psychotherapy. Failure to take these steps can be considered professionally remiss. Referring and collaboration mean that the psychotherapist has a valuable role to play and which may certainly include continued psychotherapy, as in psychosomatic conditions, depending on the condition and goals for treatment. In the absence of formal training or continuing education, the psychotherapist can independently avail themselves of a number of easy to read teaching manuals with sections on these conditions.

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