MEDICAL PRACTICE

Today's Treatment

Psychological Medicine**Stress and Distress**

R C. B. AITKEN

British Medical Journal, 1975, 1, 611-613

A patient's anxiety or depression can be the natural consequence of change in his life's circumstances, whether the death or departure of a loved one, overcrowding in the home, loss of job owing to retirement or redundancy, financial crisis, or simply loneliness and despondency. It is easy to recognize an anxiety state when it accompanies a reason for intense strain. But feelings of sadness can follow, perhaps after a delay, when it can be more difficult to connect their cause. Indeed stress can precipitate florid depressive illness, when guilt and suicidal feelings determine the clinical picture.

Moreover, anxiety and depression can contribute to the distress of many patients—and indeed their relatives—when they suffer from illness and injury, particularly if chronically. Indeed mood disturbance may be the principle cause of distress at some stage in a wide variety of conditions like cancer, coronary artery disease, stroke, viral infections, multiple sclerosis, and personality disorders. Even the patient who denies feeling upset is likely to be afflicted, because all are hyperaroused to some degree.

Clinical Features of Hyperarousal

Hyperarousal is associated with both psychological and physiological effects. The threshold of tolerance can be altered, so that pain may be either ignored or accentuated. A tendency to self-absorption can be increased and attention focused on features solely related to the stress. Concentration is impaired,

so that to undertake constructive activity and communication is more difficult. Hyperaroused patients and relatives often hear only what they want to hear, ignoring or modifying involuntarily much that is reality.

Insomnia is common when patients are hyperaroused. This can be due to delay in sleeping, restlessness or disturbance due to frequent waking or unpleasant dreaming, and early awakening accompanied by preoccupation with distress. Anorexia leads to loss of weight, mood disturbance being one of its common causes. Diarrhoea and dyspepsia are as likely to be due to hyperarousal as to gastrointestinal ulceration. Absent libido leads to disturbed sexual relationships, which obviously can accentuate marital disharmony.

Hyperventilation, agitation, and sweating can occur in hyperaroused patients for anyone to see. Simple clinical examination can disclose tachycardia, hypertension, increased flow of blood to the skin (hot hands or blushing), and hypersensitivity. Not every patient responds in the same way, specific types of physiological change being induced in certain circumstances in some patients. Increased fatigue may be a complaint due as much to increased muscle tension and cardiac output as to insufficient sleep. Hence the symptom is as likely to respond to alleviation of hyperarousal by day as to the prescription of hypnotics by night.

INFLUENCE OF PERSONALITY

Perhaps the feature of hyperarousal most likely to be neglected as such is exacerbation of inherent personality traits. A person prone to anxiety may develop a specific phobia. A phobic disorder is seldom the result of a single stressful event. More often it has several causes, some of which may do no more than reduce habituation by increasing generalized arousal level. Indeed avoidance of a stressful situation may lead to continuation of the disorder by precluding habituation to it. The agoraphobic

University Department of Orthopaedic Surgery, Princess Margaret
□ Rose Orthopaedic Hospital, Edinburgh EH10 7ED
R. C. B. AITKEN, M.D., F.R.C.P. Professor of Rehabilitation Studies

housewife may never experience anxiety while she remains housebound.

The obsessional person, particularly as he ages, may become virtually unable to proceed with his life because of preoccupation with doubt and despair and his need to consider every detail while retaining full control over his destiny. He may ruminate or indulge in useless rituals, though fortunately rarely to the extent of someone with a classical obsessional neurosis. The cause of the latter condition is unknown. Some of its phenomenology and the nature of its poor response to various treatments makes it more akin to a psychosis and unlike the conditions being discussed here.

A person notably dependent on others for his emotional integrity may require so much support that those near and dear to him, such as his wife or his general practitioner, may tire of providing it. Indeed they may reject him, being unable to tolerate responding appropriately to his real need.

Another person, more obviously poor at coping with stress, may behave histrionically and impulsively, proclaiming distress or depression while behaving aggressively or light-heartedly. He may be intolerant of frustration and immune to the effects of his behaviour on the feelings of others.

Whatever the inherent personality traits, they are likely to become more prominent in the face of adversity. Such changes will influence relationships with others, particularly within the family and with those in some kind of authority such as employers, nurses, and doctors. All moods—anxiety, apathy, and anger—can be affected, as can all activities both at work and at leisure.

Therapeutic Relationships

The most powerful aid to reducing distress in most patients is the clinical relationship. It can bring about miracles when developed to its fullest extent. It is wondrous to behold; the clinical teachers best remembered are those who practised their bedside manners as the real art of medicine.

Application of a therapeutic relationship is a clinical skill to be learned and developed like any other clinical skill. It is easy for most of us to choose our friends and hence those to whom we relate closely. Because it is impossible to choose our patients, this clinical skill has to be developed to an art so that we can relate helpfully to the variety of human nature with which we work.

Obviously the use of this skill is not the monopoly of the medical profession. Those in all the caring professions must have the capacity to listen in order to hear and understand what lies behind the utterance of a distressed person. Awareness by the patient of that understanding itself can bring about remarkable relief from substantial distress.

THERAPIST'S FEELINGS

The acquisition of the necessary information to form a therapeutic relationship may produce complicated feelings in the therapist, at least when inexperienced. It is important that he is sufficiently aware of these to take them into account when responding to the patient's needs, and so avoid becoming over- or under-involved himself. A doctor may be required to take unwelcome action, and to tolerate both the patient's and his own anxiety and annoyance by not responding to all demands. Such requirements may put a great strain on a clinical relationship and require considerable judgement to remain therapeutically effective. An example of such a requirement would be how best to handle a request for a night visit by the mother of an asthmatic child, when the request has been made on many previous occasions and found to be due to the family's anxiety rather than the child's condition.

Expression of sympathy is often less beneficial than of empathy. There are times when it may be appropriate for a doctor's feelings to be expressed, such as when his behaviour

may be communicating them covertly. A patient may be asked to return to the clinic or surgery soon, as much to relieve the doctor's anxiety or to respond to the patient's dependency needs as to review the progress of the disease and its treatment. How often do we discharge patients or only talk about their case huddled in white coats at the end of the bed because we cannot tolerate sharing with them their distressed feelings?

VALUE OF INTEGRITY

Unfortunately for us treatment based solely on the therapeutic relationship requires provision of a substantial amount of time. Where the relationship has developed over many years, as with the general practitioner, it can be used more quickly, so long as the patient has full confidence in its integrity. Such confidence can be reduced by inattention to its delicacies. Forgetting a name, delaying a response to a need, failing to fulfil an obligation, or delegating without adequate explanation to another—all understandable difficulties at times—need to be avoided. Safe placebos can be appropriately prescribed as adjuncts to a therapeutic relationship, but placebos should be recognized for what they are and used with due attention to the reasons for their prescription.

All this need be little recognized as such, or it can be elaborated into formal psychotherapy. Regular supervision, whether individually or collectively in a group, aims to utilize similar considerations, drawing to the patient's attention how his behaviour and his feelings influence the development of relationships. What has been referred to here has been known, of course, to be a powerful therapeutic weapon for centuries. Indeed it was virtually the only treatment provided for a multitude of ills until recent times. Its power can be appreciated by considering the standing of the medical profession in society when it was the sole basis for so much therapy. Let us do nothing in our current practice to depreciate its value.

It should be accepted that just as the medical profession has no monopoly for relating to those under stress, nor have doctors the monopoly of relieving clinical distress by their patient's relationship with them. The influence of the nurse, whether in community or hospital, is well recognized. (Though I wonder if it is by those in charge of their administration who seem to pay so little attention to the need for continuity of clinical care. Only by this can a therapeutic relationship become fully established and to this requirement doctors should also pay heed.) The contribution to the clinical team by others, such as physiotherapist, occupational therapist, or social worker, comprises not only their particular expertise but also their capacity to relate helpfully to the patient and his family.

Adaptation to Reality

Neurotic people fail to distinguish reality from fantasy. They experience difficulty in habituating to stressful circumstances. The boundary of neurotic disorders is determined by their features being familiar to anyone under stress. All of us can have neurotic symptoms at times. Patients with disease fear their fantasies about the future more than its reality, terrible though that may be for some. Even death itself may be less awesome than what so many patients fear will be their suffering beforehand. Myocardial infarction may make a patient more alarmed about his prospect of returning to gainful employment than about his probability of survival.

Distress can be relieved by attention to the reality of its nature. We have to be ever watchful that the treatment prescribed, though valuable for the disease, does not increase alarm or dependency excessively, and, when it does, that attention is paid to relieve the mood disturbance.

Adaptation can be enhanced by specific reduction of hyperarousal. Promotion of relaxation, physiologically and emotionally, can reduce hyperarousal and so relieve symptoms of

distress. Phobic patients can then adapt better to the reality of certain circumstances. Behaviour therapy by desensitization has been developed to allow just this. It has been found valuable in patients with circumscribed phobic disorders; the more specific the stress, the more successful the treatment. Behaviour therapy by "flooding" has also been found to be effective for phobic patients. Maximum exposure to the stress is undertaken within the setting of an established therapeutic relationship.

These treatments can be likened to entering a swimming pool at either the shallow or deep end. Either way, adaptation to the actual water temperature is generally gradually achieved. The underlying principles, though modified almost beyond recognition, can be applicable to helping all patients, whatever their stress and the nature of their distress.

MAINTENANCE OF MORALE

Motivation can be improved by reward for endeavour and accomplishment of objectives. This can be developed into a treatment programme using a "token economy" system, such as has been specifically designed for psychotic and defective patients. For the psychiatrically healthy, a sense of achievement, encouraged by verbal praise and financial reward on return to work is generally sufficient. Unfortunately, money worries imposed by not returning to work can inhibit rehabilitation, as may awaiting payment of compensation.

No one will doubt the value of maintaining high morale in a therapeutic community, particularly one dealing with the chronically disabled. Indeed, what is high morale in treatment other than the absence of fanciful anxiety, apathy, and anger? My answer is that morale is high when the emotional state relates to expectation of reality, with absence of depressive and hostile feelings resulting from intolerance of disability and related frustration.

LIVING CONDITIONS

So often it is easier to treat the disease than the patient. This is because insufficient attention is paid to additional information relevant to the full assessment of the nature of his distress. Many disorders produce immobility, particularly in the elderly, which often result in social isolation and loneliness. In the United Kingdom, one in four of the disabled have no toilet either inside their house or on the same floor on which they sleep, and one in five live alone. Do we all remember that when a patient is discharged from hospital?

Admission to hospital can relieve distress, sometimes not solely because medical treatment will be provided there. For others admission may accentuate distress. Inability to admit patients owing to shortage of beds or staff may impose an intolerable burden on relatives. Distress from this is accepted as a perfectly legitimate reason for requesting hospital care.

Advice to take a holiday can do more harm than good to many patients under strain, because stress and hence distress may accompany the patient. Recuperation will be best when relaxation is accompanied by enjoyment after full recovery from a stress, such as after depressive illness or myocardial infarction.

Unemployment, whether due to inability to obtain work or to disability, is demoralizing. Inactivity can be a considerable strain for some; prolonged bed rest is never welcomed and seldom beneficial. Patients should be encouraged to undertake activity, however menial. The assistance of an occupational therapist will be helpful for those with lengthy illnesses. To

direct patients' attention away from their troubles is always valuable.

It is incumbent on every doctor to take some account of every variable which might influence his patient's distress, and then to respond to the real needs. Sadly, so often the psychosocial ones are neglected, particularly during rehabilitation after serious disease or injury.

Psychotropic Drugs

In recent decades remedies for anxiety and depression have multiplied because none is so effective as to be a panacea. We have paid too much attention to the nuances of difference between the many drugs rather than to the fact that the effect of each is in good part due to factors unrelated to pharmacology.

Undoubtedly psychotropic drugs contribute to the relief of mood disturbances, but rarely if ever as the sole therapeutic agent. In view of the tonnage prescribed it is fortunate that they are remarkably safe—even those known to be dangerous on occasion. Nevertheless, their use should be restricted to patients with distinctive symptoms and signs of mood disturbance. Amphetamines should never be prescribed and I doubt if barbiturates should in view of their insidious unwanted effects. Dosage of antidepressant and anxiolytic drugs should be adequate. When depression is clearly present, less than 150 mg/day of a drug like imipramine is rarely adequate except for the elderly. When anxiety is sufficient to produce physiological symptoms, the dosage of a drug like diazepam should be about 30 mg/day.

Should drowsiness or dry mouth occur as unwanted effects, these drugs should be continued, if at all possible, because the distress usually abates as the primary symptom improves. Complaint of drowsiness or dry mouth sometimes even before actually taking the drug, can give a clue about severity of the primary symptom, should the latter be preferred to the relatively minor inconvenience of the former.

Encouraging Assistance by Others

The role of the doctor, particularly the general practitioner, is to be at the centre of a patient's and family's distress. Yet this does not mean that he must be the purveyor of all benefit. He can encourage further help from a variety of other resources. Members of a family can become more helpful, given his guidance and support. The contribution of a social worker may be invaluable. Benefit from "meals on wheels" may derive from the regular social call as much as from the hot calories. Referral to the disablement resettlement officer or to a doctor in the employment medical advisory service may lead to employment, and hence to the return of self respect, and so to increased tolerance of discomfort.

Assistance from people in voluntary organizations can improve a patient's welfare. In many parts of the country the various organizations are coming together to provide centralized services, one of which can be to make available information on where help can best be obtained. Patients themselves sometimes like to come together in self-help groups. Many welcome the opportunity to do so, particularly when their condition is particularly stressful—for example, after ileostomy.

Whatever the disease, its effects on the patient as a person can be its most disturbing aspect. The loneliness and boredom that can result from even simple conditions can distress the most stable. Attending to all the variables, often by simply listening to the patient's story about them, can contribute much to their relief.