Psyche and soma in general practice

their inter-relationship in crisis *

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Summary

Illness does not always have purely organic causes requiring purely organic treatment. The author aims to make GPs more aware of the effect of the psyche on the soma.

The following case reports and surveys illustrate this.

Why do our patients become ill? Medical science has unearthed many previously unknown causes such as micro-organisms, enzyme deficiencies, and hormonal imbalances which have contributed towards an answer to this question. It is however the discipline of general practice with its emphasis onan holistic approach to illness, which stresses the importance of approaching patients' problems in physical, psychological and social terms. Thus GPs are expected to appreciate that a diabetic man of 45 is not just a **case** of diabetes, but also a married man with 3 children, an overworked, overeating, heavy-smoking, business executive with a need to be in control of his environment, and whose preoccupation with success in his career has taken its toll on his health and his marriage and family life. However, most GPs would admit they devote much more time and energy to the medical management of the patient's disturbed glucose metabolism than they do to his unhealthy life-style, even though they may recognise that the two are intimately related to each other and that proper attention to the latter may well have a more beneficial effect on the patient's blood-sugar than manipulation of the dosage of his anti-diabetic drugs, not to mention the advantages to the patient's mental state and his marriage and family life.

The concept of psycho-somatic diseases implies that disturbances of the emotions can result in structural organic changes in organ systems, e.g. peptic ulcers or patho-physiclogical changes such as hyper-thyroidism. The list of such conditions has grown considerably over the years and includes virtually all the major problems encountered in general practice such as asthma, hypertension and ischaemic heart disease. In spite of this, however, most GPs, influenced by their undergraduate training, tend to focus mainly,if not exclusively on the organic aspects of their patients' problems and thus fail

to practise a truly holistic approach. Most doctors seem to implicitly share their patients' view that the illness episode is an event occuring out of the blue, and fail to appreciate that every illness has physical, psychological and social determinants. Suggestions that stresses in the patient's life may have pre-disposed him to illness, are either rejected or else regarded as too vague and nebulous to merit serious attention.

Stresses in the patient's life may predispose him to illness

There is, however, concrete evidence that emotional stress can and does predispose not only to an increased incidence of physical illness, but also to an increased mortality rate. Michael Young and his colleagues found an increase in the death rate among 4 486 widowers over the age of 54 of almost 40% during the first six months of bereavement. Another independent survey of 903 close relatives of 371 residents who died during 1960-65, showed that 4,8% of them died within one year of bereavement compared with only 0,7% of a comparable group of non-bereaved people of the same age, living in the same area. The mortality rate was particularly high for widows and widowers,12% of whom died during the same period. These two studies established a statistical relationship between bereavement and an increase in the death rate. The most frequent cause of death in bereaved people is heart disease.

Apart from an increase in the mortality rate in bereaved people, studies have shown an increase in morbidity as well. In two separate studies,[1] over 30% of widows thought their general health was worse than it had been before bereavement. According to both the studies the number of complaints attributed to bereavement was very large. Headaches, digestive upsets, rheumatism, and asthma were particularly frequent.

Newly bereaved patients consulted their doctors more often than they did before bereavement

Of particular importance to us as general practitioners is the evidence that newly bereaved people consulted their doctors more often than they did before bereavement. In one study [2] three-quarters of the widows consulted their GP within six months of bereavement and this was a 63% increase over the number who had consulted him in a similar period prior to bereavement. The largest increase was in consultations for anxiety, depression, insomnia and other psychological symptoms,which were clearly attributable to grief. These consultations were confined to widows under 65 years of age. Consultations for **physical** symptoms, however, had increased in all age groups, most notably for arthritis and rheumatic conditions. Many of the widows had osteo-arthritis, a condition that takes years to develop; it seems that the bereavement aggravated the pre-existing condition considerably.

A study shows that frequent infections are caused not only by invading viruses or bacteria.

In an Australian study,[1] 28% of widows obtained scores indicating marked deterioration in health,compared with only 4,5% of the married (i.e. non-bereaved) women. Psychological symptoms (eq. insomnia,loss of appetite, persistent fear and fatigue) were more common in the bereaved than in the married groups, as might be expected. But Maddison also found in the widows an excessive incidence of symptoms that were less obviously features of grieving. These included headaches, dizziness, fainting spells, blurred vision, skin rashes, excessive sweating,indigestion, difficulty in swallowing, vomiting, heavy menstrual periods, palpitations, chest pains, frequent infections and general aching. I would like to make special mention of the high incidence of infections. This study shows that frequent infections are caused not only by invading viruses or bacteria.

In a study of 68 Boston widows and widowers under the age of 45, it was shown that four times as many bereaved as non-bereaved people had spent part of the preceding year in hospital, and the bereaved group sought advice for emotional problems more often than did the non-bereaved.

Parkes [1] whose book is a classic which should be read by all general practitioners, says : "I think we can justly claim that many widows and widowers seek help during the months that follow the death of their spouse, and that the professional persons they most often go to are medical practitioners and ministers of religion. *I accept the evidence that bereavement, can affect physical health* and that complaints of somatic anxiety symptoms, headaches, digestive upsets, and rheumatism, are likely, particularly in widows and widowers in middle age. Finally, there are certain potentially fatal conditions, such as coronary thrombosis, blood cancers, and cancer of the neck of the womb, which seem in some cases to be precipitated or aggravated by major losses".

Giving help to the bereaved is a practical contribution to public health.

Parkes also says "It may be that measures arrived at reducing the stress of bereavement, will help to prevent such consequences. If so, then giving help to the bereaved is a practical contribution to public health".

A group of psychiatrists in Rochester, USA have developed the theory[1] that it is the **feelings of helplessness and hopelessness** that may accompany loss that are responsible for physical illness. In one remarkable study, women suspected of having cancer of the womb were 'diagnosed' by a psychiatrist with striking accuracy. These women had been admitted for investigation after a routine vaginal smear, had revealed the presence of ugly-looking cells which might or might not indicate cancer. At this stage nobody knew whether a cancer was present or not, and a minor operation was necessary to prove or disprove such a diagnosis. The psychiatrist, who was as ignorant as anyone of the true situation, interviewed each woman and asked about her feelings about any recent losses in her life. When he found evidence of both loss and feelings of helplessness or hopelessness he predicted that this woman would, in fact, be found to have cancer. In 71% of cases his diagnosis proved to be correct, a finding that was statistically significant at the 0,02 level! Similarly, high rates of loss have been reported in cases of leukaemia, ulcerative colitis, and asthma.

The studies mentioned clearly illustrate that bereavement, which is a state of emotional distress, and other life situations in which serious loss is experienced, can cause physical illness. The exact explanation for this connection is not clear, but the fact remains that there appears to be a causal link between feelings of great loss with accompanying feelings of helplessness and hopelessness, and various forms of physical illness which cover virtually the entire spectrum of conditions encountered by general practitioners in their daily work.

Emotional distress can cause physical illness.

The implications of these findings are very far-reaching for us. For while it is true that bereavement as such is not an everyday event in our practices, there is no doubt that our patients are experiencing feelings of loss in less obvious but nevertheless important ways, much more commonly. More concrete examples are loss of marriage partner due to divorce, loss of a job with loss of income and loss of self-esteem, and loss of love and companionship when a close, intimate relationship breaks up. A more subtle, but extremely important example, is a woman's loss of freedom and opportunity to give expression to professional ambitions when she has a baby. Another important example is the loss of a familiar environment when people immigrate to another country or even more from one city or place to another and lose their previous friends and feeling of security - this is particularly true of older people. In all these situations, patients can and do experience feelings of sadness, fear, anger, and guilt similar to those experienced by bereaved people. They could therefore be expected to be more prone not only to feelings of anxiety and depression but also to physical illness as well. It therefore follows that we have a duty not only to help our patients deal with the feelings of loss they may experience in various situations,but also to look for possible underlying loss situations in our patients' lives when they present with physical illness.

For many, illness is a way of dealing with stress.

Crisis intervention theorists[2] conceive of crises as having two basic underlying causes: (i) a sense of loss (ii) a disruption of the normal equilibrium of the individual's (or family's) life by forcing him to reconsider his old modes of functioning and encouraging him to mobilise his resources and find more adaptive coping mechanisms by which to lead his life. It is for this reason that therapists practising crisis intervention like to start treating their patients as soon as possible after the onset of a crisis because they believe that if they delay too long, the crisis situation may subside and the patient may slide back into his old, maladaptive, style of functioning. These concepts have very important implications for us as general practitioners. For, in a sense, every consultation could be regarded as a crisis of a kind, being as it is a disruption of the patient's normal equilibrium to the extent that it has forced him to consult a doctor, and as mentioned earlier, having often been precipitated by some experience of loss in the patient's life. In terms of the crisis intervention model, we can use the consultation to help the patient cope better with his life than was previously the case. However, we can only do this if we are able to understand the patient's illness in the perspective of his total life situation and not merely from a narrow organic viewpoint, which is not only too limited an approach, but one which can actually be harmful.

My reason for saying that a purely organic approach to illness can be harmfull is that for many people, illness is a way of dealing with stress. All GPs must have noticed that some individual and indeed some families in their practises seem to get ill more often than others. They seem to get more infections, have more accidents, skin ailments, allergic disorders in the children etc. than another dozen families in the practice put together. On the subject of allergies, a British study showed a drastic decrease in the incidence of allergic symptoms in children when they were removed from an emotionally stressful environment. The GP must find time between arranging chest X-Rays and blood chemistry investigations and organising another set of skin tests for allergies to ask himself **why** it is that **this** particular family seems to have so much illness. Is it because it is their way of dealing with the tensions and animosities in their family which they are unable to face openly? Is it their way of gaining the attention and dependency they all crave but seem unable to receive an adequate supply from each other? Or is it just their bad luck? Many if not

most GPs appear to subscribe to the latter by largely ignoring the emotional components of their patients' illnesses in favour of the organic aspects. There are several reasons for this neglect :-

(i) undergraduate medical training which grossly over-emphasises the organic aspects of illness relative to the psychological side, which results in
(ii) feelings of inadequacy by GPs with regard to the psyclological aspects of patient care with a resultant tendency to focus on the physical aspects with which they feel more comfortable.
(iii) a desire to maintain the GPs exalted role in the eyes of his patients by implying that illness is a matter out of their control, thereby making the patients feel totally reliant on the doctor for their health needs, and
(iv) fear of antagonising patients by appearing to blame them for their illnesses.

CONCLUSION

I would like to comment briefly on the above points. To begin with, the last point - I think it is most important not to induce any feeling of blameworthiness in a patient as this will result in feelings of guilt and resentment on his part. It would also be inappropriate for a GP to question a patient about any feelings of loss in his life every time he complains of a sore throat or a whitlow ! However, if for example a patient presents repeatedly with various physical ailments, the GP could ask him whether he feels he may have been more run down lately which could have predisposed him to the development of frequent infections or illness. In some cases it may be possible to identify certain stress situations which seem to precipitate episodes of physical illness. An example from my own practice is an elderly woman whose osteo-arthritis underwent acute exacerbation whenever she lost a friend through death or even after a heated argument with her daughter. Another example from my practice is an elderly widow whose angina became worse at nights although she was not exerting herself then, and it transpired that she was frightened of being alone in her house at night. In both cases, discussion with the patient and the opportunity afforded them to express their **feelings** (loss, fear etc.) resulted in symptomatic improvement of their conditions without increasing the dosage of their drug therapy. It also enabled them both to gain greater insight into the emotional aspect of the aetiology of their conditions, and they both felt better for believing that they had some control over the severity of their condition even if they could not free themselves of it completely.

Discussion and the opportunity to discuss their feelings resulted in symptomatic improvement of their conditions.

By being more aware of the effect of the psyche on the soma and conveying this awareness in a constructive and non-judgemental way to our patients, we can help them to experience a greater sense of control over their own physical and mental health. By being on the lookout for sources of stress in our patients' lives we can give them an opportunity to express the feelings of loss, anger, grief etc. which they are experiencing. In so doing we are not only providing them with the relief which such an expression of feeling brings about, but we are also materially reducing their risk of developing physical illnesses, including serious conditions such as myocardial infarction, as well as minimising the effects of such illnesses if they do occur. Furthermore, we can help our patients to explore new and more productive ways of dealing with the problems in their lives and their relationships than was previously the case. However, if we continue to treat physical illness in a purely 'medical' way as something with purely organic causes which requires purely organic treatment, we will be failing to utilise the full potential of our role as general practitioners.

REFERENCES

1 Parkes, CM (1972) : *Bereavement - Studies of Grief in Adult Life:* London, Tavistock.

2 Parad, HJ (ed) (1976) : *Crisis Intervention* : Selected Readings : New York, Family Service Association of America.

From the Journals ● Van die Tydskrifte

Author: Jones J.H.

Title: Single-dose and seven-day trimethoprim and co-trimoxazole in the treatment of urinary tract infection

Journal: Journal of the Royal College of General Practitioners

Volume & Year: 33: 1983

Page No.: 585-589

Summary:

ONE hundred and sixteen adults with symptoms of acute urinary tract infection were randomly collected into four groups and given single-dose or seven-day treatment with trimethoprim or co-trimoxazole. Of the 105 patients who completed the study, bacterial urinary infection was present in 70 patients (67%). The rates for symptomatic and bacterial cures were high and indistinguishable between the groups, and there was no difference in the rate of recurrence of urinary infection in the six weeks after treatment. Side effects were lower in the group receiving single-dose trimethoprim (P — 0,09).