APPROACH AND PSYCHOSOMATIC CONTEXT IN THE LIAISON PSYCHIATRY

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Abstract: *In the last decades, the liaison psychiatry has known an upward trend, through the integrative, physical and mental approach, of a human being in distress. The interdependence between psyché and soma, obvious especially in psychosomatic diseases and confirmed through much more studies, underlies this dual approach. This paper presents the role and the need for the psychiatrist's presence in general hospital for mainstreaming the psychosocial dimension of the patient during the medical consultation.*

Cuvinte cheie: *psihiatrie de legătură, psihosomatică, intervenție psihoterapeutică*

Rezumat: *Psihiatria de legătură cunoaște o tendință ascendentă în ultimele decade, prin prisma abordării integrative, somatice și psihice, a ființei umane aflate în suferință. Interdependența dintre psyché și soma, evidentă în special în bolile psihosomatice și confirmată prin tot mai multe studii de specialitate, stă la baza acestei duble abordări. Lucrarea de față prezintă rolul și necesitatea prezenței psihiatrului în spitalul general în integrarea dimensiunii psihosociale a pacientului în decursul actului medical.*

The beginnings of liaison psychiatry are closely related to those of psychosomatic medicine. The first research in psychosomatics included patients with somatic diseases, medical or surgical, with no defined mental disorder, but rather with reactions to illness and hospitalization. The further development of both disciplines has overlapped, the number of articles published in the journal *Psychosomatic Medicine* making reference to liaison psychiatry record an upward trend since 1975 (1,2), in parallel with the emergence of more and more such departments in general hospitals from U.S.A. and Europe.(3) In Romania, the first liaison psychiatry service was established in 1995 at Bucharest University Emergency Hospital.(4) Nowadays, although there are some hospitals, usually university hospitals, having liaison psychiatry departments, for the majority of the Romanian general hospitals, this type of consultations continue to be provided by psychiatrists outside the hospital, fact that decreases the access to consultation and re-consultation of the patients hospitalized in non-psychiatric wards and that adversely affects the communication between specialists, in fact the psychosomatic vision itself.

In the last decades, the term "psychosomatic" is reported as being insufficient by some of the psychoanalytic currents due to its duality as well as to the linear causality it entails. The juxtaposition of the two terms implies "a cleavage between a worthy spirit and an instrumentalized material body".(5) Not to mention the phrase "the psychological factors which affect a general medical condition", expression of the North American pragmatism that leads to "the semantic dissolution of psychosomatics" itself (6), while the U.S.A. liaison psychiatry is being recognized as a subspecialty, intended to terminologically replace the psychosomatic medicine.(7) Regarding the causal relationship of the psychosomatic disorders, the linear view (generating mental disorder of somatic affection or vice versa) tends to be replaced by a "circular" one, which implies a "mutual overlapping", intimate and indissociable, of the psychiatric and body manifestations.(5,8) To this psychoanalytic view is being added the discoveries in cognitive neurosciences, advocating for the simultaneity of the two manifestations, psychological and biological, as "different descriptions of the same phenomenon".(9) Although we agree with this view of mind-body unity, the conceptual boundaries, as the diagnosis ones are nevertheless useful in practicing this subject through the liaison psychiatry.

Somatic patient versus psychiatric patient

During the psychiatric consultations in general hospitals, the psychiatrist consults patients with somatic disorders without psychiatric history (but some of them with an older mental disorder, undiagnosed) as well as somatic patients with psychiatric history, some of whom are under psychiatric treatment. The very fact of being in a diagnostic category determined (or may determine) the patient's attitude toward the psychiatric consultation. The social context the hospital and medical consultation represent, as well as the diagnostic labels, tend to coerce the person in distress to enter a mechanistic pattern, often ignoring the bio-psychosocial complexity of to be (*to feel*) sick, and even converting it in *being* sick. The attention given to psychosocial dimension of the individual in relation to the liaison psychiatric consultation should aim to mitigate this perception (and self-perception) of the patient as a "malfunction body", by placing the somatic affection into a wider psychosocial context.

a) *Somatic patients without psychiatric history (the first psychiatric consultation)*

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In this situation we can often encounter patients with impairment of depressive type, anxious and/or somatoform, as well as the type of chronic alcoholism or cognitive impairment.

- Patients suffering from depressive disorders and/or anxiety preceding the emergence of somatic symptoms or as a dysfunctional response to somatic disease (recently diagnosed or chronic) generally establish a good therapeutic relation with the psychiatrist. These patients often have an emotional and behavioral regression, seeking for protection and help.
- Patients with predominant somatoform impairment often do not understand the need of psychiatric consultation (some begin their speech with "I do not know why I was sent here." or "I'm not crazy."). If the physical symptoms are experienced with anxiety, then the patient can understand the need for psychiatric treatment in improving it. Even in the context of masking the psychic distress in bodily symptoms, some of these patients accept the psychiatrist's explanations on their nature, and can cooperation, on a long term, with him following a medication or attending a structured psychotherapy.
- Patients with organic mental disorder:
  - alcoholic patients are sent to psychiatric consultation after tracking down the markers of chronic alcoholism (transaminases, of gama-glutamyl transpeptidase, macrocytosis) or when there are signs and symptoms of withdrawal. These patients often react by minimizing the alcohol consumption, even by denying it (especially women due to its social perception as a vice), sometimes becoming hostile against the psychiatrist.
  - patients with cognitive impairments or dementia of various etiologies are often diagnosed during hospitalization for somatic disorders. They are generally cooperative, sometimes in advanced stages of the disease, the confusion prevails and then they can become hostile, unable to understand what is happening. In mild forms of damage, patients complain of subjective memory failures and seek for help.
  - delirium patients with various etiologies are confused, disoriented. The therapeutic intervention in these cases is limited to specific psychiatric medication management.

b) Psychiatric patients hospitalized in general hospitals

- Patients suffering from mental disorders such as psychosis (schizophrenia, affective bipolar disorder, schizoaffective disorder, delusional disorder), following or which have followed a psychiatric treatment, may feel to be protected by the psychiatrist from the general hospital. Also, the psychiatrist can become a good binder in the communication between somatic doctors and such patients. When their attitude is hostile, uncooperative, non-compliant, the psychiatrist intervenes especially by medical intervention to facilitate the collaboration of these patients in the medical process, whilst safeguarding the medical team regarding a possible "threat" that such a patient could represent (a rarely real threat, but very often envisioned by the non-psychiatric medical staff, which often causes the psychiatric patient transfer affected by sometimes significant somatic disturbances to psychiatric hospital, accompanied by minimal treatment guidelines, which sometimes cannot be followed, due to the lack of the medication needed).
- Patients suffering from psychiatric disorders such as depressive disorders, anxiety disorders, or, rarely, obsessive-compulsive disorder, may be re-evaluated during the consultation of liaison psychiatry and also secured in the somatic context they go over. These patients may be very cooperative, even over busy for attention in relation to psychiatrist. Frequently, the somatic disease causes to these patients emotional and behavioral regression, which is manifested by the increased dependency needs (expressed, for example, through the need of repeated reassurances regarding the opportunity of favorable settlement of the somatic disease or by requesting more frequent meetings with the psychiatrist) and that may increase their responsiveness to suggestion. Moreover, in general, the diseased state is characterized by a high responsiveness to suggestion. The way in which the doctor interfere on this receptive field of the individual worried or anxious about his bodily integrity, is crucial.
- Patients suffering from somatoform disorders and/or hypochondriac disorders may recognize some of their psychiatric sufferings (depressed mood, anxiety, insomnia), but often refuse to recognize the psychogenic substrate of their suffering, fact which determines ***in extremis*** an hostile attitude towards the psychiatric consultation, up to its refusal.

Therapeutic responses and countertransference reactions

The psychiatrist's reaction towards the patient's way to present himself in front of him, as its therapeutic response do not differ essentially from those of a specialty physician that enters in relationship with his patient. Generally, there is a much higher complexity of this relationship, due to the role of the psychiatrist as confidant, a role that other specialties physicians rarely adopt.

The response which would /should be therapeutic (meaning to make the patient feel understood and to understand and accept his own suffering) may be contaminated by countertransference reactions that, unconscious or uncontrolled, can harm the therapeutic relationship and the patient himself.

a) Frequent *countertransference reactions* that may occur in the therapeutic relationship (10,11) are: aggression, excessive directivity (paternalism), identification with the patient's suffering, the attitude of "savior", failure to understand the patient suffering or its denial and the moralistic attitude.

Recognizing and controlling by the psychiatrist' of his own countertransference reactions (objective, induced by the patient attitude, and purely subjective) are extremely important for the establishment of a good therapeutic alliance, in its absence the failure of any therapeutic approach, both medical and psychological, being predictable.

b) The psychotherapeutic intervention

In addition to medication prescription and/or psychological intervention (psychotherapy), the psychiatrist must intervene psychotherapeutically during the liaison psychiatric consultation. The psychosomatic patient has a double distress and a double vulnerability, therefore highlighting the link between mental and body, as his experience redefinition, as well as the clarification of the essential aspects of his suffering, and the therapeutic plan (why and what) are essential, ways which are generally used in short psychotherapies.(9,12,13)

Clarification - means to explain the causes of patient's suffering and the way in which the psychological and somatic distress are linked together.

Most times, for the psychosomatic patient the somatic suffering over pass the mental one, the latter being minimized and its importance is unknown or unrecognizable within the somatic context that determines to patient to go to general hospital, usually in advanced stages of his subjective bodily suffering.

For example, a patient suffering from an unbalanced diabetes and depression, will to told that the diabetes may favor the occurrence of depressive mood and can maintain it, but that, in its turn, the depression will cause an unfavorably diabetes evolution. Thus, the patient can understand the need to treat the depression, although initially its main concern was just to rebalance the diabetes, considering its depressed condition as sadness that he already got used to. Or, a patient suffering from oscillating high blood pressure and panic attacks, will be explained that the influence of anxiety on the high blood pressure and he will be informed on how to control this anxiety, in order to prevent the panic attacks. Also, the patient will be informed about the importance of psychotherapy and/or anxiety medication for preventing the blood pressure increases. A delicate segment is the one of somatoform disorders hospitalized in general hospitals sometimes for new investigations or for repeating some that were negative in the "hope" of depicting the organic causes of symptoms. The reaction of such a patient to the psychiatric treatment has been previously discussed. If the patient is at his first psychiatric consultation, it is essential to explain him the mechanism of his suffering. Most of these patients are not only vexed by the fact that "nothing can not be found", but especially by the fact of being told that "they have nothing"! The explanation of the relationship between the subconscious (cognitions, emotions and the neurovegetative and endocrine system that induce dysfunctional events within the body can calm and even gain the patient as an ally in the psychiatric and psychological therapy. It is also important that these patients understand that experiencing these symptoms with anxiety does nothing else but to increase them.

The patients who consume alcohol abusively or are addictive to alcohol, will be emphasized, once again, the negative role of this consumption on their somatic and mental health.

- *Empowerment* of the patient regarding his own fate, assumes his responsibility as an active participant (through specific medication for the somatic disease, behavioral measures, and through a psychiatric and/or psychological treatment) in the process improvement or remission of the somatic disease and recovery of the psychic balance.
- *Redefinition (reframing)* - providing a more optimistic perspective of the patient's actual pathological context, by establishing new meanings to this existential situations. Psychosomatic illnesses can be submitted, paradoxically, as opportunities for the patient to know himself better, to decode his body language and to understand where exactly to intervene, what changes should do to regain his health. This could include changes in the lifestyle and in the way of thinking (dysfunctional attitudes). When the body reacts by somatic or functional imbalance, it pulls an alarm indicating, usually in the case of psychosomatic disorders, emotional imbalance. A particular situation is represented again by the somatoform patients who rather deny the psychogenic origin of their symptoms - they do not take opportunity of the somatic objectification as other patients do. In their case the therapeutic trial (by the positive response to the psychiatric medication) may have an important role in this awareness. For example, an anxiolytic medication can stabilize the blood pressure or it can significantly improve the functional symptoms.

It is important that somatic doctor identifies the need of the patient's psychiatric consultation in general hospital. Often this need is not obvious, but just enough time given to the patient and listening and understanding of his sufferings can lead to this decision. Studies in Germany and Austria have found rates of liaison psychiatry consultation of 2,66, respectively 3,30%, low compared to the prevalence of the psychiatric disorders in general hospitals, which are between 41,3 and 46,5%.(14) A study undertaken in 13 public hospitals in Spain concluded that 18,9% of the patients hospitalized for medical impairments had depressive symptoms. However, the psychiatric consultation was requested only for 13,7% of these patients.(15)

Not recognizing the psychiatric comorbidity by physician adversely affects the patient's further development both in terms of the mental state and somatic disorder, and the somatic diagnosis for a functional disorder (somatoform) - as, for example, "spasmophilia", "hyperthyroidism in functional state" or "lambliasis"- in the doctor's desire, more or less aware, to find an organic explanation for the symptoms, will organize and make „more organic" the patient's suffering. Also the psychiatric approach is extremely important in terms of psychosomatic perspective, simply prescribing the patient a medication treatment in the general hospital or being sent by a a colleague from another specialty for a psychiatric consultation, it is likely to keep the patient with this confusion, or even to increase it in lack of empathic and clarifying dialogue.

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