The Role of the Psychiatrist in the General Hospital—II
Psychiatric Patients with Somatic Complaints

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In part I, one of the important roles of the psychiatrist in the general hospital was pointed out with respect to the management and treatment of psychiatric patients with somatic complaints (PPSC) referred from other nonpsychiatric departments of the hospital. Part II deals with the way in which a PPSC is brought to the psychiatrist, and the basic principles concerning the initial interview which is crucial to the management and treatment of such patients.

The principles for the initial interview are to clarify: (1) the processes through which the patient came to the psychiatrist, (2) the patient's motivation for receiving psychiatric help, (3) the nature of his relationship to the physician, and (4) related anxiety, etc. Referral of the patient to psychiatric treatment should not be done in haste, but advice to the physician must be given on maintaining or improving his relationship with the patient.

Advice on how patients should be introduced to psychiatric treatment is included here.

(Key Words: Psychiatric Patients with Somatic Complaints, Autogenous Illness, Iatrogenous Illness, Antagonistic Doctor-Patient Relationship, Initial Interview)

INTRODUCTION

As specialization in medicine progresses and doctors become specialists in diseases of a certain limited field, patients tend to be diagnosed and treated by a physician exclusively in his own special field. This tendency is particularly conspicuous in general hospitals where specialization is advanced. Since the time of Sigmund Freud in the 1900's and Franz Alexander (1) in the 1930's, researchers have explored the possibility that a certain disease is influenced by somato-psycho-social factors and a disease inversely influences such factors at the same time from the psychodynamic and psychosomatic viewpoints. Thus, many researchers more or less accepted the idea of mutual influences (7). In general hospitals where specialization in somatic medicine is established, however, the aforementioned possibility is frequently ignored. This is why liaison psychiatry was proposed in the 1950's in the U.S., and has been practiced increasingly more widely since then (5). Circumstances are slightly different in Japan. Our previous study revealed the following facts (6):

(1) About 60% of the referrals of patients to psychiatric services from other departments of the hospital resulted for such reasons as “no
organic abnormality found" and "differential diagnosis needed".

(2) The majority of the aforementioned referrals were psychiatric patients with somatic complaints who were sent to the psychiatrist because of explicit or implicit troubles in the doctor-patient relationship.

(The nonpsychiatric clinician may have continued to treat the patient in spite of his awareness that the patient had a crucial psychogenic disturbance as long as a good doctor-patient relationship was maintained.)

From the above results, we considered it our urgent task to study how to manage and treat "psychiatric patients with somatic complaints" as the psychiatrist in a general hospital.

THE ROUTES TAKEN BY PSYCHIATRIC PATIENTS WITH SOMATIC COMPLAINTS (PPSC) TO REACH THE PSYCHIATRIST

An attempt was made to classify the processes through which these PPSC came to the psychiatrist using a large number of patients.

It is only in rare cases that PPSC come to the psychiatrist from the beginning. Usually, they are referred to the psychiatrist after wandering about to several physicians. In treating these patients, we frequently encountered difficulties from the beginning, i.e., the relationship between the patient and the psychiatrist is hampered even before a therapeutic relationship is formed because the patients have no motivation for receiving psychiatric treatment, and also because they are armed with the firm defence of somatic rationalization. How to deal with these problems in the introductory phase, therefore, is of crucial importance in treating these patients.

The usual process, taken by PPSC including cases of neurosis, PSD, hypochondria, depression and schizophrenia before they finally come to the psychiatrist can be considered as follows.

(1) A patient who feels a somatic discomfort usually visits a department of the hospital directly pertaining to that particular discomfort. In other words, the patient makes a certain self-diagnosis before he is examined by a physician. Balint (3) called this "autogenous illness" in his treatise on diagnosis.

(2) Then, the patient visits the physician with a wish to be diagnosed and treated as one suffering from a physical disease. On that point (as are in any other situation), the patient tends to have a fantasy that the physician is magically endowed with a capacity to cope with all difficulties, while harboring fears that he may be looked upon as ridiculous to say such a thing or that his secret may be exposed, etc.

(3) The first task to be performed by a doctor is to make a "diagnosis". Generally speaking, making a diagnosis is an act of identifying a certain combination of symptoms with an established model of a disease. Balint (3) called it "iatrogenous illness". Since the physician usually performs this task by illness-centered diagnosis (4) or diagnosis per exclusionism, a discrepancy arises between the patient's expectation or self diagnosis ("autogenous illness") and the phy-
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sician's diagnosis ("iatrogenous illness").

(4) What actually happens next is that the patient is excluded from the department he first visited, and the physician and patient at cross situations frequently create a mutual antagonism as the eliminator and the excluded. Such circumstances enhance the unconscious anxiety of the patient, and the patient becomes disillusioned in the physician who previously appeared to him as magically omnipotent and, suffering from a persecution anxiety, he clings more desperately to somatic rationalization. The longer the patient wanders about various departments, clinics and hospitals, the more consistently he develops a solid antagonistic relationship with the physician and the patient’s attitude toward his illness and physician follows an analogous pattern. Such a pattern evokes counter-transference in the physician, and facilitates the establishment of the antagonistic relationship.

(5) In actual situations:
1) The patient moves to another hospital,
2) The physician is compelled to treat the patient in the absence of any alternative,
3) The physician refers the patient to a psychiatrist,
4) The physician seeks psychiatric counsel.

In situation 1):
The patient wanders around various departments, and the antagonism between the physician and patient becomes worse. The patient’s attitude toward his disease and the doctor-patient relationship are repeated. The patient is excluded not only from one department, but also from the whole medical service itself.

In situation 2):
There are some cases where such antagonistic relations do not become so acute because the patient is reluctant to go to the psychiatric department, because the physician does not dare to tell the patient to visit the psychiatric department, or for other reasons. According to our research (6) covering all nonpsychiatric doctors at the Tokai University Hospital, about 40% of the doctors had such cases at that time. However, in such cases, the patients wish that the physician would cure all his pain and suffering by magic and, in return, the physician often tries to fulfil these wishes. Therefore, the antagonistic relation mentioned before is denied by either the physician or patient. In spite of superficial mutual confidence between the physician and patient, the treatment frequently falls into a stagnant condition.

In situation 3):
The doctor-patient relationships are antagonistic, and the patient, therefore, is compelled to confirm his defence of the somatic rationalization. It is very natural that the patient, who came to psychiatric department under such conditions, rejects psychiatric treatment. The patient is not adequately motivated in such a situation, and tends to visit the psychiatrist only reluctantly. More often than expected, the patient is referred to "a certain department"
without being informed that the "department" concerned is the psychiatric department. The patient-psychiatrist relationship develops, therefore, antagonistically. Langs R (8) called this "preformed transference".

In situation 4):

The doctor-patient relationship is antagonistic as in other situations, but the physician is aware of that fact quite frequently. The physician, consequently, seeks psychiatric counsel in order to relieve the stagnation in the treatment caused by the antagonistic relationship. In such a case where psychiatric intervention takes place before the psychiatrist's interview with patient, the visit to the psychiatrist and subsequent psychiatric treatment are more readily accepted by the patient. It is crucial for the improvement of the doctor-patient relationship and the prevention of an antagonistic relationship between psychiatrist and patient that the physician should make the patient realize clearly that they are antagonistic to each other. This is illustrated by the following case:

Case 1. Female, age 24, housewife

The patient had visited several hospitals with chronic constipation as the chief complaint, and was finally admitted to the Department of Internal Medicine, Tokai University Hospital, for special examinations and treatment. For about one year before admission, she had used increasingly greater doses of laxative, which had reached 100 tab. a day and then 200 tab. per day at the time of admission. The attending physician carefully examined her, but failed to discover any objective abnormality corresponding to her complaint. Meanwhile, careful observation revealed that she was taking roughly normal meals and evacuating. The physician therefore tried to prove that she had bowel movements and persuaded her to admit the fact, but she obstinately refused to admit her bowel movements and continued to complain of constipation. At this point, the young physician came to suspect the involvement of some psychiatric problems, and confronted the difficulty to communicate his suspicions to her, he sought psychiatric counseling. The psychiatrist, while listening to the physician, formed the opinion that, while the physician and patient were antagonistic to each other in some aspects of their relationship, they were cooperating with each other in pursuing the cause of the illness which implied that a fairly good dependent relationship was established between them. The psychiatrist therefore advised the physician to tell her that she needed a psychiatric help. When the physician explained the situation frankly to the patient, she asked for permission to spend several days away from the hospital, and, on returning to the hospital, confessed that she had a secret that had been annoying her. She then willingly came to the psychiatrist to whom she told a lengthy story concerning her secret as if eliminating all the problems that accumulated within her over many years. On the next day, abuse of laxative, denial of evacuation and complaints about constipation disappeared as if they had never been present. Discharge followed after several days. Naturally, she was not completely free of her psychological troubles, but the session with the psychiatrist was considered to have helped
her accept her illness as a psychological disturbance per se, and not a disturbance that could be coped with through somatic rationalization or massive intake of laxative.

In hospitals where consultation-liaison psychiatry is not incorporated in the established management system, informal psychiatric counsel preceding the interview with the patient by the nonpsychiatric clinician seems to be recommended only if the physician is personally intimate with the psychiatrist, or if the physician is young and is not ashamed of seeking counsel. This will prove to be a serious problem in the practice of consultation-liaison psychiatry.

MANAGEMENT OF PSYCHIATRIC PATIENTS WITH SOMATIC COMPLAINTS

The following discussion concerns how the psychiatrist should manage patients in situation 3) who account for 60% of the referrals. The following presentation of a typical case clearly illustrates what was mentioned previously.

Case 2. Female, age 45, housewife

Suffering from physical pain, she went to a certain department which was appropriate for her pain and was told that there were no objective findings. However, as she continued to complain, she was sent to the Psychiatric Department. She complained to the psychiatrist in tears that the physician did not interpret her symptoms as a sign of physical disease. She continued to state that he did not give her any treatment, and he even treated her as if she was insane. Obviously she was in an anxiety-hypochondriacal state. Although she admitted her psychosomatic, she never returned to the Psychiatric Department again.

In making his diagnosis, the physician did not make any mistakes, and his diagnosis was a proper one. However, since it was just a negative diagnosis, the patient was excluded not only from a certain department but also from the whole medical service system. How can such a tragedy be avoided? The following is a case which ran a different course from that in case 2.

Case 3. Male, age 24, driver

First, he visited the Department of Neurology complaining of a vertigo attack while driving. He experienced anxiety concerning further attacks. A medical examination revealed no objective findings except for slight hypertension, and the neurologist considered him a neurotic although he did not send the patient to the Psychiatric Department immediately. He referred the patient to a psychiatrist only after he tried to treat the patient's hypertension. Reluctantly the patient came to the Psychiatric Department because there was no other choice for him. Apparently he was in an anxiety-depressive state. He insisted that he was in such a state because he was told that it was so and was handled as a neurotic patient by physicians at previous hospitals where he visited before coming to the Neurological Department of this hospital. He was grateful to the neurologist because he was finally able to receive treatment in the Neurological Department. However, it was clear that he was unable to admit to himself that he had a psychiatric problem. Therefore, the psychiatrist advised the patient to see
the neurologist again and to consult with him on coming to the Psychiatric Department. At the same time, the psychiatrist informed the neurologist of what he had told the patient. One week after, the patient made up his mind to go to the Psychiatric Department, and the psychiatric treatment started. However, at the initial phase of the treatment, the role of the psychiatrist was as a substitute for the neurologist. The psychiatrist did not touch on the issues of the patient's deep seated internal conflicts any more than the neurologist had done. Despite such a superficial contact, the symptoms subsided. After such a course, he finally came to be able to talk about his internal conflicts with the psychiatrist.

DISCUSSION

Three points can be postulated as distinguishing case 3 from case 2. First, the case 3 could feel satisfaction by being identified and treated properly as a patient, i.e., the patient was told that he had hypertension by the doctor although it was not so severe, and, his complaint was accepted as a reality. Secondly, the psychiatrist established a situation in which the neurologist and the patient could discuss the subject of receiving psychiatric treatment, and also made it clear that whether or not the patient went to the Psychiatric Department was up to the patient himself and the neurologist. Thirdly, in the introductory phase of the treatment, the psychiatrist only played a role as substitute for the neurologist.

By studying these cases, the following clinical procedures were compiled and considered to be desirable in introducing PPSC properly from other departments for psychiatric treatment.

1: The patient's needs, i.e., to be accepted as having a physical disease and to receive treatment as a patient with a physical disease, must be understood and fulfilled to a certain extent by the physician. Based on such a situation, a fairly trustful relationship between the physician and the patient can be established.

2: The physician has to explain clearly to the patient that the patient has some psychiatric troubles so that he will obtain greater benefit by visiting Psychiatric Department.

3: When the patient comes to the Psychiatric Department, the psychiatrist, together with the patient, has to clarify what hospitals the patient has been going so far, what treatment the patient has received up to that time, what kind of relationship has been established between the physician and the patient, whether or not the patient came to the Psychiatric Department on his own, etc. In other words, the nature of the triangular relation between the patient, physician and psychiatrist had to be clearly recognized. At the same time, the psychiatrist must try to help the patient in establishing a situation in which the patient is aided in making his own decisions concerning his relations with the physician and the psychiatrist without much pressure. Another important point is that the psychiatrist must try to motivate the patient for psychiatric treatment. Thus, the inner process by the patient concerning exploration and integration of his relationship to the physician and the psychiatrist promotes the integration of his own psyche and soma.
However, that such a process does not actually often take place in reality. Because of the structure which exiles PPSC from the medical service as mentioned before, procedures 1 and 2 do not fare as well as are desired. The real task of the psychiatrist may lie in how to deal with the exiling structure, i.e., to promote the interrelation between the physician and the patient, and in supporting improvements in treatment.

Initial Interview

The initial interview is extremely important in the management of referrals from the other departments of the hospital. Balint et al. (3) drew up the following form for the initial interview in which they placed great emphasis in connecting the results with what they call focal psychotherapy:

A. Referral
B. 1. Appearance and manner of patient
   2. Complaints
   3. What seems to have brought the patient to the Psychiatric Department
C. Factual material
D. 1. Patient's conception of himself
   2. Patient's conception of other people
E. Doctor-patient relationship
   1. How doctor treated patient
   2. How patient treated doctor
F. Salient features of the interview (or sometimes, 'Important moments in the interview')
G. 1. Ways in which the disturbance is shown in the patient's life
   2. Interpretation of the above in dynamic terms
   3. (a) Suitability for focal therapy, with reasons
      (b) Points against focal therapy
   4. Immediate aims

In the form of the Balint group, emphasis is characteristically placed on the previous doctor-patient relationship. Using this form as a reference, the following principles for the initial interview were prepared by our group.

A. Clarification the following points while cultivating a good rapport with the patient:
   1. The route in visiting the psychiatrist
      • When did the symptoms appear?
      • What diagnoses were made in the past and where?
      • How was the patient treated?
      • Did the patient visit psychiatrists previously?
   2. Motivation for visiting the psychiatrist
      Visit to the psychiatrist
      • Who decided it?
      • What is the reason for it?
      • How and by whom was it explained to the patient?
      • How does the patient feel about it?
      • What does the patient's family think about it?
      • What is expected of the psychiatrist?
3. Doctor-patient relationship
   About the physician who referred the patient to the psychiatrist -
   • The patient's image of the physician in the past
   • The patient's image of the physician at present
   • How does the patient feel about the way in which he was looked upon by the physician?

4. Anxiety accompanying the visit to the psychiatrist
   Visiting the psychiatrist -
   • The patient's impression of the Psychiatric Department
   • The patient's feeling about the necessity of visiting psychiatrist
   • What kind of anxiety is the patient suffering from, if any?
   • Whether or not patient is prepared to maintain his relation with psychiatrist

5. Other data needed for diagnosis
   “Diagnosis” here means not the illness-centered traditional diagnosis (diagnostic clarification), which aims at merely identifying the illness with an established clinical entity, but patient-centered diagnosis (diagnostic formulation), which allows understanding of the patient as a psycho-somatic being, or an interrelationship diagnosis including diagnosis in consideration of the doctor-patient relationship.
   (In actual interviews, questions 1 to 5 need not be asked in the order specified above.)

B. Management of the situation:
   1. The psychiatrist should not be hasty in informing the patient of his diagnosis, or in introducing the patient to psychiatric treatment.
   2. If the physician-patient relationship is relatively good or not broken, the psychiatrist should relate to the patient as a secondary consultant and provide advice for preservation of the physician-patient relationship.
   3. If the physician-patient relationship is bad or in a critical condition, the patient should be sent back to the physician to provide the physician and the patient with an opportunity to talk over the patient's illness or visit the psychiatrist again. On such occasions, the psychiatrist should provide the physician with advice and consultation only (never instructions or supervision).

   In the initial interview, the psychiatrist must try to sustain the maintenance of physician-patient relationship through the aforementioned procedures and thus promote a certain degree of motivation for receiving psychiatric treatment in the patient. It is only when these tasks are completed that he gradually introduces the patient to psychiatric treatment.

   The following two points in the above mentioned procedure should be emphasized: help in maintaining the physician-patient relationship, and not taking an attitude which will provoke the physician's antipathy so that disruption of the physician-patient or physician-psychiatrist relationship will not occur. The psychiatrist should provide the physician only with
advice and consultation.

CONCLUSION

In the management of PPSC, the triangular relationship between physician, patient and psychiatrist should be carefully maintained from the beginning since this is the best way to ensure that the patient will not to be dismissed from the medical system and to promote integration of his psyche and soma that has been split. We believe that the aforementioned principle is applicable not only to the treatment of patients, but also to psychosomatic approaches, and to the increasingly more widely accepted concepts of “consultation-liaison psychiatry” and “psychiatric primary care”.

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